Hospital Value-Based Purchasing Program

Support Contractor

Hospital Value-Based Purchasing (VBP) Program
Fiscal Year (FY) 2017
Percentage Payment Summary Report (PPSR) Overview

Presentation Transcript

Moderator/Speaker:

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

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Ms. Wheeler-Bunch: Hello and welcome to our *Hospital Value-Based Purchasing Program Fiscal Year 2017 Percentage Payment Summary Report Overview*. My name is Bethany Wheeler Bunch, and I am the Support Contract Lead for this program as a Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting and presenting today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the question and answers, will be posted to our Inpatient website, www.qualityreportingcenter.com, again, that's www.qualityreportingcenter.com, within 10 business days, and will be posted the *QualityNet* at a later date. If you registered for this event, a reminder email, as well as the slides, were sent out to your email about two hours ago. If you did not receive the email, you can download slides at the Inpatient website, www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window, and our team will answer as many questions as we can directly during the webinar, and during the question-and-answer session at the end of the webinar. Any questions that are not answered during our

question-and-answer session at the end of the webinar will be posted to the qualityreportingcenter.com website within 10 business days.

The purpose of this event will provide an overview of the FY 2017 Hospital VBP Program, including identifying how hospitals will be evaluated within each domain and measure, delineating eligibility requirements, and explaining scoring methodology.

Participants will be able to 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 their PPSR.

So, before we begin, I know one of the main questions that will be submitted during the presentation: when will we have access to the Percentage Payment Summary Report? The answer is on or before August first. The reports will be accessible on the *QualityNet* secure portal, and communications will be released through the IQR and HVBP ListServes announcing the availability of the report.

The Hospital VBP Program is required by Congress under Section 1886(o) of the Social Security Act as added by the Patient Protection and Affordable Care Act. The Hospital Value-Based Purchasing Program is the first national inpatient pay-per-performance program, meaning hospitals will be paid for the services based on the quality of care not just the quantity of services provided. The program pays for care that rewards better value in patient outcomes, innovations, and cost efficiencies instead of just volume of services. The Hospital VBP Program also encourages not only for hospitals to achieve higher rates in quality metrics, but provide incentives for hospitals to improve based on their previous rates. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting, also known as the IQR Program; so, no additional burden for data submissions are placed on the hospitals half to what is required with the IQR Program.

The Hospital VBP Program is a budget neutral program and it's funded through a percentage of withholds from participating hospitals, diagnosis related group, or DRG payments. Payment amounts will be redistributed based in the hospital's Total Performance Scores in the program, in comparison to the distribution of all other hospitals' Total Performance Scores and their estimated DRG payment amounts to fund the program. It is important to note that the withholds and incentive payments are not made in a lump sum. Again, they are not made in a lump sum, but through each eligible Medicare claim made to CMS. The funding from the first year of the program, Fiscal Year 2013, came from a withhold amount of one percent. The percentage of withholds is increased by a quarter of a percentage point until Fiscal Year 2017, when the program reaches the withhold percentage of two percent. The funding to the FY17 program will come from the two percent withholds, which is estimated to be a total of $1.7 billion.

Not every hospital is eligible for the Hospital Value-Based Purchasing Program. However, the program does apply to more than 3,000 hospitals nationwide. The program applies to subsection (d) hospitals in 50 states and the District of Columbia. Ineligible hospitals, including psychiatric and rehabilitation hospitals, are listed on the slide. Even though a hospital may be eligible for the program initially, they could be excluded from the program for one of the reasons listed on a slide. If a hospital is excluded or is ineligible, they will not have their base operating DRG payment amounts withheld, nor will they received incentive payments for that fiscal year. Essentially, the program does not apply to those hospitals. CMS has five excluding reasons for the that apply to fiscal year 2017. The first exclusion reason is for hospitals that are subject to payment reductions under the Hospital IQR Program, either from the non-participations or the failure to meet one or more requirements in the Hospital IQR Program. If a hospital is receiving a reduction through IQR, they will be excluded from the Hospital VBP Program, and they will not incur the applicable withholds from VBP for that fiscal year. The next exclusion reason is for hospitals, which are cited for deficiencies during the performance period, that pose immediate jeopardy to the health or safety of patients will also

be excluded from the program. I will discuss this exclusion reason in a little more detail on the next slide. The third criteria excludes a hospital that has an approved disaster or extraordinary circumstance exception. The fourth exclusion applies to a hospital that has less than three domain scores calculated, and the hospital will be excluded and will not have their payments adjusted. The last exclusion from the Hospital VBP Program excludes hospitals in the State of Maryland. If a hospital is excluded from the program, it will state Hospital VBP ineligible on the percentage payments summary report provided to hospitals on or around August first annually. Additionally, data for these hospitals will not be publicly reported on the Hospital Value-Based Purchasing Section on the Hospital Compare website.

As I indicated on the last slide, we will talk more about the immediate jeopardy exclusion. In past fiscal years of the program, CMS used the policy to exclude hospitals with two or more immediate jeopardy citations during the performance period. In the Fiscal Year 2017 IPPS Proposed Rule, CMS is proposing to amend the regulation to change the definition of the term cited for deficiencies that post "Immediate Jeopardy" to increase the number of surveys on which a hospital must be cited for immediate jeopardy before being excluded from the Hospital VBP Program from two to three. Again, that was from two to three. In other words, CMS is proposing that a hospital must be cited on Form CMS-2567, Statement of Deficiencies and Plan of Correction, for immediate jeopardy on at least three surveys during the performance period in order to meet the standard for exclusion from the Hospital VBP Program. Because CMS expects the effective date of the change will be October first, 2016, which is the first day of the Fiscal Year 2017 Hospital VBP Program, only hospitals that were cited three times during the performance period that applies to the fiscal year 2017 program year would be excluded from the Hospital VBP Program, if this proposal is finalized. Hospitals that were, as of October 1, 2016, cited for immediate jeopardy on two surveys during the performance period that applies to the fiscal year 2017 program year to participate on a Hospital VBP Program for the fiscal year 2017 program year. The other proposed change to the Immediate

Jeopardy Policy is in the case of the "EMTALA-related Immediate Jeopardy Citations" only. CMS is proposing the change of the policy regarding the date of the immediate jeopardy citation for possible exclusion from the Hospital VBP Program from the survey end date generated in ASPEN to the date of CMS' final issuance of Form CMS-2567 to the hospital. Form-2567 is not considered final until it is transmitted to the healthcare facility either by the state survey agencies or in all EMTALA cases in certain other cases by the CMS regional office. For more information on these proposed changes, you may reference the FY 2017 IPPS Proposed Rules on the Federal Register pages 25111 through 25112. CMS anticipates the final rule will be released on or around August first.

Now, we will move on to the measures included in the Hospital Value-Based Purchasing Program and how hospitals are evaluated in the measures through the performance standards and stories.

The Hospital VBP Program has been evolving in each fiscal year. In fiscal year 2013, CMS only included two domains in the Total Performance Score: Clinical Practice of Care, weighted at 70 percent; and, the patient experience of care domain weighted at 30 percent. In fiscal year 2014, CMS adopted the outcome domain, which included the 30-Day Mortality Measures for AMI, heart failure, and pneumonia, and weighted the domain at 25 percent. This increased the clinical practice of care domain to 45 percent. In fiscal year 2015, CMS expanded the outcome domain to include the AHRQ PSI-90 Composite and the CLABSI measure. CMS also adopted the efficiency domain to measure Medicare Spending Per Beneficiary. Domains were weighted at 20 percent for clinical process, 30 percent for patient experience, 30 percent for outcome, and 20 percent for efficiencies. In fiscal year 2016, CMS adopted outcome measures CAUTI and Surgical Site Infection, a new process measure, IMM-2, and again revised the domain weighting. CMS adopted their proposal to aligning the Hospital VBPs Quality Measurement Domain with the National Quality Strategy, also known as NQS. The Patient and Caregiver Centered Experiences of Care/Coordination domain

containing the HCAHPS dimensions is weighted at 25 percent. The efficiency in cost reduction domain containing the MSPB measure is weighted at 25 percent as well. The safety domain containing the Healthcare-Associated Infections posted on the slide and AHRQ PSI-90 is weighted at 20 percent. The clinical Care domain has two subdomains, Outcomes and Process. The Clinical Care Outcome subdomain contains the three 30-Day mortality measures and is weighted at 25 percent. The Clinical Care Process domain containing AMI-7a, IMM-2 and PC-01 is weighted at five percent of the Total Performance Score. When proposing and adopting the new measures listed on the slide, CMS considered which measures are eligible for adoption based on statutory requirements, including specification under the Hospital IQR Programs posting data on the Hospital Compare websites and priorities for quality improvements as outlined in the national quality strategy. For the Fiscal Year 2017 VBP Program, CMS finalized the adoption of three new measures: MRSA, *C Diff*, and PC-01. The MRSA measure is a risk adjusted measure monitoring onset MRSA blood stream infections using the standardized infection ratio among all patient and this facility and is reported by the CDC's National Healthcare Safety Network, or NHSN. We remained concerned about the persistent public health threat presented by the MRSA infections. According to a 2013 study available of the National Institutes of Health website, MRSA results in longer hospitalizations, increased expenses, and poor patient prognosis, and has been swiftly increasing worldwide over the past several decades. Invasive MRSA infections may cause about 18,000 deaths during all hospital stays per year. *C Diff* is a risk-adjusted measure monitoring hospital onset infections using standardized infection ratio among all inpatients in a facility and has also been reported by the CDCs NHSN. According to a 2012 study, infections with *C Diff* is associated with poor outcomes for patients. Previous work has also determined that, regardless of the baseline risk of death, for every 10 patients that acquires *C Diff* in the hospital, one patient will die. *C Diff* is also associated with increased healthcare cost. Whereas the primary mechanism by which *C Diff* increases its cost is by increasing the lengths of time patient spend in the hospitals. The PC-01 measure, elective delivery prior to 39 completed weeks gestation, is a chart-abstracted

measure. Although this is a chart-abstracted measure, CMS finalized the policy in the fiscal year 2013 IPPS Final Rule indicating that this is a measure that would be collected in aggregate counts per hospital via the web-based tools. The Strong Start initiative was launched to help reduce early elective birth. At launch, the HHS secretary stated that more than a half million infants are born prematurely in America each year. Fortunately, the early elective birth rate has steadily decreased. In 2012, the number of early elective births decreased to approximately 456,000 or 11.55 percent in the total number of births. Early elective birth are a public health problem that has significant consequences for families well into a child's life.

This slide contains the baseline and performance periods used for each of the domains and/or measures. The Process, HCAHPS, CDC, and MSPB measures utilized calendar 2013 for a baseline period and calendar year 2015 for a performance period. The 30-Day Mortality Measures and AHRQ PSI-90 Composite is October 1, 2010, through June 30, 2012, for our baseline period and October 1, 2013, through June 30, 2015, for performance period.

Hospitals receive improvement and achievement points on their percentage payments summary report based upon their performance rate during the baseline period and performance periods relative to the performance standards adopted for the Hospital VBP Program. The performance standards consist of the achievement thresholds and benchmark for all measures and the floor, which is only applicable to the Patient and Caregiver-Centered Experience of Care/Coordination domain. The achievement threshold is calculated as the median or 50th percentile of all hospital rates during the baseline period. The benchmark is the mean of the top decile, which is the average of the top 10 percent during the baseline period. The floor is the rate of the lowest performing hospital during the baseline period. As indicated by the note on the slide, the MSPB measure is slightly different than the rest and uses the performance period data to calculate the performance standard instead of using a baseline period data.

The measures displayed on this slide will have a higher benchmark value than an achievement threshold. Higher rates demonstrate better quality in the measure. The measure of this description is applicable for the Clinical Care process measures in the AMI-7a and IMM-2, Patient and Caregiver Centered Experience of Care/Coordination dimensions, and the 30-Day Mortality Measures in the Clinical Care outcome sub-domain. The results for the Mortality Measures are calculated and displayed on Hospital VBP Program reports as survival rates instead of mortality rate, meaning higher rates are better for these measures.

The measure displayed on this slide will have a higher achievement threshold and benchmarks because lower rates demonstrate better quality. The measures that this subscription is applicable for are the PC-01 measure in the Clinical Care process sub-domain, AHRQ PSI-90 composite, and all the Healthcare-Associated Infections in the safety domain. Also included is the MSPB measure in the Efficiency and Cost Reduction domain.

Achievement points are awarded by comparing an individual hospital rate during the performance period with all hospital rates from the baseline period by using two performance standards that we just covered: 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 worse than the achievement thresholds, the hospital will receive the real achievement points. If the performance period rate is equal to or better than the achievement thresholds, but it's still lower than the benchmark, one to 9 points will be awarded.

Improvement points are unique to the Hospital VBP Program in relation to CMS's other inpatient pay-per-performance program. Not only can a hospital be evaluated based on their current performance and comparison to all other hospitals, they can also earn points by improving their own baseline period. CMS may award hospital improvement points if the hospital’s performance period rate is better than their baseline period rate. The maximum point value for improvement points is 9 points. If a

hospital has a rate equal to or worse than their baseline period rate, zero improvement points will be awarded. If a hospital opened after the end of the baseline period, they will not be eligible for improvement points. But, they will still have an opportunity to receive achievement points and to be eligible for a Total Performance Score. Likewise, if a hospital does not meet the minimum case count in the baseline period, if they are open, they would not be eligible for improvement points. But, if they did meet the minimum during the performance period, they would be eligible to receive achievement points. We will cover the minimum case counts for each of the domains and measures later in this presentation.

Now, we will be covering the scoring methodology of the Clinical Care domain.

The Clinical Care Process subdomain contains three measures: AMI-7a, IMM-2, and PC-01; and, is weighted at five percent of the Total Performance Score.

If a hospital does not meet the minimum requirement for a measure or dimension during the baseline period, improvement points will not be calculated for the measure or dimension. In order to receive improvement points for the Clinical Care process measures, at least 10 eligible cases must be submitted during the baseline period and the performance period. If a hospital only meets the minimum requirement of 10 cases during the performance period, and not the baseline period, only achievement points will be awarded. The Clinical Care process subdomain required at least one of the three measures displayed on the slide to receive a measure score in order to be included in the Total Performance Score that will be displayed on the Percentage Payment Summary Report.

In the next few slides, we will walk through how to calculate the achievement points, improvement points, and measure score for the new PC-01 measure and the unweighted domain score for the Clinical Care Process subdomain. I would like to note that the same process would be used for any of the other Clinical Process measures. You would just need to plug in your hospital's measure scores for either the performance or

baseline period rate and swap out the achievement threshold and benchmark for the applicable measure. To calculate achievement points, you may use the formula that's displayed at the bottom of the slide. You first divide the difference of the performance period rate and the achievement threshold by the difference of the benchmark in the achievement threshold. Then, multiply the quotient by nine and add the results to 0.5. We will calculate the achievement points by first finding the numerator and denominator in the parenthesis by subtracting the performance period rate of 0.012 by the achievement threshold 0.03125, which equals negative 0.01925. This will be our numerator. We then subtract the benchmark of zero by the achievement thresholds of 0.03125 to find your denominator, which equals negative 0.03125. The quotient of the numerator over the denominator is 0.616. Finally, we multiply that value by nine, which equals 5.544 then add 0.5 to equal 6.044. We then finally round that value to a whole number to equal six achievement points.

To calculate improvement points, you may use the formula displayed at the bottom of the slide. You first divide the difference of the performance period rate and the baseline period rate by the difference of the benchmark and the baseline period rate. Then, multiply that quotient by 10 and subtract the results by 0.5. We will calculate the improvement points by first finding the numerator and denominator in our parenthesis by subtracting the performance period rate of 0.12 by the baseline period rate 0.024, which equals negative 0.012. This will be our numerator. We then subtract the benchmark of zero as a baseline period rate of 0.024 to find our denominator, which equals negative 0.024. The quotient of negative 0.012 over negative 0.024 equals 0.5. Finally, we multiply 10 by the value 0.5 and then subtract the 0.5 to equal 4.5. And, we round to the nearest whole number which is five.

Hospitals are only awarded one score per measure, which is identified as the greater of achievement points and improvement points. This slide displays the Fiscal Year 2017 Clinical Process measure, with example achievement and improvement point value. The measure score is

populated by selecting the larger of the two values. For example, the PC-01 measure received six achievement points and five improvement points. The measure score is the greater of the two numbers, which is six. The AMI-7a row has an N/A listed in all of the columns. This indicates that there was not enough cases to meet the minimum scoring requirement. The IMM-2 row also has an incalculable score in the improvement point field. A dash or N/A in just the improvement point field would indicate the minimum case requirement was not met during the baseline period.

Now that each measure has a measure score calculated, the unweighted domain score can be calculated. The unweighted domain score is normalized to account for only the measures that the hospital met the minimum requirements for. As displayed on slide 23, the minimum requirement for the Clinical Care Process measures is 10 cases in the denominator during the performance period. To normalize the domain, you sum the measure scores in that domain. In our example, the sum of the measure scores is 16 points. We then multiply the eligible measures by the maximum point value per measure. In our example, the hospital did not meet the minimum requirement in the AMI-7 measure. So, instead of three total measures that this hospital was scored in, the hospital only received scores in two. We then multiply the two measures by 10 points possible for each measure for a total of 20. The created percentage score of the hospital are in relation to the points possible. We divide the sum of the measure scores of 16 by the maximum points possible of 20, which equals approximately 0.8. Lastly, we multiply the result by 100 to equal 80. We will cover how to calculate the weighted domain score and Total Performance Score at the end of the presentation.

The Clinical Care outcome subdomains contain three measures: the 30-Day Mortality Rate for the clinicians of AMI, Heart Failure, and Pneumonia; and, is weighted at 25 percent of the Total Performance Score. The 30-Day Mortality Measures utilize admissions from Medicare Fee-for-Service Beneficiaries aged 65 or older discharge from subsection (b) and Maryland Acute Care Hospitals having a principal discharge diagnosis of AMI, Heart Failures, or Pneumonia and meeting other

measure inclusion criteria. The results calculated are displayed as survival rates instead of mortality rates.

In order to receive an improvement points for the Clinical Care Outcome measures, at least 25 eligible cases must be submitted during the baseline period and the performance period. If a hospital only meets the minimum requirements of 25 cases during the performance period and not the baseline period, only achievement points will be awarded. The Clinical Care Outcome subdomain requires at least two of the three measures displayed on the slide to receive a domain score and in order to be included in the Total Performance Score.

In order to calculate the 30-Day Mortality Measures achievement points, you use your hospital survival rates. In our example, the hospital performance period survival rate was better than both the benchmark and achievement threshold. As you can reference at the bottom of the slide, a hospital that has a rate that is better than benchmark will receive 10 achievement points. As the performance period rate is located between the benchmark and the achievement thresholds, the achievement point formula would have been used that covered in the clinical processes of care calculation. If a hospital would have had a performance period survival rate worse than the achievement threshold, zero achievement points would be awarded.

Now that we know that our performance period rate is better than the benchmark, which resulted nine points automatically in the improvement point formula, if the performance period rate is better than the baseline period rate. If our example would have known the baseline period rate to 88 percent instead of 86.2 percent, the hospital would not have improved and the resulting improvement points would have been zero. As the performance rate, the blue box, would have been located in between the benchmark, which is the green box, and the baseline period rate, the gold box, we would have used the improvement point formula to determine how many points would be rewarded to the hospital.

Like the process subdomains, hospitals are only awarded one score per measure, which is identified as the greater of achievement points and improvement points. This slide displayes to the Fiscal Year 2017 Clinical Care Outcome subdomain measures with example achievement in improvement point values. The measure score is populated by selecting the larger of the two value. For example, the 30-Day Mortality Measure for AMI received 10 achievement points and nine improvement points. The measure score is the greater of the two numbers which is 10.

Now that each measure has a measure score calculated the unweighted domain score is calculated. The unweighted domain score is normalized to account for only the measure if the hospital met the minimum requirements for. As displayed on slide 29, the minimum requirement for Clinical Care process measures is 25 cases in the denominator during the performance period. To normalize this domain, you sum the measure scores in the domain, in our examples are sum of total measure score is 21 points. You then multiply the eligible measures by the maximum point value per measure. In our example, the hospital met the minimum requirements in all measures, so that the hospital moved forward on three measures. We then multiply the three measures by 10 point possible for each measure for a total of 30. To create a percentage score that the hospital earned in relation to points possible, we divide the sum of the measure scores of 21 by the maximum points possible of 30, which equals approximately 0.7. Lastly, we multiply the result by 100 to equal 70.

This slide displays the Percentage Payment Summary Report Clinical Care detailed report, which is page two. On the Clinical Care detail report, each period's numerator, denominator, and performance period rate will be available for the three of the Clinical Process of Care measures. The outcome section displays the number of eligible discharges and performance period rates for the measures during the baseline and performance period. It is important to note that, if the minimum case amount is not met for a measure, dashes will be displayed in the achievement points, improvement points, and measures score fields

indicating your hospital did not meet the minimum requirements for scoring calculations.

The third section of the Clinical Care Detail Report is the HVBP metrics. The HVBP metrics include the performance standards of the achievement threshold and benchmark in the scoring values of the improvement points, achievement points, measures score, and condition in procedure scores and that one is just applicable to the process measures. Lastly, the summary of the Clinical Care domain will be displayed at the bottom of the screen denoted with our purple four. This will list out the number of eligible measures, the unweighted subdomain scores and the weighted subdomain scores.

Now, we will cover the scoring methodology for the Patient-And-Care Giver-Centered Experience of Care/Care Coordination domain, which I'm going to shorten for the remainder of the presentation to just PCCEC/CC domain.

This domain is weighted at 25 percent of the total performance score. This domain is measured by the use of the Hospital Consumer Assessment of Healthcare Providers and Systems, also known as the HCAHPS, surveys dimension of communication with nurses, communication with doctors, responsiveness of hospital staff, pain management, communication about medicine, cleanliness and quietness of hospital environment, discharge information and overall rating of hospitals.

The team PCCEC/CC domain requires at least 100 completed surveys during the performance period in order to receive a domain score. In order to receive achievement points, a hospital must have at least 100 completed surveys during the performance period. In order to receive improvement points, a hospital must have at least 100 completed surveys during both the baseline period and the performance period because CMS needs to compare those two values to determine its improvement occurred at the hospital.

I'm going to skip over slides 39 and 40 as these calculations have not changed from the previous Fiscal Year. I just wanted you to be able to have these examples as a reference, if you wish to replicate the results on your first managed treatment summary report.

Like the clinical domain, hospitals are only awarded one score per dimension, which is identified as the greater of achievement points and improvement points. For example, in the communication with nurse's domain the hospital received five achievement points and four improvement points, resulting in the measure score of five.

What is different from the Clinical Process care domains is the use of the lowered dimension score in order to calculate consistency points. To calculate the lowest dimension score, you must input values into the first formula listed on the slide for all eight dimensions. The lowest resulting value becomes your hospitals lowest dimension score.

In our example, the lowest dimension is the communications about medicine dimensions with the lowest dimension score of 0.798.

To calculate the consistency score, you take the lowest dimension score value, in our case the 0.798, and multiply it by 20, then subtract by 0.5. The consistency score for our hospital in example one equals 15. In example two, we modified the row of dimension score to equal one. This means that the lowest dimension score was at least equal to the achievement threshold for that measure. In that scenario, the resulting score would equal 20, which is the maximum score for the consistency score.

To calculate the hospitals unweighted patient experience of care domain score, we first calculate the hospitals base score, which is the sum of all the dimension scores. As you can see on the slide, the base score is equal to 50. Second, we have to identify the hospital lowest dimension scores in order to calculate the consistency score. The resulting value from our calculation was 15 for the consistency score. Last, we sum the base score in the consistency score P equals 65. The maximum base score is 80

points, which would be achieved by a hospital receiving 10 achievement points in each of the eight dimensions added to the maximum 20 point consistency score, which equals 100 points for the unweighted domain score.

The detail report displays the hospitals baseline period rate indicated with the blue one and performance period rates indicated by the gold two for each of the HCAHPS dimensions. Additionally, the detailed report displays the HVBP measure, which are the performance standards of the floor achievement threshold and benchmark. This section also displays the scoring values of the improvement points, achievement points, and dimension score. At the bottom of the page, the summary score that are listed of the HCAHPS base score, the HCAHPS consistency score, unweighted domain score, weighted domain score, and the number of surveys completed during the performance period. Finally, there will be a footnote at the bottom of the page that identified the HCAHPS dimension that was used as the lowest dimension score for that hospital. The lowest dimension score can also be identified by looking at the dimensions listed on the report and the one that is bold and italicized is also the lowest dimension scores.

Now we will cover the scoring methodology for the safety domain.

In the Fiscal Year 2017 VBP program, the safety domain will be weighted at 20 percent of the total performance score. This domain utilizes two measure sets. The first being the Healthcare Associate Infection measures of CLABSI, CAUTI, SSI, MRSA, and CDI; and, second being the AHRQ PSI-90 composites.

The first safety measure displayed on your Percentage Payment Summary Report is the AHRQ PSI-90 composite. The PSI-90 composite is comprised of eight underlying Patient Safety Indicators, or PSIs. In order for a hospital to receive improvement points on the PPSR, a hospital must have at least three eligible cases on anyone underlying indicator in the baseline period and performance period. A hospital is eligible to receive achievement points when three eligible cases on any one underlying

indicator are met in the performance period. For the Fiscal Year 2017 program, CMS announced that AHRQ QI software version 4.5a would be used for the baseline period, performance period, and performance standard calculations. In addition CMS will utilize the first nine diagnosis code and first six procedure code listed on the claim for the AHRQ PSI-90 calculations.

Now as I'm sure many of you identified, the performance period rate value is worse than the benchmark and better than the achievement threshold on the slide. Remember that the AHRQ PSI-90 value is the reverse measure, meaning that lower values indicate better quality. Because of performance period rate is in between the benchmark and achievement threshold, we will use the achievement point formula, which results in six achievement points.

Moving on to a hospital improvement point, we will also use the formula because the hospital performance period rate is (a) better than the baseline period, but (b) worse than the benchmark. The resulting value from the improvement point calculation is fixed improvement point.

In order to receive improvement points for the measures of CLASBI, CAUTI, MRSA and CDI, a hospital must have least one predicted infection calculated by the CDC and the baseline period and the performance period. To receive achievement points, the minimum of one predicted infection must be calculated in the performance period. For example, a hospital received at least one predicted infection in the CLASBI, MRSA measures, but did not in the CAUTI and CDI measures with 0.000 and 0.999 predicted infections.

The same criteria apply to the surgical site infection measure. However, because the measure is stratified in to two procedure types there are additional regulations. In order to receive an SSI measure score, at least one predicted infection is required in at least one of the strata of abdominal hysterectomy or colon surgeries. If only one of the strata meets the minimum, 100 percent of the measure’s weight be placed on the measure that met the minimum. If both strata meet the minimum

predicted infections, the measured score will be weighted by the predicted number of infections during the performance period. We will cover that calculation on slide 57 and 58.

In our achievement point example, the hospital has a Standardized Infection Ratio or SIR of 1.010 in the performance period. The benchmark is 0.000, and the achievement threshold is 0.845. Because the SIR was worse than both the benchmarks and the achievement thresholds, the hospital will automatically be awarded zero achievement points, as hospitals must meet at least the achievement threshold in order to receive at least one point.

Now the hospital had a SIR of 0.4 in the baseline period and a performance period SIR of 1.010. Because the performance period SIR was worse than the baseline period SIR, the hospital would automatically receive zero improvement points.

We have addressed the minimum measure requirements for all the safety measures in the previous slide. For example, hospital met the minimum requirements and all but the CAUTI and CDI measures, in order for a hospital to receive a safety domain score, they must receive a measure for of at least three of the six total measures. As our hospital met at least three of the six measures, our example hospital will receive a safety domain score.

As indicated a few slides ago, we would cover the calculation of the combined SSI score. CMS finalized in the Fiscal Year 2014 IPPS final rule that they will reward achievement points and improvement points to each stratum of SSI measure, then compute a weighted average as the points awarded to each stratum by predicted infection. The weighted average of the points awarded will be the hospital's SSI measure score. So, what does that really mean? The rule language is first stating that CMS will calculate the individual strata of abdominal hysterectomy and colon surgery individually, like any other measure, would be calculated in the Hospital VBP Program. However, in order to just create one score, we must weigh the measured scores by predicted number of infections during

the performance period. I think this will be easier with an example, so we will go ahead and add some numbers on the next slide.

An example is that a hospital received five improvement points for the SSI colon stratum, which is the hospital's measured score for that stratum. The colon stratum also had one predicted infection during the performance period. The abdominal hysterectomy stratum having measure score of eight that resulted from the hospital receiving eight achievement points and had two predicted infections during the performance period, to calculate the combined score you first multiply the colon measure score of five by the colon predicted infection is one equaling five. Then, you do the same for the abdominal hysterectomy stratum. Multiply the abdominal hysterectomy measure score of eight by the predicted infections of two equaling 16. You then add those two values together, again the values were five, the five times one of the colon stratum to the 16, the eight times the two, for the abdominal hysterectomy stratum, which equals 21. You then work on the denominator by adding the number of colon predicted infections to the abdominal hysterectomy predicted infection, which is one plus two for a total of three. You then divide the numerator of 21 by the denominator of three, which is equals a measure score of seven.

This slide displays the same areas in which the combined SSI score would be calculated. The combined SSI formula would be used in the first scenario in which both stratum meet the minimum of one predicted infection. The next two scenarios of one stratum meeting the minimum resulting in SSI measure score still being calculated. However, the measure score will reflect the stratum that met the minimum by 100 percent. So, if the measure score of abdominal hysterectomy was eight and the colon stratum did not meet the minimum, the combined score would equal eight. An SSI score would not be calculated if neither of the strata met the minimum of one predicted infection during the performance period.

The measure scores for the other safety measures are calculated the same as every other measure in the Hospital VBP Program. The measure score is the greater of achievement points and improvement points.

Now that each measure has a measure score calculated the unweighted domain score is calculated. The unweighted domain score for this domain is normalize again to account for only the measures the hospital met the minimum requirement for. To normalize this domain, you sum of measure scores in the domain. In our example is sum of the measure scores is 26 points. You then multiply the eligible measures by the maximum point value per measure. In our example the hospital did not meet the minimum requirements in the CDI measure, so instead of six total measures, this hospital was only scoring five. Remember that the SSI measure only counts as one measure. We then multiply the number five by 10 points possible for each measure for a total of 50. They create a percent of score the hospital earned in relation to points possible, we divide the sum of the measure scores of 26 by the maximum points possible of 50, which equals approximately 0.52. Lastly, we multiply the results by 100 to equal 52.

This slide displays the safety detail report with highlighted specific to the baseline and performance period total. For our PSI-90 composite has just the index value for the baseline and performance period. The HAI measures contain number of observed infections, number of predicted infections, and the standardized infection ratio for both the baseline and performance period.

This slide still displays the safety detail report that places emphasis on the HVBP metrics and summary totals. The HVBP metric display the performance standards, improvement points, achievement points, and measure score. The summary total displays the number of eligible safety domain measure, the unweighted safety domain score, and the weighted safety domain score.

Now, we will move in to our final domain, the efficiency and cost reduction domain.

The Medicare Spending Per Beneficiary measure is the sole measure in the Efficiency and Cost Reduction domain, which is weighted at 25 percent from the Fiscal Year 2017 program. The MSPB is a claim-

based measure that assesses Medicare Part A and Part B payments for services provided to Medicare beneficiaries during a spending for beneficiary episode that spans from three days prior to the inpatient hospital admission through 30 days after discharge. By measuring cost of care through this measure, CMS hopes to increase the transparency of care for consumers and recognized hospitals that are involved in the provision of high quality care at a lower cost to Medicare.

In order to receive improvement points for the MSPB measure, a hospital must have at least 25 eligible episodes of care during the baseline and performance period. And so, if a hospital only meets the minimum requirement during the performance period, only achievement points will be awarded.

Our example hospital had a performance period rate of 0.7, which is better than the benchmark, resulting in 10 achievement points. Remember that lower rates are better for the MSPB measure.

Our example hospital has a performance period rate that was better than the benchmark that would result in nine improvement points, if and only if the performance period rate was better than the baseline period rate. However, as you can see on the slide, in our example, the hospital's baseline period rate and performance period rate are equal, indicating that, although the hospital maintains its performance, no actual improvement was observed. Because no improvement was observed, zero improvement points would be awarded to this hospital.

Like all of the other domains, the MSPB measure score is the greater of achievement points and improvement points. In the scenario that we just covered in the last couple of slides, in which the hospital has met or surpass the benchmark, a measure score of 10 will always be awarded because the achievement points have a maximum score of 10 in the designation of zero or nine improvement point are essentially ignored because the maximum was already achieved for the measure through the achievement point calculation.

The efficiency and cost reduction domain is still normalized by achievement of the measure score that is out of 10 to the unweighted domain score, which is out of 100 points possible. First you sum the measure scores, in this case you just take the MSPB measure score out of 10. Second, you multiply the total possible point, which is 10 per measure times one measure. You then divide the sum of the measure score to 10 by the total possible point of 10, which is equals one, and multiply that result by 100 which equals 100.

The efficiency detail report is broken down in to the four sections on the slide. This first section is the baseline period total, which contains your MSPB amount, the median MSPB amount across the country, and then the ratio, which is the numerator, the MSPB amount over the median MSBP amount for your hospital. That is then for both the baseline period designated with the blue one and the performance period which is the gold two. The third section is the HVBP metrics, which contain the achievement threshold and benchmark. Again, I would like to remind you that the achievement threshold and benchmark for the Medicare Spending Per Beneficiary measure is calculated using performance period data and not baseline period data. And fourth, with the purple four is the summary section, which displays the eligible measures, the unweighted domain score, weighted domain score, and number of episodes of care during the performance period.

Now, we will cover how to calculate the weighted domain score and total performance score using all four domains and just three domains.

The weighted domain score is the last calculation completed for the total performance score. We multiply the unweighted domain score values by the domain weight for the Fiscal Year. The domain weights were displayed in the pie chart in slide 14. For example, a Clinical Care process domain is weighted at five percent. So, the weighted clinical domain score would equal 3.75 points, which is the product of the unweighted domain score of 75 multiplied by five percent. To compute the total performance score, we sum the weighted domain scores. The maximum total performance score that can be calculated is 100 points. In Fiscal

Year 2015, CMS adopted a policy that allows hospitals to be allowed to receive a total performance scored based on the hospital only receiving scores in two of the four domains. CMS continued this policy in FY 2016 and modified the policy for FY 2017 to require three out of the four domains. If less than four domains are scored in the Fiscal Year, the remaining domain weight are proportionately reweighted to equal 100 percent.

In this example, the hospital received scores in four out of the four domains. Remember that CMS counts a subdomain score in at least one of the Clinical Care subdomains as being sufficient to be counted as one total domain. So, the Clinical Care domain was actually met for the purposes of this example even though you're seeing the X next to the Clinical Care process subdomain. This hospital had unweighted domain scores calculated in the Clinical Care Outcome subdomain, Safety domain, the Efficiency and Cost Reduction, and the PCCEC/CC domain. To determine the proportionate reweighted values, you first sum the original weights of the eligible domains. This result is 95 percent for example, which is comprised of the 25 percent of Clinical Care Outcome added to 20 percent to Safety, the 25 percent of Efficiency and Cost Reduction and the 25 percent to the PCCEC/CC domain. Second, individually divide original weight for the domains that are eligible by the result of step one or 95 percent. The Clinical Care Outcome subdomain, Efficiency and Cost Reduction domain and the PCCEC/CC domain are calculated at 26.3 percent by dividing their original weight of 25 percent by the sum that equals 95 percent. The safety domain is reweighted to 21.1 percent, which is calculated by dividing that domain's original weight of 20 percent by the sum of 95 percent.

This slide now shows our updated domain weight and unweighted domain scores. The unweighted domain scores remain unchanged for the exception of the removal of the Clinical Care Process subdomain. The rest of the unweighted domain scores remain the same, and we multiply those values by the newly calculated domain weights that were

proportionately reweighted. We will then still add the weighted domain scores together to equal a total performance score.

In this example, the hospital received scores in three out of the four domains. Remember again that CMS counts the subdomain score in at least one of the Clinical Care subdomains as the insufficient to be counted as one total domain. So, in this example the hospital met the minimum domain requirements in Clinical Care, Safety and Efficiency and Cost Reduction, which equaled by three domains. This hospital had unweighted domain scores calculated in those domains that I just mentioned, we follow what we did in the previous couple of slides. And the first step of that is to sum the remaining eligible domain weights. So, the result of that is 50 percent, which is comprised of five percent of Clinical Care Process added the 20 percent of Safety and 25 percent of Efficiency and Cost Reduction. Second, and we individually divide the original weight for the domains that are eligible by the result of step one or 50 percent. The Clinical Care Process domain is calculated as 10 percent by dividing the original weight of five percent by the sum of 50 percent. The Safety domain is reweighted to 40 percent by dividing the original weight of 20 percent by the sum of 50 percent. And finally, the Efficiency and Cost Reduction domain is reweighted to 50 percent, which is the original weight of 25 percent divided by the sum of 50 percent.

The slide now shows updated domain weights and weighted domain scores. The unweighted domain scores again remain unchanged with the exception of the removal of the Clinical Care Outcome subdomain and the PCCEC/CC domain. The rest of the unweighted domain scores remain the same, and we multiply the values by the newly calculated domain weights that we're proportionately reweighted. We will then still add the weighted domain scores together to equal the total performance score.

The percentage summary detail report is the first page of the Percentage Payment Summary Report and is displayed on the slide. The first section of the report displays your hospital total performance score, the state total performance score, and the national total performance score. The second section of the report displays a summary of your hospital’s unweighted

domain scores, the weight used to calculate the weighted domain score, and the weighted domain score. The third section of this report displays your hospital's payment adjustment factor, which we will cover on the next slide.

The payment adjustment factor section of this report displays five values. First, the base operating DRG payment amount reduction is the percentage withhold for the program that your hospital is incurring. This value will be the same for every hospital since the value equaling 2.0 percent. The value-based incentive payment percentage is the portion of the base operating DRG payment amount your hospital will earn back. This value is the incentive only and does not take in to account the withhold percentage. The net change in base operating DRG payment amount is the percentage your hospital payment will be changed taken in to account that withhold. So, this value is really the incentive payment percentage subtracted by the base operating DRG payment amount. A positive value indicates that your hospital will receive a net increase; with a negative amount indicates that your hospital will receive a net reduction. The value-based incentive payment adjustment factor is the value that each eligible claim will be multiplied by to determine the financial impacts of the Hospital VBP Program. The Exchange Function Slope is the value that CMS uses to convert a hospital total performance score in to the payment adjustment factors. The Exchange Function Slope is the same for each hospital but is unique to each Fiscal Year. I would like to note that the disclaimer down at the bottom of the slide says that the values displayed on this example report, including the national average in the Exchange Function Slope, may not depict the actual value used FY 2017.

If a hospital was excluded from the Hospital VBP Program, the exclusion reason will be displayed on the report in between the domain summary section and the payment information. In addition, hospital total performance score and payment information will all display Hospital VBP ineligible.

We will now move in to the review and correction section of this presentation.

Following the release of the Percentage Payment Summary Report, hospitals will have the opportunity to review their report and request a recalculation of the condition scores, domain scores, and total performance score. The review and correction period is a total of 30 calendar days, starting at the date the report is released through the secure portal. If you would like to submit a request for review and correction, you will need to complete the review and correction form on *QualityNet*, which we will cover on the next slide, and submit the completed form to the HVBP group in the *QualityNet Secure Portal* through the Secure File Exchange.

To request a review and correction, a hospital should follow the steps on the slide. The review and correction forms are located on the Review and Correction/Appeal tab navigation page under the Hospital Value-Based Purchasing dropdown menu on *QualityNet*.

The form must have the information on the slide to be considered a completed form.

Now, we will move in to the appeals section of the presentation.

The appeal of the calculation of the performance assessment should occur within 30 calendar days of the receipt of CMS' review and correction decision. Hospitals may appeal the calculation of their performance assessment within 30 calendar days of the receipt of CMS's review on correction decision. It's important to know hospitals must receive an adverse determination from CMS prior to requesting an appeal.

To request an appeal for the decision, the hospital should follow all of the steps in this slide. The appeals form is located under Review and Corrections/Appeals navigation pane under the Hospital Value-Based Purchasing dropdown menu on *QualityNet*.

Similarly, to the Review and Correction form, when completing the appeal form the following information must be presented. The date of the request, the hospital CCN, the hospital contact information including both

the CEO and *QualityNet* Security Admin., and specific reasons for each request, plus a detailed description for each of the reasons identified.

The bullet points listed on this slide are the acceptable reasons for the appeal to be submitted and considered.

Now, we will finish up the presentation with the resources that are available to hospitals. After we finish the resources, I will be handing the presentation over to Deb Price to inform you of the CE policies that we have available to hospitals. After that, we will be opening up the presentation for question and answers.

For those that joined after we started, I would like to repeat that the Percentage Payment Summary Reports will be enabled on *QualityNet* by August first. Communications for the IQR and HVBP ListServes will be released to announce the release of those reports.

We will have additional resources available, if you need assistance from the Hospital VBP Program. First, the document has been created specific to the Fiscal Year 2017 Percentage Payment Summary Report entitled *How to Read your Report*. It will be posted to *QualityNet* prior to the release of the report. We have several Hospital VBP Program recorded webinars, slides, transcripts for you to review regarding specific measure set calculations, and improvement stories. Those are all available by clicking the webinar and calls option on the Hospital VBP Purchasing pages or *QualityNet*. They are also available on the qualityreportingcenter.com website.

I would like to mention CMS Hospital Compare website at http://medicare.gov/hospitalcompare. Currently, the Fiscal Year 2016 Hospital VBP Program Data has been posted to the Linking Quality to Payment section. It is anticipated with the Fiscal Year 2017 Program Data will be posted in December 2016. This data contains all eligible hospitals improvement and achievement points, measure scores, conditional procedures scores, domain scores, and total performance scores. At this time, I will be turning over the presentation to Deb Price for her to present

on Continuing Education. I remind you, if you have a question, please submit that question into the chat box, and we will try to answer as many questions that we can after Deb's presentation on Continuing Education. But, if we do not get to your question, we will answer it through question and answer document posted to the qualityreportingcenter.com within 10 business days.

Thank you all and, Deb, the floor is yours.

Dr. Price: Well thank you very much. Today's webinar has been approved by the Boards listed on this slide. We are now nationally accredited nursing provider and as such, all nurses report their own credits to their boards using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. First way is: if you register for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk®, please pass the survey to them. After completion of the survey, you'll notice at the bottom right hand corner a little gray box that says Done, you will click the Done box and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk®. Please use your personal email for this separate registration, so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with the Learning Management Center, that means you have a firewall up that's blocking the link into your computer. Please go back to the new user link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your new user link, just wait 48

hours because remember your going to be getting another link and another survey sent to you within 48 hours.

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

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

This is what the New User screen looks like. Please register a personal email like Yahoo or G-mail or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. Notice you have a first name, a last name, and the personal email, and we're asking for a phone number in case we have some kind of back side issues that we need to get in contact with you.

This is what the Existing User slide looks like. Use your complete email address as your user ID, and of course the password you registered with. Again, the User ID is the complete email address, including what is after the @ sign.

OK, now I'm going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

Ms. Wheeler Bunch: Thank you, Deb. This is Bethany again. So, we received a few questions during the webinar. I'm going to go over some of the most frequently asked questions now.

The first one is, when will the FY 2017 Percentage Payment Summary Report be available? The answer to that question is: the FY 2017 PPSRs would be available on or around August 1, 2016. A piggyback question to that I've seen is how will they be available? The reports will be available in the *QualityNet Secured Portal* through the report run interface. This is

not one of the reports that are sent to you through Secure File Transfer in your auto route inbox. So, you will have to go into the secure portal and run this report yourself.

Next question, which nine diagnosis codes and six procedure codes will be included in the PSI-90 calculation? CMS utilized the first nine diagnosis and six procedure codes on the applicable claims for calculation of the AHRQ PSI-90 composite for the FY 2017 VBP Program. The codes utilized for the calculation will be specific to the claim submitted by the hospital. And, if you would like to review which diagnosis and procedure codes where used for the claims that you submitted for the FY2017 program, hospital specific reports were sent to you through Secure File Transfer through your auto route inbox; I believe it was in April of this year for FY 2017 performance period.

Next question is: what is the Fiscal Year time period? The Hospital Value-Based Purchasing impact payment for a Fiscal Year. So, that means that the FY 2017 program will impact payment for the Federal Fiscal Year 2017. And that runs from October 1, 2016 through September 30 of 2017. So, although it impact payments in that date range, it's based on the data from a previous time frames. And, I'm going to go back to the baseline and performance period slide here. So, you can see that the FY 2017 program is really based on data that was collected for the performance period in 2015 for most of the measures with the exception of the claims based measures of AHRQ PSI-90 and the 30-Day Mortality Measures, which is the performance period date of October 1, 2013 through June 30 of 2015. Also, people asked me to revisit this slide, so you could see the baseline and performance period. So, I will leave this slide up until I can move it for one of the future questions.

The next question that we received: how is the achievement threshold and benchmarks – threshold and benchmarks communicated out to the hospital. The performance standards are published in the IPPS rule. So, if you are out looking at the FY 2017 IPPS Proposed Rule, you'll see that a lot of the performance standards for FY 2019 are currently being proposed. And, you can look for the FY 2017 IPPS Final Rule to see if

those performance standards have been finalized. Now, in the case that the performance standards need to be updated through a technical update, historically we have posted news articles out on *QualityNet* with those updated values. And the path that generally been for the AHRQ PSI-90 composite with CMS updating to a more recent AHRQ QI software version. The performance standards will also be listed on your hospital's baseline measure report and the Percentage Payment Summary Report.

For the HCAHPS floor percentage, how is that calculated, what is the floor percentage? So, the floor is the score of the lowest performing hospital during the baseline period. And, if you remember we covered the floor a little bit when we discussed the lowest dimension score. Let me go to that slide, here it is. So, the floor as you can see is used in the formula for the lowest dimension score. Based on the lowest dimension score, you calculate the consistency score, which is then used in your unweighted domain score, which is the sum of the base score and the consistency score. So, the floor is only used in the lowest dimension score calculation. It's not actually used in determining the dimension scores for the achievement points and improvements points.

We received another question. It was a pretty specific scenario, but I thought it was a good one, and it really applied to one of the scenarios that we outlined in the presentation. It is we are a surgical hospital and the outcome measures don't apply to us. We also do not have the volume to meet the HCAHPS minimum completed survey numbers. Since we will have no data for these two domains, how will that impact us? So, if we go to, I believe, it was the last scenario that I covered for proportionately reweighting the domains, here it is. The three domain calculations, so we – in that scenario, you will eliminate two domain sort of. One is the sub domain and one is the total domain. So, the patient caregivers who have Experience of Care/Care Coordination domain is eliminated and the Clinical Care Outcome subdomain is eliminated. With Clinical Care though, as long as your meeting the one of the two subdomains, that counts as meeting the full domain. So, this scenario really makes a hospital have three domains. So, in this scenario, Clinical Care Process,

Safety, and Efficiency and Cost Reduction have their domain weight proportionately reweighted. And, as you can see that that equals 10 percent, 40 percent, and 50 percent for those domains. And then, they would be multiplied by the unweighted domain scores, and then added to receive your total performance score. So, what happens? Let's say if you also don't need the safety domain, or if you don't meet the Clinical Care process that domain, and you only have two domains. What happens then is your hospital would be excluded from the Hospital VBP Program? That withhold of 2 percent would not apply to your hospital. In addition, your hospital wouldn't be eligible for incentive payments under the program. So, essentially, the program doesn't impact you financially. But, you still would receive your Percentage Payment Summary Report. It would just display Hospital VBP Ineligible and the total performance score. But, you would get to see the scores that you received in the domains that you had data for.

The next question: the Clinical Care Process measures are weighted at five percent, do eCQMs apply? So, the three measures in the Clinical Care Process subdomain – going to find slide – are AMI-7a, IMM-2 and PC-01. These measures are chart abstracted only. The PC-01 is submitted via aggregate through the web-based measures tool, but all of these are the chart of abstracted versions of these measures. eCQMs have not yet been included in the Hospital Value-Based Purchasing Program.

Another question we received: what version of the AHRQ PSI-90 software will be used to determine PSI-90 in FY 2017? Version 4.5a will be used for AHRQ PSI-90, and that was also listed on one of the slides. Let me get to it. Here we go. So, here CMS announced the decision to use AHRQ QI software version 4.5a for calculations in the FY17 program. That includes your baseline period index value. Your performance period index value and the performance standards of the achievement threshold in the benchmark.

We received another question: I think asking for clarification on this slide. It's the SSI measure score. They are asking how we got a seven out of an Ab Hys measure score of eight and a colon surgery measure score of five?

And, so if you remember we cover this a couple slides back with the formula. So, we have a colon measure score of five and a colon predicted infection of one. And, we had an abdominal hysterectomy measure score of eight and Ab Hyst predicted infections of two. So, we use this formula, we multiply the colon measures score of five, times the predicted infection one, and we add that to the product of the abdominal hysterectomy measure score of eight, times the predicted infections of two. So, with that, it's five plus 16, we get 21. We divide by the sum of the predicted infections one plus 2 is 3. So, 21 divided by 3 equals our 7.

And that's how we got the seven in the measure score in this table.

And, that looks like we are about out of time for today. I would like to remind everyone that the slide that we use today are out on the qualityreportingcenter.com website, if you would like to download this and keep them for your reference. In addition, the transcript and the recorded webinar and the question and the answers that we didn't get to today will also be posted out through the qualityreportingcenter.com website. I would look for those in the next week or two. So with that, I think I'm going to say goodbye to you all today. Everyone, have a great rest of your day and be looking for those Hospital Value-Based Purchasing reports on or around August first. Thank you, everyone.

END