Hospltal Value-Based Purchasing (VBP) Program

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

July 2024 Public Reporting Claims-Based Measure Hospital-Specific Report Overview Presentation Transcript

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Brandi Bryant: Hello. Welcome to the July 2024 Public Reporting CBM HSR Overview webinar. My name is Brandi Bryant, and I am with the Centers for Medicare & Medicaid Services' Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, https://www.qualityreportingcenter.com/, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email about two hours ago. If you did not receive 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. Manjiri Joshi is the Measure Implementation and Stakeholder Communication Lead, Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Kristina Burkholder is the Measure Implementation and Stakeholder Communication Lead, Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Mike Miller is the Public Reporting Claims-Based Measures Delivery Manager at the Hospital Quality Reporting Application Development Organization.

The purpose of this event is to provide an overview of the Hospital-Specific Reports, or HSRs, for select Claims-Based Measures that will be publicly reported in July 2024, 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 download the HSRs from the HQR system.

The purpose of the July 2024 Public Reporting Claims-Based Measures HSR is to provide Claims-Based Measures that will be publicly reported in July 2024, so hospitals may preview their measure results prior to the public reporting of the results.

This HSR 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; 90-day episode of care for the THA/TKA measure; the Excess Days in Acute Care, or EDAC, measures for AMI and heart failure; and the THA/TKA Patient-Reported Outcome Performance Measure, or PRO-PM.

In response to the COVID-19 Public Health Emergency, CMS is not using claims data reflecting services provided January 1, 2020–June 30, 2020, Quarters 1 and 2 of 2020, in its calculations for the Medicare quality reporting programs. The reporting periods for readmission, mortality, complication, payment, and EDAC measures have been updated to reflect this policy. This change was finalized in FY 2022 Hospital Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System, or the IPPS/LTCH PPS, final rule.

The July 2024 Public Reporting HSRs were delivered May 6, 2024. 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 4. Mike will provide instructions and more details regarding the review and correction process later in the presentation.

This webinar and HSR bundle that you are currently receiving is for July 2024 Public Reporting. An additional HSR for the Hospital VBP Medicare Spending per Beneficiary, or Hospital VBP 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.

If you have any questions regarding measures and HSRs please submit your question using the Question and Answer Tool on QualityNet.

I will now be discussing how to access your July 2024 Public Reporting Claims-Based Measure Hospital-Specific Reports.

Beginning in November 2022, the Hospital VBP reports can be downloaded directly from the Hospital Quality Reporting system from the link provided in this slide. The HQR system requires that the user has a HCQIS Access Role and a HARP Profile account that has access to log in to MFT.

First, log in to the HQR system using your HARP account.

Choose the two-factor authentication method that you have set up.

Enter the code, and select Next.

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

Select Program Reporting on the menu and select Claims-Based Measures.

Select the Release Year. You will want to select 2024 for the fiscal year 2025 HSR.

Select the program of Public Reporting and select HSR for the report. Click on Export, and the file will download through your browser. Once downloaded, you will have a zip file that contains your site's report and the HVBP user guide.

Here is a summary of steps to access your HSR in the HQR system.

Here is a summary of steps to access your Procedure-level CSV file for the THA/TKA PRO-PM. I will now pass the presentation over to Manjiri. Manjiri, the floor is yours.

Manjiri Joshi: Thanks, Maria. Hi, everyone. I am Manjiri Joshi, and I am the Claims-Based Implementation Lead. Today I will be presenting on the 2024 results for Claims-Based Measures and also on the 2024 confidentially-reported CMS disparity methods.

On this slide right now, you're seeing the July 2024 Public Reporting claims-based results. You are looking at the national results for mortality, readmission, complication, and payment measures. On the left hand side, there is a list of all the measures. The column in the middle lists the 2024 national rates. On the right-hand side, it depicts the change in the national rate from the previous year. For this year, it is from the change from 2023 to 2024. This column will tell us whether the rates have increased, decreased, or have remained the same. The color green in this column denotes the increase; red denotes the decrease; and no change is shown in black. Now, let's look at the results. For the mortality measures, the 2024 national results range from 2.8 percent for CABG to 17.9 percent for pneumonia mortality. In 2024, we have experienced an increase in the national mortality rate in comparison to 2023 for COPD and heart failure for mortality. For readmission measures, the national observed readmission rates this year ranged from about 4.5 percent for the total hip/knee replacement readmissions to around 19.8 percent for heart failure readmissions. With an exception of hip/knee replacement, which slightly increased, all national readmission results have decreased from about 0.3 to 0.8 percentage points.

However, the HWR readmission measure remained the same. That's why it's black in color. Next, we'll look at the national rate for the hip/knee complication measure, which is 3.5 percent and has increased 0.3 percentage points since last year. At the bottom of the table are the national payments, which range from about $19,600 for heart failure to a little over $28,000 for AMI payments. The payment measures that you see here are inflation-adjusted, so they are presented to you in 2022-year dollars. We don't compare the payment measures across years because the national payment results are usually adjusted for inflation based on the specific year. These national rates are used by CMS to categorize hospital performance on these measures and will be displayed on the Compare tool, which was previously known as Care Compare.

Now on this slide, you are seeing what you will be receiving for 2024 confidential results for CMS disparity methods. They include measure results that are stratified by patients who are duly eligible for Medicare and Medicaid for all readmission measures that are listed in this first box that you see. Heart failure for mortality and pneumonia for mortality measures are newly added this year. Those are the ones that are underlined. Additionally, we will receive measure results stratified by patient race and ethnicity for hospital-wide readmission measures. This year, we have a new stratification, Area Deprivation Index, which is also known as ADI, which is newly added. This will include reporting on all readmission on mortality measures that we just saw in the table for duly eligible. These results can be found in your HWR mortality and readmission HSRs that you will receive. Please note again that these results are confidential and will not be publicly reported.

So, now, let's talk about ADI. Let's learn what does ADI, or Area Deprivation Index, mean. It is a composite of several variables, an indicator of an area's socio-economic disadvantage. This includes education, which tells us about the level of school, occupation, employment, and income, which includes medium income for the people in that area. Housing includes what are the home values or rents in that area.

Poverty includes percent in poverty, percent of single-parent homes, how many people have telephones, cars, etc. Now, this composite score for areas are ranked between 0 to 100. Areas with higher scores, ADI greater than or equal to 85, are labeled as more deprivation areas or areas with higher ADI, which includes lower incomes, lower home values, less schooling, etc. Then, ADIs less than 85 are labeled as area of low deprivation. Here you see a U.S. map on the right. This is one of the studies which showed the ADI calculation for the entire country. On this map, you see the red region that indicates high deprivation area for this particular study. Next, we will see the stratifications for ADI.

Same as dual-eligible stratification, ADI also has two methods for calculation, Within-Hospital and Across-Hospital method. CMS created the CMS disparity methods to measure differences in quality of care received by patients enrolled in Medicare with social risk and demographic variables when compared to similar patients without social risk and demographic variables. For instance, patients who are non-dually eligible, white, or patients living in low area deprivation index regions. There are two CMS disparity methods, the Within-Hospital and Across-Hospital disparity methods, as I mentioned earlier. On this slide, we will look at the Within-Hospital Disparity Method. The Within-Hospital Disparity Method measures differences in quality of care by comparing results for different patient social risk and demographic variables within an individual hospital. So, for example, it compares between patients who are dually eligible for both Medicaid and Medicaid and patients who are non-dually eligible, compares between patients who are white and with patients who are Black, Hispanic, or Asian American, Native Hawaiian, Pacific Islander, or between patients living in high Area Deprivation Index region, that is ADI greater or equal to 85, and patients not living in high Area Deprivation Index, that is ADI less than 85. So, with respect to ADI, it will specifically answer questions like, “Do patients living in high Area Deprivation Index regions who receive service at Hospital A have worse health outcomes than patients living in low Area Deprivation Index regions who receive services also at Hospital A?”

Now, let's look at the second method for Across-Hospital Disparity Method. The Across-Hospital Disparity Method compares performance across hospital by calculating hospital's outcome rate separately for dual eligible patients, Black, Hispanic, or Asian-American, Native Hawaiian, Pacific Islander patients, or patients living in high Area Deprivation Index. Here in the bottom, you are seeing an Across-Hospital Disparity Method label. Here, the hospital rate is compared to the national rate. If the hospital rate that is calculated lies on the left side of the scale, that is like in that green area, it means that it is less than the national rate. Then, the hospital is considered a better performing hospital. If it falls on the right side of the scale, then it is greater than the national average. It is considered the worst performing hospital. If the hospital falls in the center, it is considered as no different than the national average. Hospitals can use this to see where they stand and develop plans to reduce disparities.

On the next slide and this slide that you're looking at, we have a list of different resources that are available for CBM measures, that's the Claim-Based Measures. These include links to all the QualityNet material, which includes FAQs, Frequently Asked Questions, for Claims-Based Measures, disparity methods. It also has links to fact sheets, any measure updates and specifications, how do HSRs look, like the mock data HSRs, and so on.

The resources on this slide are basically a video to help navigate and interpret HSRs and a brief overview of EDAC measures. Now, I'm going to turn it over to Kristina to discuss 2024 THA/TKA PRO-PM results. Thank you.

Kristina Burkholder: Thanks, Manjiri. Thank you, everyone, for joining us today. I'm Kristina Burkholder, the Implementation Lead for the hospital-level PRO-PM. Today, I'll be discussing how the results in your HSR for the pre-operative data from Voluntary Reporting 1 will be calculated, a description of what data will be publicly reported in July, and a reminder about future reporting.

On slide 33 here, we have the reporting timeline for the hospital-level hip/knee PRO-PM. The HSR your hospital received on May 6 contains information regarding the pre-operative data from Voluntary Reporting 1 or 2025 Voluntary Reporting of Eligible Procedures occurring from January 1, 2023, to June 30, 2023. As a reminder, data submission for post-operative data for Voluntary Reporting 1, as well as pre-operative data submission for Voluntary Reporting 2, will begin this summer. PRO data submission ends September 30, 2024. Most importantly, pre-operative data collection for patients with an eligible hip/knee procedure for mandatory reporting has begun. Pre-operative data submission for mandatory reporting will occur next summer, 2025. Failure to meet reporting requirements will impact your facility's fiscal year 2028 payment. It's very important to start collecting pre-operative data soon if you haven't already.

CMS finalized a phased implementation approach for the hip/knee PRO-PM in the fiscal year 2023 IPPS rule. For voluntary reporting, CMS will publicly report an indication of whether or not your hospital participated, as well as your hospital's pre-operative response rate. In future years, CMS will only publicly report the overall response rate. These data will be publicly posted on CMS's Compare tool on Medicare.gov and the data catalog on data.cms.gov. During voluntary reporting, CMS will not publicly post your hospital's measure score once calculated.

The Spring 2024 HSR your hospital received on May 6 contains information regarding the pre-operative data from VR1. These data include eligible procedures occurring from January 1, 2023, to June 30, 2023. The data flow is depicted on the left side of slide 35. The first three steps in blue are for the pre-operative data steps. Your facility submits PRO data. The PRO data are then matched to claims. Claims data are used to identify eligible procedures. Future years will also contain additional risk factors used in measure calculation. I'll be discussing eligibility and the definition of "complete" in more detail in the upcoming slides.

Your reports will contain your eligible patients, noting that this is not final as patients who die within 300 days after the procedure are excluded and insufficient time has passed at the time of preparing these reports. These interim reports only include the pre-operative PRO data submitted as well as the pre-operative response rate, if applicable. There are no measure results provided at this time since that requires post-operative data. Next year and future years your facility will submit post-op data. These data will then be matched to the pre-op and claims data to determine the eligibility and completeness. From there, the overall response rate and measure results will be calculated, if feasible.

All right. Let's talk about how the pre-operative response rate is calculated. In the numerator, we have complete eligible PRO data. The two keywords here are complete and eligible, and CMS does not use any PRO data submitted to calculate the measure. CMS uses claims to determine the eligible cohort. The complete pre-operative PRO data are divided by the eligible procedures derived from claims, which is multiplied by 100 to make it a percent. Then, you have your pre-operative response rate.

Slide 37 depicts how CMS defines "complete" for pre-operative and post-operative data. Data for all of these elements listed in the table must not be missing, be in a valid format, and it in range for that variable. For example, Procedure Date should be a date with no slashes. If a survey item has response options 1 through 5, a 6 wouldn't count as complete. For pre-operative data, a PRO record will either need complete HOOS, Jr. for hip patients or KOOS, Jr. for patients with total knee replacements. They'll also need in-range data collection dates for those surveys. Mental health items from either the PROMIS Global or VIR-12 are also required. Be sure to include the generic PROM version as well, especially if you're using the PROMIS Global survey. Other risk variables include the health literacy question, BMI, or height and weight, narcotic use, and patient-reported pain in the non-operative joint and back. Lastly, in order to match the PRO data to claims, CMS requires several variables to do so.

This includes CCN, MBI, date of birth, procedure date, survey type, and procedure type.

On this slide we have who is included. Patients must be Medicare Fee for Service for both Part A and B for the 12 months prior and Part A at the time of the index admission. For post-op collection, it doesn't matter if the patient switched insurances. Say, six months after the procedure, they changed to Medicare Advantage, they'd still be included for the cohort and for data collection. Patients must also be age 65 and older, undergoing unilateral or bilateral inpatient elective primary total hip and knee replacement procedures. This does not include partial or revision procedures, fractures, bony metastasis, or mechanical complications. Patients with staged procedures who die within 300 days, have COVID, are discharged against medical advice, or have more than two procedures in a single hospitalization are excluded. You can find more details about the cohort eligibility in the methodology report or the 2025 supplemental file posted on QualityNet. Additionally, all hospitals with at least one eligible procedure received an HSR, even if you do not submit any PRO data. So, we really encourage you to take a look and become more familiar with which patients are included.

Over slides 39 to 41, I'll walk through how the response rate calculation is calculated using Example Hospital. On this slide, we have which patients are in the eligible cohort and which are excluded for this hospital. This hospital has six eligible patients: Pat, Elena, Ashaya, Sean, Dom, and Zane. These patients met the eligibility criteria described on the previous slide. This hospital also has one excluded patient, Fred. This patient could be excluded for numerous reasons. They could be an outpatient procedure, under 20, over 65, or left against medical advice.

In yellow, we have the pre-operative data submission for this hospital. Sean, Zane, Elena, and Ashaya all have complete pre-operative data submitted and count towards the pre-operative response rate. That response rate is 67%. Let's see what happened to the other patients. Pat is in the cohort. However, Pat did not have complete data. Let's say the health literacy variable was missing.

So, Pat does not count towards the pre-operative response rate. Dom had no pre-operative data submitted and, thus, also does not count. Fred did have complete pre-operative data; however, Fred does not count because they are not an eligible patient in the cohort. This is how your response rate is calculated for the pre-operative PRO data. Your HSR will identify which PRO records are included and which were not, and, if possible, why.

In the future, once CMS has post-op data, the overall response rate will be calculated. This overall response rate will be used for payment determination, once it is mandatory. In blue, you have the post-operative data submission. I green, you have the overall response rate or which eligible patients had both complete, pre-,and post-op data. For the overall response rate, Zane, Elena, and Ashaya all count since they had both complete pre-op and complete post-op data. So, this hospital's overall response rate is 50%. They would meet the requirements. Pat had complete post-op data; however, Pat had incomplete pre-op data, so they do not count towards the overall response rate. Dom and Sean also had no post-op data submitted, so they do not count.

On slide 42, you see many resources are available on QualityNet to your hospital to support collection and submission of PRO data. There are numerous fact sheets, the reporting timeline, what data to collect, who to collect on, how and when to collect, how the response rate is calculated, and other fact sheets. Measure details are listed in the methodology report, as well as the FAQs. There are also data submission templates, instructions, and a brochure you can use to customize for your patients. Please check them out at QualityNet Inpatient Measures. Then, select the hip/knee PRO-PM Now, I'll pass it over to Mike to discuss the HSRs.

Mike Miller: Hello. Thank you, Kristina. 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 are not covered here, we will go over the process for submitting questions later in the presentation.

In your bundle, you will receive six HSRs: Readmission, Hospital-Wide Readmission, Mortality, Hip/Knee Complication, Payment, and Excess Days in Acute Care, or EDAC. It also includes an HSR User Guide, also known as a HUG.

That user guide, or HUG, is zipped up along with the HSRs and also available to the public on QualityNet. The link to get that is shown here. As in previous years, the July 2024 Hospital PR Program User Guide PDF includes additional information about the data in the HSRs.

Changes to this year's IQR/PR bundles include the following. Similar to 2023, the Patient Safety Indicator, or PSI, HSRs will not be included in this bundle of IQR/PR reports. It will be released separately early this fall. New for this year, disparity stratification by area with a high Area Deprivation Index, or ADI, has been added to the readmission and mortality measures, and the method for getting to and reading a facility-level THA/TKA PRO-PM report is different this year.

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 comparisons of the risk factors used for risk adjusting the measures.

Each HSR starts with measure results or 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 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 also provided. Of note, performance categories in each of the HSRs will display with a color fill except for the Payment HSR. Generally, green equates to Better, yellow to No Different, red to Worse, and grey for Number of Cases Too Small.

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 you 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 the top picture, we have an example of a Readmission HSR. The count of discharges with an inclusion/exclusion indicator of 0, highlighted yellow, 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, called out in that same top picture as the eight yellow rows with a Yes, for the measure can be tied to the numerator in the Performance tab shown in the bottom picture. In this example, the eight Yes correspond to the numerator cell for the AMI 30-day readmission column. That is also highlighted in yellow.

As mentioned earlier, new for this year are tabs in the Readmission and Mortality HSRs that detail a hospital's performance for patients living in high Area Deprivation Index regions. The results are reported as rate differences between patients living in high Area Deprivation Index regions as compared with patients not living in high Area Deprivation Index regions. Rate differences above 0 indicate worse outcomes for patients living in high Area Deprivation Index regions. Rate differences below 0% indicates better outcomes for patients living in high Area Deprivation Index regions. For additional information, please review the 2024 Disparity Methods Updates and Specifications Report that is available at the link in the slide.

On the Mortality Discharges tab, a 0 with curly braces will display in the Stroke NIHSS column, column P, for stroke discharges that do not have an NHISS score. The 0 with curly braces indicates CMS assigned a National Institute of Health Stroke Score of 0 for that patient. If multiple National Institute of Health Stroke Scores are available but no POA is indicated, a score is picked at random for the measure. This is denoted by an asterisk after the score in the HSR. This is also explained in Footnote E on that 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.

The EDAC HSR differs from the other HSRs in that it uses two discharge-level data tabs to provide the discharge-level detail and event-level detail. The Summary of Events tab lists the discharges that are included in the measure. It follows the same inclusion/exclusion, numerator and denominator logic as the discharges 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 event on the patient-level summary tab.

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.

The Payment HSR has three tabs for providing discharge level data: the Index Stay and Summary tab and two Post-Acute Care tabs. The Index Stay and Summary tab lists the discharges that are included in the measure. It includes all discharges that meet the inclusion requirements for each measure and uses the inclusion/exclusion indicator to identify discharges that were excluded from the measure.

It provides the summary-level payment information and provides the split between facility, physician and post-acute care payments. The Total Episode Payments Value, column N, 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. The Total Index Admission Payments, column O, is further split up into the Facility and Physician Payments columns, seen in columns Q and S, along with their percentages in columns R and T.

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. I've hidden some rows here for the example. We are going to use ID Numbers 2, 15, 16, and 94 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.

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

One of the biggest changes this year is to the Measure Details page and the addition of the Measure Detail View button as seen in the top picture on this slide. The first report to utilize this upgrade is THA/TKA PRO-PM. To get to the PRO-PM report, you click on the Measure Details View button, then the IQR button, as seen to the left of the screen. Then, finally click on the THA/TKA PRO-PM button as seen in the bottom right-hand corner.

If your hospital did not participate in the voluntary reporting, you will see that on the top of the page. The arrows on the right-hand side of the page will expand the section for both performance overview and submission information for both your facility and the national results. Your hospital can also download detailed patient-level information by clicking on the blue Export button in the upper right-hand corner of the page. The zip file that is downloaded includes a user guide and a CSV file that details all the patient-level stay information used to calculate your facility scores.

This slide shows an example of a participating hospital. The blue status banner tells at a glance that the hospital did report and at what matching percentage. For this hospital, we can see that, because they participated, they have facility-level summary results where the non-participating facility had just dashes. Also of note, when there are underlined words or phrases on the page, hover text will display to provide additional information for the user.

Now, let’s go over some commonly asked preview period questions and how you can ask questions on behalf of your facility.

Questions can be submitted to QualityNet Inpatient Question and Answer Tool found on QualityNet. The URL and navigation guide is listed here. The information is also provided in each of the HSRs.

The HSRs contain personally identifiable information, or PII, and protected health information, or PHI. Any disclosure of 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 any questions on transmitting PII or PHI, please contact the QualityNet Help Desk. As a rule of thumb, use only the ID numbers located in the far left-hand column of the HSRs when asking questions about the HSRs to the QualityNet Help Desk.

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 29, 2023, that pertained to an incorrect claim originally submitted prior to September 29, 2023, the corrected claim will not be included in your measure results. Because claims data are generated by the hospital itself, hospitals in general always have the opportunity to review and correct these data prior to that deadline. Lastly, in many cases where the claims listed in the HSRs don't match internal records, it is commonly found to be that corrections were made after that deadline. This concludes my topics for the webinar, and I'll pass it back to Brandi.

Brandi Bryant: Thank you, Mike. We will now answer some of the questions submitted during the webinar. If you would like to submit additional questions at this time, please include the slide number associated with your question. The first question is: Where can I find information on ADI and other DM stratifications?

Manjiri Joshi: All information on CMS disparity method confidential reporting can be found on QualityNet. So, for updates on disparity methods you can go on QualityNet. Then, under the Inpatient tab, go to Measures.

Under that, you will see Disparity Methods. This will have a Methodology tab, and that will give you all the updates for 2024 disparity methods. For factsheets and FAQs, they can be found on QualityNet, under the Inpatient tab. Go to Measures and Disparity Methods. There is a tab for Resources. That should have all the fact sheets and FAQs for this year , as well.

Brandi Bryant: How can hospitals use the disparity methods results to improve the quality of care for their patients with these social risk factors?

Manjiri Joshi: Hospitals will receive their disparity method results in their HWR, Readmission, and Mortality HSRs. These HSRs will have results for both Within- and Across-Hospital Disparity Methods for each strata. If differences in care do exist for their patients with these social risk and demographic variables, hospitals can develop strategies to reduce those differences.

Brandi Bryant: Are these data in these Hospital-Specific Reports the same data that will appear on Care Compare or in the payment programs?

Maria Gugliuzza: These Public Reporting HSRs are provided for Claims-Based Measures that will be publicly reported in July 2024 on Care Compare. Hospitals may preview their measure results prior to the public reporting of the results. Separate HSRs or reports will be provided specifically for each of the value-based purchasing programs. On Care Compare, CMS provides results for publicly reported measures, which are different from the Hospital VBP Program measure results. The difference in the national rates between the publicly reported measures and Hospital VBP Program measures can be attributed to the different hospitals participating in the programs.

Brandi Bryant: When does the July 2024 Public Reporting preview period end?

Maria Gugliuzza: All review and correction requests must be submitted by June 4, 2024.

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

Maria Gugliuzza: If you experience issues accessing your HSR from HQR or requesting/ reviewing your Health Care Quality Information Systems Access Roles and Profile permissions, contact the Center for Clinical Standards and Quality Service Center, or CCSQ, at QNetSupport@cms.hhs.gov or call (866) 288-8912.

Brandi Bryant: Does the THA/TKA PRO-PM include outpatient procedures?

Kristina Burkholder: The THA/TKA PRO-PM in the [Hospital] IQR Program only includes inpatient procedures. Patients who are scheduled as outpatient, but are converted to inpatient, billed as a Medicare Part A claim, would be included in the measure, as long as they meet other eligibility requirements. If you are unsure if a patient is outpatient or inpatient, you should collect and submit their PRO data to give your facility the best possible opportunity for meeting the [Hospital] IQR Program requirements. While outpatient procedures are not included in the [Hospital] IQR Program, outpatient elective primary hip/knee procedures are included in the hip/knee PRO-PM in the Hospital Outpatient Quality Reporting Program. Voluntary Reporting for OQR begins with calendar 2025 procedures.

Brandi Bryant: It looks like that's all the time we have for questions today. If your question was not answered and you still have questions regarding the July 2024 Public Reporting Claims-Based Measures Hospital-Specific Reports, please submit your questions through the question and answer tool on QualityNet.

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