Hospital Inpatient Quality Reporting (IQR) Program

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

July 2022 Public Reporting Claims-Based Measures Hospital-Specific Report Overview

Presentation Transcript

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Brandi Bryant: Hello and welcome to the *July 2022 Public Reporting Claims-Based Measures Hospital-Specific Report 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, 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. Maria Gugliuzza is the Hospital Value-Based Purchasing Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. Kristina Burkholder is the Measure Implementation and Stakeholder Communication Lead at the 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 2022, 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. 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 access the HSRs in your new Managed File Transfer inboxes.

The purpose of the July 2022 Public Reporting Claims-Based Measures HSR is to provide claims-based measures (CBMs) that will be publicly reported in July 2022, so hospitals may preview their measure results prior to the public reporting of the results.

The HSRs contain 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, heart failure; and 90-day episode of care for THA/TKA; and the Excess Days in Acute Care (or EDAC) measures for AMI, and heart failure.

CMS made the following updates to the measures that will be publicly reported in July 2022. I would like to turn the attention to the third bullet. CMS will not report the CMS PSI measure results to hospitals, nor will the results be refreshed on Care Compare as part of the IQR/PR July 2022 public reporting refresh. The PSI measure results will not be calculated, as the reference period for CMS PSI 90 does not include data affected by the COVID-19 Public Health Emergency, while the applicable period does include data affected by the COVID-19 Public Health Emergency. Due to the fact that the reference period for this measure does not include data affected by the COVID-19 Public Health Emergency and the applicable period does include such data, this would result in risk adjustment parameters that do not account for the impact of COVID-19 on affected patients and would distort measure results.

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

The July 2022 Public Reporting HSRs were delivered May 16. 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 15, 2022. Josh 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 reviewing is for July 2022 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 Question and Answer Tool on QualityNet. If you experience issues accessing your HSR from Managed File Transfer (MFT) or are requesting and reviewing your HARP permissions, contact the CCSQ Service Center at qnetsupport@hcqis.org or call (866) 288-8912.

I will now be discussing how to access your July 2022 Public Reporting Claims-Based Measures Hospital-Specific Reports.

The July 2022 Public Reporting Claims-Based Measures Hospital-Specific Reports were delivered to hospitals on May 16. A Listserve communication was sent via email to those who are registered to receive notifications regarding the Hospital IQR and Improvement and the Hospital Inpatient VBP Program on QualityNet. This email announced that reports would be available no later than May 16 with instructions for accessing the reports, information regarding the measures and updated measurement periods, how to submit a review and correction request, 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, or MFT, 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.

Okay, 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 the 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 link 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 16, please contact the CCSQ Service Center 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 and Answer Tool. I would now like to past the presentation over to Kristina Burkholder. Kristina, the floor is yours.

Kristina Burkholder: Thank you, Maria. Hi, everyone. I'm Kristina Burkholder, the claims based implementation lead. Today, I'll be presenting on COVID-related changes to the measures, the revised stroke mortality measure, national rates, and interpreting your results.

Slide 26 depicts the changes to the measure cohort or who is included in the measures. All of the claims-based measures (mortality, complication, readmission, EDAC, and payment measures) in your HSRs will exclude patients who have COVID-19. This is defined by either having a principal diagnosis of COVID-19 or a secondary diagnosis of COVID-19 coded as Present on Admission.

This slide depicts how the measures handle COVID in the outcomes for the measures. For the mortality measures in your spring HSR, COVID cases are not excluded from the outcome. This means that patients who die from COVID-19 within 30 days are counted as deaths in the outcome. These cases are included since the cause of death is not available and thus cannot be excluded. For readmission measures, any readmission within 30 days with a principal diagnosis of COVID-19 or a secondary diagnosis of

COVID-19 coded as POA are not counted in the outcome. So, if you have a patient who is readmitted for COVID, they would not be counted as a readmission. For the hip/knee complication measure, some COVID cases are excluded from the outcome, while others are not. Patients who have an admission after the surgery for AMI, pneumonia, Sepsis, or pulmonary embolism, AND have a principal or secondary diagnosis of COVID-19 will not be included in the outcome. However, if the patient has a mechanical or wound complication, surgical site bleeding, or dies, these patients are included regardless of whether or not they had COVID-19. The EDAC measures are similar to the readmission measures. All readmissions, ED visits, and observation stays with a principal diagnosis of COVID-19 or a secondary diagnosis of COVID-19 coded as POA are not counted in the outcome. Thusly, for the payment measures, payments associated with a principal diagnosis of COVID-19 or a secondary diagnosis of COVID-19 coded as Present on Admission are not included. This applies to inpatient and skilled nursing claims only.

The claims-based measures risk adjust for a history of COVID-19. The measures use one of two codes, either ICD-10 code U07.1 as a principal or secondary diagnosis on a historical claim, or Z86.16 as a secondary diagnosis on the index or on a historical claim.

Starting this year, the stroke mortality measure will be risk adjusted for stroke severity using the NIH Stroke Scale. CMS made this change in response to stakeholder feedback to better account for stroke severity and is in alignment with the American Heart and Stroke Association guidelines. CMS provided your hospital with confidential results last year in August and will now be publicly reporting the stroke mortality measure using the NIH Stroke Scale this summer on Care Compare and the Provider Data Catalog. Additional details about the revised measure can be found on QualityNet.

Slide 30 provides you with information on the national results for the mortality, readmission, complication, and payment measures. To quickly orient you to the table, the column on the left-hand side lists the measures. The column in the middle, lists 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 remained the same or whether they have increased or decreased. For the mortality measures, the 2022 national results range from around 3% for CABG to 13.6% for stroke mortality. With the exception of CABG mortality, you can see that, in 2022, we have experienced a slight increase in the national mortality rate in comparison to 2021 by about .1 to .3 percentage points. For the readmission measures, the national observed readmission rates this year range from about 4% for total hip/knee replacement readmissions to 21.3% for heart failure readmission. With the exception of hip/knee replacement and COPD readmission measures, which increased slightly, all of the other readmission results have decreased from .5 to .8 percentage points. The national rate for the hip/knee complication measure is 2.4% and is unchanged from last year. At the bottom of the table are the national payments, which range from about $18,000 for heart failure to almost $27,000 for AMI payments. The payment measures that you see here are inflation adjusted, so they're presented to you in 2020 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, which is why the changes from 2021 are indeterminable. These national rates are used by CMS to categorize hospital performance on these measures.

The next two slides depict the approach that CMS uses to categorize hospital performance on these measures. First, I'll describe the approach that CMS uses for most of the outcome measures and then discuss the payment measures. I'll end with an explanation of the categorization approach that CMS uses for the EDAC, or Excess Days in Acute Care, measures. I'm going to start with the image on the left-hand side of the screen. This image describes the approach CMS uses to categorize hospital performance for the mortality, readmission, and complication measures. At the top of the image, is a small gray map of the United States that depicts the national rate. In this example, the national rate is 15.6%,and there's a small, 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. It shows you an example of a hospital that has been categorized as "better than national." In the middle, Hospital B in yellow, shows you an example for a hospital categorized 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 line under each hospital. To classify these hospitals into these categories, CMS compares the hospital's 95% interval estimate against the national observed rate. Let's pretend this example is for the AMI readmission measure with the national rate of 15.6%. If we look at the example of Hospital A, the green hospital, you can see that it's risk standardized rate is 12.6% ,and the entire interval estimate for that hospital ranges from 9.4% to 14.3%. What this means is that we estimate the hospital's AMI readmission rate to be 12.6%, and we're 95% sure that the true score is somewhere between 9.4% and 14.3%. When we compare this interval estimate, or the entire green line, to the national observed rate, represented by the grey dotted line, you can see that the entire green line is less than the national observed rate. Because the interval estimate is less than the national rate, this hospital is categorized as "better than national." In contrast, Hospital C, the entire interval estimate, the entire red line, is greater than the national observed rate of 15.6% and is classified as "worse than national." Lastly, for the yellow hospital, Hospital B, you can see that the 95% interval estimate ranges from 13.2% to 17.1% and includes the national rate of 15.6%. The yellow line crosses over the dotted line that represents the national observed rate. That means that the hospital is no different than the national rate. For the payment measures, the image on the right-hand side of the screen, a similar approach is used to categorize hospitals. This time the interval estimate is compared against a national average payment rather than a rate, and the performance categories have a different label. Instead of being categorized as "better" or "worse," they are categorized as "less than the national average payment" or "greater than the national average payment." As is done with the outcome measures, the entire interval

estimate is compared to the national results in order to determine the hospital's performance category.

Lastly, shown here on slide 32, for the Excess Days in Acute Care, 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 were performing the same as an average hospital with a similar case mix to 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% interval estimate, hospitals are categorized as "fewer days than average," "average days," or "more days that average." If the entire interval estimate is less than zero days, then the hospital is classified as "fewer days than average" as depicted with the green line. This means that your patients spent fewer days in acute care than would be expected if admitted to an average performing hospital with your case mix. If the entire interval estimate, the one in red, is greater than zero days or expected, that is classified as "more days than average." If the entire interval estimate contains zero days within that range, then the hospital is classified as "average" days. 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. Now, I'm going to turn it over to the next presenter, Josh, to discuss the Public Reporting HSRs.

Josh Gerrietts: Thank you, Kristina. Hello, folks. My name is Josh Gerrietts. I am a Project Manager on the Hospital Quality Reporting Application Development Organization contract, and I will be talking today with you about the HSRs. In this section, we'll cover what's included in the HSR bundle and some of the content in the IQR HSRs. Please note, I will not be going over every IQR HSR tab. If you have questions about a specific tab which is not covered in this presentation, we will go over the process for submitting questions later.

This is an example of an HSR bundle facilities have receive. Included in the bundle are six HSRs: Readmission; Hospital Wide Readmission (HWR); Mortality; Hip/Knee Complication; Payment; and Excess Days in Acute Care, otherwise known as EDAC. Also included in this bundle is the HSR User Guide, otherwise known as the HUG, and a resource table.

You can find the HSR User Guide on QualityNet, as well. A link is provided here in this presentation. As I mentioned earlier, it also accompanies the HSRs in their bundle. The July 2022 Hospital PR Program User Guide PDF that accompanies the HSRs includes additional information about the data in the HSRs.

Changes to this year's HSRs within IQR bundles are detailed here. Disparity stratification will not be reported in the readmission HSRs distributed in May, and History of COVID-19 risk factor was added to all six HSRs. The COVID risk factor denotes that a patient had a COVID diagnosis in the 12 months prior to the index case. This risk factor was also included in the case mix tabs. As I mentioned, COVID-19 exclusions have been added to all HSRs. This exclusion removes the index case if there is a COVID diagnosis on the index claim. Also, of note, PSI HSRs have not been included in this bundle. Pneumonia results will not be included in the mortality and readmission HSRs. Payment will not include the Pneumonia Value of Care results. Lastly, the National Institute of Health Stroke Scale Score is now being used as a risk factor in the stroke mortality measure.

Each of the 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 a performance table that provides 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 Care Choice Experience website; 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; and, for comparison, national values are provided. Performance categories in each of the HSRs will display with a color fill except for the Payment HSRs. Just as a rule of thumb, generally green equals "better;" yellow is "no different than the national average;" and red is "worse than the national average." 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. Continuing this year, both the Health Insurance Claim Number, otherwise known as the HIC Number, and the Medicare Beneficiary Identifier, otherwise known as 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. In the Readmission and HWR HSRs, if a patient had a diagnosis of COVID-19 on their unplanned readmission visit, the "Unplanned Readmission within 30 Days" column will list "N/A-COVID patient" and the readmission will not count as a numerator event for the measure.

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 Present on Admission is indicated, a score is picked at random for the measure. This is denoted with an asterisk after the score in the HSR. This is also explained in footnote "d" of this tab.

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. If there is a COVID-19 diagnosis on the claim for an AMI, pneumonia, Sepsis, or pulmonary embolism complication, the complication will be excluded and will be flagged with a "Yes" value in the Complication Excluded Due to COVID-19 column. If you filter the Additional Complications Record column to "No" and the Complication Excluded Due to COVID-19 column to "No," you can follow the same process used in the Readmissions and Mortality HSRs to identify the count of eligible discharges. As noted, new for this year is a column for Complication Excluded Due to COVID-19, highlighted here for your reference.

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. We minimized the HIC Number, 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 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.

Note the row with ID number 4 lists the patient had three emergency department visits, two observation stays, and one unplanned readmission within the 30 days following discharge. These add up to six events with 6.5 total days included in the 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. For this example, I have filtered the records to just display ID 4. 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 record(s) to the corresponding record on the Summary of Events tab. The rows here with ID number 4 include the aforementioned events from the previous slide. Recall that the total number included in measure outcome from the previous tab was 6.5 days, but adding up the days per event give you as a result of eight days. If one event led to a second contiguous event of greater significance (e.g., an ED visit results in an observation stay/readmission or an observation stay resulted in a readmission), 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 from the previous table. If there was a COVID-19 diagnosis on the claim for one of the events listed in this table, the event would not be counted towards the days included in the measure outcome. The event would be flagged with "N/A COVID Patient" in the Event Included Outcome column.

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 tabs list 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 the summary-level payment information and provides the split between facility, physician, and post-acute care payments.

The Total Episode Payments Value (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 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.

Continuing this year, 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 5 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 were 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. Some post-acute care visits may be excluded if the visit had a COVID-19 diagnosis. Those will be noted by a count greater than zero in the Incidences not Counted Due to COVID-19 column and will not be included in the measure.

Each HSR 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. “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 patient 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.

In this next section, I will briefly go over preview period 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 to find the Q&A tool section of QualityNet. This is also provided in each of the HSRs.

The HSRs contain personally identifiable information (PII) and protected health information (PHI). 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 law. 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 each HSR.

The public reporting preview period does not allow hospitals to submit corrections related to 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 a 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, 2021. The review and correction 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 claims snapshot period that pertained to an incorrect claim originally submitted prior to the claims snapshot period, 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/correct this data until the deadline. Lastly, in many cases where the claims listed in the HSRs don't match internal records, this is due to corrections which were made to those claims after the snapshot period. With that, I'll hand this back over to the host. Thank you very much.

Brandi Bryant: Thank you, Josh. We will now address some questions asked regarding the July 2022 Public Reporting Claims-Based Measures Hospital-Specific Reports. 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?

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 were the July 2022 Public Reporting Claims-Based Measures HSRs delivered?

Maria Gugliuzza: The July 2022 Public Reporting Claims-Based Measures HSRs were released on May 16, 2022.

Brandi Bryant: We have not received our Public Reporting Claims-Based Measures HSRs. How do we get it?

Maria Gugliuzza: If you experience issues accessing your HSR from Managed File Transfer or requesting and reviewing your HARP permissions, contact the CCSQ Service Center at qnetsupport@hcqis.org or (866) 288-8912.

Brandi Bryant: We feel the COVID pandemic has affected our scores during Q1 2020 and Q2 2020. How do we apply for the COVID-19 exception?

Maria Gugliuzza: Hospitals do not need to request an Extraordinary Circumstances Exception, ECE, for measures and submissions covered under the COVID-19 exception for Quarter 1 and Quarter 2 2020.

Brandi Bryant: When does the public reporting preview period end?

Maria Gugliuzza: All review and correction requests must be submitted by June 15, 2022.

Brandi Bryant: Are these the only COVID codes that are excluded for the claims-based measures?

Kristina Burkholder: For the calculation of the July 2022 claims-based measures, yes, these are the only codes currently used. CMS will continue to monitor and assess additional COVID-19 codes as they are included in ICD-10 to determine future use in its measures.

Brandi Bryant: Why aren't all COVID cases excluded from the outcome?

Kristina Burkholder: For the mortality measures and complication measures, we do not have the cause of death, so patients who died from COVID-19 cannot be excluded. Also, for the complication measure, patients who have a COVID-19 diagnosis and have either a mechanical or wound complication or surgical site bleeding are not excluded because these complications are not conceptually related to COVID-19.

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.