Hospital Value-Based Purchasing (VBP) Program

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

Reviewing Your FY 2022 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report

Presentation Transcript

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Maria Gugliuzza: Hello and thank you for tuning into the *Reviewing Your FY 2022 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report* webinar. My name is Maria Gugliuzza, and I am the Outreach and Education Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your host for the webinar.

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 at the Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Anoosha Akhlaq is the Hospital VBP Program 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 the mortality and complication measures used in the Fiscal Year (FY) 2022 Hospital VBP Program. This includes a summary of the new coronary artery bypass graft (CABG) mortality measure methodology, measure calculations, HSR access, and instructions for submitting a review and correction request.

At the conclusion of the webinar, you should be able to recall the updates to the Fiscal Year 2022 Hospital VBP Program Mortality and Complication Measures HSR, access and review the HSR, and submit a review and correction request, if desired.

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 Hospital VBP Program Mortality and Complication Measures HSR is to provide the underlying claims data that were used to calculate the measure results. Using this data, hospitals may review and request corrections to the calculations of the performance period measure rate results prior to those rates being used to calculate a hospital's Total Performance Score. This HSR contains information for the six Clinical Outcomes domain measures included in the FY 2022 Hospital VBP Program. The coronary artery bypass graft (CABG) surgery mortality measure is new to the Hospital VBP Program for FY 2022. Later in the presentation, Tamara will be reviewing the methodology for this measure.

The updated performance periods and updated discharge periods for each of the six measures are listed on this slide. On the next slide, I'll discuss why the updated performance periods end on December 31 and the updated discharge periods end on December 1 and October 2. First, I would like to address a frequently asked question: Why does the pneumonia mortality measure begin on September 1, 2017, when the other mortality measures begin on July 1, 2017? When CMS expanded the pneumonia mortality measure cohort, it substantively changed the measure. Due to statutory requirements in the Hospital VBP Program, the performance period for a measure cannot begin until one year after the measure is publicly reported. The measure was first publicly reported in August 2016, so September 2017 was the earliest a performance period could begin in the Hospital VBP Program.

In the Interim Final Rule with Comment period that was published in September, CMS announced that they would not be using claims reflecting services provided in Quarter 1 or Quarter 2 of 2020; those date ranges being January 1, 2020 through June 30, 2020. Both Quarter 1 and Quarter 2 of 2020 were part of the five mortality measure calculations, and Quarter 1 was part of the hip-knee complication measurement period initially.

Further, CMS is restricting the discharge periods to end on December 1, 2019, for the five mortality measures because the measures identify deaths within 30 days of each index stay, and ending October 2, 2019, for the hip-knee complication measure, because the complication measures identifies complications within 90 days of each index stay.

The 30- and 90-day periods from December 1 and October 2, respectively, would end on December 31, 2019, and would not include any data or events from Quarter 1 or Quarter 2. Please note that hospitals do not need to request anything to have this exception applied. The updated discharge period has already been applied to hospital calculations that are included in the HSR.

However, if a hospital believes that their performance continues to be adversely impacted beyond June 30, CMS is providing the option for hospitals to request an individual Extraordinary Circumstance Exception within 90 days of the date of the extraordinary circumstance. At the latest, an Extraordinary Circumstance Exception (ECE) request should be submitted no later than 90 days from the last date of the quarter requested. A granted ECE for the Hospital VBP Program would exclude the hospital from the Hospital VBP Program in the fiscal year in which performance was impacted. As a result of the exclusion from the program, a hospital would not incur the 2-percent reduction in payments, but it would also not be eligible to receive incentive payments for the fiscal year. Essentially, there would be no payment adjustment due to the Hospital VBP Program. If you would like to learn more about Hospital VBP Program ECEs, please refer to the link on this slide.

Hospital VBP Program HSRs were delivered April 12 and 13. Following the 30 days after the delivery of the HSRs, you have the opportunity to review the HSR and request a calculation correction. All review and correction requests must be submitted by May 13. Anoosha will provide instructions and more details regarding the review and correction process later in the presentation.

In these HSRs, only performance period data will be included. If your hospital would like to review your FY 2022 baseline period results, you can request the report by submitting a request in the *QualityNet* Question & Answer Tool. Please follow the instructions on this slide when requesting the report, so that your request can be addressed efficiently.

This webinar and HSR bundle that you are currently receiving is for the Hospital Value-Based Purchasing Program. The public reporting Claims-Based Measures Hospital-Specific Reports are anticipated to be delivered in late April or early May. When the HSRs are delivered, CMS will provide a notification through the Hospital IQR and VBP Listserve notification groups. The full names are listed on this slide. 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 the same email notification that your report is available to download once it has been delivered.

We anticipate Medicare Spending per Beneficiary HSRs will be delivered to hospitals in May or June of 2021. CMS will provide notification of the HSR delivery through the same Listserve notification groups.

If you have any questions regarding measures, HSRs, and the Hospital VBP Program, please submit your question using the Question and Answer Tool on *QualityNet*. If you experience issues accessing your HSR from the Managed File Transfer (MFT) tool, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or (866) 288-8912.

I will now be discussing how to access your Fiscal Year 2022 Hospital VBP Program Mortality and Complication HSR.

The FY 2022 Hospital Value-Based Purchasing Program Mortality and Complication Measures HSRs were delivered to hospitals on April 12 and 13. A Listserve communication was sent via email to those who are registered to receive notifications from 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 April 13 with instructions for accessing the reports, information regarding the measures and updated measurement periods, how to submit a review and correction request, and how to ask 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 log in 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 account 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 Managed File Transfer 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 April 12, 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* Question & Answer Tool.

When you download your HSR, a user guide will accompany the report and include information about the data in the HSRs and instructions to replicate the measure results using the discharge-level data. If you did not receive your report or would just like to review the user guide, it is available on *QualityNet* using the link on this slide. I would now like to turn the presentation over to Tamara Mohammed.

Tamara Mohammed:

Thank you, Bethany. Hello, everyone. My name is Tamara Mohammed, and I am a Senior Health Services Outcome Researcher at the Yale Center for Outcomes, Research, and Evaluation. Today, I'm going to provide you with a brief overview of the 30-Day CABG mortality measure. If you're not aware, this measure is being newly added to the HVBP program this year.

Some of you may already be familiar with the 30-Day CABG mortality measure. It has been publicly reported on the Hospital Compare site (which is now the Care Compare site) since 2016 when CMS added it to its IQR – Inpatient Quality Reporting – program. The measure is now being added to the HVBP program this year. That is, it will be first used in the HVBP program for FY 2022 payment determination, using data from July 1, 2017, to December 1, 2019, for measure calculation.

The CABG mortality measure in HVBP looks very much like the measure did in the IQR program: The measure specifications remain generally the same under HVBP. As this is a mortality measure, the outcome for the measure is death – for any reason – as long as it occurs within 30 days of the date of the CABG procedure. When we calculate the measure, we include hospitalizations for patients who had a qualifying isolated CABG surgery procedure during an inpatient admission where the patient was enrolled in Medicare FFS Parts A and B for the 12 months prior to the date of the index admission and enrolled in Part A during the index admission. The patient must also have been over 65 years of age, not been discharged against medical advice, and did not have a subsequent CABG procedure during the measurement period. Like all of the other mortality measures, this CABG mortality measure is a risk-adjusted measure and it risk adjusts for the patient's age, comorbidities, and indicators of patient frailty. This was just a quick overview of the measure specifications, but if you're interested in knowing more about the measure, please go to the *QualityNet* website where you can find more information about the measure. So, next up, we will have Anoosha from HCQAR who will present to you the information on the mortality HSRs.

Anoosha Akhlaq: Thank you, Tamara. My name is Anoosha Akhlaq. I am on the Hospital Value-Based Purchasing Project Lead on the Healthcare Quality Analytics and Reporting contract, also known as HCQAR. Today, I will discuss the FY 2022 Hospital Value-Based Purchasing mortality and complication Hospital-Specific Report.

The mortality HSR lists the hospital results in Table 1 with further detail in the tables that follow. As Bethany mentioned earlier, CABG mortality was added to the HVBP program for the fiscal year 2022 performance period. Table 1 provides the hospital results for the 30-day acute myocardial infarction, COPD, heart failure, pneumonia, and CABG mortality measures that will be used in the Hospital VBP Program for calculating the achievement and improvement points for these outcome measures. The achievement, threshold, and the benchmark were calculated on fiscal year 2022 baseline data and are provided here for convenience.

The following columns are found in Table 1. The Number of Eligible Discharges is a count of the discharges used for the measure calculation. The Performance Period Survival Rate will be used to calculate achievement and improvement points for these measure outcomes in the Hospital VBP Program. The Achievement Threshold was calculated as the median survival rate among all hospitals with the measure results and at 25 cases during the fiscal year 2022 baseline period. The Benchmark was calculated as the mean average of the top 10 percent of survival rates among all the hospitals with measure results and at least 25 cases during the fiscal year 2022 baseline period.

Table 2 includes the additional provider-level values that are used to calculate the Performance Period Survival Rate for AMI, COPD, HF, pneumonia, and CABG mortality measures. Other than the Number of Eligible Discharges and the survival rate, the information in this table will not be publicly reported. The following columns are found in Table 2. The Predicted Deaths is the number of predicted deaths within the 30 days from admission on the basis of your hospital's performance with its observed case mix and your hospital's estimated effect on mortality. The Expected Deaths is the number of expected deaths within 30 days of admission on the basis of the average hospital performance with your hospital's case mix and the average hospital effect. The replication process later detailed later will show how the predicted deaths and the expected deaths are calculated. The Nationally Observed Mortality Rate is calculated as the number of observed 30-day deaths nationally divided by the number of eligible discharges nationally. Since these are national values, this rate cannot be replicated with the data provided in this HSR The Risk-Standardized Mortality Rate is a mortality rate that has been adjusted for differences in case mix across hospitals in a hospital-specific effort. As shown in Footnote e, the Risk-Standardized Mortality Rate can be calculated with the values found in this table as the predicted deaths divided by expected deaths multiplied by the National Observed Mortality Rate. The Performance Period Survival Rate is calculated as 1 minus the Risk-Standardized Mortality Rate.

The discharge tables contain discharge-level data for all Part A Medicare Fee for Service patient stays with calls with a principal qualifying diagnosis of AMI, COPD, HF, pneumonia, or CABG accordingly that had a discharge date in the reporting period for patients who were over 65 and above at the time of admission. The ID number is provided as a way to reference records while avoiding sharing PII and PHI. The HICNO column through the Discharge Destination column contain data as they were pulled from the hospital claims. The Index Day column indicates whether the stay is included in measure calculations by a Yes or No. The stays that are flagged Yes represent the discharges found in the Number of Discharges column in Tables 1 and 2. For the stays that are not included in the measure calculations, the exclusion and the inclusion indicator columns have numbers 1 through 9, indicating the reason or reasons why the stay was excluded. The corresponding descriptions for these numbered reasons are defined in the user guide that accompanies the HSR. This year, Table 7 was added to the HSR and contained discharge level data for CABG 30-day mortality.

Deaths within 30 days are flagged Yes or No if a patient died within 30 days of admission. The Risk Factor Variable columns contain the model risk factors which vary by measure. For each measure, these columns start with the mean age minus 65 risk factor. The risk factors vary for each measure. Table 4 and the user guide provide a description for each. Row 8 in the HSR contains the model's coefficients for each risk factor which are estimates over data for all hospitals. The hospital effect represents the underlying risk of mortality at the specific hospital after accounting for patient risk. The average effect represents the underlying risk of mortality at the average hospital after accounting for patient risk. Beginning in Row 9 of the HSR under each risk factor column, the cell will contain a 1 if the patient was identified as having that risk factor and equals the years above 65 for the age underscore 65 variable and a 0 if otherwise. Values will only display for each index stay that is included in the measure calculations. The risk factor flags will begin in cells in column O.

The replication process for mortality measures include the following steps: 1. Calculate predicted deaths. 2. Calculate expected deaths. 3. Calculate the Risk-Standardized Mortality Rate. 4. Calculate the Performance Period Survival Rate. The user guide distributed with your HSR includes detailed instructions for application. An Excel file with sample calculations and step-by-step instructions can also be requested through the *QualityNet* Inpatient Question & Answer Tool.

To begin the replication process, save a copy of the HSR and complete the calculations in Excel, working below the actual data. The replication steps should be completed on the discharge-level worksheet for each mortality measure. The first step for replicating your hospital's results is to identify eligible discharges. To do, this limit your replication calculations to rows where the index stay column equals Yes using the filter option in Excel.

For each eligible discharge, multiply each risk factor flag by the relevant coefficient, found in Row 8. Risk factor flags begin with Column N at age minus 65. The formulas used are highlighted in blue on the slide.

Next, sum up all the products from the previous step. Risk factor flags multiply by the coefficient for each index discharge. This column is shown in Column BE. The calculation that is shown in the example is for the values in the first row. Next, add the hospital-specific effect found in cell BC8 to the sum of the risk factor flags for each index discharge calculated in the previous step. The calculation is shown in column BF. Please note that this is an example for the COPD mortality measure.

Next, calculate the predicted probability of a 30-day death for each day using the formula shown and the results from the previous step. Please note that the exp in the formula is the Excel exponential function.

Finally, sum the predicted probability of a 30-day death for all the stays to get the number of the predicted deaths within 30 days from admission. When the valley is rounded to two decimal places, it should match the predicted death value for this measure in Table 2.

The example formula shown in blue was used to sum the values of the predicted beds. Each hospital will likely have a different quantity of discharges so the formulas will need to be adjusted accordingly.

To calculate the predicted death, start with the summed products risk factor flags multiplied by the coefficient that were created in the predicted death calculations as the average hospital effect found in cell BDA. Next, calculate the probability of a 30-day death for each day using the formula shown and the results from the previous step.

Finally, sum the predicted probability of a 30-day death to get the number of predicted deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the expected death values for this measure in Table 2. Again, each table will likely have a different quantity of discharges and will need to adjust the formulas accordingly.

To calculate the risk-standardized mortality rate, first divide the predicted deaths by the expected deaths. The result is the standardized mortality rate. Next, multiply the standardized mortality rate by the National Observed Mortality Rate from Table 2 to get the Risk-Standardized Mortality Rate. When this valley is rounded to six decimal places, it should match the Risk-Standardized Mortality Rate found in Table 2. The Excel formulas used for this calculation are shown in Column BH. The results of these calculations are shown in Column BI.

The performance period survival rate is calculated as 1 minus the Risk-Standardized Mortality Rate. When the value is rounded to six decimal places, it should match the performance period survival rate found in Table 2. The Excel formula used for the calculation is shown in column BH. The result of the calculation is shown in B1. Due to the difference in rounding between SAS and Excel, there may be minor differences at the fifth and sixth decimal places. When CMS calculates your hospital rates, it uses SAS Viya. The values in your HSRs are based on the SASS calculation.

Now, I will be discussing the HVBP program complication HSRs.

Similar to the mortality HSR, the complication HSR lists your hospital results in the first table with further detail in later tables. The following columns are found in Table 1: The number of eligible discharges is the count of discharges used for the measure calculation. The Risk-Standardized Complication Rate will be used to calculate achievement and improvement points for this outcome measure in the Hospital VBP Program. The achievement threshold was calculated as a median complication rate among hospitals with measure results and minimum case size greater than 25 during the fiscal year 2022 baseline period. The benchmark was calculated as the mean of the top of the complication rates among all hospitals with measure results and minimum case size greater than 25 during the fiscal year 2022 baseline period.

Table 2 includes additional provider-level values that are used in the calculation of the Risk-Standardized Complication Rate. The following columns are found in Table 2: The predicted admissions with a complication is a number of predicted admissions with a complication within 90 days from admissions based on your hospital's performance with its observed case mix and your hospital's estimated effect on the complications. The Expected Admissions with a Complication is a number of expected admissions with a complication within 90 days of admission based on average hospital performance with your hospital's case mix and the average hospital effect on complications. The replication process detailed earlier shows how the predicted and expected rates are calculated. The national observed rate is the number of observed admissions with a complication within 90 days nationally divided by the number of eligible discharges nationally. The risk-standardized complication rate is the predicted admissions with a complication divided by the expected admissions with a complication then multiplied by the National Observed Complication Rate.

The complication HSR discharge table contains many of the same columns as the mortality HSR discharge tables. A state may appear multiple times on your discharge tab if the patient had more than one complication for that discharge; however, it is only included once in the calculation of the measure. Similar to the IQR complications HSR, the Additional Complication Record column is used to flag additional complications. In the example seen here, the first two rows are the same index charge unless two complications records are attributed to that discharge. This is easily identified in the Additional Complication Record column, which has a Yes value for the second record.

The discharge table contains further discharge-level data for the complication measure. The complication field identifies the complication that occurred. If a patient did not have a complication, it will appear as N/A. The rest of the columns shown here contain specific information pertaining to the listed complications.

The replication process for complication measures is the same as the mortality measures, with one difference. In the first step, when you limit your application calculations to rows where index states Column H equals Yes, you must also limit to rows where additional complication records, or Column I, equals No. The rest of the replication process would follow the same steps as outlined for the mortality measures.

I will discuss the Hospital VBP HSR review and correction period.

The Hospital VBP Program review and correction period for fiscal year 2021 is April 14, 2021, through May 13, 2021. Please pay special attention to the review and correction period deadline. Requests sent after May 11, 2021, will not result in a correction.

Review and correction requests can be submitted via email at qnetsupport@hcqis.org or over the phone on to the number on your screen.

When emailing a request, please include Hospital VBP Program Mortality review and corrections inquiry or hospital VBP Program Complication Review and Corrections inquiry in the subject line to aid in the Help Desk process. Review and correction requests can also be submitted through the *QualityNet* Inpatient Question & Answer Tool. Please ensure you select Inpatient Claim-Based Measures under Program and HVBP Mortality and Complication Review and Correction request under Topic. Please include your hospital six-digit CMS Certification Number, CCN, when submitting your request.

The HSRs contain PII and PHI. Emailing PII or PHI is a security violation. If you have questions on transmitting data, please contact the *QualityNet* Help Desk. If you are referring to a specific case or discharge, please use the ID number found in the HSR rather than sending patient information through email.

The suspected calculation errors on your report can be submitted for review with the possibility of correction. General questions about HSRs, the mortality measures, or the complication measure may also be submitted. Requests for submission of new or corrected claims are not allowed. A snapshot of administrative claims available approximately 90 days after the end of the applicable period is taken in order to perform program calculations. For fiscal year 2022, the administrative claims data file used for calculations was produced on September 25, 2020. The review and corrections process does not allow hospitals to submit additional corrections related to the underlining claims data used to calculate the rates nor add new claims to the data extracts used to calculate the rates. CMS cannot regenerate the report for this year to reflect corrected claims. If your facility submitted or wishes to submit a corrected claim after September 25, 2020, that originally pertained to an incorrect claim originally submitted prior to September 25, 2020, the corrective claim will not be included in your measure results. Because the claims data are generated by the hospital itself, the hospital in general always has the opportunity to review and correct this data until the deadline specified.

	In many cases where the claims listed in the HSRs do not match internal records, it is due to the fact that corrections were made to those claims after the deadline. Thank you for your time. This concludes my portion of the presentation
Maria Gugliuzza:	Thank you. All right, our first question: I didn't receive a Hospital VBP Program HSR. What do I do?
Anoosha Akhlaq:	Contact the *QualityNet* Help Desk at (866) 288-8912 or qnetsupport@hcqis.org to request your hospital's fiscal year 2022 Hospital VBP Program Hospital-Specific Report, HSR. Provide your CCN for a faster turnaround time. Please note Critical Access Hospitals do not receive HSRs for most programs, including Hospital VBP.
Maria Gugliuzza:	Describe the differences between the Hospital VBP mortality data and the IQR PR mortality data?
Anoosha Akhlaq:	The difference in the inclusion indicators between HVBP and IQR discharges is due to the different measure calculation process used by each program. Differences in discharge information shown between HVBP and IQR are due to patients with multiple eligible index admissions in a calendar year. IQR and HVBP have different measure calculation programs, so their random selection of an index admission can be different from each other.
Maria Gugliuzza:	Next question: When will I receive my Hospital VBP Percentage Payment Summary Report?
Anoosha Akhlaq:	The fiscal year 2022 Hospital VBP Percentage Payment Summary Report, PPSR, will be available by August 1, 2021.
Maria Gugliuzza:	OK. Next question: What are the impacts of the COVID-19 waiver on the publicly reported mortality complication measures?

Tamara Mohammed: So, in accordance with the CMS COVID-19 data waiver for 2021 public reporting, data for encounters occurring from January to June 2020 will be excluded from the outcome measures, including the mortality and complication measures. Other than the removal of these data, no changes in response to the COVID-19 pandemic were made to the measures for 2021 public reporting. The measures still have acceptable validity and reliability even with the shortened measurement periods.

Maria Gugliuzza: Next question: Do the measures also adjust for social risk factors?

Tamara Mohammed: No. The mortality measures currently do not adjust for social risk factors such as dual eligibility or race. This is because the intent of the measure is to adjust for patients' clinical characteristics only.

Maria Gugliuzza: Are hospice patients included in the COPD mortality measure?

Tamara Mohammed: No. The COPD mortality measure excludes patients who are enrolled in the Medicare health program at any time during the 12 months prior to the index submission, including the first day of the index submission.

Maria Gugliuzza: Why were the performance periods updated on the FY 2022 HSRs?

Bethany Bunch: The discharge period in this HSR has been updated due to the CMS COVID-19 exception. The AMI, COPD, HF, PN, and CABG measures identify deaths within 30 days of each index stay, and the THA/TKA measure identifies complications within 90 days of each index stay; therefore, the performance periods for the mortality measures and the complication measure end 30 days, and 90 days, respectively, before January 1, 2020, so that no claims from Q1 and Q2 2020 are used in the measure calculations.

Maria Gugliuzza: Thank you. Next question: Our hospital is still affected from the COVID-19 pandemic. Where can we find the exception request?

Bethany Bunch: Please move the slide deck to slide 14. Hospitals can submit an Extraordinary Circumstances Exception (ECE) no later than 90 days from the last date of the quarter requested. Click on the link on this slide to review more information regarding the ECE.

Maria Gugliuzza: We have not received our FY 2022 HSR. What do we do?

Bethany Bunch: I would recommend logging into your Managed File Transfer (MFT) account to ensure you didn't receive your HSR. If you have done that already, and you did not receive your report, go into the HQR Secure Portal and click on My Profile at the top, right-hand side of the dashboard in the navigation screen. When you do that, you can go in and review the permissions your account has. You need to ensure that you have the Auto-Route (IQR) and Managed File Transfer permissions. That is two separate permissions. The first one is Auto-Route (IQR). The second is Managed File Transfer. You needed to have those in place prior to April 12, when the delivery of the HSRs started. If your accounts did not have those, go ahead and request those through your Security Administrator/Official. The Security Administrator/Official would need to approve those. After you have done that, you can reach out via the *QualityNet* Q&A Tool and request for the HSR to be resent. If you went into the HQR Secure Portal and your permissions did include the Auto-Route (IQR) and the Managed File Transfer permissions, please reach out to the *QualityNet* Help Desk to report that and they can help you triage.

Maria Gugliuzza: OK. It looks like that is all the time we have for questions. If your question wasn't answered and you still have questions regarding measures, HSRs, and the Hospital VBP Program, please submit your questions through the Question & Answer Tool on *QualityNet*.

Thank you again for joining. We hope you have a great day.