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

Presentation Transcript

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Maria Gugliuzza: Hello and welcome to the *July 2021 Publicly Reporting Claims-Based Measures Hospital-Specific Report Overview* webinar. My name is Maria Gugliuzza, and I am with the Centers for Medicare & Medicaid Services Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, and I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, www.QualityReportingCenter.com.

I would like to welcome our speakers for this webinar. Bethany Bunch is the Hospital Value-Based Purchasing Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. Tamara Mohammed is the Senior Health Services Outcome Researcher for the Center for Outcomes Research and Evaluation Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Josh Gerrietts is the Public Reporting Claims-Based Measures Project Lead at CMS's Healthcare Quality Analytics and Reports Contractor.

The purpose of this event is to provide an overview of the hospital-specific reports (HSRs) for select claims-based measures that will be publicly reported in July 2021, including a summary of national results, steps to access and navigate the HSR, and an overview of measure calculations.

At the conclusion of the 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. Bethany, the floor is yours.

Bethany Bunch: Thank you, Maria. My name is Bethany Bunch, 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 access the HSRs in your new Managed File Transfer inboxes.

The purpose of the July 2021 Public Reporting Claims-Based Measures HSR is to provide claims-based measures (CBMs) that will be publicly reported in July 2021, so hospitals may preview their measure results prior to the public reporting of those results.

This HSR contains information for the six 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, Pneumonia, 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, Heart Failure, Pneumonia, a 90-day episode of care for THA/TKA; and the Excess Days in Acute Care (or EDAC) Measures for AMI, Heart Failure, and Pneumonia.

The HSRs also include CMS PSI 04: Death Rate Among Surgical Inpatients with Serious Treatable Conditions, CMS PSI 90: Patient Safety and Adverse Events composite, and its underlying patient safety indicators.

CMS made the following updates to the measures that will be publicly reported in July 2021: First, CMS calculated the CMS PSIs using Version 11 of the PSI software. CMS updated the planned readmission algorithm with ICD-10 code-based specifications to identify planned readmissions with Version 4.0 2020 for the readmission measures. CMS also updated the Within-Hospital and Across-Hospital Disparity Methods tabs of the Readmission HSR workbook by removing the decile rankings for hospitals, adding performance categories, and applying a minimum threshold for the number of hospitals reporting.

In the Interim Final Rule with Comment period that was published in the *Federal Register* in September, CMS announced that they would not be using claims reflecting services provided in Quarter 1 or Quarter 2 2020 in the measure calculations; those date ranges being January 1, 2020, through June 30, 2020. CMS is further restricting the discharge period for the measures, so that no data or events from Quarter 1 or 2 of 2020 are included. For example, CMS is restricting the discharge period to end on December 1, 2019, for the 30-day readmission, 30-day mortality, 30-day payment, and 30-Day EDAC measures because the measures identify events or episodes of care for 30 days following the index stay. The complication and payment measures for THA/TKA identify events or episodes of care for 90 days following the index stay. So, those are ending on October 2, 2019.

Please note that hospitals do not need to request anything to have this exception applied. The updated discharge period has already been applied to all hospital calculations that are included in the HSR.

The July 2021 Public Reporting HSRs were delivered May 3. Following the 30 days after the delivery of the HSRs, you can preview the HSR and ask any questions related to the calculation to CMS and CMS contractors. Josh will provide instructions and more details regarding the preview period later in this presentation.

This webinar and HSR bundle that you are currently receiving is for July 2021 Public Reporting. An additional HSR for the Medicare Spending per Beneficiary, or 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 Questions and Answers Tool on *QualityNet.*

If you experience issues accessing your HSR from Managed File Transfer (MFT) or if you have questions while you are reviewing your HARP permissions, contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or by calling (866) 288-8912.

I will now be discussing how to access your July 2021 Public Reporting Claims-Based Measures Hospital-Specific Reports.

The July 2021 Public Reporting Claims-Based Measures Hospital-Specific Reports were delivered to hospitals on May 3. A Listserve communication was sent via email to those who are registered to receive notifications regarding the Hospital IQR and Improvement Program and the Hospital Inpatient VBP Program on *QualityNet*. This email announced that reports would be available no later than May 3 with instructions for accessing the reports, information regarding the measures and updated measurement periods, information regarding the preview period, and where to send questions.

When your hospital's HSR was delivered to your Managed File Transfer inbox, an Auto Route file delivery notification was sent to your email. An example of what that email would look like is on this slide.

I know there may be some of you that previously received the HSRs in the old Secure File Transfer Auto Route inbox that may not have received an email notice this year. When permissions were transitioned to the HQR system, users that were Security Administrators/Officials for their facilities were granted the appropriate roles to see the reports. However, if you are a basic user, those permissions were not automatically placed in your account. To request access to reports that are being sent via Managed File Transfer for your facility, you'll need to request permissions in your profile in the HQR Secure Portal. The steps to complete this action are provided in the announcement linked on this slide.

When you've received the email notification that your reports have been delivered to your Managed File Transfer inbox, please follow the steps to access your report.

Please note that you'll need to login to the Managed File Transfer page specifically. Your Managed File Transfer inbox is not located in the HQR Secure Portal. When you login to the Managed File Transfer application, you'll need to use your HARP ID and password. Reports will be available for just 30 days after the delivery. So, if you are interested in reviewing or saving your report, please download those reports soon.

OK. So, what do you do if you didn't receive an email notification stating the report was delivered to your inbox? First, we recommend logging into Managed File Transfer using the instructions from the previous slide. If the report is not in your inbox, please review your profile in the HQR Secure Portal to ensure that you had the Auto Route (IQR) and MFT permissions listed on your account. If you do not, you can request these permissions using the instructions detailed in the notification linked on this slide. However, you would need to request that the reports be resent after you have the approved permissions to receive the reports. If your profile did have these permissions prior to the start of the deliveries on May 3, please contact the *QualityNet* Help Desk for assistance.

If you need your HSR to be resent, please follow the instructions on this slide for requesting the report in the *QualityNet* Questions and Answers Tool. I would now like to past the presentation over to Tamara Mohammed.

Tamara Mohammed: Thanks, Bethany. Hi, everyone. My name is Tamara Mohammed, and I am a Senior Health Services Outcome Researcher at the Yale Center for Outcomes Research and Evaluation. Over the next couple of slides, I'm going to be providing you with a brief overview of the national results for the 2021 public reporting of the claims-based outcome and payment measures. I'll also provide you today with a quick summary of the approach taken to assign hospitals to the performance categories that are also publicly reported for these measures. So, to begin, what we have here are the 2021 national results for the mortality, the admission, complication, and payment measures. You'll notice that the slide does not contain information on the national results for the EDAC (Excess Days in Acute Care) measures.

This is because national measures for these results are not calculated or publicly reported. So, for the measures that we do report national results on, as you can tell from this slide in general, national rates have gone down just a bit in 2021 for the mortality, the admission, and complication measures in comparison to 2020. In fact, all of the measures have experienced declines or no changes in the national results in 2021 compared to 2020 with the exception of the COPD readmission and the pneumonia readmission measures, which in 2021 have seen small increases in rates compared to 2020. So, starting at the top, we can see that the national rates for the mortality measures in 2021 range from 2.9 percent for CABG mortality to 15.3 percent for pneumonia mortality. The national 2021 rates for the readmission measures are a bit higher. They range from 4.0 percent for hip/knee readmission to 21.9 percent for heart failure readmission. The hip/knee complication measure remains at 2.4 percent in 2021, experiencing no change obviously in comparison to its 2020 reach. Finally, for the payment measures, the 2021 national payments range from $18,060 for the heart failure payment measure to $26,304 for the EMI payment measure, where these payments are standardized to 2019 dollars. You'll notice that we don't compare the national 2021 payments against 2020 payment results, and this is because the dollar values are standardized for different years and are therefore not comparable.

Moving on next to performance categories. So, in addition to publicly reporting hospital results, CMS also publicly reports hospital performance categories on the mortality, readmission, complication, EDAC, and payment measures. Overall, the same general approach is taken to categorize hospital performance on these measures, although there are some nuanced differences. If we begin with the approach taken for the mortality, readmission, and complication measures, this is represented by the figure on the left-hand side of your screen, then, as long as the hospital has at least 25 cases, CMS classifies the hospital's performance into three categories: Better than National, No Different than National, and Worse than National. CMS does this by comparing each hospital's interval estimate which is represented by the horizontal, colored lines on the screen against a national rate.

In this example, the national rate, shown in that map of the United States at the top, is 15.6 percent. The Hospital A, which is the green hospital at the top left, the interval estimate, as shown by that horizontal green line, is 9.4 percent to 14.3 percent. As this estimate lies entirely less than the national rate of 15.6 percent, this hospital is classified as Better than National. For Hospital B, the yellow hospital in the middle, the interval estimate is 18.2 percent to 17.1 percent, again shown by the horizontal yellow line. As this interval estimate overlaps with or includes that national rate of 15.6 percent, this hospital is therefore classified as No Different than National. Then, for Hospital C, which is the red hospital at the bottom right, the interval estimate, shown by that red horizontal line this time, is 16.1 percent to 20 percent. Since this interval estimate is entirely more than or to the right of the national rate of 15.6 percent, this hospital is classified as Worse than National. Now, for the payment measures, which is now the image on the right side of your screen, the same general approach is used. We compare the interval estimate against the national average payment. I won't walk you through the numbers again this time, but I want to note that the only real difference here in comparison to the approach I just described for the mortality readmission and complication measures is the category labels that are used. We have a payment. Instead of Better, Worth, or No Different than the National, we use Less Than, or Different Than, or Greater than the National.

Then, finally, the approach used to classify performance for the EDAC measures is essentially the same. We compare the interval estimate, but instead of comparing that interval estimate against a national rate, we compare this time against 0. Similar to the payment measures, the difference here with EDAC is that we use different labels. So, we use Fewer Days than Average for this Measure, Average Days, and More Days on Average to categorize hospital performance. That's it for me. I'll now hand it off to Josh to talk you through HSRs and HSR User Guides.

Josh Gerrietts: Thank you, Tamara. Hello, everyone. My name is Josh Gerrietts. I am the Public Reporting Claims-Based Measure Project Lead for the Healthcare Quality Analytics and Reporting Contractor.

In this section, we'll cover what's included in the HSR bundle and some of the content of the IQR HSRs. Please note, I will not be going over every IQR HSR tab. If you have questions about specific tabs which are not covered here in this presentation, we will go over the process for submitting questions later.

This is an example of the HSR bundle facilities will receive. Included in the bundle are seven HSRs, which you can see here: Hospital-wide readmission, mortality readmission, hip/knee complication, Patient Safety Indicators (otherwise known as CMS PSI), Excess Days in Acute Care (otherwise known as EDAC), and payment. Also included in the bundle is the HSR User Guide. Not shown, but also included in the bundle this year, is the resource table which provides information and locations for the IQR measures on *QualityNet*.

You can find the HSR User Guide on *QualityNet.* An example is provided here. As mentioned earlier, it also accompanies the HSRs. The July 2021 hospital PR program user guide PDF that accompanied the HSRs includes additional information about the data in the 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 risk factors used for risk adjusting the measures.

Each HSR starts with measure results or performance tables that provides your hospital's measure results for the measures included in the given HSR. This provides the following information: the performance category that were 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. With the exception of CMS PSI, state values are also provided for comparison.

New for this year are color fills applied to the performance category cells. Performance categories in each of the HSRs will display with color fill, except for the payment HSR. Generally, green equals better, yellow no different from national rate, and red is worse than national rate.

Each Public Reporting 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, complication, and CMS PSI 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 0 can be tied to the denominator for each measure in the Performance tab. These are the eligible discharges. Due to the volume of PSI discharges in the measures, the CMS PSI HSR includes discharges that are part of the numerator for each measure. The hospital-wide readmission HSR includes discharges for both planned and unplanned readmissions. The count of events and eligible discharges (for example, readmission, death, or complication) for the measure can be tied to the numerator in the Performance tab. Continuing this year, both the Health Insurance Claim Number, HICNO, and the Medicare Beneficiary Identifier, MBI, can be found for each discharge. If a Medicare beneficiary identifier is not available for a patient, then a double dash will display in the corresponding row.

On the Mortality Discharges tab, a 0 with curly braces will display in the Stroke National Institutes of Health Stroke Score (NIHSS) column for stroke discharges that do not have an NIHSS. The 0 with curly braces indicates CMS assigned a National Institutes of Health Stroke Score of 0 for the patient.

If multiple National Institutes of Health Stroke Scores are available but no Present on Admission indicator is indicated, a score is picked at random to display. This is denoted by an asterisk. Additionally, this is also explained in Footnote D on this tab.

In the hip/knee complication 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. If you fill the Additional Complications Record column to No, you can follow the same process used in the readmissions and mortality HSRs to identify the count of eligible discharges.

The EDAC HSR differs from other HSRs in that it uses two discharge-level data tabs to provide the discharge-level detail and event-level detail. We minimize the HICNO, the MBI, and the medical record number fields here to allow the rest of the table to fit. The Summary of Events tab lists the discharges that are included in the measure. It follows the same inclusion/exclusion, numerator, and denominator logic as the Discharges tab 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. Note the row with ID Number 7 lists the patient had one emergency department visit, two observation stays, and no unplanned readmission within 30 days following discharge. These add up to three events with seven Total Days Included in Measure Outcome.

The EDAC Patient-Level Summary tab provides the detail-level information for the emergency department, observation, and unplanned readmission visits listed in the Summary of Events tab. There are one-to-many patient-level summary records for each Summary of Events tab record that had an event. Each individual event for a given discharge is listed on its own row.

The ID Number on the patient-level summary tab can be used to tie the records to the corresponding record on the Summary of Events tab. The rows here with ID Number 7 include the one emergency department visit and two observation stays. Note the individual days per event for these three ID Number 7 records add up to seven days, although basic math indicates that would be eight. If one event led to a second contiguous event of greater significance (e.g., an emergency department visit results in an observation stay), only the event of greater significance is included in the measure outcome; therefore, days per event may not add up to the total days included in Measure Outcome column in the previous table.

The payment HSR has three tabs for providing discharge-level data: the index day 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 met the inclusion requirements for each measure and uses the inclusion/exclusion indicator to identify discharges that were excluded from the measure. It provides the summary-level payment information and provides a split between facility, physician, and post-acute care payments. The Total Episode Payments Value, Column N on the HSR, 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 O and U, along with their percentages in Columns P and V on the HSR. The Total Index Admission Payments, Column O on the HSR, is further split up into the Facility and Physician Payments column, seen in Columns Q and S, along with their percentages in Columns R and T on the HSR.

Continuing this year, the ID Numbers and the post-acute care tabs will correspond to the same ID Numbers 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 tabs break out the post-acute care cost to provide further detail on where the post-acute care payments were made.

The Condition Payment Post-Acute Care tab provides distribution 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 distribution of post-acute care costs across 13 care settings for the hip/knee payment measure.

Each HSR, except for CMS PSI, includes one or two case-mix 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. NA 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.

These 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 patient experience 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.

Continuing this year, the Within-Hospital Disparity Methods tab will include the calculation for the difference or disparity in 30-day, risk standardized readmission rates for AMI, COPD, heart failure, pneumonia, CABG, and hip/knee between dual eligible and non-dual eligible patients. New this year, decile rankings have been replaced with comparative performance. The comparative performance categories are conditionally highlighted with a gradient of blue color fills.

Possible values are Better Outcomes for Dual Eligible Patients, Similar Outcomes for Dual Eligible and Non-Dual Eligible Patients, Worse Outcomes for Dual Eligible Patients, and Number of Cases Too Small. Please note that the data within this tab is confidential and will not be publicly reported. It is included here for your reference.

The Across-Hospital Disparities Method tab compares performance across hospitals by calculating a hospital's outcome rate for dual eligible patients only. Like the Within-Hospital Disparity Method tab, deciles have been replaced with comparative performance. Possible values are Better than National Rate, No Different than National Rate, Worse than National Rate, and Number of Cases Too Small. For the Across-Hospital Disparity Method, your hospital's comparative performance is calculated by comparing the hospital's Risk Standardized Readmission Rate for duals and the national observed readmission rate for duals. As with the Within-Hospital Disparity Method tab, the data within this tab is also confidential and will not be publicly reported. It is included here for your reference.

In this section, I will be going over basic HSR preview period questions.

Questions can be submitted to the *QualityNet* Help Desk via the email address provided or by calling the phone number here on screen. Questions can be submitted to the *QualityNet* Inpatient Questions and Answers Tool found on *QualityNet*. The *QualityNet* URL is listed here. Use the navigation guide listed to find the Q&A tools 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 PII or PHI should only be in accordance with and to the extent permitted by the HIPAA Privacy and Security Rules and other applicable laws. Emailing such data is a security violation. If you have questions on transmitting data please contact the *QualityNet* Help Desk. A good rule of thumb is to use the ID Number found within the HSR when referring to the contents of the report.

The public reporting preview period does not allow hospitals to submit corrections related to the underlying claims data or to add new claims to the data extract used to calculate results. Suspected calculation errors on your report can be submitted for review with the possibility of correction. Requests for submission of new or corrected claims are not allowed. A snapshot of the administrative claims data available was taken on or around September 25, 2020. 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 September 25, 2020, that pertain to an incorrect claim originally submitted prior to that time period, the corrected claim will not be included in your measure results. Because claims data are generated by the hospital itself, hospitals in hospitals in general always have the opportunity to review and or correct these data until the deadline specified. Lastly, in many cases where the claims listed in the HSRs do not match internal records, it is due to corrections which were made to those claims after the deadline. I will turn it over to Maria for a question-and-answer session.

Maria Gugliuzza: Thank you, Josh. We will now address some questions asked regarding the July 2021 Public Reporting Claims-Based Measures Hospital-Specific Report. Our first question: Is the National Institutes of Health Stroke Score included in risk-adjustment for the stroke mortality measure?

Josh Gerrietts: No. For fiscal year 2022, the National Institutes of Health Stroke Score is not included in the risk adjustment for the stroke mortality measure.

Maria Gugliuzza: Is it possible to have a heart failure index admission claim included in my Hospital VBP Program heart failure mortality HSR and excluded from my Hospital Compare heart failure mortality HSR?

Josh Gerrietts: Yes. It is possible for index admissions in your Hospital VBP Program HSRs and Hospital Compare HSRs to be slightly different.

Although the results use the same measure specifications and timeframes of eligible Hospital Value-Based Purchasing (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 Hospital Compare.

For the mortality measures reported on Hospital Compare, the mortality measure calculations include index admissions to short-term acute care hospitals in the U.S. (including the U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa), critical access hospitals (CAHs), Veterans Health Administration hospitals, and Maryland short-term acute care hospitals participating in the All-Payer model. For the mortality measures in the Hospital VBP Program, measure calculations include only index admissions to subsection (d) hospitals located 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 Hospital Compare HSR. In addition, it is important to note that the mortality measures randomly select one eligible index admission per patient, per split year 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 Hospital Compare and the Hospital VBP Program.

Maria Gugliuzza: Can you explain the difference between the Within-Hospital Disparity Method and the Across-Hospital Disparity Method?

Josh Gerrietts: The Within-Hospitals tab contains information for both dual and non-dual eligible readmission. The Across-Hospitals tab contains information for duals only. Ultimately, the Within-Hospitals tab allows the reader to compare hospital-specific, dual versus non-dual eligible readmissions along with state and national readmission rates; wherein, the Across-Hospitals table allows the reader to compare risk-standardized dual eligible readmission with state and national risk standardized readmission rates.

Maria Gugliuzza: Great. Thank you. Next question: Were any changes made to the outcome and payment measures this year?

Tamara Mohammed: For 2021 public reporting, the only changes that were made to the outcome and payment measures were updates to the data that we used to calculate the measures, which is something we do every year. Updates to the ICD codes that we use to calculate the measures is also something that we do every year. New this year is that we added data from the Veterans Affairs hospitals to the hip/knee readmission complication measures.

Maria Gugliuzza: Are changes in the national results from 2020 to 2021 percent changes?

Tamara Mohammed: No. The changes from the 2020 to 2021 national results are percentage point changes. They're calculated as a national 2021 rate minus the national 2020 rate.

Maria Gugliuzza: For payment measures, does Less than National mean better or worse performance?

Tamara Mohammed: For the payment measures, a category level of Less than National does not imply better or worse performance in the measure. This is because the payment measures are not quality measures. They don't provide an indication of the quality of care provided by that hospital. This is also true if the category label is Greater than National for the payment measure. The payment category of Less than [National] or Greater than National simply indicates that the average cost of treatment at that 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 or procedure in the nation.

Maria Gugliuzza: CMS announced that they would not be using claims reflecting services provided in Quarter 1 or Quarter 2 of 2020 in the measure calculations with those date ranges being January 1, 2020, through June 30, 2020.

Do we need to request an Extraordinary Circumstances Exception for measures and submissions covered under this exception?

Bethany Bunch: Thanks for that question, Maria. No. Hospitals do not need to request an individual ECE for the blanket ECE that CMS granted for Quarter 1 and Quarter 2 of 2020. Claims from those quarters are automatically removed and the discharge period would be modified to how we discussed back on slide 16, which is now displayed on your screen.

Maria Gugliuzza: Thank you. If we are having issues accessing our HSR from the new Managed File Transfer, whom should we contact?

Bethany Bunch: Thanks, Maria, for that question. If you're not receiving your Hospital-Specific Report, I would like you to reference slide 24. If you did not receive your Hospital-Specific Report or you didn't receive a notification that your HSR was delivered via email, first, I would like you to log into the Managed File Transfer application to confirm that the report was indeed not delivered. If you did not see the report in your Managed File Transfer inbox, I recommend checking your HQR Secure Portal My Profile and checking to see if you had an Auto Route IQR permission and a Managed File Transfer permission. If you do not have those permissions, you can request those permissions. Then, once approved by your Security Administrator/Official, you would be able to receive all future reports. However, because you did not have those permissions at the time the reports were delivered, you would have to request that the report be resent to you. Now, if you did have those permissions on your account, we recommend contacting the *QualityNet* Help Desk for further assistance. Their email address is on the slide. it is QNetSupport@hcqis.org.

Also, I just wanted to follow up. If you do need to request that your HSRs be resent, slide 25 details the instructions for submitting that request. You would submit the request through the *QualityNet* Questions and Answers Tool. The link is on the slide. When submitting the request, just follow these few tips here. Select Inpatient Claims-Based Measures for the Program drop down. Select Requests for HVBP Hospital-Specific Reports from the HVBP Mortality and Complication topics drop down menu.

Also, please, please, please, for us to most efficiently assist you and get those reports over to you, include your hospital's six-digit CMS Certification Number, or CCN.

Maria Gugliuzza: Will the July 2021 Public Reporting Claims-Based Measures Hospital-Specific Report include CMS's PSI 90 Patient Safety and Adverse Events composite measure?

Bethany Bunch: Yes. Earlier in the presentation, we walked through the included measures in the HSR. They are on slide 12 and then continue through 13 and 14. Slide 14 details the CMS Patient Safety Indicator measures that will be included in the HSRs. They include PSI 04: Death Rate Among Surgical Inpatients with Serious Treatable Complications and CMS PSI 90: Patient Safety and Adverse Events composite with all of the underlying patient safety indicators that that feed into PSI 90.

Maria Gugliuzza: OK. That's all the time we have for questions. If your question wasn't answered and you still have questions regarding measures in the HSRs, please submit your question using the Questions and Answers Tool on *QualityNet*. Thank you again for joining. We hope you have a great day.