HospItal Value-Based Purchasing (VBP) Program

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

July 2023 Public Reporting Claims-Based Measure Hospital-Specific Report Overview Presentation Transcript

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Brandi Bryant: Hello. Welcome to the *July 2023 Public Reporting CBM HSR Overview* webinar. My name is Brandi Bryant, and I am with the Centers for Medicare & Medicaid Services Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, https://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 this email, you can download the slides at our inpatient website, www.QualityReportingCenter.com.

I would like to welcome our speakers for this webinar. Maria Gugliuzza is the Hospital Value-Based Purchasing Program Lead at the CMS Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor; Kristina Burkholder is the Measure Implementation and Stakeholder Communication Lead, Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor; and Angie Drake is the Public Reporting Claims-Based Measures Delivery Manager at the Hospital Quality Reporting Application Development Organization.

The purpose of this event is to provide an overview of the Hospital-Specific Reports, or HSRs, for select claims-based measures that will be publicly reported in July 2023, including a summary of national results, steps to access and navigate the HSR, and an overview of measure calculations.

At the conclusion of this webinar, you should be able to understand how to determine performance categories, access and preview your hospital's HSR, and know where to submit questions during the preview period.

This slide displays a list of acronyms that will be referenced during the webinar. That concludes my introductions. I will now turn the webinar over to our first speaker. Maria, the floor is yours.

Maria Gugliuzza: Thank you, Brandi. My name is Maria Gugliuzza, and I'll be covering topics such as the measures included in the HSRs; the measurement periods associated with those measures, including the impact due to the COVID-19 exception; other HSRs that are on the horizon; and how to download the HSRs from the HQR system.

The purpose of the July 2023 Public Reporting Claims-Based Measures HSR is to provide claims-based measures that will be publicly reported in July 2023, so hospitals may preview their measure results prior to the public reporting of the results.

This HSR contains information for the condition- or procedure-specific readmission measures displayed on this slide.

The HSRs also contain the Hospital-Wide Readmission measure, the 30-Day Mortality measures for AMI, COPD, heart failure, stroke, and CABG; the 90-day complication measure following total hip arthroplasty and/or total knee arthroplasty; the payment measures associated with a 30-day episode of care for AMI and heart failure, and the 90-day episode of care for THA/TKA; and the Excess Days in Acute Care (or EDAC) measures for AMI, heart failure, and pneumonia.

CMS made the following updates to the measures that will be publicly reported in July 2023. CMS expanded the THA/TKA payment and complication measures so the measure outcome will include 26 additional clinically-vetted mechanism complication ICD-10 codes. CMS also increased the minimum number of eligible cases for the EDAC AMI measure to 50, from 25, during the measurement period.

In response to the COVID-19 public health emergency, CMS is not using claims data reflecting services provided January 1, 2020–June 30, 2020 (Q1 and Q2 2020) in its calculations for the Medicare quality reporting programs. The reporting periods for readmission, mortality, complication, payment, and EDAC measures have been updated to reflect this policy.

This change was finalized in the fiscal year 2022 Hospital Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System, better known as the IPPS/LTCH PPS final rule.

The July 2023 Public Reporting HSRs were delivered May 2, 2023. Following the 30 days after the delivery of the HSRs, you can review the HSR and request a calculation correction. All review and correction requests must be submitted by June 1. Angie will provide instructions and more details regarding the review and correction process later in the presentation.

This webinar and HSR bundle that you are currently receiving is for July 2023 Public Reporting. An additional HSR for the HVBP Medicare Spending per Beneficiary, or the HVBP MSPB, measure is anticipated to be delivered in late May to early June. When the HSRs are delivered, CMS will provide a notification through the Hospital IQR and VBP Listserve notification groups. If you are not signed up for those Listserve groups, you can sign up using the link available on this slide. In addition, you will receive an email notification that your report is available to download once it has been delivered.

If you have any questions regarding measures and HSRs please submit your question using the question-and-answer tool found on QualityNet.

I will now be discussing how to access your July 2023 Public Reporting Claims-Based Measures Hospital-Specific Reports.

Beginning in November 2022, the VBP reports can be downloaded directly from the Hospital Quality Reporting system from the link provided in this slide.

The HQR system requires that the user has a HCQIS Access Role and a HARP Profile account that has access to log into MFT.

Step 1: Log into the HQR system using your HARP account.

Next, choose the two-factor authentication method that you have set up.

Now, enter the code.

Go to the menu on the left side of your screen.

Now, select Program Reporting on the menu. Then, select Claims-Based Measures.

Select the Release year. You will want to select 2023 for the fiscal year 2024 HSR. Select the program, Public Reporting, and, on the report, HSR. Click on Export, and the file will download through your browser. Once downloaded, you will have a zip file that contains your site's report and the VBP user guide.

The steps for downloading the 2023 Public Reporting HSR from the HQR system can be found on this slide. I will now pass the presentation over to Kristina. Kristina, the floor is yours.

Kristina Burkholder: Thanks, Maria. Hi, everyone. I'm Kristina Burkholder, the claims-based implementation lead. Today, I'll be presenting the 2023 results for the claims-based measures and interpreting your results.

On slide 25, we provide you with information on the national results for the mortality, readmission, complication, and payment measures. The column on the left-hand side lists the measures. The column in the middle lists the 2023 national, observed results to be displayed on Care Compare this summer. The last column, on the right-hand side, depicts the change in the national rate from last year. This column tells you whether the rates increase, decrease, or remain the same. For the mortality measures, the 2023 national results ranged from about 3 percent, for CABG, to 18.2 percent for pneumonia mortality. With the exception of CABG mortality, you can see that, in 2023, we have experienced an increase in the national mortality rate in comparison to 2022. For the readmission measures, the national observed readmission rates this year range from about 4 percent, for the total hip/knee replacement readmissions, to 20.2 percent for heart failure readmissions.

With the exception of hip/knee replacement and CABG readmission measures, which increase slightly, all the national readmission results have decreased from about .1 to 1.1 percentage points. The national rate of the hip/knee complication measure is 3.2 percent, and this increased 8 percentage points since last year. At the bottom of the table are the national payments, which range from about $19,000 for heart failure, to a little over $27,000 for AMI payments. The payment measures that you see here are inflation adjusted, so they're presented to you in 2021 dollars. We don't compare the payment measures across years because the national payment results are usually adjusted for inflation based on a specific year. These national rates are used by CMS to categorize hospital performance on these measures and will be displayed on Care Compare this summer.

The next two slides depict the approach CMS uses to categorize hospital performance on these measures. First, I'll describe the approach used by most of the outcome measures. Then, I'll discuss the payment measures. I'll end with an explanation of how CMS categorizes the EDAC, or Excess Days in Acute Care, measures. The image on the left-hand side of the screen describes the approach CMS uses to categorize hospital performance for the mortality, readmission, and complication measures. At the top is a small gray map of the US that depicts the national rate.

In this example, the national rate is 15.6 percent, and there's a dotted line going down that shows you how each of the three hospitals compare to the national rate of 15.6. Three performance categories are depicted in this image. At the top left-hand corner, you can see the Green Hospital, Hospital A, shows you an example of a hospital that's been categorized as better than the national. In the middle, Hospital B in yellow shows you an example of a hospital characterized as no different than national. At the bottom, Hospital C in red depicts an example of a hospital categorized as worse than national. Also provided in this graphic are the risk-standardized rates and the interval estimates represented by the square and the line under each hospital. They classify these hospitals into categories. CMS compares the hospital's 95 percent interval estimate, against the national observed rate.

Let's pretend using this example for the AMI readmission measure, with a national rate of 15.6 percent. If we look at the example of Hospital A, the green hospital, you can see that its risk standardized rate is 12.6 percent, and the entire interval estimate for that hospital ranges from 9.4 percent to 14.3 percent. What this means is that we estimate the hospital's AMI readmission rate to be 12.6 percent, and we are 95 percent sure that the true score is somewhere between 9.4 percent and 14.3 percent. When we compare this interval estimate, or the entire green line, to the national observed rate of 15.6 percent, you can see that the entire green line is less than the national rate. Because the entire interval estimate is less than the national rate, this hospital is characterized as better than national. In contrast, Hospital C, the entire interval estimate, or the entire red line, is greater than the national observed rate, and this is classified as worse than national. Lastly, for Hospital B, the yellow hospital, you can see that the 95 percent interval estimate, which ranges from 13.2 percent to 17.1 percent, includes the national rate of 15.6 percent. Thus, the yellow line crosses over the dotted line. So, this hospital is classified as no different than national. For the payment measures, or the image on the right-hand side of the screen, a similar approach is used to categorize hospitals. This time, interval estimates compare it against the national average payment, rather than a rate. The performance categories are greater than the national average payment or less than the national average payment, rather than better or worse.

Here on slide 27, for the Excess Days of Acute Care, or EDAC, measures, the concept is essentially the same, but, this time, instead of using a national rate, we are comparing against zero days or the expected performance for Hospital A. This measure looks at the difference between your hospital's performance and the expected performance for your hospital if you're performing the same as an average hospital with a similar case mix as you. If these two numbers are the same, the difference would be zero days, which is depicted by the blue dotted line. Positive numbers mean the hospital had more days, and negative indicates less.

Using a similar approach as the other measures, the 95 percent interval estimate, hospitals are categorized as fewer days than average, average days or more days than average. As a reminder, you will see updated information for your hospital's performance on each of these measures, and these performance categories will be publicly reported on Care Compare this summer.

Along with your public reporting results of the payment and outcome measures, you are also receiving confidential results of CMS disparity methods. This includes measure results stratified by patients dually eligible for Medicare and Medicaid, for all readmission measures, as listed here. Additionally, you'll receive measure results stratified by patient, race, and ethnicity for the Hospital-Wide Readmission measure. These results can be found in your HWR and Readmission HSRs. These results are confidential and will not be publicly reported. Now, I'm going to turn it over to you, Angie, to discuss the Public Reporting HSRs.

Angie Drake: Hello, I am Angie Drake. I am the Delivery Manager for the ADO for the public reporting of claims-based measures. In this section, we'll cover what's included in the HSR bundle and some of the content in the [Hospital] IQR [Program] HSRs. Please note, I will not be going over every [Hospital] IQR [Program] HSR tab. If you have any questions about a specific tab which is not covered here, we will go over the process for submitting questions later in the presentation.

In your bundle, you will receive six HSRs: Readmission; Hospital-Wide Readmission; Mortality; Hip/Knee Complication; Payment; Excess Days in Acute Care. It also includes the HSR User Guide. You can find the HSR User Guide on QualityNet, and the link is provided here. However, like I said, the guide will also be included in your download of the HSR.

Changes to this year's bundle include disparity stratification reported in the Readmission HSRs, distributed in May. PSI HSRs will not be included. Pneumonia results will be included in the Mortality and Readmission HSRs.

Each of the Public Reporting HSRs use the same basic structure for consistency with tabs providing the following information: your hospital's measure results, distribution of state and national performance categories, discharge-level data used to calculate your hospital's measure results, and case mix comparison of the risk factors used for risk adjusting the measures.

Each HSR starts with measure results or performance tables that provide your hospital's measure results for the measures included in the given HSR. This provides the following information: the performance category that will be reported on Hospital Compare; the number of eligible discharges included in the measure; your hospital's rate for each measure; and the interval estimates that were used to define the performance category that was assigned to your hospital. For comparison, national values are provided. Performance categories in each of the HSRs will display with a color fill except for the Payment HSR. Generally, green is better; yellow is no different; and red is worse.

Each HSR includes a Distribution tab that shows the distribution of hospitals across the different performance categories within the nation and within your state. When coupled with the performance categories for your hospital from the previous tab, this can show how your hospital's performance compares to the rest of the hospitals in the nation and in your state. The Readmission, Mortality, Hospital-Wide Readmission and Complication [HSRs] have a Discharges tab that provides the discharge-level data that was used to produce each measure. The Readmission and Mortality HSRs include all discharges that meet the inclusion requirements for each measure and use the inclusion/ exclusion indicator to identify discharges that were excluded from the measure. In these HSRs, the count of discharges with an inclusion/exclusion indicator of zero can be tied to the denominator for each measure in the Performance tab. These are the eligible discharges. The count of events in eligible discharges (for example, readmission, death or complication) for the measure can be tied to the numerator in the Performance tab.

On the Mortality Discharges tab, a zero with curly braces will display in the Stroke NIHSS column (Column O) for stroke discharges that do not have an NHISS score.

The zero with curly braces indicates CMS assigned a National Institute of Health Stroke Score of zero for that patient. If multiple National Institute of Health Stroke Scores are available, but no POA is indicated, a score is picked at random for the measure. This is denoted by an asterisk after the score in the HSR. This is also explained in footnote d.

In the Hip/Knee Complications HSR, an index discharge can have more than one complication associated with it; however, only one complication is included in the calculation of the measure. When there is more than one complication the Additional Complication Record column will have a No value for the first complication and a Yes value for each additional complication attributed to that index discharge.

The EDAC HSR differs from the other HSRs in that it uses two discharge-level data tabs to provide the discharge-level detail and event-level detail. The Summary of Events tab lists discharges that are included in the measure. It follows the same inclusion/exclusion, numerator, and denominator logic as the Discharge tabs from the other HSRs. It lists summary-level event information about emergency department visits, observation stay visits, and unplanned inpatient readmissions within 30 days following a discharge. The ID Number on this tab is used to tie to the events on the Patient-Level Summary tab. The EDAC Patient-Level Summary tab provides the detailed-level information for the emergency department, observation, and unplanned readmission visits listed in the Summary of Events tab.

The Payment HSR has three tabs for providing discharge-level data: the Index Stay and Summary tab and two Post-Acute Care tabs. The Index Stay and Summary tab lists the discharges that are included in the measure. It includes all discharges that meet the inclusion requirements for each measure and uses the inclusion/exclusion indicator to identify discharges that were excluded from the measure. It provides summary-level payment information and provides the split between facility, physician, and post-acute care payments.

The Total Episode Payments Value in Column O is split into payments for the index admission and payments after the index admission represented by the Total Index Admission Payments column and the Total Post-Acute Care Payments column, shown in Columns P and V along with their percentages in Columns Q and W. The Total Index Admission Payments column, which is Column P, is further split up into the Facility and Physician Payments columns, seen in Columns R and T, along with their percentages in Columns S and U.

The ID numbers in the Post-Acute Care tabs will correspond to the same ID number on the Index Stay and Summary tab. There are one to many post-acute care records for each Summary of Events tab record on the Index Stay and Summary tab. ID Numbers 2, 3, and 4 will be shown on the next slide.

The Payment Post-Acute Care tables break out the post-acute care costs to provide further detail on the care setting where the post-acute care payments are made. The Condition Payment Post-Acute Care tab provides distributions of post-acute care costs across 11 care settings for AMI, heart failure, and pneumonia payment measures. The Procedure Payment Post-Acute Care tab provides distributions of post-acute care costs across 13 care settings for the hip/knee payment measure.

Each of the Public Reporting HSRs includes one of the two mix case comparison tabs with a distribution of patient risk factors for the included measures. Procedure-based measures are listed in a separate tab from the diagnosis-based measures for the Readmission, Mortality, and Payment HSRs. Not all risk factors apply to every measure. N/A is used to denote risk factors that do not apply to a given measure. If your hospital has no qualifying cases for a measure, then NQ will show in the risk factor cells. The listed risk factors are the conditions that are used to risk adjust the measure rate to account for differences in the health of your patient population in comparison to the national average. Hospital percentages are provided along with the state and national percentages to let you see how your patient population compares for each risk factor.

In the Complication HSR, Table 2 displays the percentage of eligible index admissions where the patients experienced each type of complication. A patient may have more than one complication associated with an index admission, but only one complication is counted in the raw complication rate. The percentages for the individual complications may not add up to the raw complication rate. If a patient has the same specific complication coded multiple times, this is only counted once in the specific complication rates provided in the table.

All right. Next, I will discuss the HSR preview period and questions.

Questions can be submitted to [QualityNet Inpatient Question and Answer Tool](#) found on QualityNet. The URL is listed here. Use the navigation guide listed here to find the Q&A tool section of QualityNet. This is also provided in each of the HSRs.

The HSRs contain personally identifiable information and protected health information. Any disclosure of PHI should only be in accordance with, and to the extent permitted by, the HIPAA Privacy and Security Rule and other applicable law. Emailing such data is a security violation. If you have questions on transmitting data, please contact the QualityNet Help Desk. The rule of thumb is to use the ID number found within the HSR when referring to the contents of the report.

The review and corrections process does not allow hospitals to submit additional corrections related to the underlying claims data used to calculate the rates, nor add new claims to the data extract used to calculate the rates. CMS cannot regenerate the report for this period to reflect corrected claims. If your facility submitted, or wishes to submit, a corrected claim after the day that pertained to an incorrect claim originally submitted prior to September 25, the corrected claim will not be included in your measure results. Because claims data are generated by the hospital itself, hospitals in general always have the opportunity to review and correct these data until the deadlines specified. Lastly, in many cases where the claims listed in the HSRs don't match internal records, it is due to corrections which were made to those claims after the deadline.

Brandi Bryant: Thank you, Angie. We will now address some questions asked regarding the July 2023 Public Reporting Claims-Based Measures Hospital-Specific Reports. The first question is: Are the data in these HSRs the same data that will appear on Care Compare or in the payment programs?

Maria Gugliuzza: These Public Reporting HSRs are provided for claims-based measures that will be publicly reported in July 2023 on Care Compare. Hospitals may preview their measure results prior to the public reporting of the results. Separate HSRs or reports will be provided specifically for the value-based purchasing programs. On Care Compare, CMS provides results for publicly reported measures, which are different from the Hospital VBP Program measure results. The difference between the national rates between the publicly reported measures and Hospital VBP Program measures can be attributed to the different hospitals participating in the programs.

Brandi Bryant: Since CMS adjusted the reporting periods to exclude Q1 and Q2 2020 data due to COVID-19, how will CMS adjust the next cycle of reports?

Maria Gugliuzza: For future public reporting years, CMS will assess the impact on measures and communicate measure updates to stakeholders accordingly. Hospitals can review future CMS communications for insight into any changes to upcoming public reporting years.

Brandi Bryant: When does the July 2023 Public Reporting preview period end?

Maria Gugliuzza: All review and correction requests must be submitted by June 1, 2023.

Brandi Bryant: We are having trouble downloading our Hospital-Specific Report from the Hospital Quality Reporting system.

Maria Gugliuzza: If you are experiencing issues downloading your HSR from the HQR system or you have any questions reviewing your HARP permissions, please contact the CCSQ Service Center at QNetSupport@cms.hhs.gov, or you can call them at (866) 288-8912.

Brandi Bryant: Are there any new changes to the claims-based measures due to COVID-19?

Kristina Burkholder: Great question. New to this year is the addition of two codes for risk adjustment for history of COVID-19. These codes are ICD-10 codes J12.82, or pneumonia due to coronavirus disease, and U09.9 post COVID-19 condition.

Brandi Bryant: That's all the time we have for questions today. If your question wasn't answered and you still have questions regarding measures and HSRs ,please submit your question using the question-and-answer tool on QualityNet. Thank you again for joining. We hope you have a great day.