Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Inpatient Hospital Quality Programs: Payment Updates and Overview

Questions and Answers

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October 11, 2017
2 p.m. ET

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Question 1: **When will the fiscal year (FY) 2018 HAC Reduction Program data be published?**

The FY 2018 HAC Reduction Program data will be publicly reported on *Hospital Compare* in December 2017.

Question 2: **Where can I find the component weights for the underlying indicators of the modified Patient Safety Indicator (PSI) 90 (Patient Safety and Adverse Events Composite) for FY 2019??**

The FY 2019 PSI component weights are not yet available. The FY 2018 component weights are included in Table 1 of Question 22 of the FY 2018 HAC Reduction Program Frequently Asked Questions (FAQ) under the Resources web page on the *QualityNet* website, located here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298670

Question 3: **We clarified with the Healthcare Quality Improvement System (HCQIS) that our corrected claims data would be accepted if they were submitted before the 9/27/17 cutoff date. However, your slide states 9/30/2016 as the cutoff date. Please clarify the year.**

The 9/30/2016 date is the claim cutoff date for FY 2018. The 9/27/2017 date is the claims cutoff date for FY 2019.

Question 4: **What are the performance periods for the FY 2019 HAC Reduction Program?**

Performance periods are as follows:

FY 2019

Domain 1: 10/1/2015–6/30/2017
Domain 2: 1/1/2016–12/31/2017

FY 2020

Domain 1: 7/1/16–6/30/18
Domain 2: 1/1/17–12/31/18

Question 5: **Will there be a release of hospital-specific reports (HSRs) for the modified PSI 90 Composite scores for FY 2018?**

The initial reports were released on 7/19/17 with a 30-day review and correction period; the second review and correction period started on 9/14/17 and ended on 10/13/17. The results will be posted to *Hospital Compare* in December 2017.

Question 6: **Are critical access hospitals (CAHs) subject to the HAC Reduction Program?**

No. As defined under the Social Security Act, all subsection (d) hospitals are subject to the HAC Reduction Program. CMS exempts certain hospitals and hospital units from the HAC Reduction Program. The following list includes exempted hospitals and units:

- CAHs
- Children's hospitals
- Long-term care hospitals (LTCHs)
- Prospective payment system (PPS)-exempt cancer hospitals (PCHs)
- Psychiatric hospitals
- Rehabilitation hospitals and units
- Short-term acute care hospitals located in Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa
- Religious nonmedical health care institutions (RNHCI)

For a full description of subsection (d) hospitals, refer to the Social Security Act on the Social Security Administration website, located at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm.

Maryland hospitals are exempt from payment reductions under the HAC Reduction Program. These hospitals currently operate under a waiver agreement between CMS and the State of Maryland.

Question 7: **Do these five CMS programs include CAHs?**

CAHs are not included in the HAC Reduction Program, the Hospital Readmissions Reduction Program (HRRP), or the Hospital VBP Program. In the Hospital IQR Program, CAHs do not receive payment reductions from nonparticipation or failure to meet one or more of the requirements. However, CMS does encourage CAHs to report the data for their own quality improvement

purposes, for the data to be available on *Hospital Compare*, and for other initiatives that may use the posted data. CAHs are included in the Electronic Health Record (EHR) Incentive Program. For more information, please visit the Medicare EHR Incentives Program page on the CMS website.

Question 8: **Where can I find more information regarding the modified PSI 90 Composite?**

In FY 2018, the HAC Reduction Program and Hospital IQR Program used the modified version of the Recalibrated PSI 90 Composite, calculated using the recalibrated version 6.0.2 of the PSI software. You can find more information on *QualityNet* at this direct link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774294977.

Question 9: **Is anything being studied to evaluate the impact of the HAC Reduction Program penalty on small hospitals?**

CMS appreciates the feedback and continues to review the data used in the program and evaluate options for situations where facilities have low denominator volume or few infections.

Question 10: **Where can I find a reference list for the requirements for the Hospital IQR Program?**

A reference checklist for FY 2019 is available on the Hospital IQR Program Overview page on *QualityNet*.

Question 11: **Why is the payment for the Hospital IQR Program in FY 2015 and subsequent years not given as a percentage point? Why is one-fourth of the market basket update (MBU) used?**

In FY 2015, the MBU reduction for not meeting one or more of the requirements or not participating in the Hospital IQR Program was changed from 2.0 percentage points to one-fourth of the MBU.

For example, if the MBU was 3 percent in FY 2014, the reduction from the Hospital IQR Program would be 2 percentage points of the 3 percent, netting an increase of 1 percent after the Hospital IQR Program (not including

other adjustments).

If the MBU was 3 percent in FY 2015, the reduction from the Hospital IQR Program would be one-fourth of the 3 percent, netting an increase of 2.25 percent after the Hospital IQR Program (not including other adjustments).

Question 12: Does CMS adjust payments based on the calendar year or fiscal year for the EHR Incentive Program?

The EHR payment adjustments are based on the fiscal year. For example, the FY 2018 payment adjustments for the 2017 program year would begin on October 1, 2017, and will continue for the entire fiscal year, which would end on September 30, 2018.

Question 13: Can you clarify the payment percentages on slide 27?

CMS considers what is outside of the sequestration; a CAH is normally reimbursed at 101 percent of reasonable cost. Therefore, you could see every time a CAH is not a meaningful user, its reimbursement is reduced accordingly. Currently, the reduction is at 100 percent of reasonable cost, which is 1 percent less than 101 percent.

Question 14: What is the difference between the Hospital IQR Program reflected on *Hospital Compare* and the Hospital VBP Program?

The Hospital VBP Program is built on the framework of, and uses measures submitted to, the Hospital IQR Program; however, there are some differences between the programs. For example, the Hospital IQR Program used a modified version of the PSI 90 Composite in FY 2018 and the Hospital VBP Program used the older version.

For more information regarding the PSI 90 Composite in CMS programs, refer to the March 29, 2017 webinar Updates on Patient Safety Indicators (PSIs) for Use in CMS Programs, available on the *Quality Reporting Center* website at this direct link: https://www.qualityreportingcenter.com/inpatient/iqr/events/.

If you have a specific question regarding the comparison of the Hospital IQR Program to the Hospital VBP Program, please submit your question to the Hospital Inpatient Questions and Answers tool on *QualityNet*.

Question 15: **Please explain further the calculations on slide 37**.

To translate your Total Performance Score (TPS) to a payment adjustment factor, follow three steps.

In Step 1, calculate your value-based incentive percentage by multiplying the following values:

- Percent reduction (withhold) in fiscal year 2018 of 2 percent
- TPS/100
- Exchange function slope

In Step 2, take your hospital's value-based incentive percentage (the result of Step 1) and subtract the percentage reduction (withhold) of 2 percent. The resulting value is known as the net percentage change in base-operating diagnosis-related group (DRG) payment amount.

In Step 3, take your net percentage change amount in the numerical form (as opposed to percentage form) and add the value of 1.

For more information on these calculations and other calculations in the Hospital VBP Program, please refer to How to Read Your Fiscal Year (FY) 2018 Hospital Value-Based Purchasing (VBP) Program Percentage Payment Summary Report (PPSR), available on the Resources web page on *QualityNet*.

Question 16: **What rate is the actual rate used in the HRRP? What is the difference between expected and predicted readmissions?**

The HRRP uses the excess readmission ratio (ERR) to assess performance. The ERR is calculated as the ratio of predicted readmissions to expected readmissions.

- Predicted readmissions are the number of unplanned 30-day readmissions predicted based on your hospital's performance with its case mix and the estimated effect of readmissions, known as the hospital-specific effect.
- Expected readmissions are the number of unplanned 30-day readmissions expected based on the average hospital performance given your hospital's case mix and the average hospital effect.

If your hospital is deemed to have excess readmissions, the ERR will be above 1.0.

Question 17: **Can you elaborate on the anticipated changes based on the 21st Century Cures Act provisions for FY 2019 on slide 55?**

The 21st Century Cures Act requires CMS to assess penalties based on a hospital's performance relative to that of other hospitals with a similar proportion of patients that are dually eligible for Medicare and full-benefit Medicaid. The legislation further requires that estimated payments under the stratified methodology equal payments under the unstratified methodology, also known as budget neutrality. The unstratified methodology will be used to calculate payment adjustments for FY 2018. The stratified methodology will be applicable starting in FY 2019. More information on the new methodology was provided in the FY 2018 Hospital Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule.

Question 18: **Can you describe the changes made to the modified PSI 90 Composite?**

CMS modified the recalibrated version 6.0.2 PSI software so the parameters (i.e., risk-adjustment coefficients, signal variance, and component weights) in the Recalibrated PSI 90 Composite derive from Medicare fee-for-service (FFS) claims data for July 2013 through June 2015. Recalibration does not affect the individual PSI measure specifications or which PSIs are in the composite.

The Recalibrated PSI 90 Composite is a weighted average of the risk- and reliability-adjusted versions (i.e., smoothed versions) of these ten recalibrated PSIs. The changes to the Recalibrated PSI 90 Composite include the following:

- Changed PSI 90 Composite name from "Patient Safety for Selected Indicators Composite" to "Patient Safety and Adverse Events Composite."
- Removed PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate from the composite because of potential overlap with the Central Line-Associated Blood Stream Infection (CLABSI) measure in Domain 2.
- Changed PSI 08 name from "Postoperative Hip Fracture" to "In-Hospital Fall with Hip Fracture Rate."
- Changed PSI 15 name from "Accidental Puncture or Laceration Rate" to "Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate."
- Added the following:
  - PSI 09 Perioperative Hemorrhage or Hematoma Rate
  - PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
  - PSI 11 Postoperative Respiratory Failure Rate

- Re-specified PSIs 08, 12, and 15:
  - The modified PSI 08 targets all hip fractures from inpatient falls.
  - The modified PSI 12 component indicator no longer includes extracorporeal membrane oxygenation (ECMO) procedures in the denominator or isolated deep vein thrombosis (DVT) of the calf veins in the numerator.
  - The modified denominator of PSI 15 is limited to discharges with an abdominal/pelvic operation, rather than including all medical and surgical discharges. To identify preventable events likely to become clinically significant, CMS modified the PSI 15 numerator to require (1) a diagnosis of an accidental puncture and/or laceration, and (2) an abdominal/pelvic reoperation one or more days after the index surgery.
- Modified the weight of each individual component indicator in the Recalibrated PSI 90 Composite, based on the volume of the adverse event (i.e., numerator weight) and the harm associated with the adverse event (i.e., harm weight). Previous versions only based component indicator weighting on volume.

For more information regarding PSI 90 Composite in CMS programs, refer to the March 29, 2017 webinar *Updates on Patient Safety Indicators (PSIs) for Use in CMS Programs* on the Quality Reporting Center website, located at this direct link: http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/.

Question 19: **We are a small hospital. How is our score handled when we don't meet the minimum of one predicted infection and one or more of the healthcare-associated infection (HAI) measures in the HAC Reduction Program?**

For the HAC Reduction Program, CMS follows the minimum set by the Centers for Disease Control and Prevention (CDC) for the HAI measures, which is 1.0 predicted infection. In a case where a hospital does not meet that predicted threshold for a measure, which could be for a small hospital, then that measure is not considered in the scoring for the HAC Reduction Program. A hospital that only met the predicted infection threshold for two of the measures in Domain 2 (rather than five), CMS would calculate the hospital's Domain 2 score based on those two measures rather than all five measures.

Question 20: **Is there a minimum eligible claim amount for the calculations in HRRP?**

Yes. For your ERR to be eligible to enter the payment adjustment factor formula, you need to have at least 25 cases for the measure.

Question 21: **Can you tell us when the results will be available to hospitals?**

CMS provides PPSRs on or around August 1 annually for the Hospital VBP Program. For FY 2018, the PPSRs were made available on July 27, 2017, in the *QualityNet Secure Portal*. On November 3, 2017, CMS released Table 16B, which contains the payment adjustment factors for all eligible hospitals in FY 2018. In December 2017, CMS anticipates releasing the measure data and scoring for the FY 2018 Hospital VBP Program on *Hospital Compare*.

The HAC Reduction Program had its initial review and correction period from July 19, 2017, through August 17, 2017; those PPSRs were delivered to hospitals via *QualityNet Secure Portal* Secure File Transfer. An error discovered with surgical site infection (SSI) data led to a second review and correction period that began September 14, 2017, and ended October 13, 2017. Hospitals are only allowed to review those data elements directly affected by the SSI error during the second review and correction period. Starting this year, the results will be posted only on *Hospital Compare* and no longer posted on *CMS.gov*.

For HRRP for FY 2018, the hospitals' ERRs and eligible discharges are provided to them in the HSR, which is distributed via *QualityNet Secure Portal* Secure File Transfer. The review and correction period started on June 1. With the release of the FY 2018 IPPS/LTCH PPS Final Rule in August, the hospitals' payment adjustment factors were posted on the CMS.gov website in sections related to the final rule.

Question 22: **Does CMS post publicly available results for the EHR Incentive Program?**

Public use files (PUFs) are posted quarterly on the EHR Incentive Programs web page of the CMS.gov website, located at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PUF.html.

The CMS Medicare EHR Incentive Program Eligible Hospitals PUF is an eligible hospital-level file in which each record provides the hospital type with each hospital's responses to the meaningful use (MU) core and menu measures.

Question 23: **What is the method of submission for the Hospital VBP Program measures? If the measures use claims data, do they use ICD-10 codes?**

The Hospital VBP Program uses measures that were submitted through a variety of methods, such as chart abstraction, the National Healthcare Safety Network (NHSN), Hospital Consumer Assessment of Healthcare Providers and Systems® (HCAHPS) Survey, and claims. Claims-based measures that use data beginning on October 1, 2015, use International Classification of Diseases, Tenth Revision (ICD-10) codes.

Question 24: **What is a good source of dual-eligible patient percentages by state for the HRRP?**

The Medicare-Medicaid Coordination Office at CMS releases national- and state-level numbers for dual-eligible enrollment on *CMS.gov*. However, the stratified methodology for the HRRP will not calculate the proportion of dual-eligible beneficiaries by state.

Under the stratified methodology, the dual proportion is the proportion of Medicare FFS and managed care stays in a specific hospital, where the patient was dually eligible for Medicare and full-benefit Medicaid during the performance period.

The full-benefit dual status (numerator) is identified using data from the Medicare Master Beneficiary Summary File (MBSF), which is sourced from the State Medicare Modernization Act (MMA) files. Stays for a full-benefit dual patient are stays where the patient was identified as full-benefit dual status for the month the beneficiary was discharged from the hospital.

Hospital Medicare FFS and managed care stays were identified using the Medicare Provider and Analysis Review (MedPAR) files.

Beginning in FY 2019, HSRs will include information on hospitals' dual proportions.

Question 25: **Will CMS combine the HRRP and the Hospital VBP Program into one program?**

At present, there are no plans to combine HRRP and the Hospital VBP Program into one program.

Question 26: **Can you provide a more definite date for release of table 16A for the Hospital VBP Program?**

Table 16A is available on *CMS.gov* now. Also, Table 16B was published on November 3, 2017.

Question 27: **For the HRRP, what diagnosis would be used in the predicted/expected population that would trigger a higher expected score?**

In the CMS readmission measures, a patient who had an eligible index admission is considered "readmitted" if he or she has one or more unplanned inpatient admissions at a short-term acute care hospital within 30 days of discharge from the original index admission (regardless of whether the readmission[s] occurred at the same or a different hospital).

An index admission is a hospitalization that meets the measure's inclusion and exclusion criteria and acts as an anchor point for the observation of the measure's outcome.

CMS then calculates ERRs for each of the six measures in the program. If a hospital has above average readmissions, then the expected readmission rate will be higher than the predicted readmission rate, resulting in an ERR above 1.0. Each measure adjusts for age, comorbid diseases, and indicators of patient frailty that are clinically relevant and have strong relationships with the outcome.

Question 28: **How is the exchange function slope calculated?**

For more information on how the exchange function slope was calculated, please refer to the help guide, How to Read Your Fiscal Year (FY) 2018 Hospital Value-Based Purchasing (VBP) Program Percentage Payment Summary Report (PPSR), available on the Hospital VBP Program Resources web page on *QualityNet*.

For more information on the methodology of the exchange function slope, please refer to the Hospital Inpatient VBP Program Final Rule (76 FR 26531–26534).

Question 29: **If a major mistake is made in data entry for HAI data on *Hospital Compare* and identified during the preview period, why can't it be fixed? Why would CMS allow a data discrepancy to be published that affects the hospital and the integrity of the database?**

Under the Hospital IQR Program, hospitals have 4.5 months from the end of the reporting quarter to submit, review, or correct their CDC NHSN HAI data. HAI data submitted to NHSN cannot be modified after the submission deadline for use in CMS programs. Immediately following the submission deadline, the CDC creates a file of the data for CMS to use in quality reporting and pay-for-performance programs (e.g., HAC Reduction Program, Hospital VBP Program). This effectively creates a snapshot of the data at the time of the submission deadline.

CMS understands hospitals have the capability to update data in the NHSN system after the deadline; however, CMS does not receive or use data that were entered in NHSN after the submission deadline. It is CMS's expectation that hospitals review and correct their data, including mapping of patient locations, prior to the Hospital IQR Program submission deadline.

Question 30: **Is a transfer to a hospice healthcare facility from an inpatient admission considered a readmission in HRRP?**

No. A transfer to a hospice facility or hospice unit is not considered a readmission. Hospice facilities do not meet the definition of short-term acute care hospitals and are therefore not included when identifying index admissions and readmissions. Only admissions to short-term acute care hospitals are counted as readmissions.

Question 31: **To which payment is the HAC Reduction Program reduction applied?**

Subsection (d) hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment reduction applies to all Medicare discharges between October 1, 2017, and September 30, 2018 (i.e., FY 2018). The payment reduction occurs when CMS pays hospital claims. Hospitals that do not rank in the worst-performing quartile will not be subject to a payment reduction. In FY 2018, CMS notified hospitals whether they will receive a payment reduction in the HAC Reduction Program HSR.

CMS applies payment adjustments in the following order:

1. Disproportionate share hospital (DSH) and indirect medical education (IME)
2. Hospital VBP Program payment adjustment and HRRP payment adjustment (if applicable)
3. HAC Reduction Program payment reduction (if applicable)

For example, if both the Hospital VBP Program and HRRP payment adjustments are based on a $1,000,000 base operating diagnosis-related group (DRG) payment amount, then the hospital loses 2 percent for the Hospital VBP Program and 2 percent for HRRP and the net loss is $40,000. If the hospital is also subject to the HAC Reduction Program payment reduction, then CMS bases the 1 percent reduction on $960,000 (instead of $1,000,000).

Question 32: **Where can we find the annual base-operating DRG reimbursement estimate or actual amount by CMS Certification Number (CCN)?**

For CCN-level data, we recommend submitting a request for Medicare Provider and Analysis Review (MedPAR) data from Research Data Assistance Center (ResDAC).

Question 33: **Regarding the Medicare EHR Incentive Program, does the hospital's performance with the case mix index (CMI) (predicted) only include Medicare patients or the CMI of all patients?**

The EHR Incentive Program does not align with the CMI.

A hospital's CMI represents the average DRG relative weight for that hospital. It is calculated by summing the DRG weights for all Medicare discharges and dividing by the number of discharges. CMIs are calculated using both transfer-adjusted cases and unadjusted cases. CMS intends to annually update the CMI on the following website to coincide with updates to IPPS/LTCH PPS proposed and final rules: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS022630.html.

Question 34: **Is MU a penalty program now with a 75 percent decrease of the 2 percent in payments?**

Eligible hospitals that are not meaningful EHR users are subject to a payment

adjustment, beginning on October 1, 2017. This payment adjustment is applied as a reduction to the applicable percentage increase to the IPPS payment rate, thus reducing the update to the IPPS standardized amount for these hospitals.

Eligible hospitals receive the payment adjustment amount that is tied to a specific fiscal year. For example, eligible hospitals that did not successfully demonstrate MU for an applicable EHR reporting period in 2015 are receiving a reduction to the IPPS applicable percentage increase in FY 2017. The table below illustrates the application of the reduced update to the IPPS standardized amount.

Hospital Adjustment	2017+ (2015 Reporting Period)
% Decrease	75%

Regarding market basket update, the 2.025 percentage point decrease in payments is three-quarters of the market basket update for FY 2018 of 2.7 percent. The 2.025 percent would be reduced in columns two and four when the hospital is not a meaningful EHR user. The rule adds the following language regarding this line item:

"… a reduction of three-quarters of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase [with no adjustments]) for hospitals not considered to be meaningful electronic health record (EHR) users in accordance with section 1886(b)(3)(B)(ix) of the Act, … For FY 2018, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the standardized amount as specified in the table that appears later in this section."

Question 35: **The HRRP states the acute myocardial infarction (AMI) measure is for those discharged with a principal diagnosis of AMI; does this definition include non-ST elevation (NSTEMI) patients or those with elevated troponin levels?**

The Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization measure, also known as the AMI readmission measure, only assesses principal discharge diagnoses to identify the measure cohort and does not use clinical assessments, such as troponin levels. In addition, the AMI readmission measure includes patients with a principal diagnosis of NSTEMI myocardial infarction in the measure cohort.

A full list of the ICD-10 codes used to define the AMI readmission cohort can be found below.

- I21.01 ST elevation (STEMI) myocardial infarction involving left main coronary artery
- I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
- I21.09 ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
- I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery
- I21.19 ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
- I21.21 ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
- I21.29 ST elevation (STEMI) myocardial infarction involving other sites
- I21.3 ST elevation (STEMI) myocardial infarction of unspecified site
- I21.4 Non-ST elevation (NSTEMI) myocardial infarction

These codes can also be found in Table D.1.1 of the 2017 Condition-Specific Readmission Measure Updates and Specifications Report on *QualityNet* at this direct link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841. More information about the

AMI readmission measure can be found in Appendix D.1 of this report.

Question 36: **Regarding the Hospital VBP Program, I have seen the estimates of value-based payment annual totals before, but I have never seen anything published to demonstrate that the program is truly budget neutral. Is that information available somewhere to show exactly how much was withheld and how much was distributed?**

The Hospital VBP Program is an estimated budget-neutral program meaning, that when the exchange function slope is calculated, CMS determines the funding available by estimating the base-operating DRG payment amounts for all eligible hospitals. The estimated base-operating DRG payment amounts are not publicly provided; however, the results of previous fiscal year payments in aggregate are available on *Hospital Compare*, located at https://www.medicare.gov/HospitalCompare/Data/payment-adjustments.html.