Hospital Value-Based Purchasing (VBP) Program

Support Contractor

HSR Fast-Track: The Quickest and Easiest Way to Examine Your July 2019 *Hospital Compare* and FY 2020 Hospital VBP Claims-Based Measure Hospital-Specific Reports

Questions and Answers

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Question 1: **How many patients are needed for each measure to receive a [performance] category?**

For these measures, if the hospital has at least 25 eligible cases during the performance period, they'll be classified into one of three [performance] categories. Otherwise, they'll be assigned to the category called "Number of cases
too small."

Question 2: **Are the changes in national results from 2018 to 2019 percent changes?**

No, the 2018 listed changes are percentage point changes. They are the national rates from 2019 minus the national rates from 2018.

Question 3: **For the payment measures, does "less than national" mean better or worse performance?**

For the payment measures, a performance category of "less than national" does not imply whether the hospital is performing better or worse because the measure results do not indicate the quality of care at hospitals. Also, payment measures are not meant to be interpreted in isolation. They're meant to be considered alongside existing quality measures, such as mortality measures. This is also true for the payment category "greater than national."

A payment categorization of "less than national" or "greater than national" simply indicates that the average cost of treatment at your hospital for acute myocardial infarction (AMI), heart failure, and pneumonia tends to be either significantly less or significantly more than the average cost of treatment for that condition in the nation.

Question 4: **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 in Table I and II of the Hospital VBP Program Hospital-Specific Reports (HSR) through replication. Further explanation of the replication process can be found in your hospital-specific report user guide. Please note that the national rate and risk factor coefficient cannot be replicated.

Question 5: **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 hip/knee procedure codes during the index admission, they would meet exclusion criteria for the measure. Explanations of the measure and inclusion and exclusion indicators can be found in the hospital-specific report user guide sent with your Hospital VBP Program [claims-based outcome measures] hospital-specific report.

Question 6: **Why is the Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) complication measure reporting baseline period for fiscal year (FY) 2020 the same as FY 2019?**

To extend that performance period to three years, the same baseline period would be used for FY 2019 as FY 2020. The FY 2020 performance period includes all performance periods of the FY 2018, adding one year.

Question 7: **What is the MBI variable?**

The MBI is the Medicare Beneficiary Identifier. Beginning in July 2019, *Hospital Compare* HSRs and FY 2020 Hospital VBP Program HSRs will contain health insurance claim numbers (HICNOs) and the MBI for each discharge. If an MBI is not available for the patient, then a double dash (--) will display in the corresponding row.

Question 8: **Is it possible to have a heart failure index admission claim included in my Hospital VBP Program heart failure mortality HSR and excluded from my *Hospital Compare* heart failure mortality HSR?**

Yes, it is possible for index admissions in your Hospital VBP Program HSRs and *Hospital Compare* HSRs to be slightly different. Although the results use the same measure specifications and timeframes of eligible

cases, the differences you observe between your heart failure mortality measure results are likely related to the differences in hospitals included in the Hospital VBP Program and on *Hospital Compare*.

For the mortality measure reported on *Hospital Compare*, the mortality measure calculations include index admissions to short-term acute care hospitals in the U.S. (including U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa), critical access hospitals (CAHs), Veterans Health Administration hospitals (for the AMI, heart failure, and pneumonia mortality measures), and Maryland short-term acute care hospitals participating in the All-Payer model.

For the mortality measure in the Hospital VBP Program, measure calculations include only index admissions to subsection (d) hospitals located in the 50 states and the District of Columbia. Please note it is possible for an admission to appear in both your Hospital VBP Program HSR and *Hospital Compare* HSR.

In addition, it is important to note that the mortality measures randomly select one eligible index admission per patient, per split year (July–June), per measure. Therefore, if a patient had multiple eligible heart failure index admissions in a given split year, it is possible that different admissions can be randomly selected for inclusion in the cohort when the measure results are run for *Hospital Compare* and the Hospital VBP Program.

Question 9: **Why aren't the ID numbers on the Condition Payment Post-Acute Care tab (Table V.4) and the Procedure Payment Post-Acute Care tab (Table V.5) in sequential order?**

Beginning with the July 2019 *Hospital Compare* payment HSRs, the ID numbers in the Post-Acute Care tabs will correspond to the same ID number on the Index Stay and Summary tab. There are one to many post-acute care records for each Summary of Events tab record on the Index Stay and Summary tab. The ID numbers from the Index Stay and Summary tab now correspond to the 11 or 13 records in the corresponding Post-Acute Care tab to help find the records that go together.

Question 10: **Why are there more rows in Table III than eligible discharges in Tables I and II in the Complication HSR? How do multiple complications affect complication rate calculation?**

There are more discharges in Table III, but they are not all eligible. Reasons for ineligibility include the patient left against medical advice, the patient was transferred to a facility where index admission occurred, and the patient had more than two THA/TKA procedures during the index admissions.

Additionally, some discharges have multiple rows if there are multiple complications during the stay. These are indicated by 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 Table I.

Additionally, complication rate replication should be performed using only rows in which the Index Stay equals Yes and Additional Complication Record equals No. This is necessary because a patient may have more than one complication associated with the index admission, but the raw complication rate only counts one complication.

Question 11: **How is my National Institutes of Health Stroke Scale (NIHSS) percentage calculated in Table I of my Mortality HSR for *Hospital Compare*?**

The NIHSS percentage is calculated as the total number of eligible stroke discharges with the NIHSS score assigned, divided by the total number of eligible stroke discharges on or after October 1, 2016, which is the date NIHSS data collection began.

Question 12: **There are two new tabs included on the Readmission HSR for disparity methods. Can you explain the difference between the Within-Hospital Disparity Method and the Across-Hospital Disparity Method?**

The Within-Hospital Disparity Method identifies disparities in health outcomes between dual eligible and non-dual eligible patients within a hospital. The Across-Hospital Disparity Method calculates an outcome rate for dual eligible patients to compare hospital performance to other hospitals, as well as state and national rates. This method only assesses performance for dual eligible patients.

Question 13: **What does a negative Excess Days in Acute Care (EDAC) value represent in my HSR?**

A negative EDAC value indicates your patient spent fewer days in acute care than would be expected if admitted to an average performing US hospital with a similar case mix.

Question 14: **Why is there an overlap between the three different [performance] categories on slide 18?**

The graphic on the left side of slide 18 illustrates the results and performance categories of **three different hospitals** on **one** outcome measure. The three hospitals in the example have different performance categories for this measure:

- Hospital A is performing "Better than National" because its entire 95% interval estimate surrounding its hospital rate of 12.6% is lower than the national observed rate of 15.6%.
- Hospital B is performing "No Different than National" because its 95% interval estimate surrounding its hospital rate of 15.0% includes the national observed rate of 15.6%.
- Hospital C is performing "Worse than National" because its entire 95% interval estimate surrounding its hospital rate of 18.1% is higher than the national observed rate of 15.6%.

The interval estimates are unique for each hospital. Thus, an interval estimate for one hospital can visually overlap with an interval estimate for a different hospital. Furthermore, the performance categories are created by comparing a hospital's outcome rate and interval estimate to the national observed rate. The above clarifications also hold true for the payment measures graphic on the right side of slide 18.

Question 15: **Which HSR does slides 42 and 43 show?**

Slides 42 and 43 show the FY 2020 Hospital VBP Program Mortality HSR.

Question 16: **What is the readmission reporting period for the *Hospital Compare* National Readmission Rates included in this presentation?**

The *Hospital Compare* National Readmission Rates listed in slide 27 cover a reporting period of July 1, 2015 through June 30, 2018.

Question 17: **Regarding slide 14, is the HSR the same as the Hospital IQR Program HSR? I am looking for our annual Hospital IQR Program report and *QualityNet* told me the Hospital IQR Program report should be posted this month. Is this correct?**

The July 2019 *Hospital Compare* HSRs are the same as the previously named Hospital IQR Program HSRs. Some measures were removed from the Hospital IQR Program and are now reported through the Hospital-Acquired Condition (HAC) Reduction Program, Hospital VBP Program, or Hospital Readmissions Reduction Program (HRRP). The goal of the new naming convention is to prevent confusion due to Hospital IQR Program measure removals and to specify when the data would be reported on *Hospital Compare* compared to the fiscal year.

Question 18: **Slide 32 references Observation Stay (Facility) and Observation Stay (Physician). Please define these terms. How are they similar and how are they different?**

Observation Stay (Facility) claims are those identified in the Part A Hospital outpatient claims data. Observation Stay (Physician) claims are those identified using Part B physician claims data. Often, the observation claims identified from these two sources cover the same or overlapping period. The measure will only count the individual day once, even if it is listed in both facility and physician sources.

Question 19: **Why is the denominator different in the Hospital VBP Program HSR than the *Hospital Compare* HSR?**

There are several reasons the denominators presented in your Hospital VBP Program HSR could differ from those presented in your *Hospital Compare* HSR:

1. The pneumonia mortality measure cohort used to calculate your results for the *Hospital Compare* Mortality HSR differs from the cohort used

to calculate your results for the Hospital VBP Program HSR. The pneumonia mortality measure reported on *Hospital Compare* uses an expanded cohort that includes eligible admissions for:

- Patients with a principal discharge diagnosis of pneumonia.

OR

- A principal discharge diagnosis of sepsis (not including severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission and no secondary diagnosis of severe sepsis coded as present on admission (POA).

2. This cohort criteria has been in use for the public reporting of the pneumonia mortality measure on *Hospital Compare* since 2016, while the Hospital VBP Program will not use the expanded cohort until FY 2021. Therefore, the number of eligible pneumonia patients in your *Hospital Compare* HSR and Hospital VBP Program HSR may differ.

3. Although the results use the same measure specifications (with the exception of the pneumonia cohort mentioned above) and timeframes of eligible cases, please note that the sets of hospitals included in the results for public reporting on *Hospital Compare* and for the Hospital VBP Program are different, specifically:

   - For the mortality measure reported on *Hospital Compare*, the mortality measure calculations include index admissions to short-term acute care hospitals in the U.S. (including U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa), CAHs, Veterans Health Administration hospitals (for the AMI, heart failure, and pneumonia mortality measures), and Maryland short-term acute care hospitals participating in the All-Payer model.
   - For the mortality measure in the Hospital VBP Program, measure calculations include only index admissions to subsection (d) hospitals located in the 50 states and the District of Columbia.

   Therefore, because non-subsection (d) hospitals are removed from the Hospital VBP Program, transfers to these hospitals would not appear in the Hospital VBP Program results. For example, if a patient was transferred to a CAH, the patient could be included in Hospital VBP Program results but not in the *Hospital Compare* results.

4. The measures randomly select one eligible index admission per patient, per measure, per split year (June–July). Therefore, it is

possible for a patient to have multiple, eligible index admissions that occur at different hospitals during a split year and only one included in the measure results. Thus, your cohort size may vary slightly based on whether an eligible index admission at your hospital is randomly selected for Hospital VBP Program or *Hospital Compare* results.

Question 20: **What does CBM stands for?**

CBM stands for Claims-Based Measures.

Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 21: **Are the changes from 2018 considered statistically significant?**

Although CMS monitors changes in the national observed outcome rates annually, we do not perform significance testing because the number of observations in each measure is large and small changes could appear significant. Instead, we examine the annual results to identify unusual or unexpected changes in rates.

For the 2019 results, many measures stayed the same or decreased slightly. Only chronic obstructive pulmonary disease (COPD) mortality had a slight increase.

Question 22: **Regarding slide 32, please explain difference in the Days per Event between Observation Stay (Physician) and Observation Stay (Facility) for the same EDAC post-discharge encounter.**

Observation Stay (Facility) claims are those identified in the Part A hospital outpatient claims data. Observation Stay (Physician) claims are those identified using Part B physician claims data. Often, the observation claims identified from these two sources cover the same or overlapping period. The measure will only count the individual day once, even if it is listed in both facility and physician sources.

Question 23: **Please explain HOSP_EFFECT and AVG_EFFECT. Is the goal to have a risk adjustment effect closer to 0?**

The hospital-specific effect (HOSP_EFFECT) reflects the underlying risk of mortality or complication at a hospital after accounting for patient risk; it takes into consideration the number of patients eligible for the cohort, patient risk factors, and number of how many died or had a complication. The average effect (AVG_EFFECT) is the average of all individual hospital effects in the national sample.

The hospital-specific effect is used in calculating the predicted outcome rate, while the average effect is used in calculating the expected outcome rate for the mortality measures and THA/TKA complication measure.

- The predicted mortality or complication rate is the number of deaths or complications within 30 days (90 days for complication) from the start of the index admission that are predicted based on a hospital's performance with its observed case mix. It is calculated using the coefficients estimated by regressing the risk factors identified for the measure and an estimated "hospital-specific effect" for your hospital. The results are log transformed and summed over all patients attributed to a hospital to get the predicted value.
- The hospital-specific effect will be negative for a better-than-average hospital, positive for a worse-than-average hospital, and close to zero for an average hospital.
- If a hospital has a hospital-specific effect close to zero, the overall ratio of predicted to expected outcomes will be lower, which indicates lower-than-expected outcome rates or better quality.
- The expected mortality or complication rate is the number of deaths within 30 days or complication within 90 days from the start of the index admission that are expected based on the nation's performance (or average hospital performance) with a hospital's case mix. It is calculated in the same manner except the average hospital-specific effect is used in the model in place of the hospital-specific effect.
- To create risk-standardized mortality or complication rates, CMS compares the predicted mortality or complication rate to the expected mortality or complication rate and multiples that ratio by the national observed mortality or complication rate.

Finally, please note the goal for risk adjustment is to compare hospitals that have sick patient populations with hospitals that have healthier patients. It is not clear what you might have meant by "risk adjustment

effect close to 0." If you are referring to an average performing hospital with a hospital effect close to zero, then you are correct.

Question 24: **Slide 15 states CMS anticipates MSPB HSRs will be delivered to hospitals in June or July 2019. If CAHs voluntarily report to *Hospital Compare* will a CAH system administrator receive this report as a secure file?**

The Medicare Spending per Beneficiary (MSPB) measure calculation only includes hospitals subject to the Inpatient Prospective Payment System (IPPS). As a result, CAHs are excluded from the MSPB measure calculation and will not receive an MSPB HSR.

Question 25: **Regarding slide 19, how would a hospital calculate EDAC throughout the year to monitor its performance?**

If you wish to calculate a raw summary of utilization of emergency department (ED) visits, observation stays, and unplanned readmissions to your hospital for a time period outside the HSR performance period, you may add the amount of time each patient spends in EDs, observation stays, and unplanned readmissions within 30 days of discharge from their index admission at your hospital for the condition of interest that falls within the date range of interest and fulfills the cohort inclusion and exclusion criteria described in Appendix D of the *2019 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report.* The report is available on *QualityNet* > Hospitals – Inpatient > Claims-Based and Hybrid Measure > Excess Days in Acute Care (EDAC) Measures > Measure Methodology. Appendix D of this report also includes code definitions for ED visits and observation stays, and Appendix E contains important details to determine "unplanned" readmissions. For information on how to weight ED visits, observation stays, and unplanned readmissions, please see Section 2.2.2 of the aforementioned report.

Please note that an internally calculated raw summary will not capture major changes to your hospital's case mix that affect your risk-standardized EDAC result, nor will it include ED visits, observation stays, or readmissions to other hospitals. However, if your hospital's case mix and the proportion of same-hospital acute care visits are stable over time, your raw rate can be used to track internal improvement over time.

Question 26: **On slide 32, Observation Stay (Facility) and Observation Stay (Physician) are listed separately. Does this "double" count a single episode of patient observation stay?**

The measure will only count the individual day once even if it is listed from both facility and physician sources.

Question 27: **What happened to the Star Ratings HSR?**

CMS will not be updating the Overall Hospital Quality Star Ratings in July 2019. We are currently working on a timeline for when the next refresh of Star Ratings will occur. July 2019 HSRs will not be available as Overall Hospital Ratings will not be refreshed.

Question 28: **Where can we find the interval estimates (upper and lower interval limits for Better Than National, No Different Than National, and Worse Than National) for each measure similar to those found on slide 18? Are these available for all of the metrics so we know exactly where we fall in each interval for each metric?**

Your hospital's interval estimate values surrounding your measure outcome rates, as illustrated by examples on slide 18, are available for all of the claims-based outcome and payment measures and are provided in your July 2019 *Hospital Compare* HSRs.

In terms of the mortality, THA/TKA complication, readmission, and payment measures, the Upper Limit of 95% Interval Estimate and Lower Limit of 95% Interval Estimate values comprise each hospital's interval estimate range. Specifically, this data is located in the following tables in the *Hospital Compare* HSRs:

- Mortality measures HSR: Table III.1
- THA/TKA Complication measure HSR: Table IV.1
- Readmission measures HSR: Table I.1
- Payment measures HSR: Table V.1

Note that the EDAC measures do not use interval estimates. Instead, CMS categorizes hospital performance based on how the hospital's 95% **credible interval** compares to zero (which represents performance no

different than expected). Hospital credible interval values are reported in Table II.1 of the EDAC measures HSR. Please note that these values are inadvertently labeled as "interval estimates" in the HSRs. We apologize for the confusion.

Question 29: **Where can you find a list of the deadlines for claims data changes?**

A "snapshot" of administrative claims data available approximately 90 days after the end of the applicable measure reporting period is taken to perform program calculations. For FY 2020, the applicable reporting period ended on June 30, 2018, and the administrative claims data file "snapshot" used for calculations was produced on September 28, 2018.

Question 30: **Will the data for the FY 2021 Hospital VBP Program adjust previous data (e.g., CY 2016 data) to reflect changes? For example, pneumonia mortality changes begun in FY 2021 could change the numerator/denominator for CY 2017 compared to the report we received on FY 2020.**

Yes, when you receive the HSR report for FY 2021 program year, the updated MORT-30-PN cohort will have been adopted for performance period September 1, 2017–June 30, 2019. The numerator and denominators within the FY 2021 HSR report will reflect updates to the MORT-30-PN measure cohort.

Question 31: **For the July STAR rating calculation for mortality, is the RSMR at your hospital being used to calculate the STAR rating score or is the RAW Mortality rate being used to calculate the STAR rating score?**

Yes, the RSMR (Risk-Standardized Mortality Ratio) for the mortality measures in the Star Ratings HSR is used when calculating a hospital's Overall Star Rating.