Inpatient Quality Reporting Program

Support Contractor

Hospital Value-Based Purchasing (VBP) Claims-Based Measures

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Question 1: Did the last speaker say the VBP Summary Report will be sent in August?

Answer 1: The Percentage Payment Summary Reports will be released by August 1 each year.

Question 2: Will Critical Access Hospitals also receive this report?

Answer 2: The Hospital VBP Hospital-Specific Reports (HSRs) and Percentage Payment Summary Reports will be made available to acute care hospitals only at this time.

Question 3: Is there any limit to who can access the QualityNet Secure Portal? Our quality people have access, but Finance does not have direct access. Can multiple staff have access?

Answer3: Yes, the additional staff would need to request a QualityNet Secure Portal account be created.

Question4: This example seems like a very low Inpatient Amount. Slide 27.

Answer 4: Yes, this spending amount is less than the national average amount of $8,997.

Question 5: Slide 28: Isn't the inpatient spending LOWER than the state/national numbers, or is this an inverse number measure?

Answer 5: Correct, in this example the hospital's spending on inpatient is less than the state and national averages.

Question 6: For Medicare Spending per Beneficiary (MSPB): Our hospital has a wonderful Inpatient Rehab unit that is billed for under a separate CCN, and many patients/physicians choose to utilize our hospital for their inpatient visit so that they can easily move to the Inpatient Rehab unit post discharge. We also have a large number of patients that are discharged to skilled nursing facilities (SNFs). Is there any consideration in your methodology that would incorporate this type of relationship between the index admission and post level of care? There must be other hospitals that might be impacted by their relationships to the post discharge care. It appears we could be penalized for sending our patients to these post-acute care facilities and [thereby] incur higher costs.

Answer 6: The MSPB measure includes all spending in the 30-day period post-discharge. While the MSPB is risk-adjusted to account for differences in patient characteristics, there are no exclusions or revisions to this spending for hospital characteristics.

Question 7: How often are hospitals finding errors in the mortality review?

Answer 7: Errors in the coding of claims varies by hospital, depending on their quality assurance efforts in the coding and/or billing departments.

Question 8: When will the HSRs be released? (Apologies if you've already announced that.)

Answer 8: The HSRs for FY 2016 Hospital VBP Mortality Measures and AHRQ PSI-90 Composite are currently scheduled to be released sometime in April 2015, but the date is subject to change. The Hospital VBP MSPB HSRs are anticipated to be released in May-June 2015.

Question 9: If we are not able to correct claims data at this point, when do we have that opportunity?

Answer 9: If your quality review identifies a coding error on your claim, we suggest you correct the claim using CMS' standard process and follow up with your coding and/or billing department to ensure this type of error does not occur in the future.

Question 10: What is the most current hospital-specific data available? Is 3rd Quarter 2014 available? Our main question is, when will the FY 2015 data be available and are there interim reports?

Answer 10: The most current HSR with claims detail had claims that went through June 30, 2013 for the Mortality and AHRQ PSI-90 measures. The next Hospital VBP HSR will contain claims dated through June 30, 2014. The HSR is the only report sent that contains claims. No interim reports are sent.

Question 11: Thank you. Am I correct then, that no FY 2016 or FY 2017 data will be available until June 2016 and June 2017? We're interested in FY 2017 data to ID current opportunities. We're particularly interested in more recent 30-day mortality data.

Answer 11: FY 2016 is the report that will be sent out this year and will contain data through June 30, 2014 for the Mortality Measures and AHRQ PSI-90. More current data will not be available until later program years. The MSPB HSR will contain data from the FY 2016 performance period spanning from January 1, 2014 – December 31, 2014.

Question 12: How often are the AHRQ HSR and Mortality HSR available? Quarterly? Monthly?

Answer 12: Hospital VBP HSRs for AHRQ and Mortality are sent out annually. The MSPB HSR for the Hospital VBP Program is also provided annually.

Question 13: What version of AHRQ indicators is the VBP utilizing, and how many diagnosis codes are used to identify the numerators (1-9) or (1-25)?

Answer 13: The HSR that will be produced in 2015 for the FY 2016 will use AHRQ version 4.4 and use diagnosis codes 1-9 and procedure codes 1-6. The FY 2017 Baseline and Performance period results will utilize AHRQ version 4.5a and use diagnosis codes 1-9 and procedure codes 1-6.

Question 14: Can you explain more about *average hospital effect* and *hospital effect*? It seems like it is related to their case mix index, but it definitely seems to impact the results.

Answer 14: Hospital-specific effect and hospital-average effect are used, along with Risk Factors that determine case mix, to calculate the predicted and expected deaths as is detailed in the Description of the Hospital VBP document that is available on QualityNet.org

Question 15: I just want to confirm [that] only one episode is required for the MSPB measures to be calculated, and 25 episodes are required for Hospital Compare reporting?

Answer 15: One episode is required for the MSPB measures to be calculated, and 25 episodes are required for Hospital Compare Reporting.

Question 16: Slide 32: Which risk score system is used for beneficiaries, HCCs, APRDRGs, other?

Answer 16: The MSPB measure uses the HCCs in the risk adjustment model to account for illness severity. Please note that the MSPB does not use the risk scores produced by the CMS-HCC software, since they are meant to predict annual per capita cost. The purpose of the MSPB measure is different in that it assesses the cost of services performed by hospitals and other healthcare providers during an MSPB episode. In this case, re-estimating the model using HCCs is more appropriate, as these variables can have different effects on MSPB cost than they do on annual per capita cost.

Question 17: Since the hospitals are paid on a Diagnosis-Related Group (DRG) basis, reducing inpatient spending does not have impact on reducing MSPB.

Answer 17: If a hospital reduces inpatient readmissions or discharges to inpatient rehabilitation, it will reduce post-discharge inpatient spending for that MSPB episode. This, in turn, will improve the hospital's MSPB measure, since the MSPB measure captures costs three days prior to the start of hospitalization through 30 days post discharge.

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