



Inpatient Quality Reporting Program

Support Contractor

Overview of the Hospital Value-Based Purchasing (VBP) Fiscal Year (FY) 2017

Presentation Transcript

Moderator:

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Speaker:

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Hospital Reporting, Reports and Analytics Contactor

April 21, 2015

2 p.m.ET

Matt McDonough: This is Conference #: 17028515.

Good afternoon, everybody, and thank you for joining this afternoon's Hospital Value-Based Purchasing WebEx Event. My name is Matt McDonough, and I'm going to be your virtual training host for today's event.

Before we turn it over to our first presenter of the day, I'd like to cover some housekeeping tips with you so that you have the tools available so that you can interact with our presenters throughout the course of today's event. Some notes on the screen that you would see right now: audio for this event is available via Internet streaming. If you are streaming right now then you hear my voice. But, if for some reason your streaming acts funny during today's event or you have some audio issues, please send a chat message. We do have a very limited number of audio telephone dial-in numbers that we can utilize for today's event. However, if you are hearing me loud and clear, you'll note that no telephone line is required. Today's primary way of transmitting audio is going to be over the Internet. If you are listening, hopefully you have computer speakers or headphones connected; either of those two are necessary to listen to today's streaming audio. Headphones are probably preferable for your neighbors so that they're not interrupted during today's work.

So obviously, with a one-way audio transmission today, there may be some limitations on submitting questions to our panelists, but fear not, you do have the ability to submit questions to our panelists throughout today's event via our chat window. Now, our chat window is located on the left side of your screen. It is the panel on the left. So simply type your question into [the] chat window at the bottom of the screen. It says, "Chat with Presenter." Type your question in that white box and then click the

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“Send” button. When you click your “Send” button, your question will be sent to all of our presenters that are online today. And, as time and resources allow, we’ll get back to you with an answer if we’re able to throughout the course of today’s event. But, at any time during today’s event, if you have a question, feel free to submit it directly using that chat panel.

That’s going to do it for my introduction. So without further ado, I’m going to hand it over to Bethany Wheeler, who will be our first presenter of the day. Bethany, take it away.

Bethany Wheeler: Thank you, Matt. Hello and welcome to our Hospital Value-Based Purchasing Program monthly WebEx. My name is Bethany Wheeler, and I am the lead of the Hospital Value-Based Purchasing Program with the VIQR support contractor, and I will be your host for today’s event.

Before we begin, I’d like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the Q&A, will be posted to our Inpatient website, www.qualityreportingcenter.com. Again, that’s www.qualityreportingcenter.com, and that is all one word. If you registered for the event, a reminder email, as well as the slides, were sent out to your email one or two hours ago. If you didn’t receive the email, you can download the slides at our Inpatient website. Again, that’s the www.qualityreportingcenter.com.

As many of you may have noticed, your hospital receives a Hospital-Specific Report containing patient level data for the 30-day mortality measures of AMI, heart failure and pneumonia, and the AHRQ PSI-90 composite for the Hospital Value-Based Purchasing Program on approximately April 10th through the *QualityNet Secure Portal*. This webinar was intended to provide information regarding these hospital-specific reports, how to calculate the measures, and how to submit a Review and Correction Request if you find a question or an error during the review and correction period.

We are excited to announce that the Reports and Analytics Contractor, the contractor who calculated and created the hospital-specific report are here to provide that overview. If you have any questions during the presentation, please do not hesitate to enter your questions into the chat tool. Any questions not answered during today’s presentation, either through the chat tool or after the presentation during the Q&A session, will be answered and posted in the Q&A document on the Quality Reporting Center website.

Without further ado, I would like to introduce today’s speaker, Kayte Hennick. Kayte is a senior analyst with the Hospital Reporting Reports and Analytics Contractor. Now, [the] Reports and Analytics Contractor is responsible for producing the hospital-specific report for the claims-based measure of the AHRQ PSI-90 Composite and the 30-day Mortality Measures.

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Kayte, the floor is yours.

Kayte Hennick: Thank you, Bethany. So today, as Bethany said, I'm just going to go over the hospital-specific reports that AHRQ PSI-90 Composite Measure and the 30-day Mortality Measure.

So if you can please advance the slide.

And I believe Bethany already touched on this. We're just going to discuss how to receive your HSRs, go over the calculations and how to read the HSR, and then review the process for submitting a Review and Correction Request.

Next slide please. Okay, and next slide.

So the first item is to go over how to receive your HSR and the *QualityNet* notification indicating the reports are available sent via e-mail to those who are registered for the notifications regarding the Hospital Inpatient Quality Reporting Program. Hospital users with the Hospital Reporting Feedback-Inpatient role and the File Exchange and Search role will have access to the HSRs and the User Guide. For those with the correct access, the HSRs and User Guide will be in the My *QualityNet* Secure File Transfer Inbox.

Next slide please.

So, first is the HVBP AHRQ HSR. Please note that there is data contained within this presentation; however, it is mock data.

Next slide please.

The HVBP AHRQ HSR is laid out to present hospital results. In the first table, (the table that followed going to further detail to show how that information were derived) Table 1 provides the hospital results for the AHRQ PSI-90 Composite Measure that will be used in a Hospital Value-Based Purchasing Program for calculating achievement and improvement claims for the AHRQ PSI-90 Measure. The following columns that are found in Table 1, the Performance Period Index Value, which is a weighted average of eight individual Patient Safety Indicators, this will be to calculate achievement and improvement points for the AHRQ PSI-90 Outcome Measure and the Hospital Value-Based Purchasing Program.

The achievement threshold was calculated as the median index value among all hospitals with the measure results and minimum valid discharges during the fiscal year 2016 baseline period. The benchmark was calculated as the mean average of the unrounded composite rate of hospitals in the lowest 10 percent of index values among all hospital with measure results and minimum valid discharges during the fiscal year 2016 baseline period. The achievement threshold and benchmark are provided here for your convenience.

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Next slide please.

Table 2 provides more details about the AHRQ PSI Component Measure that makes up the PSI-90 Composite. The composite is calculated from PSI 3, 6, 7, 8, 12, 13, 14, and 15. And one thing to note here is the number of outcomes or numerator row because this (passes) to the information shown on Table 3.

Next slide please.

Table 3 contains information on patient discharges that has an outcome interest for at least one PSI during the reporting period. The (count) of discharges for each measure in this table should tie out to the number of outcomes and numerator value that is shown for each PSI measure in row 11 of Table 2.

The measure column identifies which PSI the discharge had an outcome for the PSI-triggered diagnosis or procedures column as the diagnosis or procedures that triggered the discharge for the specific PSI. For the survey, in this table, which is not shown on the slide, are the diagnosis codes, but they're related present on admission or POA codes for the procedure codes for each discharge. A triggered-diagnosis will have a corresponding POA code of N or U. And N indicates the diagnosis was not present at the time of admission.

Next slide please.

So replication instructions are included in the HSR description document that is distributed with the HSR. These instructions enable hospitals to complete the calculation and verify the results presented in the HSR are correct. A sample replication document in Excel format can be requested through the *QualityNet* Help Desk. This Excel document provides step-by-step instructions, as well as sample calculations. The following values can be replicated with these instructions: the observed rate, the risk-adjusted rate, the smoothed rate, and the composite value.

Next slide please.

So this slide shows the kind of Table 2 to show an example of the calculation. It's advised to use Excel when performing the calculation. So the first step is to save a separate copy of the HSR to begin. Next, delete the footnotes under the table so there is room to perform the calculation below the data.

Moving on to the calculation, the first step is to calculate the observed rate. This is done by dividing the number of outcomes in row 11 by the total number of eligible discharges in row six then multiply the results by 1,000 to get the observed rate per 1,000 discharges. Please note the example on the slide only shows the process for column D, but each step in the replication instruction should be completed for every PSI.

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In Column C, below the table, there is an example of the calculation being used to calculate the observed rate per 1,000 eligible discharges for PSI-6. The results of performing those calculations are shown in cell D18 and D19. When the calculated value is rounded at two decimal places, the result should match cell D12. The observed rate is the actual number of outcomes per eligible discharges times 1,000, which is also referred to as the row rate.

Next slide please.

Next, calculate the risk adjusted rate per 1,000 eligible discharges. Continue this calculation below the one you performed in the previous step. The first step is to take the unrounded observed rate which was calculated in the previous step and derived by the expected rate, which is row 14 of the HSR, then multiply the result by the HCUP national rate for each measure. And these values are found in the HSR User Guide that were distributed with your HSRs and can also be found on the *QualityNet* website.

Lastly, multiply this value by 1,000. When the result is rounded to two decimal places, this should match the risk-adjusted rate in row 13 of your HSR. Again, the same calculation should be done for each component measure. The risk adjusted rate per 1,000 eligible discharges is an estimate of the hospital's performance on each PSI, except PSI-90 Composite if the hospital had an average patient case mix given the hospital's actual performance.

Next slide please.

Next, calculate the smoothed rate per 1,000 eligible discharges. Again, just a reminder to continue these calculations below the ones performed in the previous step. To calculate the smoothed rate per 1,000 eligible discharges, multiply the unrounded risk-adjusted rate from the previous step by the reliability rate shown in row 15, then multiple the national risk-adjusted rate in row eight by one minus the reliability rate. Finally, add these two values. If the calculated value is rounded to two decimal places, it should match the smoothed rate per 1,000 eligible discharges for this measure shown in cell D7 of the report. The same calculation should be done for each component measure.

Reminder to continue using Excel to perform these calculations, which are shown here in column C below the table. The results of performing those calculations are shown in column D. The smoothed rate is calculated for each hospital, and it is the weighted average of the hospital's risk-adjusted rate and the national Medicare risk-adjusted rate.

Next slide please.

Next, we'll calculate the PSI-90 Composite. The composites combined all of the component measures. So ensure the previous step has been completed for each component measure. Again, continue these

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calculations below the ones in the previous step. The rows are hidden in the slide for purposes of this presentation.

In order to calculate the PSI-90, the first step is to divide the unrounded smoothed rate from the previous steps by 1,000, then divide that result by the HCUP national rate for that measure. Next, multiply the results by the measure's weight and composite. If the measure has fewer than three eligible discharges, as in the case for PSI-13 in this example, the national risk-adjusted rate is used in place as the smoothed rate for that measure. So the calculations, in turn, would be the national risk-adjusted rate divided by 1,000. Then divide that result by the HCUP national rate for the measure and multiply by the measures weight and) composite.

The final step is to sum the values calculated in the previous step, the results of which are shown in row 35 on the example. This value, when rounded to six decimal places, should equal the composite index value in cell B9. Note that the results for the PSI-90 calculation may be different from the PSI-90 composite index value, and in cell B9 of Table 2 of the HSR, out to the fourth, fifth, or sixth decimal to the differences in rounding between Excel and (that).

Once CMS calculates the PSI-90 Composite for the Hospital Value-Based Purchasing Program, it uses that. So the values reflected in the HSR are based on the (fact) calculations method in Excel. Again, the simple calculations here are shown in cell B of the table. The results of performing those calculations are shown in column C through J.

And just an added note here regarding smoothed rates; so smoothed rates calculated by taking the weighted average of a hospital's risk-adjusted rate and the national risk-adjusted rate, the weight used for the hospital's risk-adjusted rate, is an estimate of its reliability. Sometimes the hospital's risk-adjusted rate may be zero as a result of having zero numerator count. When this occurred, they will (hear) cases which estimate performance.

So the weight given to the risk-adjusted weight tends to be smaller while the weight given to the national risk-adjusted rate tends to be larger because of data reliability. Therefore, it's not uncommon that hospitals with smaller sample sizes, their numerator counts may have smoothed rates closer to the national risk-adjusted rates better than their own risk-adjusted rates.

The smoothed rate reflects the fact that results for hospitals with small sample sizes are measured less accurately and less reliably than for hospitals with a much larger sample size. The smoothed rate also adjusts for small numbers of discharges and offers the more accurate prediction of the hospital's expected performance with a large number of patients than the hospital risk-adjusted rate.

Okay, next slide please.

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Another thing to touch on here is differences in the IQR and HVBP results per AHRQ, and those are due, in part, to a few factors. The first is different data periods were used for the calculation. Another is the diagnosis and procedure codes. The HVBP program always uses the same number of diagnosis and procedure codes for the baseline and performance period. So during the HVBP baseline period, which was October 15, 2010 to June 30, 2011, only nine diagnoses and six procedure codes [were] available. For the first time, not 25 diagnoses and procedure codes were used for VBP within the fiscal year 2019 baseline.

Another item is a difference in software versions for HVBP versus the IQR program. The most recently available software is used to calculate the HVBP baseline result, which was 4.4. And so, again, for consistency, the same version of the software is used for the VBP performance period. For IQR, the most recently available software is used, which is 4.5a.

Okay, next slide please. So next – I'll move on [to] the HVBP Mortality HSR. Next slide.

To measure the VBP AHRQ HSR, the mortality HSR is laid out to provide the hospital results in the first table and then go into further details in the tables that follow to show how the information was derived. Table 1 provides the hospital results for acute myocardial infarction, heart failure, and pneumonia mortality measures that will be used in the Hospital Value-Based Purchasing program for calculating achievement and improvement points for these outcome measures.

The achievement threshold and benchmark were calculated in fiscal year 2016 baseline data and are provided here for convenience. The following columns can be found in Table 1. The number of eligible discharges, which is the count of the discharges used for the measure calculation to perform (its period) survival rate will be used to calculate achievement and improvement points for these outcome measures in the VBP program.

The achievement threshold is calculated as the median survival rate among all hospitals with measure results in at least 25 cases during the fiscal year 2016 baseline period. The benchmark was calculated as the mean average of the top 10 percent of survival rates among all hospitals with measure results in at least 25 cases during the fiscal year 2016 baseline period.

Next slide please.

Table 2 includes additional provider-level values that are used in the calculation of the performance period survival rate, as shown in footnote F. The risk-standardized mortality rate or RSMR can be calculated with values found in this table, and the predicted deaths divided [by] expected deaths multiplied by the national observed mortality rate.

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Footnote B shows that subtracting the risk-standardized mortality rate value from one results in a performance period survival rate shown here in (201). Footnote E shows that the national observed mortality rate is calculated as the number of observed 30-day deaths nationally divided by the number of eligible discharges nationally. Since these are national values, these rates cannot be replicated in the data provided in the HSR.

The following columns are found in Table 2. The predicted deaths is the number of predicted deaths within 30 days from admission on the basis of the hospital's performance with its observed case mix and your hospital's estimated effect on mortality. The "expected deaths" is the number of expected deaths within 30 days of admission on the basis of the average hospital performance with your hospital case mix and the average hospital effect. The replication process detailed later will show how to predict the deaths and expected deaths that are calculated.

The national observed mortality is calculated as the number of observed 30-day deaths nationally divided by the number of eligible discharges nationally. The risk-standardized mortality rate, or RSMR, is a mortality rate that has been adjusted for differences in case mix across hospitals and hospitals which have specific effect and is calculated as predicted death divided by expected death and multiplied by the national observed mortality rate. The performance period survival rate is calculated as one minus the RSMR.

Next slide please.

The discharge table contained discharge level data for all Part A Medicare fee-for-service patient stays with primary qualifying diagnosis of AMI, heart failure, or pneumonia, accordingly, that had a discharge date in the reporting period for patients who are aged 65 and above at the time of admission. The ID number on the discharge table is provided as a way to reference records who are all avoiding sharing protected health information.

The HICNO column through the Discharge Destination column contained the data as it was pulled from hospital claims. The Index Stay column indicates whether the stay is included in another calculation by a "Yes" or a "No." The stays that are (found) – "Yes" represents the discharges found in the Number of Discharges column in Tables 1 and 2. For stays that are not included in the measure, the inclusion/exclusion indicator column has number or numbers one through eight indicating the reason or reasons why the stay was excluded. The corresponding descriptions for the numbered reasons are defined in the User Guide by the company, the HSR.

Next slide please.

The death was in 30-day flag; "Yes" or "Nno" indicates that the patient died within 30 days of admission. The Risk Factor Variable column

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contained the model risk factors which vary by measure. For each measure, these columns start with the Male Risk Factor and end with the Age 65-Risk Factor. The risk factors vary by measure, so Table 4 in the User Guide provides the description for each.

Row 8 in the HSR contains the model coefficient for each risk factor which are estimates over data for all hospitals. Beginning in row nine of the HSR, under the risk factor, this cell will contain a one if the patient was identified as having that risk factor and equal the years above 65 for the age 65-variable and a zero otherwise. The Hospital Effect represents the underlying risk of a mortality at the specific hospital after accounting per patient risk, and the Average Effect represents the underlying risk of a mortality at the average hospital after accounting per patient risk.

Next slide please.

Again, the User Guide is distributed with your HSR and an Excel document with sample calculation and step-by-step instruction can be requested from the *QualityNet* helpdesk. The replication process for the mortality measure includes the following steps: calculate predicted death, expected death, the risk-standardized mortality rate, and the performance period survival rate.

Next slide please.

As with the AHRQ Replication, to begin, save a copy of the HSR to work from and complete the calculations in Excel, working below the actual data. The replication step should be completed on the discharge level worksheet for each mortality measure. So, step number one of the replication process is to identify eligible discharges. To do this, limit the Index Stay column to "Yes."

Next slide please.

For each eligible discharge identified in the previous step, multiply the risk factor flag by the relevant coefficient found in row eight. As an example of the calculation, the formula shown in cell L26 was used for the cell next to it, so M26. When the results are compared to the table above, note the coefficient has gone down for those that had the risk factor of one.

Next slide please.

Next, sum all the products of the risk factor times coefficient from the previous step for each index discharge. The calculation [is] shown in the example as sum of M26 through AM26. Then add the Hospital Specific Effect, which is the Hospital Effect Value found in cell AN8. The calculation [is] shown in the example as AP26 plus AN8. Note that this is just an example for the AMI mortality measure. The heart failure and pneumonia measure both have more risk factors, so the formula example shown in these steps would be different for those measures.

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Next slide please.

Next, calculate the predicted probability of a 30-day death for each day using the formula shown. Note that EXP in the formula is the Excel and Exponential Function, and then add the Hospital Effect Result from the previous step.

Next slide please.

Finally, sum the predicted probability of a 30-day death for all stays to get the number of predicted deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the predicted death value for this measure in Table 2. The example formula of (sum) AR26 through AR37 was used to sum the values with the predicted deaths in cell AR40. Each hospital will likely have a different quantity of discharges, so the formula will need to be adjusted accordingly.

Next slide please.

To calculate the expected deaths, death with the summed products of the risk factor flags times the coefficients that were created in the predicted death calculation and add the Average Hospital Effect, which is the Average Effect Value found in cell AL8. Next, calculate the expected probability of a 30-day death for each day using the formula shown. Again, EXP is the Excel Exponential Function, and add average effect results from the previous death.

Next slide please.

Finally, sum the expected probability of a 30-day death for all days to get the number of the expected deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the expected death values for this measure in Table 2. The example formula shown was used to sum values for the predicted deaths in cell AU40. Again, each hospital will likely have [a] different quantity of discharges and will need to adjust the formulas accordingly.

Next slide please.

To calculate the Risk-Standardized Mortality Rate, first, divide predicted death by expected death. This results in the standardized mortality ratio. This value is then multiplied by the National Observed Mortality Rate from Table 2 to get the Risk-Standardized Mortality Rate. When this value is rounded to six decimal places, it should match the risk-Standardized Mortality Rate Found in Table 2. The Excel formulas used for the calculations are shown in column AS as the result – excuse me – the result of those calculations are shown in column AP.

Next slide please.

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The Performance Period Survival Rate is calculated as one minus the risk standardized mortality rate. When this value is rounded to six decimal places, it should match the Performance Period Survival Rate found in Table 2. The Excel formula used for the calculation is shown in column AS. The result of the calculation is shown in AP.

Next slide please.

The fiscal year 2016 HVBP HSR User Guide PDF that accompanies the AHRQ and Mortality HSRs includes additional information on the HSR and also includes the examples for [the] replication processes that were just covered.

Next slide please.

So, now we'll move on to the Review and Correction Process.

Next slide please.

The Review and Correction Period for fiscal year 2016 is April 10, 2015 thru May 11, 2015. Please pay special attention to the deadline of the Review and Correction Period. Hence, requests sent after May 11, 2015 will not result in the correction.

Next slide please.

Review and Correction Requests can be submitted via email to gnetsupport@hcqis.org or over the phone at 866.288.8912 or 877.715.6222. When emailing the Review and Correction Request or referencing content in your report, please ensure if you're referencing a specific date of discharge to use the ID number associated in the HSR rather than sending patient information via email.

Next slide please.

So, suspected calculation errors on your report can be submitted for review with the possibility of a correction. In addition to general questions about the HSRs, the mortality measures or the AHRQ measures may be submitted. Request for submission of new or corrected claims are not allowed, and this is due to the fact that a snapshot of the administrative claims data is taken approximately 90 days after the applicable period in order to perform program calculation. So, for fiscal year 2016, the applicable period ended on June 30, 2014, and the administrative data file used for those calculations was produced on September 26, 2014. The review and correction process does not allow hospitals to submit additional corrections related to the underlying claims data used for the calculations or as new claims to the data extract used to calculate the rate. CMS cannot regenerate the report for the page request corrected claim, so those will not be updated.

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One thing to check is that in many cases where claims listed in the HSRs don't match internal records at the hospital, is due, in part, to the fact that corrections were made after the snapshot date referenced previously.

Next slide please.

Okay, the slide is just for resources for the HVBP Program, as well as links to more information regarding the AHRQ PSI-90 Composite and 30-day Mortality Measures.

So – and with that, I will hand things back over to Bethany.

Bethany Wheeler: Great, thank you, Kayte. Can we go to the next slide, please?

Kayte listed some great references and resources for you to contact if you have any questions in regards to the 30-day Mortality Measures or the AHRQ PSI-90 Measures. But, if you have any questions regarding the Hospital Value Based Purchasing Program or Hospital IQR Program in general, here is another set of resources for you to contact the VIQR support contractor, and we would be happy to assist you in any questions you may have.

Next slide please.

One of the most common questions that came in during the WebEx was “Is this program being recorded?” Yes, the answer is yes, this program is being recorded. A transcript of the presentation along with the Q&A will be posted to our inpatient website, www.qualityreportingcenter.com. Today's webinar has been approved for one continuing education credit by the boards listed on the slide.

Next slide please.

We now have an online CE Certificate process. You can receive the CE Certificate two ways: if you registered for this webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey takes you to the certificate. We will also be sending out the survey links and an email to all participants within the next 48 hours. If there are others listening to this event that are not registered in ReadyTalk®, pass the survey on to them.

Next slide please.

This is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click “Done” at the bottom of page when you are finished.

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This is what pops up after you click “Done” on the survey. If you have already attended our webinars and received CEs, click “Existing User.” If this is your first webinar for credit, click “New User.”

Next slide.

This is what the main user screen looks like. Please register a personal email, like Yahoo or Gmail, (inaudible) not blocked by hospital firewall. Remember, your password [was] sent to you. Remember your password since you will use it for all of your – all logins.

Next slide please.

This is what the existing user screen looks like. Use your complete email address and your user ID and the password you registered.

Next slide, please.

Now, it’s time to move to our Q&A session, and I would like to turn the presentation back over to Shannon Derow, Senior Reports and Analytics Contractor, to address any of the questions and answering these that were posted in today’s WebEx.

Shannon Derow:

Hello. I will just read some of the questions that we’ve gotten and their answers so far in this presentation. Okay, one of the ones we’re getting here a little more frequently is, “Where are the HCUP rates found?” The HCUP rates can be found on your Hospital Specific Report User Guide that was delivered with the report and is also available on the *QualityNet* website on the Hospital Value-Based Purchasing page. If you are in your User Guide, they can be found on page 27, okay?

Another popular question we’ve been getting is, “How many secondary diagnosis codes are used to identify the PSI patients?” The first nine diagnosis codes and the first six procedure codes are used in identifying PSI patients.

Okay, “PSI-90 is part of both HVBP and the HAC Reduction programs. Will the hospital’s PSI-90 score always be the same across these two programs?” The answer is no, not necessarily. The PSI-90 score for these two programs will not necessarily be the same. For example, for the fiscal year 2016 period, the calculations for the PSI-90 score for these two programs are using different reporting periods and different AHRQ software versions, which will result in different rates.

Another question here, “Is the risk-Adjusted Rate different for different hospitals?” The risk-Adjusted Rate is an estimate of your hospital’s performance on each PSI, if your hospital had an average patient case mix. Therefore, since this is calculated for each individual hospital, this rate can be different between hospitals and most likely will be.

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Okay, "What version of the AHRQ software was used to calculate the PSI performance scores?" AHRQ software version 4.4 is used for the fiscal year 2016 Hospital VBP Program to calculate the results.

"What is the Smoothed Rate?" The Smoothed Rate is the estimate of your hospital's expected performance with the large population of patients for each PSI.

Okay, let me grab another one here. "If our internal audits found coding errors, how can we request a review and correction of our report?" If you have identified coding errors during your internal review, you can submit or to correct the claim using the CMS standard profit – process, but CMS cannot generate a new report for you. If you have previously corrected these claims, but had done so after September 26, 2014, the corrected claims will not be in your measure results.

Oh, look here, I got a question to "repeat the explanation of the Smoothed Rate." The Smoothed Rate is the estimate of your hospital's expected performance with large population of patients for each PSI.

Question, "Does the Medicare fee-for-service include Medicare advantage, example, Humana?" No. It's not.

Down here, let me find an earlier question. "Where can I find more information on the AHRQ indicators used in that Hospital VBP Program?" More information may be found on the *QualityNet* Website in the AHRQ section under Hospital-Inpatient Claims-Based Measures page. This page will contain a lot of information on the AHRQ Program, including which software version is used for the different programs that include AHRQ, how many procedure and diagnosis codes are used, links to the hospital's specific reports, technical specifications and coefficient tables. You may also find more information on the AHRQ PSI website. The link for that can also be found on *QualityNet*.

If you are having trouble replicating the scores using that data on your HSRs and the replication instructions in the User Guide, an Excel example can be requested through the Helpdesk. This example will show the individual steps and the formulas used and contains mock data from which you can replicate your own scores using your HSR.

Another question, "When is the deadline for submitting a Review and Corrections Request?" The deadline for submission of Review and Corrections Requests is 11:59 p.m., Pacific Time on May 11, 2015.

Question: "Does a code of (W) count is 'not present on admission?'" The answer is, only POA codes N or U count is not present on admissions for the AHRQ calculations.

Okay, we have a question here. "Can you please elaborate more on what it means 'request for submission of new or corrected claims to the underlying data are not allowed?'" This means that you're not allowed to

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submit corrected or new claims and have them cause a recalculation of your scores on this HSR. That you can follow the CMS standard process to collect these claims, but they will not be included on this year's reports.

Question, "What does HCUP stand for?" The answer is Healthcare Cost and Utilization Project. This is the rates that are used as part of your PSI-90 calculations as explained in your User Guide.

Okay, question: "Where can I find the Inclusion and Exclusion Criteria for the patients that are on the Mortality HSR?" The Mortality Inclusion Criteria can be found in the User Guide that accompanies your HSR. These are listed out on page eight of your HSR or – I'm sorry, of your hospital's specific user guide. These correspond to column "J" on your discharges table.

Okay, let me grab maybe one or two more questions here. OKAY, question, "Even though it is past the correction date to update to CMS report, is there any benefit to submit corrections to the coding errors?" Yes, there is a benefit due to the length of the reporting period. If claims are not corrected, they will continue to show up on your reports, and if it's a case where they are hurting your score, it will continue to do so if they are not corrected.

Okay, question, "If you would like to refer to a specific claim on your HSR when requesting a review or correction or asking general questions, there are two ways you can do this without causing a security violation and without using secured file transfer?" This can be done by either referencing the ID number from column A of your discharges table or by the Excel row number. When you're doing so, please indicate which you are using, the ID number or the row number. This will help avoid confusion while – for those answering your questions.

If you would like an example of the formulas used in this presentation, in the replication instructions slides, you can request [them] from the Helpdesk – the additional information sheet that contains this. In the – when you're doing so in the subject line, put "Request for Hospital VBP replication example," and this will get you the Excel sheet with the mock data and the examples of the replication.

Okay, Bethany, I think that's most of the questions here.

Bethany Wheeler: Great, thank you, Shannon. So, that brings our presentation to a close today. I want to thank the Reports and Analytics Contractor for presenting and answering so many questions that they did today. And I want to thank you all for joining our WebEx today. Everyone, have a great day. Thank you.

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