



Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Fiscal Year (FY) 2018 Percentage Payment Summary Report (PPSR) Overview

Presentation Transcript

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Maria Gugliuzza: Hello and welcome to our Hospital Value-Based Purchasing Program Fiscal Year 2018 Percentage Payment Summary Report Overview. My name is Maria Gugliuzza, and I am the Clinical Project Manager at the Hospital Inpatient, Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded and a transcript of the presentation, along with the question and answers, will be posted to the inpatient website www.qualityreportingcenter.com in the upcoming weeks and will also be posted at quality.net at a later date. If you are registered for this event, a reminder email and the slides were sent out to your email about two hours ago. If you didn't receive the email, you can download slides at our inpatient website at www.qualityreportingcenter.com. If you have a question as you go through the webinar, please type your question into the chat window with the slide number associated, and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to the qualityreportingcenter.com website in the coming weeks.

This event will provide an overview of the FY 2018 Hospital VBP Program including: identifying how hospitals will be evaluated within each domain and measure, delineating eligibility requirements, explaining scoring methodology. Participants will be able to perform the following: identify how hospitals will be evaluated within each domain and measure, recall the Hospital VBP Program eligibility requirements, interpret the scoring methodology used in the Hospital VBP Program and analyze the PPSR. I would now like to introduce our speaker for today's event, Bethany Bunch. Bethany is the Hospital VBP Program Lead for the Hospital VBP Program at the Values, Incentives, and Quality Reporting Outreach and Education Support Contractor. Bethany, the floor is yours.

Bethany Wheeler-Bunch: Thank you, Maria. I want to welcome everyone to today's event to cover the FY 2018 Hospital VBP Program. I've broken our session up into two sections today. In the first section of today's webinar, we will cover a high-level overview of the Hospital VBP Program, including updates to

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the Program, high-level scoring and a report overview, the review and correction process and resources that are available. We will then have a question and answer session in the middle of the webinar to address your questions on that material. After that initial Q&A session, I will cover more detailed scoring, such as how to calculate the improvement points, achievement points, domain scores and the Total Performance Score. We will have a second Q&A session to cover questions you may have during that section. I would just like to remind everyone before we get started to please add the slide number at the beginning of your question when you type it into the chat window.

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. CMS has used this Program to adjust payments for every fiscal year subsequent. The Hospital VBP Program is the first national inpatient pay performance program, in which hospitals are paid for services based on the quality of care rather than the quantity of services provided. Like the second bullet states, the Hospital VBP Program was built on the Hospital Inpatient Quality Reporting Program framework, which is pay for reporting rather than a pay for performance program. All measures in the Hospital VBP Programs are collected under the Hospital IQR Program first. The Hospital VBP Program pays for care that rewards better value, improves patient outcomes, innovations and cost efficiencies over volume of services. CMS views value-based purchasing as an important driver of change, moving towards rewarding better value and improved patient outcome, which in turn will lead to better care and healthier patients.

The Hospital Value-Based Purchasing Program is an estimated budget neutral program, and is funded through percentage withhold from participating hospitals' DRG payments. Incentive payments will be redistributed based on the hospital's Total Performance Score in the Hospital VBP Program in comparison to the distribution of all hospitals' Total Performance Scores and 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. The funding from

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the Fiscal Year 2018 Program will come from a 2 percent withhold from participating hospitals' base operating DRG payment amounts. CMS anticipates the total value-based incentive payments will total \$1.9 billion in Fiscal Year 2018.

The Hospital VBP Program adjusts payments for approximately three thousand hospitals each year. The Program applies to subsection (d) hospitals in fifty 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 the slide applies. Those exclusion reasons include: hospitals subject to payment reductions under the Hospital IQR Program, hospitals cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients, hospitals with less than three out of the four domains calculated, hospitals within approved extraordinary circumstance exception, 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 would not be publicly reported in the Hospital VBP Program tabled on *Hospital Compare*. Excluded hospitals will not have their payments adjusted, which includes the 2 percent withhold to payments, and the opportunity to receive incentive payments.

Now we will move into evaluating hospitals, where we will cover which domains and measures are included in the Program as well as a summary of changes from Fiscal Year 2017 to Fiscal Year 2018.

This slide displays the four domains hospitals will be evaluated on in the Fiscal Year 2018 Hospital VBP Program. Each domain is weighted equally at 25 percent of the Total Performance Score. The Clinical Care domain contains the 30-day mortality measures for AMI, heart failure and pneumonia. The Experience of Care domain contains the HCAHPS survey dimensions. The Safety domain contains the PSI 90 Composite, five CDC healthcare-associated infection measures, and the PC-01 measure. The Efficiency and Cost Reduction domain contains the Medicare Spending per Beneficiary measure.

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This slide provides the high-level summary of changes that were made from the Fiscal Year 2017 Program Year to Fiscal Year 2018. If you remember back to the Fiscal Year 2017 Program Year, CMS renamed and realigned the measures within new domains that more closely followed the National Quality Strategy. With that change, CMS created two subdomains under the overarching Clinical Care domain. Those two subdomains were Process and Outcomes. In the Fiscal Year 2018 Program, CMS adopted their proposal in which they would remove AMI-7a and IMM-2 from the Hospital VBP Program, move the PC-01 measure from the Process subdomain to the Safety domain, and completely remove the Clinical Care-Process subdomain because there were no remaining measures. With the removal of that subdomain, there were four remaining domains that CMS is weighting at 25 percent each.

The other major changes to the Program were the adoption of the Care Transition dimensions, and removal of the Pain Management dimension within the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain, which we will reference as the Experience of Care domain throughout this presentation.

Since the Care Transition measure is new to the Hospital VBP Program, let's take a deeper dive on the impact of that measure. The Care Transition dimension, also known as the CTM-3, was added to the HCAHPS survey Understanding Your Care When You Left the Hospital. The dimension added three questions to the survey, including: "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left;" and "When I left the hospital, I had a good understanding of the things I was responsible for and managing my health;" and "When I left the hospital, I clearly understood the purposes for taking each of my medications."

The whole list of these questions and response choices are displayed as the graphic on this slide. There will be no overall scoring impact to the Experience of Care domains based on the addition of the Care Transition measure because of the parallel removal of the pain management dimension. Within the Experience of Care domain, you have two scores:

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the base score and the consistency score. The base score is the sum of the eight-dimension score values with the maximum score of 10 points per dimension or a total maximum of eighty points. Because Pain Management was removed in the same fiscal year that Care Transition was added, there will still be just be eight dimensions within that domain. If you are interested in seeing exactly how the Experience of Care Domain is scored, we will cover an example calculation in the second part of the webinar.

In the next few slides, I would like to transition to a couple of reminders regarding the measures that will help in reviewing your data and understanding why it may be different in CMS' other programs such as the Hospital IQR and HAC Reduction Program in comparison to Hospital VBP [Program]. For the Fiscal Year 2018 Hospital VBP Program calculations, CMS elected to use the older version of the PSI 90 Composite, containing the underlying indicators listed on the slide. Whereas, as in the Hospital IQR Programs, and HAC Reduction Program, CMS will be using the new version of the measure. CMS was unable to adopt the modified PSI 90 Composite in the Hospital VBP Program beginning with FY 2018 Program Year due to certain statutory requirements in the Hospital VBP Program which are not required in the Hospital IQR Program or HAC Reduction Program. Specifically, regulations require the Hospital VBP Program to refrain from beginning the performance period for a new measure until data on the measures have been posted on *Hospital Compare* for at least one year. The following is a high-level summary of the changes from the old to the new version of the measure. The measure name changed. The number of component indicators increased from eight to 10. PSI 8, 12 and 15 have specification changes. Component weighting now incorporates harm, and component weights are more equally distributed among the component indicators. For more information regarding the PSI 90 Composite, I would recommend referencing the Q&A transcript from the *Updates on Patient Safety Indicators for Use in CMS Programs* webinar that was presented on March 29th and is available on qualityreportingcenter.com.

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We will provide a link in the chat window shortly, where all of the archived Hospital VBP Program events are available on Quality Reporting Center. For the Fiscal Year 2018 Hospital VBP Program calculation, CMS elected to use recalibrated software version 5.0.1; whereas, the Hospital IQR Program and HAC Reduction Program use recalibrated software version 6.0.2. Also in Fiscal Year 2018, CMS used the first nine Diagnosis codes and first six Procedure codes listed on the claims that calculates the measure [in FY 2018 Hospital VBP]; whereas, using the first 25 Diagnosis codes and Procedure codes in the Hospital IQR program and HAC Reduction Program. A summary of these differences is available at the link provided on the slide.

The other set of measures that you may see a variance in is the CDC's HAI Measures. This may be due to three reasons. First, CDC expanded the CLABSI/CAUTI measure location to include select wards in addition to the already reported ICU locations in Calendar Year 2015. Selected ward locations are defined as adults or pediatric medical, surgical and medical surgical wards. The Hospital VBP Program will not start using the expanded locations until Fiscal Year 2019. Second, the standard population also known as the CDC's baseline, used to calculate the predicted number of infection, was updated starting with Calendar Year 2015 data. Like the first change, this update will not be used in the Hospital VBP Program until Fiscal Year 2019. The last reason your data may not match in NHSN would occur if someone at your hospital added, removed or modified data in NHSN after the quarterly submission deadline. Once the submission deadline has passed, CDC takes a snapshot of that data, and sends to CMS for use in programs such as the Hospital VBP Program. Any changes made in NHSN after that snapshot would not then be subsequently sent to CMS, although you can still see those changes in NHSN. I would like to pause on this slide to also clarify a recent communication provided that described the CLABSI/CAUTI error for the rebaseline data. Because the error only impacted the rebaseline data there would be no impact to the Fiscal Year 2018 Hospital VBP Program because CMS will not be using the new standard population or the rebaseline data until Fiscal Year 2019.

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This slide displays the baseline and performance periods used to calculate the measure results in the Fiscal Year 2018 Hospital VBP Program. The HCAHPS survey, HAI measures, PC-01 and MSPB measures are calendar year measures and utilize the performance period of Calendar Year 2016 and a baseline period of Calendar Year 2014. The Mortality Measures use the performance period of October 1, 2013, through June 30, 2016, and a baseline period of October 1, 2009, through June 30, 2012. The PSI 90 Composite uses a performance period of July 1, 2014, through September 30, 2015, and a baseline period of July 1, 2010, through June 30, of 2012.

When we were covering the eligibility of the Program, we discussed the hospital being excluded if they had fewer than three domain scores calculated. So, in order to cover the minimum data required for the Hospital VBP Program I would like to start there, which is the last row on the table on the slide. In order to have at least three domains calculated, a hospital would have to meet the minimum data requirements within three domains. For Clinical Care, a hospital must have at least two of the three mortality measures with a minimum of 25 cases. For the Experience of Care domain, a minimum of 100 HCAHPS Surveys is required. In the Safety domain, a minimum of three measure scores is required. Those three can be received from having at least three cases for any one underlying indicator for PSI 90, one predicted infection in the HAI measures, and 10 cases in the denominator for the PC-01 measure. For the Efficiency and Cost Reduction domain, a minimum of 25 episodes of care is required.

Hospitals have the opportunity to receive improvement and achievement points on their Percentage Payment Summary Report based upon their performance rate during the baseline period and performance period relative to the performance standards. The performance standards consist of the achievement threshold and benchmark for all measures and the floor, which is only applicable for the Experience of Care domain. The achievement threshold is calculated as the median or 50th percentile of all hospital rates for measures during the baseline period. The benchmark is the mean of the top decile, which is the average of the top 10 percent

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during the baseline period. The floor used calculating the HCAHPS consistency score 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 demonstrates better quality in that measure. The measures that this description is applicable for are the 30-day mortality measures in the Clinical Care domain, and the HCAHPS dimensions. A quick reminder, the mortality measures use survival rates in the Hospital VBP Program.

The measures displayed on this slide will have higher achievement threshold values than benchmarks because lower rates demonstrate better quality in that measure. The measures that the description is applicable for are the PC-01 measure, the PSI 90 Composite, all the healthcare-associated infections in the Safety domain, and the MSPB measure in the Efficiency and Cost Reduction domain. Please note that the MSPB measure uses data during the performance period instead of the baseline period to calculate the performance standards.

The next three slides display the performance standards used in the Fiscal Year 2018 Program. These performance standards, with the exception of MSPB, were included on your baseline measures report. It will be included on your hospital Percentage Payment Summary Report.

Here are the performance standards for the HCAHPS dimensions. Please note the addition of the floor that we don't see in any of the other domains.

And here are the performance standards for the Safety domain.

Performance standards are first published in the IPPS or OPPS Proposed and Final Rules. Changes or updates to those values are made technical updates issued by CMS. For the Fiscal Year 2018 VBP Program, CMS issued two technical updates based on data that was first finalized in the IPPS rules. The first update listed on this slide was due to a CBI risk-adjustment error. The second was a normal update to the PSI 90 results based on a more recent software version. Both updates were included on

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your baseline measure report and included on the safety domain performance standards on the previous slide. For more information on each of these technical updates, please feel free to use the links on the slide.

Achievement points are awarded by comparing the individual hospital rates during the performance period with all hospital rates from the baseline period by using two performance standards: the achievement threshold and the benchmark. If a hospital has a performance period rate that is equal to or better than the benchmark, 10 achievement points will be awarded. If the rate is lower than the achievement threshold, the hospital will receive zero achievement points. If the performance period rate is equal to or better than the achievement thresholds, but still lower than the benchmark, one to nine points will be awarded.

Improvement points are unique to the Hospital VBP Program in relation to CMS's other inpatient pay for performance programs such as the HAC Reduction Program or the Hospital Readmission Reduction Program. Not only can hospitals be evaluated based on their current performance in comparison to all other hospitals, but they can also earn points by improving from the baseline period. CMS may award hospitals improvement points if the hospital's performance period rate is better than their baseline period rate. The maximum point value for improvement points is nine points. We will cover more detailed examples of improvement and achievement points in the second half of the presentation.

We will now move into a brief overview on reviewing and reading your report. The Percentage Payment Summary Report has five pages. The first page is a summary of your hospital scores and the payment adjustment information. The first section contains your hospital's Total Performance Score, the state average, and the national average. The domain scoring section contains each domain's unweighted domain score, domain weight, and weighted domain scores.

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The payment summary section contains five values. The base operating DRG payment amount will display 2 percent for all eligible hospitals because that is the amount that is withheld for Fiscal Year 2018. The value-based incentive payment percentage is the incentive percentage a hospital will receive without taking into account the 2 percent withhold. The net change in payment amounts is the value-based incentive payment percentage less the 2 percent withhold. If this value is positive, your hospital will receive an overall increase in payments due to the Hospital VBP Program. The payment adjustment factor is the number that you can multiply against the DRG to determine what you will be paid for that DRG based on the Hospital VBP Program. The last value is the Exchange Function Slope. This value is the same for each hospital and is used to calculate the hospital's payment adjustments that we just covered. Please note that the slope displayed on the slide is not the slope that will be used in Fiscal Year 2018.

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 the slide in the blue 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 Care detail report. This page will contain the measure level results, such as the number of eligible discharges in the baseline and performance period rates. In addition, the Clinical Care detail report will display the performance standards, improvement points, achievement points and measures 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 weighted domain score.

The third page will display results for the HCAHPS Survey including the baseline and performance period rates.

In addition, the performance standards, improvement points, achievement points and dimension scores will also be displayed. Under the table, the

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domain summary is displayed including the HCAHPS base and consistency score, 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 calculation.

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

The right side of the table displays the performance standards, in point calculation.

The summary beneath the table includes the number of measures the hospital is scored, the unweighted domain score, and weighted domain score.

The last page of the report displays the information for the MSPB measure within the Efficiency and Cost Reduction domain including the baseline period total, performance period total, performance standards and scoring in the domain summary. This slide displays select values from the report and the precision for those values. For example, the 30-day mortality measures have a baseline and performance period rate that is displayed six places to the right of the decimal on the Percentage Payment Summary Report. I would like to highlight the asterisk on HCAHPS and PC-01 baseline and performance period rate. Please note that these values have displayed precision of two places and six places to the right of the decimal respectfully. However, a greater precision of those rates is used to calculate the improvement and achievement point values than is displayed. If you have any questions regarding the calculations on your report, please feel free to ask your questions through the inpatient Q&A tool on QualityNet.

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

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Hospitals may review their data used in CMS programs in two different stages. The first stage is considered a patient level data review in which hospitals insure 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, depending on the measure. The second stage of the review is the scoring and eligibility review. During the second stage, hospitals can ensure that the data reviewed during stage one is properly displaying on the reports that they're scoring, such as improvement points, measure scores, or remains scores were calculated correctly based on the already finalized measure results, or that your eligibility is correctly applied. Corrections or modifications to the underlying data is not allowed during this stage two review. Examples of stage two reviews include the Hospital IQR Program Preview Report period, the Hospital VBP Program review and correction period, and the claims-based measures review and correction period.

For chart-abstracted and web-entry measures, the stage one review allows hospitals to use the approximate four and a half months after the quarterly reporting period ends to submit and review their data. Corrections or modifications to the data after the quarterly submission deadline is not allowed. For CDC NHSN measures, the stage one review also allows hospitals to use the approximate four and a half months after the quarterly reporting period ends to submit and review their data in 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 in NHSN. For the HCAHPS survey stage one review, CMS allows hospitals to have a seven-day period after the submission deadline to access and/or review the HCAHPS data in a review and corrections report. Please note though, that new data is 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.

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Now that we have covered the stage one items, we'll discuss the details of stage two. The stage two review for the claims-based measures includes having 30 days to review and correct scores based on claims included in the Hospital Specific Report. If a hospital suspects a calculation error in the Report, a request for review with the possibility for correction can be submitted during this 30-day window. A request for submission of new or corrected claims to the underlying data are not allowed. We do recommend contacting your MAC if you identify an error to the underlying 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 the Total Performance Score. Requests for correction of the underlying data, such as your baseline or performance period rates, is not allowed during this period and should have been addressed during the stage one review for each of the measure types.

Some best practices for reviewing your data during stage one include: having a second person review submitted data for errors, creating a plan for spot checking or sampling the data submitted for errors, reviewing the data a vendor submits for accuracy before submission or prior to the submission deadline, and performing routine coding audits to ensure claims are being coded and billed correctly.

The benefits of having correct data include having usable data quickly that can assist in 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 in assessing how well a hospital is performing.

So now that we understand when the underlying data should be reviewed versus the review of hospital scores and eligibility, let's move on to the

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process to submit a Percentage Payment Summary Report and a review and correction request if your hospital identifies a potential scoring error.

Hospitals may review and request a recalculation of scores for each measure, domain, and Total Performance Scores. Hospitals have 30 days after the percentage payment summary report is released to request this review. If you would like to submit a request, please submit the completed review and correction form through the secure file exchange on the *QualityNet secure portal* to the HVBP group. The review and correction form is posted to *quality net*. This page describes where to find the form if you would like to access it. When completing the forms please make sure you are providing the following information; the date of the review and corrections request; the hospital's CCN; hospital contact information; the reason or reasons for the request; and a detailed description for the reasons identified.

Now we will move on to appeals. 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 wave your eligibility to submit an appeal request. To submit an appeal, you would follow the same process on sending a completed appeal form to the HVBP group through secure file exchange within the *portal*. To access the appeal form, please use the steps listed on the slides to access the form. When completing the appeal form, please include the information provided on the slide including the date of your hospital's review and correction requests, the hospital CCN, the hospital contact information, specific reasons for your request, and the detailed description. The topics listed on the slide are the appealable items during the appeals period, including calculation of scores, incorrect domain weights applied, or if your hospital's open flow status was incorrectly specified.

The following resources are available to you. For Fiscal Year 2018, Percentage Payment Summary Reports will be made available through the

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QualityNet Secure Portal on or around August 1st. In order to access the Report, you must have the roles listed on the slide assigned to your *QualityNet* account. If you are not able to access the Report and you believe you should be able to, please contact your internal *QualityNet* administrator.

In order to download the Percentage Payment Summary Reports when they are made available, please use the steps listed on the slide. If you are having technical issues accessing the Report once it is made available, please contact the *QualityNet* helpdesk. CMS will release a listserv notification in addition to the *QualityNet* news article once the reports have been made available in the *Portal*.

If you have questions or would like to learn more about the Hospital VBP Program, I would recommend checking out the resources listed on the slide. Specifically, as you are reviewing your Report and you have questions, please reference How to Read Your PPSR or general information on *QualityNet*. Our previous webinars and additional educational materials such as quick reference guides are available on the qualityreportingcenter.com website. If you have a question, you can reference the Frequently Asked Questions in the inpatient Q&A tool on *QualityNet*. And if your question is not answered, you can also submit a new question through that same tool.

If you would like to review Hospital VBP Program data for previous fiscal years, you can access that data through *Hospital Compare* by clicking on the HVPB link on the bottom left side of the page under Additional Information. Data from Fiscal Year 2017 will be posted on *Hospital Compare* until December 2017 when the Fiscal Year 2018 Programs will be refreshed on the page. Fiscal Year 2013 through Fiscal Year 2016 data is also available in the *Hospital Compare* archives.

Now we will have our first question and answer session. And then after, we will move into more specific scoring examples. Maria, what are some of the questions that we received?

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Maria Gugliuzza: Thanks, Bethany. The first question, what are the baseline period and the performance period for HCAHPS Surveys?

**Bethany
Wheeler-Bunch:** The baseline and performance periods for all measures are listed on slide 19. We will move the slide deck there for reference.

Maria Gugliuzza: Thank you. When will payments be adjusted based on this report?

**Bethany
Wheeler-Bunch:** For Fiscal Year 2018, Hospital VBP Program will impact statements made by CMS in Fiscal Year 2018. That means the Fiscal Year would be October 1st, 2017, through September 30th, 2018.

Maria Gugliuzza: Okay, so the next question is with respect to slide 20, what happens to the percentages if a hospital does not meet the Clinical Care domain due to less than 25 eligible cases in all three measures?

**Bethany
Wheeler-Bunch:** If a hospital is unable to receive enough measure scores to receive a domain score, the domain would not be scored. If less than three domains are scored in FY 2018, the hospital would be excluded from the Program. Hospitals excluded from the Hospital VBP Program would not be eligible for payment adjustment which includes the withhold, and the possibility or opportunity for incentive payments. We will cover more detailed calculation examples for domain reweighting if only three domains are scored in the second half of the presentation.

Maria Gugliuzza: Bethany, on slide 17, can you restate what software version will be used to calculate the PSI 90 results?

**Bethany
Wheeler-Bunch:** Sure. The software version 5.0.1 was used to calculate the PSI 90 Composite results in Fiscal Year 2018 for Hospital VBP [Program]. For more information on the announcement of the software version, please reference the *QualityNet* news article published on March 2nd.

Maria Gugliuzza: Thank you. The next question, do the HAI, PC-01 and PSI 90 Composite carry equal weights in the calculation of the score for the Safety domain?

Bethany Sure, that's a good question. Each measure within the Safety domain

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- Wheeler-Bunch:** carries an equal weight. We will also cover how to calculate the Safety domain score in the second half of the presentation. So, hopefully whoever the questioner was will get a better answer at that point.
- Maria Gugliuzza:** Wonderful. What happens if a 100 HCAHPS Surveys are not completed within the two time periods?
- Bethany**
Wheeler-Bunch: If a hospital is unable to submit enough completed Surveys during the performance period, the Experience of Care domain would not be scored. And as we covered it in a couple questions back, if less than three domains are scored in Fiscal Year 2018, the hospital would be excluded from the Program. Once again, hospitals that are excluded from the Program would not be eligible for a payment adjustment. If a hospital does not submit at least 100 HCAHPS Surveys during the baseline period, but does during the performance period only, only achievement points can be awarded as improvement points which are based on a comparison between the baseline period and the performance period could not be made.
- Maria Gugliuzza:** The next question is, are children's hospitals and critical access hospitals exempt from the VBP Program?
- Bethany**
Wheeler-Bunch Only short-term acute care hospitals or subsection (d) hospitals are included in the Hospital VBP Program. A good way to check if your hospital is included is only CMS certification numbers or CCNs with a third digit that is 0 are included in the Program. So, if your third digit in your CCN is a 3, or is a 1 for example, you would not be included in the Hospital VBP Program.
- Maria Gugliuzza:** Thank you for the clarification. Can you move to slide 17? The AHRQ website still shows PSI 9, PSI 10 and PSI 11 being part of the PSI 90. However, this slide does not have 9, 10 and 11.
- Bethany**
Wheeler-Bunch: Sure. So, if you take a step back to what we covered on the slide, I mentioned CMS would use the old version of the PSI 90 Composite in the Fiscal Year 2018 Program. In comparison, the Fiscal Year 2018 HAC Reduction Program and the Hospital IQR Program would use the updated version of the measure which includes PSI 9, 10 and 11. PSI 7, which is

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the central-line related bloodstream infection rates, was removed from the new version of the measure, but is still included in the old version.

Maria Gugliuzza: Thank you. Again, on slide 17, will the PSI 90 Composite be removed from the FY 2019 Hospital VBP Program?

Bethany Wheeler-Bunch: Sure. That's actually a question that we get pretty often. CMS proposed the removal of the old version of the PSI 90 Composite starting with FY 2019 in the FY 2018 IPPS Proposed Rule. I would recommend reading the FY 2018 IPPS Final Rule when it is released to review the result of CMS's proposal. We also plan to hold a Fiscal Year 2018 IPPS Final Rule webinar in the upcoming month to discuss all of CMS's finalizations of their proposals. So, keep an eye out for that webinar coming up.

Maria Gugliuzza: Thank you, Bethany. On slide 48, for claims-based measures, is there a cut-off time to refile a claim with CMS if we discovered the first claim was incorrect?

Bethany Wheeler-Bunch: Sure. And I think this one, as you mentioned, Maria has referenced this slide 48, so I will move the slide deck there so everyone can put this better into context what we're talking about. So, CMS generally pulls claims at the end of September following the end of the calculation period for PSI 90 and the 30-day mortality measures. For example, if the claims-based measures of PSI 90 and the 30-day mortality measures end on June 30, 2016, CMS would pull those claims using the calculation at the end of September of 2016. The next claims pull for Fiscal Year 2019 results is anticipated for the end of September 2017.

For the Medicare Spending per Beneficiary measure, CMS pulls claims around the first week of April, which allows a three-month claim run-out, also known as claims maturity period. Claims submitted or modified after those claims pull date would not be included or revised in CMS's calculations.

Maria Gugliuzza: The next question, is FY 2018 Calendar Year 2016?

Bethany Sure. So Fiscal Year 2018 is the year in which payment adjustments will

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Wheeler-Bunch be made. The performance period and baseline periods range in Fiscal Year 2018. However, the general idea is that Fiscal Year 2018 utilizes a performance period of Calendar Year 2016, and a baseline period of Calendar Year 2014. This wouldn't apply to claim-based measures, such as PSI 90 or the 30-day mortality measures. But, in a general sense, that's a good way to remember the calendar years and the fiscal years.

Maria Gugliuzza: Next question: when will the Percentage Payment Summary Reports be available?

Bethany
Wheeler-Bunch: The reports will be released on or around August 1st. When they are released, an announcement will be made through the *QualityNet* news article and also through a listserv. So, if you aren't signed up for those listserves yet, just go out to *QualityNet* and on the *QualityNet* home page there should be a link to sign up for a listserv. I would sign up for the IQR and the HVBP listserv in order to receive those announcements.

Maria Gugliuzza: Thank you. Slide 17. Why is CMS only using nine Diagnosis and six Procedure codes for HVBP?

Bethany
Wheeler-Bunch: Sure. CMS will use up to 25 Diagnosis and Procedure codes for the calculation of PSI 90 for the Hospital VBP Program when up to 25 Diagnosis and Procedure codes are processed through the entire baseline and performance period. So, CMS began processing up to 25 Diagnosis and Procedure codes in April 2011 because the Hospital VBP Program, the PSI 90 baseline period for Fiscal Year 2018 starts on July 1st, 2010, a portion of that period is prior to that April 2011 date. The Fiscal Year 2019 baseline results for the Hospital VBP Program were calculated using 25 Diagnosis and Procedure codes because the baseline period started on July 1st, 2011, which is after the April 2011 implementation date.

Maria Gugliuzza: Thank you, Bethany. No more questions.

Bethany
Wheeler-Bunch: Great. We will move on to the second half of the presentation to take a deeper dive and look at the scoring examples. So, for those of you following along with your own slide decks, we are now on slide 67.

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Moving on to slide 68. So, as we covered earlier in the first half of the presentation, achievement points are awarded by comparing an individual hospital's rates during the performance period with all hospital rates from the baseline period by using two performance standards: the achievement threshold and the benchmark. The first scenario listed under the achievement point category is when a hospital has a performance period rate that is equal to or better than the benchmark. In our example, the hospital has the same performance period rate as the benchmark, with a score of 0 for the CAUTI measure. Because the rate is equal to the benchmark, 10 achievement points will be awarded. If the hospital has a performance period score of 1.010, which was worse than the achievement threshold, the hospital would receive zero achievement points.

If you have a performance period rate that falls in between the benchmark and achievement threshold, you would use the achievement point formula. The formula first has you subtracting the achievement threshold from the performance period rates and then dividing that value from the difference of the benchmark and the achievement threshold. You would take that calculated value and multiply it by nine, and finally adding 0.5. We have placed in our example numbers in the formula and we receive a result of five achievement points after rounding to the nearest whole number.

Now we will cover the three scenarios for improvement points. The first scenario is the hospitals whose performance period rate is equal to or better than the benchmark, and this is an important and whose performance period rate is better than the baseline period rate. The result of this scenario is nine improvement points.

The second scenario is the hospitals whose performance period rate is equal to or worse than the baseline period rate, regardless of the performance period rate in comparison to the benchmark. Because that the performance period rate is equal to the baseline period rate, no improvement was realized in the rates, so 0.4 awarded. I would like to point out though that this scenario would be awarded 10 achievement points because the performance period rate is equal to or better than the benchmark.

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The following example shows a hospital whose performance period rate is worse than their baseline period rate. This example would also result in zero points.

The last example comes from a hospital whose performance period rate falls in between the benchmarks and the baseline period rate. Under this scenario, we would use the improvement point formula that is calculated by dividing the difference of the performance period rate and the baseline period rate by the benchmark less the baseline period rate, multiplying that result by 10 and subtracting 0.5. We have plugged in our example numbers into this formula and received the result of 5 once rounding to the nearest whole number.

Once we've calculated both achievement and improvement points for every measure, we identify which value should be used for the measure score. The measure score is defined as the greater of achievement and improvement points. On this slide the hospital received a measure score of 10 for the 30-day mortality measure for AMI, which resulted in the greater of 10 achievement points versus the nine improvement points. In the heart failure measure, the hospital received five achievement points, but had a dash for improvement points. This would mean the hospital had met the minimum number of cases for the measure calculation in the performance period that led to five achievement points, but did not meet the minimum of 25 cases during the baseline period. So, improvement points were not calculated. Under this scenario, the achievement point value is automatically awarded. The pneumonia measure displays dashes for each scoring value. This indicates that there were not enough cases in the performance period of first scores to be calculated.

After calculating each measure score, we can calculate the unweighted domain score. The unweighted domain scores for the Clinical Care, Safety, and Efficiency and Cost Reduction domains are normalized to account for only the measures the hospital met the minimum requirements for. So normalized domains use some of the measure scores in that domain, and are examples of some of the measure scores is 15 points, which is the 10 from AMIs added to the 5 from heart failure. You then

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multiply the eligible measures by the maximum point value per measure. In our example, the hospital did not have the minimum data required for the pneumonia measure. So, instead of three total measures, this hospital was only scored in two. We then multiply the two measures by 10 points possible for each measure for a total of 20. To create a percentage score the hospital earned in relation to points possible, we divide the sum of the measure scores of 15 by the maximum points possible of 20 which equals 0.75. Lastly, we multiplied the result by 100 to equal 75.

The dimension score is calculated the same as the measure score, which is the greater of achievement or improvement points. The step that is different was the Experience of Care domain is the identification of the lowest dimension score in order to calculate the consistency score. The lowest dimension score may not be your hospital's lowest actual performance period rate. CMS uses the formula listed at the top of the slide to calculate which dimension has the lowest value. In our example, our discharge information is the lowest dimension score with the result of 1.016, even though the rate of 87 percent is actually the highest in comparison to all the other dimensions.

Once you have identified your hospital's lowest dimension rate, you input that score into the formula, which multiplies the lowest dimension score by 20, and then you subtract 0.5. Our example of discharge information with the lowest dimension score of 1.016 results in a maximum score of 20 points because the performance period rate was equal to or better than the achievement threshold of 86.60 percent. If the hospital's performance period rate was worse than the achievement threshold, generally less than 20 points will be awarded based on the formula. If your hospital's performance period rate is less than the floor value for that dimension, zero consistent consistency points would be awarded.

In order to calculate the unweighted domain score for the Experience of Care domain, you would sum the eight dimension scores, which then becomes your hospital's base core. Add that base score value to the consistency score value that we just calculated in order to calculate your unweighted domain score. In this example, the sum of our dimension

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scores if 42, which is then added to the 20-point consistency score, which results in 62 points. The maximum score a hospital can receive is 100 points, 80 for the base score and 20 for the consistency score.

Moving into the Safety domain, there is one variance to the calculation of the SSI measure score to be aware of. In the Fiscal Year 2014, the IPSS Final Rule, the CMS finalized the policy in which CMS will award an achievement and improvement points to each stratum of the SSI measure, then compute the weighted average of the points awarded to each stratum by predicted infections. This weighted average becomes the hospital's SSI measure score.

So, in order to calculate your SSI measure score, you would first calculate improvement in achievement points and identify the greater value to identify each stratum's measure score. This is the same process as we've just been doing for every other measure. Once you have the measure scores identified you would then use the weighted average formula to calculate your combined measure score. In our example, the colon stratum had a measure score of 5 with one predicted infection, and the abdominal hysterectomy stratum had a measure score of 8 with two predicted infections. You first multiply each of the measure scores by their predicted infections, so five times one for colon and eight times two for abdominal hysterectomy. You then add these two values together, which equals 21. You then divide that result by the sum of the predicted infection. So, one plus two on our example equals three. Our result is seven which is the 21 divided by the three.

This slide displays the scenarios in which the SSI measure would be scored. If the hospital has at least one predicted infection calculated during the performance period for either strata, the combined score would be calculated. The table displays a checkmark if the stratum had at least one predicted infection and an X when the predicted infections were less than one. All but the scenario in which neither stratum met the minimum of one predicted infection results in the hospital receiving an SSI score. When just one stratum is scored that stratum will receive 100 percent of the weight within the combined score.

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With the exception of the SSI measure score, the Safety domain measures identify the measure score as the greater of achievement or improvement point. Similar to the Clinical Care domain, the Safety domain is normalized to account for only the measures the hospital met the minimum data requirement for. In our example, the hospital met the minimum data requirements in all but the CDI measure. The sum of the measure scores is 33 in our example, which is divided by the maximum points possible for the domain in our example. That is calculated by multiplying six measures by 10 points possible for each measure. Then divide 33 by 60, that equals 0.55 and multiplying by 100 to equal a score of 55.

The MSPB measure score is also identified as the greater of achievement and improvement points.

The unweighted efficiency and cost reduction domain score is calculated by dividing the MSPB measure score by the maximum points possible, which is 10. In our example, the MSPB domain score is 10, which has been divided by the maximum points possible of 10 to equal one. You then multiply the result of one by 100, to equal 100.

The weighted domain score's last calculation completed for the Total Performance Score, we multiply the unweighted domain score values by the domain weight for the fiscal year. For example, the Clinical Care unweighted score of 75 is multiplied by 25 percent to equal 18.75. The weighted domain scores are then summed to equal the Total Performance Score that has a maximum value of 100.

For Fiscal Year 2018, CMS allows hospitals to still have a Total Performance Score calculated if the hospital received domain scores in at least three of the four domains. If only three domains are scored, the remaining domain weights are proportionally reweighted to equal 100 percent. To reweight the domain's proportionally, you first subtract the domain weight not receiving a score from 100 percent. In this fiscal year, because all the domains are weighted at 25 percent, the resulting value will always be 75 percent. You then divide the remaining domain's

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original weight by 75 percent. So, in our example, you would divide each of the original weights of 25 percent by 75 percent which equals a new weight of 33.3 percent. That concludes the second half of our presentation. Maria, did we receive any questions based on scoring?

Maria Gugliuzza: Thank you, Bethany. Yes, we had several questions. The first question: Is there someone we can reach out to who can assist us with calculating the score for the domains, in case we need help?

Bethany Wheeler-Bunch: Sure. Questions may be submitted through the inpatient question and answer tool on the *QualityNet* website <https://cms-ip.custhelp.com>. That link is also displayed on slide 64, which should be displaying on the webinar. We would be more than happy to answer any questions that you have regarding calculations.

Maria Gugliuzza: Thank you. How do we determine the monetary impact with the TPS? We have executives that are interested in the dollar amounts impacted by VBP scores.

Bethany Wheeler-Bunch: Sure. That's a pretty common question, as well. You may use the payment adjustment factor listed on your hospital's Percentage Payment Summary Report. This value is multiplied against your hospital's base operating Diagnosis Related Group payment amount. You may estimate the total impact of VBP by multiplying the factor by an estimated base operating DRG payment amount, and then determine the difference between the results and the original base operating DRG payment amount.

Maria Gugliuzza: Excellent. Can hospitals receive an incentive greater than the 2 percent withhold and a 2 percent incentive payment?

Bethany Wheeler-Bunch: Yes. They can, at least with the 2 percent incentive payments. The maximum reduction that a hospital can incur is 2 percent for Fiscal Year 2018. However, a hospital can earn back more based on the Exchange Function Slope and the hospital's performance for the fiscal year.

Maria Gugliuzza: Thank you. Slide 80. What is the HCAHPS floor percent?

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Bethany Wheeler-Bunch: Sure. Let's move the slide deck to slide 80. The floor is the score of the lowest performing hospital during the baseline period. The floor is used to determine a hospital's lowest dimension score and then subsequently the consistency score. So, if you remember back – I will switch it to slide 81, as well. When we were calculating the consistency score, if the hospital had a performance period rate used for the lowest dimension floor that was above the achievement threshold, they are going to receive 20 points for their consistency score. If the hospital's performance period rate is in between the floor and the achievement threshold, you're going to have in between zero to 20 points calculated. Now, if your performance period rate used for your lowest dimension score is actually worse than the floor value, you're going to receive zero points for the consistency score. So that's the importance of the floor value.

Maria Gugliuzza: Thank you. Can you move to slide 85? If a hospital does not have an SSI for colon, are they eligible for points?

Bethany Wheeler-Bunch: So, a hospital only has to meet the minimum of one predicted infection in one of the two strata: colon surgery and abdominal hysterectomy. If only the abdominal hysterectomy minimum is met, the measure score would be weighted 100 percent to the abdominal hysterectomy stratum. This is also true for the reverse with the colon surgery stratum, if the minimums are only met for that stratum. If both strata meet the minimums, the measure scores will be weighted by the predicted number of infections, which is what we covered actually in the previous slide, on slide 84. You would use this formula if both strata received at least one predicted infection. So, the only scenario in which a surgical site infection measure score would not be awarded is when the hospital does not meet the minimum of one predicted infection in either stratum.

Maria Gugliuzza: Thank you. Can you move to slide 78? Can you cover normalization one more time?

Bethany Wheeler-Bunch: Sure. So, normalization is the scoring process that CMS takes to score a hospital on only the measures that met the minimum requirements, in order to compare hospitals. So, to normalize, you first sum the measure

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scores and divide by the total maximum points for the hospital. Essentially, what you are doing is you're creating a percent of the scores that you received by the total scores that were possible for your hospital. The total maximum points will vary by hospital based on the number of measures that you met the minimum for. So, in our example going back to the slide, the hospital had a minimum required data in two of the three measures. So, the maximum points would be 20, which is 10 points per measure multiplied by the two measures that the hospital met the minimum for. You would divide the sum of the measure scores and in our case 15 by 20 to equal 0.75 for that domain. If this hospital would have instead met the minimum required data for the pneumonia measure, the maximum point value would be 30, which is 10 points multiplied by three measures. If you would like more assistance in understanding normalization on your report or any of the other calculations, please feel free to submit your specific question to the inpatient Q&A tool on *QualityNet*.

Maria Gugliuzza: Thank you, Bethany. That is our last question.

Bethany Wheeler-Bunch: Great. Thanks, Maria. I would like to thank everyone for joining today's webinar. It was great having you and, as always, you submit really great questions. If your questions were not answered during today's webinar, they will be posted to the qualityreportingcenter.com website in the upcoming week through the Q&A transcript. I would now like to pass the presentation to Deb Price. The floor is now yours to present on continuing education credits. Thank you everyone and have a great day.

Debra Price: Well, thank you for that introduction. And now, I will start talking about the continuing education credits. This is Debra Price. Today's webinar has been approved for 1.5 continuing education credits by the boards listed on this slide. We're now a nationally accredited nursing provider, and as such, all nurses report their own credits to their respective boards using our national provider number shown on the last bullet here. It's number 16578. It is your responsibility to submit this form to your crediting body.

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We now have an online CE certificate process. You can receive the CE certificate two different ways or two different times. One, if you register for the webinar through ReadyTalk, you will get a survey at the end of our slides. The survey will allow you to get your certificate. However, you will only be able to get that certificate if you are the one that registered.

The second way to get a certificate is, within 48 hours, we will be sending out a separate survey. When you receive survey, please give people who are in the room listening, but did not register through ReadyTalk, please give them the survey. They take the survey and then they will get the certificates themselves. After the completion of the survey, you click the Done button on the bottom of the page, and another page will open. You will need to choose to register as either a new user or an existing user. If you've been receiving certificates with us all along, and you haven't had any problems, go ahead and click on the existing user link. If you have never received a certificate or if you had problems in the past getting your certificate, please register as a new user, using a personal email. Just to note that healthcare facilities have firewalls that are continually being upgraded, and you may have a firewall up on this event that wasn't up last week if you have attended any of our other events.

If you do not immediately receive an email to the address you have registered with after the survey, that means that there is a firewall up. And what you'll need to do is, go back and register as a new user using your personal e-mail address.

This is what the survey will look like. It will pop up again at the end of the event, and again, we will send you a survey within 48 hours. You see in the bottom right hand corner, the little Done button. That's what you're going to click on when you are finished with the survey.

This is the page that pops up when you click the Done button. This is what I was talking about previously where you have two links, a New User Link and an Existing User Link. New User is if you have never gotten a certificate from us, or if you've had problems in the past getting a certificate. Use the New User Link, and make sure you fill in the form for

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your personal email. If you have been receiving certificates all along, please click on the Existing User Link.

This is what the New User screenshot looks like. So, if you clicked on the New User Link, you put your first name, your last name, your personal email, and a phone number that will be identified with that email.

Remember, again, to use a personal e-mail, because hospitals and other healthcare facilities have firewalls that are constantly changing and being upgraded.

This is what the existing user screen looks like. If you've been receiving certificates all along, please fill in your username, which is your e-mail address complete with what is ever after the @ sign. So, it would be your complete email address and whatever password you used when you registered. If you don't remember what your password is, then you'll have to get back with us and we'll have to reset your password.

Thank you for your time, and have a great rest of the day.