Hospital Value-Based Purchasing (VBP) Program

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

July 2021 Public Reporting Claims-Based Measures Hospital-Specific Report Overview Question and Answer Summary Document

Speakers

Bethany Bunch, MSHA
Program Lead, Hospital VBP Program
Inpatient VIQR Outreach and Education Support Contractor
Tamara Mohammed, MHA, PMP
Senior Health Services Outcome Researcher
Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor
Josh Gerrietts
Public Reporting Claims-Based Measures Project Lead
Healthcare Quality Analytics and Reports Contractor

Moderator

Maria Gugliuzza, MBA
Outreach and Education Lead
Inpatient VIQR Outreach and Education Support Contractor

May 11, 2021
2:00 p.m. Eastern Time (ET)

DISCLAIMER: This presentation question-and-answer (Q&A) summary document was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated. The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations.

Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 1: **Were any changes made to the outcome and payment measures this year?**

The following changes were made to the outcome and payment measures for 2021 public reporting:

- Updates to the data used to calculate the measures
- Updates to the ICD codes used to calculate the measures
- The addition of Veterans Administration (VA) hospitals to the Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) readmission and complication measures

Question 2: **Are the changes in the national results from 2020 to 2021 percent changes?**

No. The changes from 2020 to 2021 are percentage point changes; they are calculated as the national 2021 rate minus the national 2020 rate.

Question 3: **For the payment measures, does "less than national" mean better or worse performance?**

For the payment measures, a category label of "less than national" does not imply better or worse performance on the measure. This is because the payment measures are not quality measures; they don't provide an indication of the quality of care in the hospital.

This is also true of the "greater than national" category.

A payment category of "less than" or "greater than" national simply indicates that the average cost of treatment at your hospital (for the condition or procedure under question) tends to be either significantly less or significantly more than the average cost of treatment for that condition/procedure in the nation.

Question 4: **Is the National Institutes of Health Stroke Scale included in risk-adjustment for the stroke mortality measure (MORT-30-STK)?**

No. For fiscal year (FY) 2022, the National Institute of Health Stroke Scale (NIHSS) is not included in the risk-adjustment for the stroke mortality measure. NIHSS is scheduled to be included in risk-adjustment for the stroke mortality measure in FY 2023 under the IQR program.

Question 5: **Is it possible to have a heart failure index admission claim included in my Hospital VBP Program heart failure mortality Hospital-Specific Report (HSR) and excluded from my Care Compare (previously, Hospital Compare) heart failure mortality HSR?**

Yes, it is possible for index admissions in your Hospital VBP Program HSRs and Care Compare HSRs to be slightly different. Although the results use the same measure specifications and timeframes of eligible Hospital VBP Program hospitals, the differences you observe between your heart failure mortality measure results are likely related to the differences in hospitals included in the Hospital VBP Program and on Care Compare.

For the mortality measure reported on Care Compare, the mortality measure calculations include index admissions to short-term acute care hospitals in the U.S. (including U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa), critical access hospitals (CAHs), VA hospitals (for the acute myocardial infarction (AMI), heart failure, chronic obstructive pulmonary disease (COPD), and pneumonia mortality measures), and Maryland short-term acute care hospitals participating in the All-Payer model. For the mortality measure in the Hospital VBP Program, measure calculations include only index admissions to subsection (d) hospitals in the 50 states and the District of Columbia.

Please note that it is possible for an admission to appear in both your Hospital VBP Program HSR and Care Compare HSR. In addition, it is important to note that the mortality measures randomly select one eligible index admission per patient, per split year (July–June), per measure. Therefore, if a patient had multiple eligible heart failure index admissions in a given split year, it is possible that different admissions can be randomly selected for inclusion in the cohort when the measure results are run for Care Compare and the Hospital VBP Program.

Question 6: **Can you explain the difference between the Within-Hospital Disparity Method and the Across-Hospital Disparity Method?**

The Within-Hospitals tab contains information for Medicare and Medicaid dual eligible patient readmissions as well as non-dual eligible patient readmissions (where a dual eligible patient refers to a Medicare Part A and/or Part B patient who also receives "full" Medicaid coverage). The Across-Hospitals tab contains information for dual-eligible readmission only. Ultimately, the Within-Hospitals tab allows the reader to compare hospital-specific dual vs. non-dual eligible readmissions along with state and national readmission rates. The Across-Hospitals tab allows the reader to compare risk-standardized, dual-eligible readmissions with state and national risk- standardized readmission rates.

Question 7: **What are the new performance categories for the Within-Hospital Disparity Method for 30-day readmissions?**

For the Within-Hospital Disparity Method, the new performance categories used for 2021 confidential reporting are the following:

- "Better outcomes for dual eligible patients" for hospitals that have lower readmission rates for dual eligible patients (compared to non-dual eligible patients)
- "Similar outcomes for dual eligible and non-dual eligible patients" for hospitals that have similar readmission rates for their dual eligible and non-dual eligible patients

"Worse outcomes for dual eligible patients" for hospitals that have greater readmission rates for dual eligible patients (compared to non-dual eligible patients)

Question 8: **How do we receive help if we have issues accessing our HSR from Managed File Transfer (MFT)?**

Because this Q&A summary was published more than 30 days after the reports were delivered, the report will no longer be in your MFT inbox. To have the reports resent to you, first confirm that your profile in the Hospital Quality Reporting (HQR) Secure Portal has the appropriate permissions to receive the report. To confirm this, log into the HQR Secure Portal and select *My Profile* at the top, right-hand side of the dashboard. The Auto-Route (IQR) and Managed File Transfer permissions must be listed on your profile for the hospital to receive the report. If your account does not have these permissions, refer to the instructions in the *Important: Request Access to Managed File Transfer (MFT) & Auto-Route Now to Ensure You Receive Your Reports* email notification.

Once you have confirmed that the required permissions are active for your profile, you can request the report through the Questions and Answers tool on *QualityNet*:

- When submitting the request, select Inpatient Claims-Based Measures from the Program drop-down menu. Then, select Request for public reporting Hospital-Specific Reports from any of the measure topic drop-down menus.
- In the subject line, type **Request to Resend July 2021 Public Reporting Claims-Based Measures HSR**. Please describe your question or request the report in the text box and include your hospital's CMS Certification Number (CCN).

If you experience issues accessing your HSR from MFT, requesting your HQR profile permissions, or reviewing your HQR profile permissions, contact the QualityNet Help Desk at qnetsupport@hcqis.org or (866) 288-8912.

Question 9: **For performance category, slide 28, if one of the end points touches, instead of crossing, the national rate, would it be considered No Different Than National?**

Correct. If one of the end points (i.e., the upper or lower limit of the confidence interval) is equal to the national rate, then the hospital's performance is categorized as No Different than National.

Question 10: **When comparing the national rates from 2020 to 2021, what is the date ranges for each period?**

For 2021 public reporting, the date ranges are July 1, 2017–December 1, 2019, for all mortality, readmission, payment, and Excess Days in Acute Care (EDAC) measures, except for the following:

- July 1, 2019–December 1, 2019 for the Hospital-Wide Readmission (HWR) measure
- April 1, 2017–October 2, 2019 for the THA/TKA payment measure
- April 1, 2017–October 2, 2019 for the THA/TKA complication measure

For 2020 public reporting, the date ranges were July 1, 2016–June 30, 2019, for all mortality, readmission, payment, and EDAC measures except for the following:

- July 1, 2018–June 30, 2019 for the HWR measure
- April 1, 2016–March 31, 2019 for the THA/TKA payment measure
- April 1, 2016–March 31, 2019 for the THA/TKA complication measure

Note – Per CMS COVID 19 Quality Reporting Guidance Memo (linked here: https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf) qualifying claims were excluded from the measure calculations for January 1, 2020–March 31, 2020 (Q1 2020) and April 1, 2020–June 30, 2020 (Q2 2020).

Question 11: **Could you clarify if the mortality discharge data are for patients with those diagnoses as the primary diagnosis, or do they also include any secondary diagnosis?**

For the AMI, heart failure (HF), and stroke mortality measures, the diagnoses must be a primary diagnosis. For the COPD and pneumonia mortality measures, the diagnosis may be the primary diagnosis, but there are scenarios where the combinations of primary and secondary diagnoses are considered for inclusion in the measure cohort. For the Coronary Artery Bypass Graft (CABG) mortality measure, a qualifying CABG procedure had to have occurred during the index admission.

Question 12: **Are VA beneficiaries NOT eligible for inclusion in the readmission measures unless they also have Medicare Part A?**

VA beneficiaries are included in the readmission measures if they have an index admission at a VA hospital regardless of their Medicare enrollment. However, if they have an index admission at a non-VA hospital, they must be enrolled in Medicare Part A.

Question 13: **Are data from CAHs included in the publicly reported measures?**

Yes, CAHs are included in the measures. The publicly reported measures include index admissions to non-federal acute care hospitals in the U.S. (including U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa) and CAHs.

Question 14: **Do you know if the same dates in this report will be the same date ranges for data used in next five star hospital reports?**

As finalized in the Calendar Year 2021 Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule, the Overall Star Rating will be published yearly using publicly available measure results from Care Compare from a quarter within the prior year. For example, for a January Overall Star Ratings release, CMS could use data refreshed on Care Compare in April, July, or October.

CMS has not determined the next release date or the reporting periods for measures. Typically, the measures used in the current release will continue to be included moving forward unless they are removed from public reporting or no longer meet the measure inclusion criteria found in the Comprehensive Methodology Report.

The Overall Star Rating displayed will be maintained on Care Compare until the next publishing of the Overall Star Rating. Please note, release dates are subject to changes at CMS' discretion.

Question 15: **Are the data in these HSRs the same data that will appear on Care Compare or in the payment programs?**

These Public Reporting HSRs are provided for claims-based measures (CBMs) that will be publicly reported in July 2021 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. It is important to note that performance rates for a measure may differ by program as a result of the reasons cited in Question 5. 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.

Question 16: **Since CMS adjusted the reporting periods to exclude Q1 and Q2 2020 data due to COVID, how will CMS adjust the next cycle of reports?**

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.

Question 17: **Does CMS have software or a means for hospitals to obtain a more recent listing of patients that meet measure criteria for claims-based measures? For instance, if we wanted to evaluate/review cases for Q1 2021, do you have suggestions for ways to accomplish this?**

Hospitals can request the Measure Calculations Packages (MCPs) via the QualityNet Help Desk or reference the measure methodologies on the QualityNet site to ascertain criteria for identifying claims which are included in each of the measures. Note: The criteria in both the MCPs and the measure methodologies are specific to the fiscal year release. The most recent is FY 2022. Criteria can change between releases, so they may not be identical from year to year. FY 2022 MCPs are scheduled to be available in mid-July 2021. An example measure methodology can be found on QualityNet at this direct link: https://qualitynet.cms.gov/inpatient/measures/mortality/methodology

Question 18: **Is there a section on the CMS Patient Safety Indicator (PSI) HSR Excel worksheet in the file delivered on May 3 that shows the cost impact for each of the PSIs for our hospital?**

No, this is not a feature of the PSI HSR.