Hospital Value-Based Purchasing (VBP) Program

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

Hospital VBP Program, HAC Reduction Program, and Hospital Readmissions Reduction Program FY 2021 Provider Data Catalog Refresh

Presentation Transcript

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February 18, 2021
2:00 p.m. Eastern Time (ET)

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Maria Gugliuzza: Hello and welcome to the Hospital VBP Program, HAC Reduction Program, and the Hospital Readmissions Reduction Program webinar focusing on the fiscal year 2021 Provider Data Catalog refresh. My name is Maria Gugliuzza, and I am with the CMS Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, and I will be the moderator for today's event. Before we begin, I'd like to make our first few of our regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at www.QualityReportingCenter.com. If you would like to complete the survey after today's event, please stay on until the conclusion of today's event. After the question-and-answer session, we will display a link to the survey. The survey will no longer automatically be available, if you leave the event early. If you do need to leave prior to the conclusion of the event, a link to the survey will be available in the summary email sent out one to two business days after the event.

I would now like to introduce today's speakers. Bethany Bunch is the Hospital Value-Based Purchasing Program Lead for the Centers for Medicare & Medicaid Services' Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. Madeline Pearse is the HAC Reduction Program Lead at the Centers for Medicare & Medicaid Services' Division of Value, Incentives, and Quality Reporting Program Support Contract. Kristanna Peris is the Hospital Readmissions Reduction Program Lead also at the Centers for Medicare & Medicaid Services' Division of Value, Incentives, and Quality Reporting Program Support Contract.

Today's event will provide an overview of publicly reported data for CMS inpatient hospital value-based purchasing programs, including the Hospital VBP Program, the HAC Reduction Program, and the HRRP.

Participants will be able to locate publicly reported data for the CMS inpatient hospital value-based purchasing programs in the Provider Data Catalog, recall the changes to the inpatient hospital pay-for-performance programs from fiscal year (FY) 2020 to FY 2021, and obtain comma-separated value, CSV, files of the publicly reported data.

As a reminder, we do not recognize the raised hand feature in the Chat tool during webinars. Instead, you can submit any questions, pertinent to the webinar topic, to us via the Chat tool. All questions received via the Chat tool during this webinar that pertain to this webinar topic will be reviewed and a Q&A transcript made available at a later date. To maximize the usefulness of the Q&A transcript, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions will be addressed in a questions-and-answers transcript, to be published at a later date. Any questions received that are not related to the topic of the webinar will not be answered in the Chat tool nor in the questions-and-answers transcript for the webinar. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool. You can access the Q&A tool using the link on this slide. There you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question to us via the Q&A tool, which, again you can access at the link on this slide.

Here is a list of acronyms that will be used on today's call for your reference. I will now turn the call over to our first speaker. Bethany, the floor is yours.

Bethany Bunch: Thank you, Maria. My name is Bethany Bunch. I am the Program Lead for the Hospital Value-Based Purchasing (VBP) Program under the Inpatient VIQR Support Contract. In this portion of the presentation, I will briefly discuss the shift from Hospital Compare to Care Compare and the Provider Data Catalog. I will also present how to navigate the Provider Data Catalog and respond to some frequently asked questions.

As part of the eMedicare initiative, two tools were launched in early September 2020 to replace the eight existing quality compare tools. Care Compare on Medicare.gov presents a single user-friendly interface with quality, price, volume, and other data that help patients make informed decisions about their health care. This replaced the need for a user to locate multiple different sites based on the care setting, such as Hospital Compare, Nursing Home Compare, and Physician Compare to access this information. The Care Compare site is focused in providing information to Medicare beneficiaries, patients, and consumers. The Provider Data Catalog, the second tool, was also launched in early September 2020 replacing Data.Medicare.gov and is geared towards more data-minded stakeholders, such as academia, researchers, and parts of the healthcare industry. The PDC serves as a repository of the data included on the Care Compare website and additional datasets that are more complex and would be difficult for the intended focus groups of the Care Compare site to understand. These complex datasets include the results from the three inpatient hospital value-based purchasing programs that we're covering today – the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Readmissions Reduction Program. These datasets are not available on Care Compare.

The Provider Data Catalog gives you direct access to the data repository of CMS official data. When using the PDC, you can either view the data in a table form in your browser, download the data in a CSV format, or access the data through an API (Application Program Interface).

Now, we're going to take a quick walk through of the Provider Data Catalog. The link to the Provider Data Catalog is provided on this slide.

The home screen of the Provider Data Catalog gives you a few different launch points to access the datasets you're seeking. You can search for key terms regardless of setting. For example, if you search the term "survey," you currently will receive 26 datasets that include that include that term across all care settings. Because we are focusing on the hospital value-based purchasing programs today, I'll walk through how to display just the hospital care setting.

When scrolling down past the initial search screen, care settings will display that can be selected. The hospital value-based purchasing programs are located in the Hospital care setting selection.

After clicking on the Hospital care setting, you will be directed to a searchable list of just hospital related datasets. You can scroll through these datasets to find the specific tables you are seeking, or you can search using the search bar. Now, I'm going to open a dataset to display what options and information are available. For this example, I'm selecting the Unplanned Hospital Visits – State dataset.

When I open a dataset, I will see the name of the dataset, a brief description, and the last updated date at the top of the screen. To the right, I can confirm that this dataset relates to the Hospital care setting. I can also download the dataset in a CSV format and I can download the data dictionary.

In the dataset explorer, you have the opportunity to filter the datasets without downloading the dataset into a CSV file. For example, if my hospital was in the state of Missouri, I may want to see only the state-level data for Missouri. Currently, Alaska is displaying on my screen.

You can filter by typing into the search box under each column heading. For our example, I typed "MO" into the State search box, which resulted in my screen displaying the state-level results for Missouri. You can perform similar types of actions for searching for your hospital's CMS Certification Number, or CCN, and filtering to a specific measure when a dataset has multiple measures included.

Under the table, additional information about the dataset is provided, including the release date for the dataset and who to contact if you have questions regarding the dataset. To the right and below additional information, information regarding accessing the API is displayed.

Here are some frequently asked questions that I've already received and, to be honest, had myself.

How do I download the entire hospital database instead of individual files? How do I find previous releases, or archived, hospital files? These two questions have the same answer, and I'll walk through how to access them on the next few slides.

From the Provider Data Catalog home screen, select Topics from the menu.

The Topics page will direct you to two links for each care setting: one to view archived data and one to download all datasets. Download All Datasets will download the current version of the all datasets available for that care setting. So, that's our answer to the first question: How do I download the entire hospital database instead of individual files? The answer to the second question (How do I find previous releases, or archived, hospital files?) can be found by selecting View Archived data.

When selecting View Archived data, the site will direct you to the listing of data from each of the refreshes from 2014 and forward.

Now, we will be shifting our focus to the three hospital value-based purchasing programs that had data refreshed on the Provider Data Catalog website in January. I will be reviewing the Hospital Value-Based Purchasing Program.

The Hospital VBP Program was set forth under Section 1886(o) of the Social Security Act. The Hospital VBP Program was first adopted in fiscal year 2013, and CMS has used this program to adjust payments for every fiscal year subsequent. Fiscal year 2021 is the ninth year of the program. The Hospital VBP Program was one of the first national inpatient pay-for-performance programs in which hospitals were paid for the services based on the quality of care, rather than the quantity of services, provided. The program strives to pay for care that rewards better value, improved patient outcomes, innovations, and cost efficiencies over volume of services. The Hospital VBP Program works by awarding a hospital two types of scores for each measure included in the program: one for achievement and one for improvement.

Achievement points are awarded by comparing your hospital's measure rate in the performance period against set performance standards, known as the benchmark and achievement threshold. Improvement points are awarded by comparing your hospital's rate in the performance period against your own hospital's rate during an earlier period, known as the baseline period. The greater of a hospital's achievement and improvement points becomes the hospital's measure score. Measure scores are used in determining the hospital's domain scores which is then rolled up into the hospital's Total Performance Score. Based on your hospital's Total Performance Score in comparison to all other hospitals participating in the Hospital VBP Program, your hospital will have a payment adjustment factor determined. This payment adjustment factor can range from a hospital receiving a maximum reduction of 2 percent of their base-operating DRG payments if the hospital were to have 0 for a Total Performance Score, to having a hospital have a neutral payment adjustment, to having a hospital receive an increase in their base-operating DRG payments, and everywhere in between. In FY 2021, the highest performing hospital is receiving a net increase in base-operating DRG payments of 3.94 percent; the lowest performing hospital is incurring a net reduction of 1.62 percent. In total, approximately 55 percent of the hospitals participating in the Hospital VBP Program will receive net increases as opposed to incurring net reductions. If you would like more background information on the Hospital VBP Program, I recommend watching the *Fiscal Year 2021 Percentage Payment Summary Report Overview* webinar from July 2020, which is available in the Hospital VBP Program's archived events section on QualityReportingCenter.com.

When comparing the FY 2020 Hospital VBP Program to FY 2021, CMS implemented the changes displayed on this slide. First, CMS added the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Hospitalization to the Clinical Outcomes domain. Next, CMS updated the 30-Day Pneumonia mortality measure to expand the patient cohort. Previously, only patients with a principal discharge diagnosis of pneumonia were included in the patient cohort.

This cohort is included in the updated version of the measure, which now also includes the following cohorts: patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis (not including severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission and no secondary diagnosis of severe sepsis codes as present on admission. The last update listed on the slide is the removal of the PC-01 measure from the Safety domain beginning in this fiscal year, fiscal year 2021.

In fiscal year 2021, hospitals were evaluated based on four domains: Clinical Outcomes, Person and Community Engagement, Safety, and the Efficiency and Cost Reduction domain. The Clinical Outcomes domain consists of four 30-day mortality measures for AMI, COPD, heart failure, and pneumonia, in addition to the hip/knee complication measure. The Person and Community Engagement domain is evaluated through the use of eight HCAHPS Survey dimensions. The Safety domain contains the five healthcare-associated infection measures of CLABSI, CAUTI, SSI, MRSA, and CDI. The Efficiency and Cost Reduction domain contains the Medicare Spending per Beneficiary measure. Each domain was weighted at 25 percent of the Total Performance Score.

This slide contains the baseline and performance measurement periods for fiscal year 2021. A reminder, achievement points are awarded by comparing your hospital's measure rate in the performance period against set performance standards, known as the benchmark and achievement threshold. Improvement points are awarded by comparing your hospital's rate in the performance period against your own hospital's rate during the baseline period. When reviewing the Hospital VBP Program data from the Provider Data Catalog, please note that CMS excepted all hospitals from submitting HAI and HCAHPS data for fourth quarter 2019. Data submissions were considered optional and voluntary to CMS. Any data that was optionally submitted for the HAI measures and HCAHPS Survey were used in the Hospital VBP Program.

If data were not submitted for these measures by the hospital, a shortened performance period was used to determine measure rates. The same measure minimums still applied with the potential shortened performance period. For example, at least one predicted infection as calculated by the CDC during the performance period was required for the HAI measures for a hospital to be scored in the measure. At least 100 complete HCAHPS Surveys were required during the performance period to receive a Person and Community Engagement domain score.

The Hospital VBP Program has three sets of data that are publicly reported. The payment adjustment factors for fiscal year 2021 were published in November 2020 to the CMS.gov website. In January 2021, two Hospital VBP Program data sets were published. The fiscal year 2021 data and scoring information, including the measure, domain, and Total Performance Scores, were posted, in addition to the aggregate payment results from fiscal year 2019. I will cover each of these data sets in more detail in the next few slides.

CMS posted the fiscal year 2021 payment adjustment factors in Table 16B on CMS.gov. Table 16B contains the actual payment adjustment factors by CMS Certification Number, or CCN, for each hospital that was eligible for the program. Please note that Table 16B will not include your CCN if you were excluded from the program. Exclusion reasons include your hospital not being a subsection (d) hospital, not meeting the minimum number of domains in order to receive a Total Performance Score, being subject to payment reductions under the Hospital IQR Program, and being a hospital located in the state of Maryland, just to name a few examples.

To locate the Hospital VBP results, once you are on the Provider Data Catalog main page, scroll down past the Search box. You will find a list of healthcare settings, as shown on the next slide.

Select the Hospitals healthcare setting in the “Explore, download, & investigate provider data” menu.

You will be redirected to the current Hospital datasets. To quickly find the Hospital VBP Program datasets, type "VBP" into the search tool.

There are five datasets for the Hospital VBP Program: one for each of the four domains and one for the Total Performance Score. Each of the domain-level datasets include a hospital's baseline period rate, performance period rate, achievement points, improvement points, measure score, and performance standards for each measure or dimension. The Total Performance Score file contains a hospital's unweighted domain scores, weighted domain scores, and the Total Performance Score.

Also, refreshed in January was the payment adjustment information for fiscal year 2019. These data are based on a different payment year than the scoring that we had just covered for fiscal year 2021. CMS reports the payment adjustment information in an aggregated form for the net change in base-operating DRG payment amounts, distribution of net change base-operating DRG payments amounts, and the percent change in base-operating DRG payment amounts. In addition, there's also range fields for the value-based incentive payment amounts. This data, once again, are reported at an aggregate level and will not be broken down by CCN. If you are looking for your payment adjustment at the CCN level, we recommend going to CMS.gov and viewing Table 16B containing each hospital's payment adjustment factor.

These are the names of the four aggregate payment adjustment table datasets that can be found in the Provider Data Catalog.

On this slide, I listed resources available to assist in finding and understanding the data. The first link is to the home page of the Provider Data Catalog. If you have any questions regarding the Provider Data Catalog or Care Compare websites, a great starting point is to submit your question through the *QualityNet* Q&A tool. Please follow the instructions listed on the second bullet point to send your questions to the appropriate team. Background information on the Hospital VBP Program can be accessed on the Hospital VBP Program CMS.gov website pages.

More comprehensive information on the program, including scoring methodology, calculations, and general information for many fiscal years can be accessed on the Hospital VBP Program *QualityNet* webpages. If you have questions regarding the Hospital VBP Program specifically, please do not hesitate to contact us via the *QualityNet* Q&A tool by phone or by chat.

Now, I would like to hand off the webinar to Madeline Pearse to discuss the HAC Reduction Program.

Madeline Pearse: Thank you, Bethany. Hello, my name is Madeline Pearse, and I am the Hospital-Acquired Condition Reduction Program, or HAC Reduction Program, manager under the DPS contract. I will be going over the program changes for the FY 2021 program year and what data you can find on the Provider Data Catalog.

For some background on the program, the HAC Reduction Program is a value-based purchasing program established under Section 1886(p) of the Social Security Act. As required by the act, hospitals with a Total HAC Score in the worst-performing quartile of all subsection (d) hospitals receive a 1 percent reduction to overall Medicare FFS payments. Each year CMS provides hospitals 30 days to review and submit corrections to their program results prior to publicly reporting results. The scoring calculation review and correction period for the FY 2021 HAC Reduction Program occurred from July 20, 2020, to August 18, 2020.

There were no changes to the scoring methodology or the measure methodology for the FY 2021 program year. There were standard annual updates that occurred from the FY 2020 program year. These updates include using the most recent version of CMS PSI software, version 10.0, to calculate CMS PSI 90 results and advancing performance periods for the measures in the program by one year.

The FY 2021 HAC Reduction Program includes six measures: one claims-based composite measure of Patient Safety Indicators, the CMS PSI 90, and five chart-abstracted infection measures of healthcare-associated infections, the HAI measures, which are collected by the Centers for Disease Control and Prevention's National Healthcare Safety Network, or NHSN. These measures are CLABSI, CAUTI, SSI for abdominal hysterectomy and colon procedures, MRSA bacteremia, and CDI.

The FY 2021 performance period for the CMS PSI 90 measure was from July 1, 2017, through June 30, 2019. The five chart-abstracted measures' performance period for FY 2021 was from January 1, 2018, through December 31, 2019. CMS excepted all hospitals from healthcare-associated infections reporting requirements for quarter four 2019 due to the COVID-19 public health emergency. All quarter four 2019 HAI data submitted to the NHSN by the May 18, 2020, deadline were used in program calculations.

In FY 2021, CMS updated the data on the Provider Data Catalog website to include publicly reported data for the HAC Reduction Program. This includes individual measure scores for the CMS PSI 90 and CDC NHSN HAI measures; Total HAC Score, which is calculated as the equally weighted average of hospitals' measure scores; and hospitals' Payment Reduction Indicator, which denotes if the payment reduction will be applied to a hospital's overall Medicare Fee for Service payments in FY 2021.

Hospitals' measure scores are calculated as the Winsorized z-score of their raw measure results. In order to calculate a hospital's measure score for a given measure, the national mean of measure results for all subsection (d) hospitals is subtracted from the hospital's measure results, and this is divided by the standard deviation of measure results for all subsection (d) hospitals. National mean and standard deviations for measure results, as well as the 75th percentile Total HAC Score, are not publicly reported in this Provider Data Catalog release of data but can be found within the FY 2021 Hospital-Specific Report User Guide.

This is publicly available on the *QualityNet* website, which can be found on the HAC Reduction Program Resources slide at the end of this section of the presentation.

Similar to HVBP, to find the HAC Reduction Program data sets on the Provider Data Catalog, you can navigate to the Provider Data Catalog home page search bar.

Alternatively, on the home page, you can scroll down to Topics, including Hospitals, seen in this slide.

Search HAC Reduction Program in the search bar and click Hospital-Acquired Condition Reduction Program link. This will bring you to the HAC Reduction Program page where you can access the downloadable dataset. To access the dataset with HAC Reduction Program data, click Download This Dataset under the Downloads column on the right-hand side of the program page.

Here you can find several HAC Reduction Program resources including links to the PDC website, the program methodology, and general information about the program on *QualityNet*. We encourage hospitals to submit questions via the *QualityNet* Q&A tool. You can find instructions on this slide for how to submit questions related to Provider Data Catalog or general inquiries about the program. Now, I will hand it off to my colleague, Kristanna.

Kristanna Peris: Thank you, Madeline. My name is Kristanna Peris. I am the Lead analyst for the Hospital Readmissions Reduction Program under the DVIQR Program Support contract. In this portion of the presentation, I will be reviewing the Hospital Readmissions Reduction Program and the publicly reported information that was recently released on the Provider Data Catalog website.

The Hospital Readmissions Reduction Program, or HRRP, is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions. The program was established by Section 1886(q) of the Social Security Act and was first implemented in FY 2013.

All subsection (d) hospitals are subject to the Hospital Readmissions Reduction Program. As of FY 2015, the maximum payment reduction is 3 percent. The 21st Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits. Dual-eligibility for Medicare and full Medicaid benefits is an indicator of a patient's social risk. As of FY 2019, CMS compares a hospital's performance against other hospitals with similar patient populations to reduce the financial burden on safety-net hospitals. Each program year, CMS provides hospitals 30 days to review and submit corrections prior to publicly reporting results. The FY 2021 Hospital Readmissions Reduction Program 30-day review and correction period was from August 10, 2020, to September 9, 2020.

As finalized in the FY 2020 IPPS rule, a new definition of dual-eligibility was implemented in the Hospital Readmissions Reduction Program in the FY 2021 program year. In the new definition, dual-eligible stays for beneficiaries who die in the month of discharge are identified using the previous month's dual eligibility status. The dual-eligibility definition for beneficiaries who did not die in the month of discharge stayed the same.

This slide shows the six claims-based measures included in the FY 2021 Hospital Readmissions Reduction Program. The program includes four condition-specific readmission measures for acute myocardial infarction (AMI), COPD, heart failure, and pneumonia. The remaining two measures in the program are procedure-specific measures for CABG surgery and THA/TKA. The FY 2021 performance period for all six measures includes discharges from July 1, 2016, through June 30, 2019.

CMS publicly reports the data elements listed on the slide for each of the six Hospital Readmissions Reduction Program measures on the Provider Data Catalog. For each measure, information is only reported for hospitals with 25 or more eligible discharges. The number of readmissions will only be reported if the hospital has 11 or more readmissions. CMS also reports hospitals' predicted readmission rate, expected readmission rate, and excess readmission ratio, or ERR.

The ERR is a measure of a hospital's relative performance and is used in the Hospital Readmissions Reduction Program payment reduction formula to assess that hospital's excess readmissions for each of the conditions or procedures included in the program. CMS released the measure results for FY 2021 Hospital Readmissions Reduction Program on the Provider Data Catalog in January.

In addition to the data posted on the Provider Data Catalog, CMS also releases payment adjustment factor and component information in the FY 2021 Final Rule Supplemental Data File. This file includes information that is not posted on the Provider Data Catalog, including:

- Payment Adjustment Factors
- Dual Proportions
- Peer Group Assignments

CMS posted this file in September 2020 after the review and correction period. To access the file, you can visit the FY 2021 IPPS Final Rule home page, using the link shown on the slide.

Similar to HVBP and the HAC Reduction Program, to find the newly released Hospital Readmission Reduction Program data, navigate to the Provider Data Catalog home page. The home page features a search bar that you can type your search term in.

Alternatively, on the home page, you can scroll down to the topics, including Hospitals, seen in this slide.

Clicking on the Hospital topic, shown in the previous slide, will bring you to a page that allows you to search all Hospital datasets. In the search bar at the top of this page, type the keyword search term to search for the Hospital Readmissions Reduction Program dataset, as shown in this slide. You can download the dataset as a CSV for Excel by clicking on Download CSV.

This slide lists additional resources for the Hospital Readmissions Reduction Program. If you have questions about the program after this presentation, please submit questions via the *QualityNet* Q&A tool, linked to on this slide, and follow the navigation instructions to submit questions related to Provider Data Catalog, the measure methodology, or general inquiries about the program.

Maria Gugliuzza: Thank you, Kristanna, Bethany, and Madeline for your presentations. We will now address questions regarding today's topics. If you would like to submit additional questions at this time, please either include the slide number associated with your question or the program of your applicable question. The first questions are for Bethany and the Hospital Value-Based Purchasing Program. Bethany, are Critical Access Hospitals (CAHs) exempt from the Hospital Value-Based Purchasing Program?

Bethany Bunch: The Hospital VBP Program only includes subsection (d) hospitals. Hospitals such as Critical Access Hospitals are excluded. Detailed information on eligibility is available on the Hospital VBP Program page on *QualityNet*.

Maria Gugliuzza: Next question: When were the Hospital Value-Based Purchasing Program reports released for review?

Bethany Bunch: The FY 2021 Hospital VBP Program Percentage Payment Summary Reports were made available through the *QualityNet Secure Portal* in July 2020. Following the release in late July, hospitals were given a 30-day period to review and request correction of the calculated scores, such as domain scores and the Total Performance Score.

Maria Gugliuzza: When will we receive the Fiscal Year 2022 Hospital Value-Based Purchasing Program reports?

Bethany Bunch: CMS anticipates making the FY 2022 Hospital VBP Program Percentage Payment Summary Reports available on or around August 1, 2021.

Maria Gugliuzza: If your hospital is subject to penalties for both Hospital Value-Based Purchasing and Hospital Readmissions Reduction Programs, are both penalties applied or is it just the largest one?

Bethany Bunch: The payment adjustments would apply for both programs. So, in the scenario in which CMS determined a hospital would receive a reduction in the Hospital VBP Program and HRRP, both reductions would be applied.

Maria Gugliuzza: How do I determine what my hospital's payment adjustment factor was for the Hospital VBP Program?

Bethany Bunch: There are two approaches you could take currently for finding your hospital's fiscal year 2021 Hospital VBP Program payment adjustment factor. You can find this value on your hospital's FY 2021 Percentage Payment Summary Report. You can also find this value for your hospital by referencing Table 16B on CMS.gov. Links to Table 16B are available on slide 32.

Maria Gugliuzza: Thank you. The next question is for Madeline. Can I calculate the 75th percentile of Total HAC Scores from publicly reported data on the Provider Data Catalog?

Madeline Pearse: The 75th percentile of Total HAC Scores cannot be calculated using the dataset available on the Provider Data Catalog because not all hospitals' results are publicly reported. The FY 2021 HAC Reduction Program's 75th percentile can be found in the Hospital-Specific Report User Guide, which is publicly on the *QualityNet* website.

Maria Gugliuzza: When can my hospital review our HAC Reduction Program results?

Madeline Pearse: Each year, during the Scoring Calculations Review and Corrections period, CMS provides hospitals 30 days to review their HAC Reduction Program data, submit questions about their calculations, and request corrections to their measure scores and Total HAC Scores. This period begins when Hospital-Specific Reports with detailed program results are made available to hospitals via a secure portal within the *QualityNet* website.

The Scoring Calculations Review and Corrections period for the FY 2021 HAC Reduction Program was from July 20, 2020, through August 18, 2020.

Maria Gugliuzza: Can my hospital's claims data and NHSN submissions be revised during the Scoring Calculations Review and Corrections Period?

Madeline Pearse: No. The Scoring Calculations Review and Corrections period allows hospitals to review their HAC Reduction Program data, submit questions about their calculations, and request corrections to their measure scores and Total HAC Scores. Underlying claims data for the CMS PSI 90 and HAI measure submissions to the NHSN cannot be reviewed and revised during the Scoring Calculations Review and Corrections Period because hospitals have the opportunity to review and correct those data before they are used in program calculations.

For the CMS PSI 90 measure and all other claims-based measures used in quality reporting programs except Medicare Spending Per Beneficiary, CMS takes an annual snapshot of claims data to perform measure calculations for quality reporting programs on the final Friday in September. CMS received the snapshot of the data for the FY 2021 HAC Reduction Program on September 27, 2019. Medicare Administrative Contractors must have processed all corrections to underlying Medicare Fee for Service claims data by the snapshot date. Corrections to claims data after this date are not reflected in Hospital-Specific Reports or program results.

For the NHSN HAI measures, hospitals can submit, review, and correct chart-abstracted or laboratory-identified data for four and a half months following the end of each reporting quarter. Each year, quarter 1 (January, February, and March) data are due on August 15. Quarter 2 (April, May, and June) data are due on November 15. Quarter 3 (July, August, and September) data are due on February 15 of the following year, and quarter 4 (October, November, and December) data are due on May 15th of the following year.

The CDC creates a data file for CMS to use in quality reporting and pay-for-performance programs immediately following these submission deadlines. Updates after these deadlines are not reflected in Hospital-Specific Reports or program results.

Maria Gugliuzza: Thank you, Madeline. The next questions are for Kristanna. Why are my HRRP readmission measure results different from the readmission measure results on the Provider Data Catalog?

Kristanna Peris: The readmission measure results in the Unplanned Hospital Visits dataset on the Provider Data Catalog are also posted on Medicare Care Compare. HRRP and Medicare Care Compare use the same readmission measure methodology and hospital performance period in a given reporting cycle; however, each includes a different set of hospitals. HRRP includes subsection (d) hospitals, as well as hospitals in Maryland. By contrast, the measure results on Medicare Care Compare include non-subsection (d) hospitals, such as Critical Access Hospitals and hospitals in U.S. territories. Most hospitals will have similar results for HRRP and Medicare Care Compare.

Maria Gugliuzza: How do I determine if my hospital was penalized for HRRP if FY 2021?

Kristanna Peris: CMS publishes hospital payment adjustment factors in the FY 2021 Final Rule Supplemental Data File. This file is posted on the FY 2021 IPPS Final Rule page on CMS.gov. This file includes hospitals subject to HRRP that have measure results for at least one measure in the program. Hospitals with a payment adjustment factor less than 1 have a payment reduction in FY 2021. Hospitals with a payment adjustment factor equal to 1 do not have a payment reduction in FY 2021.

Maria Gugliuzza: Do the HRRP readmission measures count planned readmissions in the calculation of excess readmission ratios?

Kristanna Peris: No, planned readmissions do not count as readmissions in the CMS 30-day readmission measures because they are not an indicator of the quality of care.

CMS worked with experts in the medical community, as well as other stakeholders, to identify procedures and treatments that should be considered planned and excluded from readmissions. CMS uses an algorithm to identify admissions that are typically planned and may routinely occur within 30 days of discharge from the hospital. For more information, please refer to the HRRP measure methodology resources posted on the *QualityNet* website.

Maria Gugliuzza: Thank you, Kristanna.. That's all the time we have for questions today. If you have an urgent question that was not answered today, please submit your question through the question-and-answer tool on *QualityNet*. As a reminder, a recording of today's webinar will be available shortly on the QualityReportingCenter.com website for On Demand viewing or if you would like to share today's presentation with a colleague. All of our webinars produced, including detailed webinars on calculating the fiscal year 2021 Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, and Hospital Value-Based Purchasing Program scores and results, are available in the Archived Webinar section on the QualityReportingCenter.com website. Be on the lookout for our future webinar announcements by signing up for the Listserve notification groups on *QualityNet*.

Thank you for joining us today. This concludes our presentation.