Hospltal Value-Based Purchasing (VBP) Program

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

Where's My Report? Everything You Want to Know About the FY 2022 Hospital VBP Program Percentage Payment Summary Report

Presentation Transcript

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Brandi Bryant: Hello and thank you for tuning into the Hospital Value-Based Purchasing Program webinar focused on the Fiscal Year 2022 Hospital VBP Program Percentage Payment Summary Report. My name is Brandi Bryant, and I will be your virtual host for today's webinar.

This event will provide an overview of the Fiscal Year 2022 Hospital VBP Program Percentage Payment Summary Report, including a discussion of the background of the report, hospital eligibility, how to download the report, the measures and domains included in the Hospital VBP Program, the scoring methodology, and the data within the reports.

At the end of the event, participants should be able to identify the way hospitals will be evaluated within each domain and measure, recall the Hospital VBP Program eligibility requirements, and interpret the Hospital VBP Program's new scoring methodology that was established due to the COVID-19 Public Health Emergency (PHE).

Here is a list of acronyms that I may reference on today's webinar.

Our presentation will start with the background and framework of the program. I will now turn the presentation over to Maria. Maria, the floor is yours.

Maria Gugliuzza: 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 the 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 reduction from participating hospitals' DRG 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 the total estimated DRG payments. Please note that withholds and incentive payments are not made in a lump sum, but through each eligible Medicare claim made to CMS. However, in the FY 2022 Inpatient Prospective Payment System (IPPS) Final Rule, issued on August 13, 2021, CMS determined that circumstances caused by the COVID-19 Public Health Emergency significantly affected NHSN HAI, HCAHPS Survey, and the Medicare Spending per Beneficiary (MSPB) measures in the FY 2022 Hospital VBP Program. As a result, in the final rule, CMS suppressed those measures from the FY 2022 Hospital VBP Program. Because CMS is suppressing many measures, CMS believes there will not be enough data to award a Total Performance Score to any hospital in FY 2022. As a result, no hospital will have a Total Performance Score calculated and no hospital will have payments adjusted due to the Hospital VBP Program in FY 2022.

The Hospital VBP Program adjusts payments for approximately 3,000 hospitals each 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 this slide appears. 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 with an approved extraordinary circumstance exception (ECE), 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 Care Compare 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 also want to reiterate that all eligible hospitals will also not have their base operating MS-DRG payments reduced by 2.00 percent due to the COVID-19 Public Health Emergency.

In the FY 2022 Hospital VBP Program, the 30-Day Mortality Measure for CABG was adopted to the Clinical Outcomes domain. In the first bullet point, you can click the link to the FY 2017 IPPS Final Rule to learn more about CMS's adoption of the measure into the Hospital VBP Program. Like the other mortality measures, the CABG measure includes Medicare Fee-for-Service patients aged 65 or older. The cohort specifically looks at those beneficiaries who receive a qualifying CABG procedure. The measure uses the same general approach for risk-adjustment as the other 30-day mortality measures.

In a press release dated March 22, 2020, and a guidance memo issued March 27, 2020, CMS announced that it was excepting all hospitals from CMS's HAI and HCAHPS Survey data submission requirements for Q4 2019, Q1 2020, and Q2 2020 because of the COVID-19 Public Health Emergency. Data submissions for Q4 2019 for those measures are relevant for the FY 2022 Hospital VBP Program. Although discharges and care delivery for Q4 2019 were not impacted by COVID-19, CMS excepted hospitals from reporting requirements because the submission deadline for the quarter was scheduled while hospitals were impacted by the Public Health Emergency. CMS excepted hospitals to assist health care providers while they directed their care toward their patients and ensuring the health and safety of staff.

Just another reminder that, in the FY 2022 Inpatient Prospective Payment System (IPPS) Final Rule, CMS finalized that no hospital will have a Total Performance Score calculated and no hospital will have payments adjusted in FY 2022 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 November 19. Reports are available to run through the new *Hospital Quality Reporting,* or HQR*, QualityNet Secure Portal*. In order to access the new HQR portal, you must use your new HARP ID, password, and two-factor authentication. If you have not established your HARP ID yet, you can still do so by logging into the old *QualityNet Secure Portal* and following the prompts that will be displayed to establish your HARP ID and link your QualityNet accounts. I would also like to note that you will need to run the Percentage Payment Summary Report and it will not be available in the Secure File Transfer, or the new Managed File Transfer, inbox, like the claims-based measure HSRs or the HAC Reduction Program reports.

Step 1: To run your report, you are first going to go to the *QualityNet HQR Secure Portal* at hqr.cms.gov/hqrng/login. Enter your HARP ID and password. Select Login.

Select the method to receive your two-factor authentication code. Once you've received your code, enter the code in the box. 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. Then, select Baseline and Performance from the Report selection menu.

Select 2022 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.

This slide provides step-by-step instructions to access the Percentage Payment Summary Reports. If you have any issues relating to running the report or establishing your new HARP ID, please contact the QualityNet Service Center by e-mailing them at qnetsupport@hcqis.org.

I will now touch on the domains and measures used to evaluate hospitals in the Hospital Volume-Based Purchasing Program.

This slide displays the four domains for the fiscal year 2022 Hospital VBP Program. The Clinical Outcomes domain contains the 30-day mortality measures for AMI, COPD, CABG, 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 Survey dimensions. The Safety domain contains the five CDC healthcare-associated infection measures. The Efficiency and Cost Reduction domain contains the Medicare Spending per Beneficiary measure.

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, and MSPB measure are calendar year measures that utilize a performance period of calendar year 2020 and a baseline period of calendar year 2018. The mortality measures and complication measure use multi-year baseline and performance periods that are listed on this slide.

For FY 2022, only the Clinical Outcomes domain will have scores calculated. For the Clinical Outcomes domain, a hospital must have at least two of the five measures scored, requiring a minimum of 25 cases in each of the measures.

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.

This slide displays the performance standards used in the fiscal year 2022 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 Percentage Payment Summary Report.

There are three values calculated for the clinical outcomes measures: achievement points, improvement points, and a measure score. We will cover achievement points first. Achievement points are awarded by comparing your hospital's rates on a measure during the performance period with all other hospitals.

So, how does CMS compare you to all hospitals? The answer is through the use of performance standards of the achievement threshold and the benchmark that we just discussed.

To recap, the achievement threshold was the median of all hospital performance and the benchmark is the mean of the top 10 percent. You can determine how many achievement points your hospital will receive by reviewing these scenarios. Is your hospital's performance period rate at or better than the benchmark value? If yes, your hospital will get the maximum of 10 achievement points. Is your hospital's rate worse than the achievement threshold? If that answer is yes, your hospital would receive 0 achievement points. Is your hospital's rate at or better than the achievement threshold, the median value, but not quite at that benchmark?

Improvement points are unique to the Hospital VBP Program in relation to CMS' other inpatient pay-for-performance programs, such as the HAC Reduction Program and the Hospital Readmissions Reduction Program. Not only can hospitals be evaluated based on their current performance in comparison to all other hospitals, but they can earn points by improving from the baseline period. CMS may award hospitals improvement points if the performance period rate is better than their own baseline period rate. The maximum point value for improvement points is 9 points. If your hospital's performance period rate is better than the benchmark and also better than your own baseline period rate, you will receive a maximum of 9 improvement points. If your hospital's performance period rate is worse than or equal to the baseline period rate, you will receive 0 improvement points, because no improvement in the rates were actually realized. If your hospital's performance period rate is in between the baseline period rate and the benchmark, your hospital will receive 0 to 9 improvement points based on the improvement-point formula.

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

On this slide, you will see the first page of the PPSR for FY 2022. You see that it looks a little different, but we will go step-by-step. The Total Performance Score is the first section there that you see. For Facility, it will say "Hospital VBP Ineligible" because all hospitals will not be eligible for receiving a TPS score in FY 2022 because of the COVID-19 Public Health Emergency. The state and national average will be displayed as N/A. For the unweighted domain scoring, the sum of your hospital's scores for the domain, only the Clinical Outcomes domain will have a domain score. The domain weighting will be 25 percent. The weighted domain score will also be calculated. Again, this is only for the Clinical Outcomes domain.

The Payment Summary section contains five values. The base operating DRG payment reduction will be displayed as "Hospital VBP Ineligible" or the 2 percent. The value-based incentive payment percentage will be "Hospital VBP Ineligible" or will be 2 percent. The net change in base operating DRG payment amount will read "Hospital VBP Ineligible" or 0 percent. The incentive payment adjustment factor will be displayed as "Hospital VBP Ineligible" or N/A. The exchange function slope will be displayed as "Hospital VBP Ineligible" or N/A. Again, these numbers are being displayed as "Hospital VBP Ineligible" or N/A due to the COVID-19 Public Health Emergency.

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 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.

Page 3 of the report will be the 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 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 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 are the actual number of infections your hospital reported during that specific measurement period. The number of predicted infections are 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.

On this slide, we have highlighted 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. Just a reminder, only the Clinical Outcomes domain will have these scores displayed.

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. If you have any questions regarding the calculations on your report, again, just the Clinical Outcomes domain will have calculations, 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 Care Compare preview report, the Hospital VBP Program review and correction period, and the claims-based measures review and correction period.

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, 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. Again, just a reminder, hospitals may request a review of the recalculations of the scores for the Clinical [Outcomes] domain only.

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 in the Clinical Outcomes domain. 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 one of the methods listed on this slide. If emailing the form, please ensure that you are not submitting PII or PHI, since this is not a secure method. If you are submitting a request, please have it submitted by December 17 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 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. Again, this only applies to the Clinical Outcomes domain.

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. We provide educational events and webinars such as these throughout the year and then store the recordings and slides to watch On Demand on the Quality Reporting Center website. Please feel free to check out the website if you want to learn more about the baseline measures reports, the claims-based measure Hospital-Specific Reports, and any proposed or finalized changes that were announced in the IPPS proposed and final rules. If you want to have quick references to the measures used or the performance standards in the Hospital VBP Program for a fiscal year, we have those easily accessible on the Hospital VBP Program pages on QualityNet. If you would like a tutorial video of the resources available for the Hospital VBP Program, the Quality Reporting Center website has an On Demand webinar that walks through all of the QualityNet pages for Hospital VBP, the resource documents, how to run reports, and how to ask and check the status on questions in the Q&A tool.

If you have any additional questions, 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. Specifically, as you are reviewing your report and you have questions, please reference the *How to Read Your Report Help Guide*. If you need assistance in calculating your values on the report, the *Scoring Quick Reference Guide* is a nice handy cheat sheet to use.

I would now like to hand the presentation over to Brandi, our virtual host. She will read the questions that were asked during the webinar.

Brandi Bryant: We will now answer some of the questions that were submitted during the webinar. If you would like to submit additional questions at this time, please include the slide number associated with the question. The first question: What are the baseline periods and the performance periods for Hospital Consumer Assessment of Healthcare Providers and Systems surveys?

Maria Gugliuzza: The baseline and performance periods for all measures are listed on slide 28. Could we please move the deck to slide 28? The Clinical Outcomes domain mortality measures have a baseline period of July 1, 2012–June 30, 2015, and a performance period of July 1, 2017–June 30, 2020. The complication measure has a baseline period of April 1, 2012–March 31, 2015, and a performance period of April 1, 2017–March 31, 2020. The Person and Community Engagement domain (HCAHPS Survey measures) have a baseline period of January 1, 2018–December 31, 2018, and a performance period of January 1, 2020–December 31, 2020. The Safety domain healthcare-associated infection (HAI) measures have a baseline period of January 1, 2018–December 31, 2018, and a performance period of January 1, 2020–December 31, 2020. The Efficiency and Cost Reduction domain Medicare Spending per Beneficiary (MSPB) measure has a baseline period of January 1, 2018–December 31, 2018, and a performance period of January 1, 2020–December 31, 2020.

Brandi Bryant: When will payments be adjusted based on this report?

Maria Gugliuzza: The Fiscal Year 2022 Hospital VBP Program was impacted by the COVID-19 Public Health Emergency; therefore, no hospital will have a Total Performance Score calculated and no hospital will have payments adjusted.

Brandi Bryant: 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?

Maria Gugliuzza: If a hospital is unable to receive enough measure scores to receive a domain score, the domain will not be scored. Just a reminder that the Clinical Outcomes domain is the only domain that will be scored for FY 2022.

Brandi Bryant: Do the HAI measures carry equal weight in the calculation of the score for the Safety domain?

Maria Gugliuzza: Yes. each scored measure within the Safety domain carries an equal weight.

Brandi Bryant: What happens if 100 HCAHPS Surveys are not completed within the two periods?

Maria Gugliuzza: If a hospital is unable to submit enough completed surveys during the performance period, the Person and Community Engagement domain will not be scored. Remember only the Clinical Outcomes domain will be scored in FY 2022.

Brandi Bryant: Are children’s hospitals and critical access hospitals (CAHs) exempt from the Hospital VBP Program?

Maria Gugliuzza: Yes, only subsection (d) hospitals, short-term acute care hospitals located in D.C. and the 50 states paid under the Inpatient Prospective Payment System, are included in the Hospital VBP Program.

Brandi Bryant:. We received a letter that our hospital is ineligible to participate in the FY 2022 Hospital VBP Program. When will my IJs fall off so we can participate in the program?

Maria Gugliuzza: Hospitals will be excluded from the Hospital VBP Program for a particular program year if, during the performance period for that fiscal year, they were cited three times for deficiencies that pose immediate jeopardy to the health or safety of patients. For FY 2022, the performance period is April 1, 2017–December 31, 2020.

Brandi Bryant: Is fiscal year 2022 the same as calendar year 2020?

Maria Gugliuzza: FY 2022 refers to the year in which payment adjustments will be applied, which is from October 1 of 2021 through September 30 of 2022. The measure performance periods and baseline periods range for the FY 2022 program year depending on the measure. Some measures for the fiscal year 2022 program year utilize a performance period of calendar year 2020 and a baseline period of calendar year. However, this generalization does not apply to the claims-based measures, such as the 30-day mortality measures and the hip/knee complication measure, as they use multi-year baseline and performance periods.

Brandi Bryant: Can you restate when the PPSRs were made available?

Maria Gugliuzza: The reports were released on November 17. 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 groups on QualityNet.org.

Brandi Bryant: When does the review and correction period end?

Maria Gugliuzza: The review and correction period ends on Friday, December 17, 2021, at 11:59 p.m. Pacific Time.

Brandi Bryant:. Who do I contact if I am having trouble running my report?

Maria Gugliuzza: For technical questions or issues related to accessing the PPSR, contact the QualityNet Service Center. You can email them at qnetsupport@hcqis.org.

Brandi Bryant: That is all the time we have for questions today. Thank you for participating.