



## Hospital Inpatient Quality Reporting (IQR) Program

### Support Contractor

## Reviewing Your 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 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report* webinar On Demand. 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 virtual 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. Kristina Burkholder is the Measure Implementation and Stakeholder Communication Lead at CMS's Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Ellen Jarosinski is the Hospital VBP Program Project Lead at CMS's Healthcare Quality Analytics and Reports Contractor.

The purpose of the event is to provide an overview of Hospital-Specific Reports for the mortality and complication claims-based measures used in the fiscal year 2021 Hospital VBP Program, including a summary of the new COPD mortality measure methodology, other measure calculations, ways to receive and read the HSR, and steps to submit a review and correction request.

At the conclusion of the webinar, you should be able to recall the updates to the Fiscal Year 2021 Hospital VBP Program Mortality and Complication Measures HSR, access and review the HSR, and submit a review and correction request, if desired.

If you have questions during the webinar, you may submit them to the following email address, [WebinarQuestions@hsag.com](mailto:WebinarQuestions@hsag.com). Again, the email address is [WebinarQuestions@hsag.com](mailto:WebinarQuestions@hsag.com). When sending questions, please use the webinar title in the subject line. The webinar title is *Reviewing Your Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report*. In the email body, please include your question and, if your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible.

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If you have questions unrelated to the current webinar topic, we recommend searching for the topic in the [QualityNet Inpatient Questions and Answers tool](#). If you do not find a similar topic, feel free to use the tool to submit a new question.

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, and thank you for tuning in and joining us for the On Demand webinar.

Before we discuss the methodology of the new COPD mortality measure and steps to read your HSRs, I wanted to make sure everyone has a good understanding of the measures and the updates for this year. The Fiscal Year 2021 Hospital VBP Program HSR contains five measures: the mortality measures for AMI, COPD, heart failure, and pneumonia, and the complication measure for total hip and knee arthroplasty. The baseline and performance periods vary by measure and are listed on this slide for you to reference.

The Hospital VBP Program-specific HSRs were delivered April 9 or 10 to your *QualityNet Secure Portal* Secure File Transfer Auto Route Inbox. If you received the report, you should have received the notification in your email that the reports were available to download. 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 12. Ellen 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 in the HSR. If you are interested in seeing your baseline period rates for these five measures and all the other measures in the Hospital VBP Program, you can run a Baseline Measures Report for fiscal year 2021 in the *QualityNet Secure Portal* or HQR Portal, if you've established your new HARP ID.

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There are a few items you should be aware of when reviewing your Hospital VBP Program HSRs. First, the CMS PSI 90 measure is not included in the fiscal year 2021 Hospital VBP Program and is not included in the Hospital VBP Program HSR. However, it will be included in your Public Reporting HSRs that we anticipate delivering soon. The PSI 90 measure used in the Hospital VBP Program from fiscal year 2015 through fiscal year 2018 underwent National Quality Forum maintenance review and re-endorsement, leading to several substantive measure changes. Due to statutory requirements in the Hospital VBP Program, CMS was unable to adopt the newly re-endorsed version of the PSI 90 measure into the Safety domain for fiscal year 2019 through fiscal year 2022. As a result, CMS finalized the removal of the current PSI 90 measure, Patient Safety for Selected Indicators, in the fiscal year 2018 IPPS final rule. In the fiscal year 2018 IPPS final rule, CMS also finalized the proposal to adopt a new version of PSI 90 beginning in the fiscal year 2023. To summarize, CMS removed the current version of PSI 90 in fiscal year '19 through fiscal year '22—reminder, you are currently receiving HSRs for fiscal year '21—and adopted the new version of the measure for inclusion in the Hospital VBP Program beginning in fiscal year '23. In fiscal year '21, CMS will use the 30-day mortality measure for COPD for the first time in the Hospital VBP Program. Many of you are probably aware of this measure with it publicly reported on the *Hospital Compare* website and included in your *Hospital Compare* HSRs in the past. For those that aren't, or want a refresher, Kristina will provide a short overview of the measure methodology in a few minutes.

The third item you should be aware of is the updated patient cohort of the pneumonia mortality measure. Fiscal year '21 is the first year that CMS will begin using the expanded cohort for the 30-day pneumonia mortality measure. The measure now includes a cohort of patients with a principal diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis, not including severe sepsis, with a secondary diagnosis code of pneumonia, including aspiration pneumonia coded as present on admission and no secondary diagnosis of severe sepsis.

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These expanded cohorts are in addition to the original cohort of patients with a principal discharge diagnosis of pneumonia.

This webinar and HSR bundle that you are currently receiving is for the Hospital Value-Based Purchasing Program. The Public Reporting, also known as the *Hospital Compare*, 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 Program 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 the same email notification that your report is available to download once it has been delivered.

We anticipate the Medicare Spending per Beneficiary HSRs will be delivered to hospitals in May or June of 2020. CMS will provide notification of the HSR delivery through the same Listserve notification groups. I would now like to hand the presentation over to Kristina Burkholder.

**Kristina Burkholder** Thanks, Bethany. Today I will provide a high-level overview of the 30-day, risk-standardized COPD mortality measure.

This measure was first publicly reported in 2014 as part of the Hospital Inpatient Quality Reporting Program and will be included as part of the Hospital VBP Program for FY 2021. As mentioned earlier, the performance period is July 1, 2016, to June 30, 2019.

The COPD mortality measure assesses all-cause, 30-day mortality. This means it counts any death as a mortality outcome if the death occurs within 30 days from the start of the of the qualifying index admission. The deaths can occur while the patient is in the hospital or post-discharge. All-cause means the measure considers death for any reason, not just those the patient was initially admitted for.

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For an index admission to be included in the measure, it needs to meet the following criteria: a principal discharge diagnosis of COPD or a principal discharge diagnosis of acute respiratory failure with a secondary diagnosis of COPD; the patient must be enrolled in Medicare Fee For Service Part A and B for the twelve months prior to the date of the index admission and Part A of the index admission; and the patient is 65 or older and is not transferred from another acute care facility or discharged against medical advice. Like our other mortality measures, the COPD measure takes into account how sick people are when they are initially admitted into the hospital by adjusting for patient characteristics like age and patient comorbidities such as hypertension or asthma. They are clinically relevant or have a strong relationship with the outcome.

For additional information, please see the resources available on *QualityNet*. Now Ellen will take you through the HSR and the HSR User Guide.

### **Ellen Jarosinski**

Thank you, Kristina. My name is Ellen Jarosinski, and I am the Hospital Value-Based Purchasing Project Lead on the Healthcare Quality Analytics and Reports Contract, also known as HCQAR. Today, I will be discussing the Fiscal Year 2021 Hospital Value-Based Purchasing Mortality and Complication Hospital-Specific Reports.

The FY 2021 Hospital Value-Based Purchasing Mortality and Complication HSRs were delivered to hospitals on April 9 and 10. A Listserve communication was sent via email to those who are registered to receive notifications regarding the Hospital IQR and Improvement Program and the Hospital (Inpatient) VBP Program on *QualityNet*. A second auto route file delivery notification was sent to your email notifying you that your hospital's HSRs were delivered.

Please note that only hospital users with the Hospital Reporting Feedback-Inpatient role and the File Exchange and Search role will receive a notification and be able to access the HSRs and User Guide.

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To download the reports and user guide, please continue to log in to the *QualityNet Secure Portal*, Secure File Transfer destination, with your *QualityNet* User ID and password. Users will not be able to access the reports through the HQR portal using HARP credentials. For those with the correct roles, the HSRs and User Guide will be in your *QualityNet* Secure File Transfer Auto Route Inbox folder.

The FY 2021 Hospital VBP Purchasing HSR User Guide that accompanies the mortality and complication HSRs includes additional information about the data in the HSRs and includes instructions to replicate the complication and mortality measure results using the discharge-level data.

Now, we are going to take a closer look at the contents of the Hospital VBP Program mortality HSR. The mortality HSR lists the hospital results in Table 1 with further detail in the tables that follow. Table 1 provides the hospital results for acute myocardial infarction (AMI); COPD; heart failure (HF); and pneumonia 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 FY 2021 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 calculations. The Performance Period Survival Rate will be used to calculate achievement and improvement points for these outcome measures in the Hospital VBP program. The Achievement Threshold was calculated as the median survival rate among all hospitals with measure results and at least 25 cases during the FY 2021 baseline period. The Benchmark was calculated as the mean average of the top 10 percent of survival rates among all hospitals with measure results and at least 25 cases during the FY 2021 baseline period.

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Table 2 includes additional provider-level values that are used to calculate the Performance Period Survival Rate for the AMI, COPD, HF, and pneumonia mortality measures. Other than the number of eligible discharges and the survival rate, 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 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, detailed later, will show how the Predicted Deaths and Expected Deaths are calculated. The National 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 and a hospital-specific effect. As shown in footnote [e], the Risk-Standardized Mortality Rate, or RSMR, 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 one minus the RSMR. The discharge tables contain discharge-level data for all Part A Medicare Fee for Service patient stays with a principal qualifying diagnosis of AMI, COPD, HF, or pneumonia, accordingly, that had a discharge date in the reporting period, for patients who were age 65 and above at the time of admission. The ID Number is provided as a way to reference records while avoiding sharing PII or PHI. The HICNO column through the Discharge Destination column contain the data as it was pulled from hospital claims.



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The Index Stay 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 stays that are not included in the measure, the Inclusion/Exclusion Indicator column has number(s) 1–9 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.

Deaths within 30 days are flagged Yes or No if the 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 and end with the “Chronic Liver Disease Risk” factor. The risk factors vary for each measure. Table 4 in the user guide provides a description for each.

Row 8 in the HSR contains the model coefficients for each risk factor, which are estimates over data for all hospitals. The HOSP\_EFFECT represents the underlying risk of a mortality at the specific hospital, after accounting for patient risk. The AVG\_EFFECT represents the underlying risk of a 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\_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 be in cells beginning in column O.

The replication process for the mortality measures includes the following steps: One, calculate Predicted Deaths. Two, calculate Expected Deaths. Three, calculate the Risk-Standardized Mortality Rate, or RSMR. Four, calculate the Performance Period Survival Rate, or PPSR.

The user guide distributed with your HSRs includes detailed instructions for replication. An Excel file with sample calculations and step-by-step instructions can also be requested from the *QualityNet* Help Desk.

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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 identified, multiply each risk factor flag by the relevant coefficient found in row 8. Risk factor flags begin with Column N, "Age minus 65".

Next, sum all the products from the previous step, risk-factor flags multiplied by the coefficient, for each index discharge. This is shown in column AZ. The calculation that is shown in the example is for the values in the first row.

Next, add the hospital-specific effect, which is the HOSP\_EFFECT value found in cell AX 8, to the sum of the risk-factor flags for each index discharge calculated in the previous step. The calculation is shown in column BA.

Please note that this example is for the pneumonia mortality measure. The AMI and HF measures both have less risk factors, while COPD has more risk factors. So, the formula examples shown in these steps would be different for those measures.

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

Finally, sum the predicted probability of a 30-day death for all of the stays 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 Predicted Deaths value for this measure in Table 2.

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The example formula shown in blue was used to sum the values for the Predicted Deaths in cell BA 25. Each hospital will likely have a different quantity of discharges, so the formulas will need to be adjusted accordingly.

To calculate the Expected Deaths, start with the summed products (risk factor flags multiplied by the coefficient) that were created in the predicted deaths calculations. Add the average hospital effect, which is the AVG\_EFFECT value found in cell AY 8.

Next, calculate the expected probability of a 30-day death for each stay using the formula shown and the results from the previous step.

Finally, sum the expected probability of a 30-day death for all of the stays to get the number of expected deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the Expected Deaths value for this measure in Table 2. Again, each hospital 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 value is rounded to six decimal places, it should match the Risk-Standardized Mortality Rate found in Table 2. The Excel formulas used for the calculations are shown in column BC. The result of those calculations are shown in column BD.

The Performance Period Survival Rate is calculated as one minus the Risk-Standardized Mortality Rate. When this 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 BC. The result of the calculation is shown in BD.

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Due to differences in rounding between SAS and Excel, there may be minor differences at the sixth decimal place. When CMS calculates your hospital's rates, it uses SAS. The values in your HSR are based on these SAS calculations.

Now, I will discuss the Fiscal Year 2021 Hospital VBP Program Complication HSR.

Similar to the mortality HSR, the complication HSR lists your hospital's results in the first table with further detail in the later tables. The following columns are found in Table 1: The Number of Eligible Discharges is a count of the discharges used for the measure calculations. 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 the median complication rate among all hospitals with measure results and minimum case size, greater than 25, during the FY 2021 baseline period. The Benchmark was calculated as the mean of the top decile of complication rates among all hospitals with measure results and minimum case size, greater than 25, during the FY 2021 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 the number of predicted admissions with a complication within 90 days from admission, based on your hospital's performance with its observed case mix and your hospital's estimated effect on complications. The Expected Admissions with a Complication is the 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 Complication Rate is the number of observed admissions with a complication within 90-days nationally divided by the number of eligible discharges nationally.

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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 Discharges table contains many of the same columns as the Mortality HSR Discharge table.

A stay can appear multiple times on your Discharges 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 discharge and list the two complication records that 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 (AMI, pneumonia, sepsis, surgical site bleeding, pulmonary embolism, death, mechanical complication, or infection). 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 complication.

The replication process for the THA/TKA complication measure is the same as the mortality measures with one difference: In the first step, when you limit your replication calculations to rows where “Index Stay” (column H) equals “Yes,” you must also limit it to rows where “Additional Complication Record [c]” (or Column I) equals “No”. The rest of the replication process would follow the same steps as those outlined for the mortality measures.

Now I will discuss the Hospital VBP Program HSR Review and Correction Period.

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The Hospital VBP review and correction period for fiscal year 2021 is April 13, 2020–May 12, 2020. Please pay special attention to the review and correction period deadline. Requests sent after May 12, 2020, will not result in a correction.

Review and corrections requests can be submitted via email to [qnetssupport@hcqis.org](mailto:qnetssupport@hcqis.org) or over the phone to the numbers 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.

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 referencing a specific case or discharge, please use the ID number found within the HSR rather than sending patient information through email.

Suspected calculation errors on your report can be submitted for review with the possibility of a correction. General questions about the 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 the administrative claims data available approximately 90 days after the end of the applicable period is taken in order to perform program calculations. For fiscal year 2021, the applicable period ended on June 30, 2019, and the administrative claims data file used for calculations was produced on September 27, 2019.

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 27, 2019, that pertained to an incorrect claim originally submitted prior to September 27, 2019, the corrected claim will not be included in your measure results. Because claims data are generated

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by the hospital itself, hospitals in general always have the opportunity to review/correct these data until the deadlines 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. Now back to Maria.

**Maria Gugliuzza** Thank you, Ellen. We will now address some frequently asked questions regarding the Hospital VBP Program claims-based measures and the HSRs.

First question, Are hospice patients included in the COPD mortality measure?

**Kristina Burkholder** No. The COPD mortality measure exclude patients who were enrolled in the Medicare hospice program at any time during the 12 months prior to the index admission, including the first day of the index admission.

**Maria Gugliuzza** Thank you. Next question: Do the measures also adjust for social risk factors?

**Kristina Burkholder** No. Currently, the mortality measures do not adjust for social risk factors, such as dual eligibility or race. The intent is for the measure to adjust for patient clinical characteristics only.

**Maria Gugliuzza** Thank you. Next question: Why is the pneumonia mortality measure time period different than the other mortality measures?

For the FY 2021 Performance Period, CMS has adopted an expanded cohort for the pneumonia mortality measure to include cases with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia that is present on admission. The performance period of September 1, 2017–June 30, 2019 was adopted for the updated cohort and will be reflected on the FY 2021 Hospital VBP HSR.

**Maria Gugliuzza** Thank you. Next question: I didn't receive a Hospital VBP HSR. What do I do?

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**Ellen Jarosinski** Contact the *QualityNet* Help Desk at (866) 288-8912 or [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) to request your hospital's FY 2021 Hospital VBP Hospital-Specific Reports. Please provide your CCN for a faster turnaround. Please note Critical Access Hospitals do not receive HSRs for most programs, including Hospital VBP.

**Maria Gugliuzza** Please describe the differences between the Hospital VBP mortality data and the IQR/PR mortality data.

**Ellen Jarosinski** The differences in exclusion indicators between HVBP and IQR discharges are 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** When will I receive my Hospital VBP Percentage Payment Summary Report?

**Ellen Jarosinski** The FY 2021 Hospital VBP Percentage Payment Summary Report (PPSR) will be available by August 1, 2020.

**Maria Gugliuzza** If you had questions during the webinar that were not addressed, you may submit them to the following email address, [WebinarQuestions@hsag.com](mailto:WebinarQuestions@hsag.com). When sending questions, please use the webinar title in the subject line. The webinar title is *Reviewing Your Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report*. In the email body, please include your question. If your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible. If you have questions unrelated to the current webinar topic, we recommend searching for the topic in the [QualityNet Inpatient Questions and Answers tool](#). If you do not find a similar topic, feel free to use the tool to submit a new question.

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