Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Where's My Report? Everything You Want to Know About the FY 2020 Hospital VBP Percentage Payment Summary Report

Presentation Transcript

Speaker

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

Moderator

Maria Gugliuzza, MBA
Outreach and Education Lead
Inpatient VIQR Outreach and Education SC

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Maria Gugliuzza: Hello and welcome to *Where's My Report? Everything You Want to Know About the FY 2020 Hospital VBP Percentage Payment Summary Report*. My name is Maria Gugliuzza and I'm the Provider and Education Outreach Lead at the Inpatient VIQR Support Contractor, and Bethany Bunch is the Hospital VBP Program Lead at the Inpatient VIQR Support Contractor. 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 questions and answers, will be posted to the inpatient website *www.QualityReportingCenter.com* in the upcoming week. If you registered for this event, a reminder email and the slides were sent out to your email about two hours ago. If you didn't receive that email, you can download the slides at our inpatient website *www.QualityReportingCenter.com*. If you have questions as we move through the webinar, please type your question in the chat window with the slide number associated, and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to the *www.QualityReportingCenter.com* website in the upcoming week. I would now like to turn our presentation over to Bethany Bunch. Bethany, the presentation is yours.

Bethany Bunch: Thank you, Maria. My name is Bethany Bunch and I'm the Hospital VBP Program Lead at CMS Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contract. For those that have been with us through our previous webinars, welcome back. For those newcomers, I'm glad you could make it, and I hope we can help you start navigating through the Hospital Value-Based Purchasing Program.

This event will focus on some high-level topics in the Fiscal Year 2020 Hospital VBP Program, including the background of the program, which hospitals are eligible, how to download your report, which measures and domains are included in FY 2020, a high-level look at the scoring methodology, understanding what's on each page of the report, and helping you understand what that data means.

Our list of objectives for today's presentation are listed on this slide.

So, like I mentioned during the Purpose slide, this presentation is going to be a high-level look at some of the main topics of the Hospital VBP Program. We have a second webinar tomorrow for those that either love math or want to or need to learn more about how the calculations are completed in order to make a plan for targets in the future for moving your hospital up the totem pole of scores and payments. My goal of the calculation presentation is to break down the calculations step by step to make the process easier on you. This will be an interactive session, so please bring your calculator to tomorrow's session, and I hope to see you there!

Today our presentation will start with the background and framework of the program.

The Hospital Value-Based Purchasing Program is required by Congress under Section 1886(o) of the Social Security Act. The Hospital VBP Program was first adopted for fiscal year 2013 and CMS has used this program to adjust payments for every fiscal year subsequent. The Hospital Value-Based Purchasing Program was the first national inpatient pay-for-performance program in which hospitals are paid for services based on the quality of care rather than the quantity of services provided. The Hospital VBP Program pays for care that rewards better value, improved patient outcomes, innovation, and cost efficiency over volume of services.

The Hospital Value-Based Purchasing Program is an estimated budget-neutral program and is funded through a percentage withhold or reduction from participating hospital DRG (diagnosis related group) payments. Incentive payments will be redistributed based on the hospital's Total Performance Score in comparison to the distribution of all hospitals' Total Performance Scores and total estimated DRG payments. Please note that the withholds and incentive payments are not made in a lump sum but through each eligible Medicare claim made to CMS. The funding from the fiscal year 2020 program will come from a 2 percent withhold from participating hospital base operating DRG payment amount. CMS anticipates the total value-based incentive payment will total $1.9 billion in fiscal year 2020. For those of you that are new to the Hospital VBP

Program, I hope the graphic on this slide helps with your understanding of the funding process. On each claim, your hospital will have a withhold or reduction of 2 percent of the DRG amount. Then, based on how your hospital performed in the program, your hospital will earn value-based incentive payments, which can be less than, equal to, or more than the 2 percent that was initially withheld. The graphic shows a hospital earning value-based incentive payments of 3 percent. So, when you withhold 2 percent, but then gain 3 percent, you are netting a positive adjustment of 1 percent on each claim. If your hospital was to earn back less than the 2 percent, let's say your hospital earned value-based incentive payments of 1.5 percent, you would have a net reduction of 0.5 percent on each claim. Your value-based incentive payment percent is displayed on the Percentage Payment Summary Reports for you to review. We generally are asked each year, "What is the highest value-based incentive payment percentage that can be gained each year?" There isn't a set value each year and it ultimately depends on the distribution of scores and the base operating DRG payments in that fiscal year. However, I can tell you that last year, in fiscal year 2019, the highest value-based percentage was around 5.7 percent, which resulted in a net increase of around 3.7 percent, after the 2 percent withhold.

The Hospital VBP Program adjusts payments for approximately 3,000 hospitals each fiscal year. The program applies to subsection (d) hospitals 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 this slide applies. Those exclusion reasons include hospitals that are subject to payment reductions under the Hospital IQR Program, hospitals cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients, hospitals with less than three out of the four domains calculated, hospitals with an approved extraordinary circumstance exception (ECE), and hospitals that are 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 *Hospital Compare* website. Excluded hospitals will not have their payments adjusted, which includes not being subject to the 2 percent withhold to payments 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 these reasons listed on this slide will not have their payments reduced by 2 percent, and they will not have the opportunity to receive incentive payments.

This slide provides a timeline of the Hospital VBP Program. We are currently at the box with the You Are Here stamp. CMS released the fiscal year 2020 Percentage Payment Summary Reports to hospitals on July 30. Following the release of that report, hospitals have a 30-day period to review the reports and the scoring calculations and request a correction. If you are submitting a review and correction request, the request is due by August 29 at 11:59 p.m. I will cover more on the request process later in this presentation. Prior to the report release, the Baseline Measures Reports for fiscal year 2020 were released in March of 2018. The Baseline Measures Reports provide the baseline period rates and performance standards to assist hospitals in setting targets in the performance period. In April 2019, CMS released the Mortality and Complication measure HSRs, and, in early July 2019, CMS released the MSPB HSRs. Following the release of each of those reports, hospitals had a 30-day period to review and request correction of the calculations of these specific measures. Looking ahead, payment adjustments for fiscal year 2020 will begin on October 1, 2019 and continue through September 30, 2020. In the fall of 2019, CMS will post Table 16B to the CMS.gov website, which is a table that contains each eligible hospital's payment adjustment factor. We anticipate, in January 2020, that CMS will update the *Hospital Compare* website with the fiscal year 2020 scoring results for the Hospital VBP Program.

The next set of slides will show the steps for running your Percentage Payment Summary Report.

CMS made the Percentage Payment Summary Report available last Wednesday, July 30. Reports are available to run through the *QualityNet Secure Portal* for the *QualityNet* users that have been assigned the Hospital Reporting Feedback – Inpatient and File Exchange and Search roles. Please note that you will need to run the Percentage Payment Summary Report, and it will not be available in you Secure File Transfer Inbox, like the claims-based measure HSRs or the HAC Reduction Program reports that were recently provided to hospitals.

After logging in to the *QualityNet Secure Portal* from the home page select Run Reports from the My Reports drop down.

Click Run Reports.

Again, select Run Report(s).

From the Report Program drop down, select IQR.

From the Report Category select Hospital Value-Based Purchasing Feedback Reports.

Then, click on the View Reports box in blue. There are two reports available, the Percentage Payment Summary Report and the Baseline Measures Report. To run the Percentage Payment Summary Report, select the Hospital Value-Based Percentage Payment Summary Report.

In the report parameters screen, select Fiscal Year 2020 in the Reporting Period dropdown and then click Run Report.

Now, that you have ran your report, let's locate where to find the report. Again, from the *QualityNet* home page select Search Reports.

Once again, you will need to click Search Report(s) again.

On the Search Report screen, you will see the reports you just ran in the queue. When the reports are ready for download, a green arrow will appear. Click on the green arrow to download your report. If your report is not in your dashboard, click Refresh Report Status.

Once you click on the green arrow, you will have the option to open or save.

This slide displays a list of the steps that we just covered, if you would like a quick guide for when you are running your reports later.

I would now like to know how many of you have already downloaded your reports. Please respond to the polling question.

We'll leave the polling question open for a few more seconds.

We hope that you will all go out to *QualityNet* and run your report to review your scores and payment adjustment factors.

I will now touch on the domains and measures used to evaluate hospitals in the Hospital VBP Program.

This slide displays the four domains hospitals will be evaluated on in the Fiscal Year 2020 Hospital VBP Program. Each domain is weighted equally at 25 percent of the Total Performance Score. The Clinical Outcomes Domain contains the 30-day mortality measures for AMI (acute myocardial infarction), heart failure, and pneumonia. The Hip-Knee Complication measure is also included in the Clinical Outcomes domain. The Person and Community Engagement Domain contains the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey dimensions. The Safety Domain contains the five CDC (Centers for Disease Control and Prevention) healthcare associated infection [HAI] measures, and the (Perinatal Care) PC-01 measure. The Efficiency and Cost Reduction Domain contains the Medicare Spending per Beneficiary (MSPB) measure. The only change in the domains or measures used in the program from last year was the update to the Clinical Care domain name to Clinical Outcomes.

The Hospital VBP Program is unique in that it allows hospitals to earn improvement, which is scored based on how a hospital improved in their own performance from the baseline period to the performance period, in addition to the opportunity for achievement, which is scored based on how

a hospital compares versus all other hospitals in the country. We have two periods listed on this slide, baseline and performance, in order to calculate both of those scores. The HCAHPS Survey, HAI measures, PC-01, and MSPB measure are calendar year measures and utilize a performance period of calendar year 2018 and a baseline period of calendar year 2016. The mortality measures and complication measure use multi-year baseline and performance periods that are listed on the slide.

When we were covering the eligibility of the program, we discussed a hospital being excluded if they had fewer than three domain scores calculated. So, in order to cover the minimum data required for the Hospital VBP Program, I would like to start there, which is the last row in the table on this slide. In order to have at least three domains calculated, a hospital would have to meet the minimum data requirements within each of those domains. For the Clinical Outcomes domain, a hospital must have at least two of the four mortality measures and complication measures scored, requiring a minimum of 25 cases in those measures. For the Person and Community Engagement domain, a minimum of 100 HCAHPS surveys are required to receive a score. In the Safety domain, a minimum of two measure scores is required. Those two measures can be received from having at least one predicted infection in the HAI measures and 10 cases in the denominator for the PC-01 measure. For the Efficiency and Cost Reduction domain, a minimum of 25 episodes of care are required.

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 performance rates during the baseline period and performance period relative to the performance standards. The performance standards consist of the achievement threshold and benchmarks for all the 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 and the HCAHPS dimension. 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 value because lower rates demonstrate better quality in the measure. The measures that this description is applicable for are the complication measure, the PC-01 measure, all healthcare-associated infections in the Safety domain, and the MSPB measure in the Efficiency and Cost Reduction domain. Please note that the MSPB measure uses data during the performance period instead of the baseline period to calculate performance standards.

This slide displays the performance standards used in the fiscal year 2020 program. These performance standards, with the exception of MSPB, were included in your baseline measures report and will also be displayed on your hospital Percentage Payment Summary Report.

Moving on to the two scores a hospital can receive per measure, achievement points are awarded by comparing an individual hospital rate 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, 10 achievement points will be awarded. If the rate is lower than the achievement threshold, the hospital will receive 0 achievement points. If the performance period rate is equal to or better than the achievement threshold, but is still lower than the benchmark, 1 to 9 points will be awarded.

The second set of scores is improvement points which are awarded based on a hospital's rates during the performance period compared to their own rates during the 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 9 points.

For more discussion and examples on the scoring of the Hospital VBP Program, including a breakdown of how to calculate achievement points and improvement points, please join our session tomorrow.

We will now move into a brief overview of reviewing and reading your reports.

The Percentage Payment Summary Report has five pages. The first page is a summary of your hospital's scores and the payment adjustment information. The first section contains your hospital's Total Performance Score, the state average, and the national average. The domain scoring section contains each domain's unweighted score, domain weight, and weighted score.

The payment summary section contains five values. The Base Operating DRG Payment Amount (Reduction) will display "2%" for all eligible hospitals because that is the amount that is withheld for fiscal year 2020. The Value-Based Incentive Payment Percentage is the incentive percentage a hospital will receive without taking into account the 2-percent withhold. The net change in payment amount is the Value-Based Incentive Payment Percentage minus the 2-percent withhold. If this value is positive, your hospital will receive an overall increase in payments due to the Hospital VBP Program. The payment adjustment factor is the number that you can multiply against a DRG to determine what you will be paid for that DRG based on the program. The last value is the Exchange Function Slope. This value is the same for each hospital and is used to calculate the hospital's payment adjustments that we just covered. Please note that the slope displayed on this slide is not the slope that will be used in fiscal year 2020.

If your hospital is excluded from the program, the first page will display the reason for your hospital's exclusion in the middle of the page, which is displayed on this slide in the yellow highlighting. In addition, your hospital's Total Performance Score and payment adjustment fields will display "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. At the bottom of the table, there is a summary of the domain results, which includes the number of measures receiving a measure score, the unweighted domain score, and the weighted domain score.

The third 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 be displayed. 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 fourth page of the report displays the measure results for the Safety domain, including the baseline and performance period totals for each measure.

The right side of the table displays the performance standards and point calculations. 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 pages 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, performance standards, scoring, and the domain summary.

This slide displays select values from the report and the precision for those values. For example, the 30-day mortality measures have a baseline and performance period rate that is displayed six places to the right of the decimal on the Percentage Payment Summary Report. I would like to highlight the asterisk on the HCAHPS and PC-01 baseline and performance period rate. Please note that these values have a displayed precision of two places and six places to the right of the decimal, respectively. However, a greater precision of those rates is used to calculate the improvement and achievement point values than is displayed on the report. If you have any questions regarding the calculations on your report, please feel free to ask your questions through the inpatient Q&A tool found on *QualityNet*.

Now, we're going to move into reviewing your data.

Hospitals may review their data used in CMS programs in two different stages. The first stage is considered a patient-level data review stage in which hospitals ensure their underlying data or claims are accurate either prior to the submission deadline, the claims pull date, or during the HCAHPS review and correction period. The second stage of review is the scoring and eligibility review. During the second stage, hospitals can ensure that the data reviewed during phase one is properly displaying on the report and that the scoring, such as improvement points, measure scores, or domain scores, were calculated correctly based on the already finalized measure result. Corrections or modifications to the underlying data are not allowed during a stage two review. Examples of stage two reviews include the *Hospital Compare* preview report, the Hospital VBP Program review and correction period, and the claims-based measures review and correction period.

For chart-abstracted and web-entry measures, the stage one review allows hospitals to use the approximate 4.5 months after the quarterly reporting period ends to submit and review their data. Corrections or modifications to the data after the quarterly submission deadline are not allowed.

For CDC NHSN measures, the stage one review also allows hospitals to use the approximate 4.5 months after the quarterly reporting period ends to submit and review the data into NHSN. Corrections or modifications to the data after the quarterly submission deadline will not be reflected in CMS reports or programs, although the data can still be entered or modified into NHSN.

For the HCAHPS Survey stage one review, CMS allows hospitals to have a seven-day period after the submission deadline to access and review the HCAHPS data in a review and corrections report. Please note that new data are not accepted into the warehouse during the review and correction period, just modifications to existing data. After the quarterly HCAHPS review and correction period, no changes can be made to the underlying HCAHPS data.

Now that we have covered the stage one items, we will discuss the details of stage two. The stage two for the claims-based measures includes 30 days to review and correct scores based on a hospital's claims included in a Hospital-Specific Report (HSR). If a hospital suspects a calculation error on the report, a request for review with a possibility for correction can be submitted during this 30-day window. Requests for submission of new or corrected claims to the underlying data are not allowed. We do recommend contacting your MAC, or your Medicare Administrative Contractor, if you identify an error to the underlying claims data, so the claims are correct during the next claims pull.

Another stage two review is the review and correction period for the Percentage Payment Summary Report. After the release of the report, hospitals will have 30 days to review and request correction of the calculation of scores for each measure, domain, and TPS. Requests for correction of underlying data, such as your baseline or performance period

rates, are not allowed during this period and should have been addressed during a stage one review for each of the measure types.

Some best practices for reviewing your data during stage one 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.

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 consumers with how well a hospital is performing.

So, now that we understand when the underlying data should be reviewed versus the review of a hospital's score and eligibility, let's move on to the process to submit a Percentage Payment Summary Report review and correction request if your hospital identifies a potential scoring error.

Hospitals may review and request recalculation of scores for each measure, domain, and Total Performance Score. Hospitals have 30 days after the Percentage Payment Summary Report is released to request this review. If you would like to submit a request, please submit the completed review and correction form through the Secure File Exchange on the *QualityNet Secure Portal* to the "HVBP" group. If you are submitting a request, please have it submitted by August 29 at 11:59 p.m. for CMS consideration.

The review and correction form is posted on *QualityNet.* This page describes where to find the form if you would like access it.

When completing the form, please make sure you are providing the following information: the date of the review and corrections request, the

hospital CCN, or CMS Certification Number, the hospital contact information, the reason or reasons for the request, and a detailed description for the reasons identified.

Next, we will review the appeals process.

A hospital may appeal the calculation of their scores through an appeal only after receiving an adverse determination from CMS following a request for review and correction. Hospitals will have 30 days in order to request an appeal after receiving the review and correction decision. If your hospital did not submit a review and correction request, you waive your eligibility to submit an appeal request. To submit an appeal, you would follow the same process on sending a completed appeal form to the "HVBP" group through the Secure File Exchange within the *QualityNet Secure Portal*.

To access the appeals form, please use the steps listed on this slide to access the form on *QualityNet.*

When completing the appeals form, please include the information provided on this slide, including the date of your hospital's review and correction request.

The topics listed on this slide are the appealable items during the appeals period, including the calculation of scores, incorrect domain weights applied, or if your hospital's open/closed status was incorrectly specified.

The following resources are available to you.

If you have questions or would like to learn more about the Hospital VBP Program, I would recommend checking out the resources listed on this slide. If you have a question, you can reference the FAQs in the inpatient Q&A tool on *QualityNet* and, if your question is not answered, submit a question through the same tool.

The resources available on this slide can be found by clicking on the link in the slide or visiting *QualityReportingCenter.com*. Specifically, as you

are reviewing your report and you have questions, please reference the How to Read Your Report Help Guide. We rolled out a new resource last year, the Scoring Quick Reference Guide, and we updated it for fiscal year 2020. If you need assistance in calculating your values on the report, it's a nice handy cheat sheet for you to use.

If you would like to review Hospital VBP Program data from previous fiscal years, you can access that data through the *Hospital Compare* website by clicking on the HVBP link on the bottom of the page under Additional Information. Data from fiscal year 2019 will be posted on *Hospital Compare* until approximately January of 2020 when the fiscal year 2020 program will be refreshed on the page. Fiscal year 2013 through fiscal year 2018 data are also available in the *Hospital Compare* archive. That concludes my portion of the webinar. I would just like to remind everyone that, if you would like a more comprehensive look at the calculations used in the program, please join us for tomorrow's calculations webinar. You can register for that webinar out on the *QualityReportingCenter.com* website. Maria, I'm happy to address some of the questions that we received during the presentation.

Maria Gugliuzza: Great! Our first question: What are the baseline periods and the performance periods for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys?

Bethany Bunch: The baseline and performance periods for all measures are listed on slide 31. We will move the slide deck there for reference.

Maria Gugliuzza: Great. Next question: When will payments be adjusted based on this report?

Bethany Bunch: I'd like to move back to the timeline slide, I believe it's 13. The fiscal year 2020 Hospital VBP Program will impact payments made by CMS in fiscal year 2020, which is from October 1 of 2019 through September 30 of

2020. You can use this slide for reference of the major milestones of the fiscal year 2020 program, including payment start and end dates.

Maria Gugliuzza: Our next question: What happens to the domain weights if a hospital does not meet the requirements for the Clinical Outcomes domain because there are less than 25 eligible cases in all four measures?

Bethany Bunch: If a hospital is unable to receive enough measure scores to receive a domain score, the domain will not be scored. If less than three domains are scored in fiscal year 2020, the hospital will be excluded from the fiscal year 2020 program. Hospitals excluded from the Hospital VBP Program will not be eligible for the payment adjustment, including the withhold and the incentive payment. For more information on how the domains are weighted when three domains are scored, please join us for tomorrow's presentation. If you are not able to join, the slides will be posted on the *QualityReportingCenter.com* website.

Maria Gugliuzza: Our next question. Do the healthcare-associated infection (HAI) and Perinatal Care (PC)-01 measures carry equal weight in the calculation of the score for the Safety domain?

Bethany Bunch: Each scored measure within the Safety domain carries an equal weight.

Maria Gugliuzza: Our next question: What happens if 100 HCAHPS surveys are not completed within the two periods?

Bethany Bunch: If a hospital is unable to submit enough completed surveys during the performance period, the Person and Community Engagement domain will not be scored. If less than three domains are scored in fiscal year 2020 program, the hospital will be excluded from the FY 2020 program. Again, hospitals that are excluded from the Hospital VBP Program will not be eligible for the payment adjustment. Also, if at least 100 surveys are not submitted for the baseline period, but at least 100 surveys are completed

during the performance period, only achievement points can be awarded because improvement points are calculated by comparing the baseline period with the performance period. This is one of the scenarios that we'll run through on tomorrow's presentation.

Maria Gugliuzza: Thank you, Bethany. The next question: Are children's hospitals and critical access hospitals (CAHs) exempt from the Hospital VBP Program?

Bethany Bunch: Yes, only subsection (d) hospitals, short-term acute care hospitals, are included in the Hospital VBP Program.

Maria Gugliuzza: Next question: What happened to the Patient Safety Indicator (PSI) 90 composite measure in the Hospital VBP Program? Was it removed? I do not see it on my FY 2020 Percentage Payment Summary Report (PPSR).

Bethany Bunch: CMS finalized its proposal to remove the old version of the PSI 90 measure from the Hospital VBP Program beginning in fiscal year 2019 in the fiscal year 2018 IPPS final rule. The PSI 90 measure was not used in determining your hospital's Safety domain score, Total Performance Scores (TPS), or your payment adjustments. I would like to note that CMS adopted the use of the new version of the PSI 90 measure in the Hospital VBP Program beginning in fiscal year 2023 program. This is the same measure currently used in the HAC Reduction Program and reported on *Hospital Compare*.

Maria Gugliuzza Regarding slide 57, for claims-based measures, is there a cut-off time to refile a claim with CMS if we discover the first claim was incorrect?

Bethany Bunch: Yes. CMS generally pulls claims at the end of September following the end of a calculation period for the 30-day mortality measures. For example, if the claims-based measures have a performance period end date of June 30, 2018, CMS will pull those claims in the calculation at the end of the September of 2018. The next claims pull for fiscal year

2021 results is anticipated for the end of September of 2019. For the Medicare Spending Per Beneficiary (MSPB) measure, CMS pulls claim around the first week of April, which allows a three-month claim run-up or maturity period.

Maria Gugliuzza: We have time for a few more questions. The next one is, "Is fiscal year 2020 the same as calendar year (CY) 2018?"

Bethany Bunch: So, fiscal year 2020 is the year in which payment adjustments will be made. The performance periods and baseline periods range in fiscal year 2020. However, fiscal year 2020 generally utilizes a performance period of calendar year 2018 and a baseline period of calendar year 2016. However, this generalization does not apply to the claims-based measures, such as the 30-day mortality measures and the complication measure, as they use multi-year baseline and performance periods.

Maria Gugliuzza: The next question. Can you restate when the PPSRs were made available?

Bethany Bunch: Yes. The reports were released on July 30. An announcement was made through a *QualityNet* news article and a ListServe notification. You can sign up for the Hospital IQR and Hospital VBP Program Notification ListServes group on *QualityNet*.

Maria Gugliuzza: When does the review and correction period end?

Bethany Bunch: The review and correction period ends on Thursday, August 29, at 11:59 p.m. Pacific Time.

Maria Gugliuzza: All right, time for one more question. Who do I contact if I am having trouble running my report?

Bethany Bunch: Great question. For technical questions or issues related to accessing the PPSR, contact the *QualityNet* Help Desk. You can email them at qnetsupport@hcqis.org.

Maria Gugliuzza: Great and that is all the time we have today for questions. I would like to thank everybody for their participation in today's event. Thank you, Bethany, for a wonderful presentation.

On the next few slides, we will review the CE credit process. I hope everyone has a great day.