



Hospital Value-Based Purchasing (VBP) Program

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

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

Questions and Answers Summary

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Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 1: I didn't receive a Hospital Value-Based-Purchasing (VBP) Program Hospital-Specific Report. What do I do?

Because this Questions and Answers (Q&A) summary was published more than 30 days after the reports were delivered, the report will no longer be in your Managed File Transfer (MFT) inbox. To have the reports resent to you, first confirm your profile in the Hospital Quality Reporting (HQR) Secure Portal has the appropriate permissions to receive the report. To do that, log into the HQR Secure Portal and select *My Profile* at the top, right-hand side of the dashboard. The Auto-Route (IQR) and Managed File Transfer permissions must be listed on your profile for the hospital to receive the report. If your account does not have these permissions, refer to the instructions in the [Important: Request Access to Managed File Transfer \(MFT\) & Auto-Route Now to Ensure You Receive Your Reports](#) email notification.

Once you have confirmed the required permissions are active for your profile, you can request the report through the Questions and Answers tool on [QualityNet](#):

- When submitting the request, select Inpatient Claims-Based Measures from the Program drop-down menu and select Request for HVBP Hospital-Specific Reports from the HVBP Mortality & Complication topic drop-down menu.
- In the subject line, type **Request to Resend FY 2022 Hospital VBP Program Mortality and Complication Measures HSR**. Please describe your question or request to resend the report in the text box and include your hospital's CMS Certification Number (CCN).

If you experience issues accessing your HSR from MFT or issues requesting and reviewing your HQR profile permissions, contact the [QualityNet](#) Help Desk at qnetsupport@hcqis.org or (866) 288-8912.

Question 2: When will I receive my Hospital VBP Program Percentage Payment Summary Report (PPSR) for the fiscal year (FY) 2022?

Generally, the Hospital VBP Program PPSRs are available to view approximately 60 days prior to the start of the fiscal year in which payments will be adjusted. For example, the FY 2021 PPSRs were made available in late July 2020, approximately 60 days prior to the start of FY 2021 on October 1, 2020.

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In the FY 2022 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule, CMS stated, “We note that, due to operational complications associated with extended deadlines for Q3 2020 data submissions for the HCAHPS and HAI measures granted in response to the system issues as well as the proposed changes in the FY 2022 scoring methodology, and in order to allow enough time for the appropriate notice and comment period process, we may not be able to provide hospitals with the feedback reports for FY 2022 until after August 1, 2021. We intend to provide hospitals with these feedback reports for FY 2022 as soon as possible and estimate that we will be able to provide reports before the end of 2021.”

When the FY 2022 Hospital VBP PPSRs are available in the HQR Secure Portal, a notification will be sent to users who subscribed to the HVBP Notify: Hospital Inpatient Value-Based Purchasing (HVBP) Program Notifications QualityNet group. You can sign up for that program notification group here: <https://qualitynet.cms.gov/listserv-signup>. (The PPSRs will not be delivered via MFT.)

Question 3: Why were the performance periods updated on the FY 2022 HSRs?

The discharge period in this HSR was updated due to the CMS “blanket” COVID-19 Extraordinary Circumstances Exception (ECE) applicable for the 1st and 2nd quarter 2020 data. The AMI, COPD, HF, PN, and CABG measures identify deaths within 30 days of each index stay, and the THA/TKA measure identifies complications within 90 days of each index stay. Therefore, the performance periods for the mortality measures and the complication measure end 30 days and 90 days, respectively, before January 1, 2020, so that no claims from Q1 and Q2 2020 are used in the measures calculations.

Question 4: Our hospital is still affected by the COVID-19 pandemic. Where can we find the Extraordinary Circumstances Exception (ECE) request form?

If a hospital believes this extraordinary circumstance adversely impacted its performance beyond June 30, 2020, the hospital can submit an individual ECE request to CMS for the Hospital VBP Program within 90 days of the date of the extraordinary circumstance. At the latest, due to operational timelines and constraints, ECEs should be submitted no later than 90 days from the last date of the quarter requested. A granted individual ECE in the Hospital VBP Program would exclude the hospital from the Hospital VBP Program in the fiscal year in which performance was impacted. An excluded hospital will not incur the 2 percent withhold in payments, but it

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would also not receive incentive payments for the fiscal year. Additional Hospital VBP Program ECE information is on [QualityNet](#).

Question 5: When will the FY 2023 Baseline Measure Reports be available?

The FY 2023 Baseline Measures Reports became available in the HQR Secure Portal on June 2, 2021. Refer to this [QualityNet news article](#) for more information regarding the release of the report.

Question 6: Describe the differences between the Hospital VBP Program mortality data and the Hospital Inpatient Quality Reporting (IQR) Program publicly reported mortality data?

While the AMI, COPD, HF, PN, and CABG mortality measures are technically no longer in the Hospital IQR Program, the measure data are still available for patients, consumers, providers, and other members of the public on CMS' Care Compare website. The difference in the performance results for the mortality measures between the Hospital VBP Program and Care Compare is likely related to the differences in hospitals included in the Hospital VBP Program and on Care Compare.

For the mortality measures reported on Care Compare, the mortality measure calculations include index admissions to short-term acute care hospitals in the U.S. (including U.S. Virgin Islands, Puerto Rico, Guam, Northern Mariana Islands, and American Samoa), critical access hospitals (CAHs), VA hospitals (for the acute myocardial infarction (AMI), heart failure, chronic obstructive pulmonary disease (COPD), and pneumonia mortality measures), and Maryland short-term acute care hospitals participating in the All-Payer model. For the mortality measures in the Hospital VBP Program, measure calculations include only index admissions to subsection (d) hospitals in the 50 states and the District of Columbia.

In addition, it is important to note that the mortality measures randomly select one eligible index admission per patient, per split year (July–June), per measure. Therefore, if a patient had multiple eligible heart failure index admissions in a given split year, it is possible that different admissions can be randomly selected for inclusion in the cohort when the measure results are run for Care Compare and the Hospital VBP Program.

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Question 7: Does Column B on slide 47 show hospital results?

Column B on slide 47 is not hospital results; the column shows the Health Insurance Claim Number (HICNO), a 6–12-digit Medicare health insurance claim account number. (Note that the HICNO is different from the Social Security Number.)

Question 8: Our COPD value does not have coefficients for the risk factors; should it have them? If so, how do we obtain them?

The provider's HSR should have coefficients for COPD. If you are unable to locate them, contact the *QualityNet* Help Desk at qnetssupport@hcqis.org.

Question 9: Which table and cell will show my hospital's results, or do I calculate them? I am brand new and I want to know my hospital's performance.

Table 1 in the second worksheet in the Mortality file presents your hospital's measure results on the five mortality measures for the FY 2022 performance period. Risk-Standardized THA/TKA Complication Measure Results for the FY 2022 Hospital VBP Program Performance Period presents your hospital's results on the 90-day risk-standardized THA/TKA complication measure for the FY 2022 performance period.

Question 10: Which column (Performance Period Survival Rate or Achievement Threshold) contains hospital results?

In the second worksheet in the Mortality workbook file (Table 1 Hospital results) for 30-day mortality measure results for the FY 2022 Hospital VBP Program Performance Period, you can find the Performance Period Survival Rate in Column C and the Achievement Threshold in Column D.

Question 11: Could the speaker please briefly explain how the risk factors' coefficients were determined?

The risk factors' coefficients are determined by using a hierarchical logistic regression model. The model includes data at the patient- and hospital-level to account for the variation in outcomes within and between hospitals.

For more information, please see the complication methodology report (<https://qualitynet.cms.gov/inpatient/measures/complication/methodology>) and the mortality methodology report

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(<https://qualitynet.cms.gov/inpatient/measures/mortality/methodology>)
on *QualityNet*.

Question 12: What does a negative risk factor coefficient mean?

If the risk factor is a binary variable (Yes/No), then having a negative risk factor coefficient means that, compared to those without the risk factor, patients with the risk factor have lower odds of having an outcome (death or complication). For more information, please see the complication methodology report

(<https://qualitynet.cms.gov/inpatient/measures/complication/methodology>)
and the mortality methodology report

(<https://qualitynet.cms.gov/inpatient/measures/mortality/methodology>)
on *QualityNet*.

Question 13: Does a greater sum of risk factor flag * the coefficient mean a greater risk for a discharge?

Yes. At the patient level, the greater the sum of patient's characteristics * coefficients, the higher the risk of having an outcome (death or complication). However, the estimated hospital-specific effect, or risk that can be attributed to a hospital's quality of care, also contributes to the risk of the patient.

Question 14: Do the measures also adjust for social risk factors?

No. The mortality and complication measures do not adjust for social risk factors (e.g., dual eligibility or race) because the intent of the measure is to only adjust for patient clinical characteristics.

Question 15: Are hospice patients included in the COPD mortality measure?

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

Question 16: What is the benefit of accurately identifying all additional risk factors?

Identifying all risk factors in the claims data for the complication and mortality measures ensures CMS can comprehensively include this information in measure calculation and more accurately generate measure results that reflect patient risk.

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Question 17: **Why does CMS not set the Risk-Standardized Mortality Rate to 0 when there are no observed deaths?**

Your facility can have a raw (unadjusted) rate of 0 but a non-zero risk-standardized rate. This is because the risk-standardized rate is based on the ratio of the predicted number of deaths (based on a facility's case mix and hospital-specific effect) to the expected number of deaths (based on the case mix for an average hospital). This ratio will always be greater than 0, but a ratio of less than 1 indicates a better-than-expected mortality rate relative to other hospitals.

In addition, the occurrence of zero patient deaths is typically associated with relatively low case size. Estimated outcome rates for smaller facilities will likely be closer to the national observed outcome rate because the limited number of eligible hospitalizations at the hospital tells little about that hospital's true outcome rate.

Question 18: **What version is used for the Risk Model Value for complication measures?**

Version 10.0 is used for the 2021 Procedure-Specific Complication Measure Updates and Specifications Report. The latest version of the complication methodology report can be found on [QualityNet](#).

Question 19: **How can we tell if our hospital is better or worse as a performance category?**

A hospital's comparative performance category (Better, No Different, or Worse) can be found in the Hospital-Specific Report (HSR) for the complication and mortality measures. In the complication HSR, your hospital's comparative performance category can be found in Tab IV, THA-TKA C Perf, Row 6; in the mortality HSR, it can be found in Tab III, 1 30-Day M Perf, Row 6.

Question 20: **It would seem that a finance department, rather a quality department, would reconcile Hospital VBP Program mortality data in an HSR. What do you see as standard in the field?**

Since a variety of data values appear in the report, consider asking members from different disciplines on your hospital team to evaluate the various aspects of the report and reconcile the information.

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Question 21: **If a patient is placed in Palliative Care during the stay due to a family request, does that exclude the patient from the mortality cohort?**

No. Patients in palliative care or comfort care are included in the mortality and complication measures, assuming they meet the inclusion and exclusion criteria for the measure. However, the measures do risk adjust for factors associated with the likelihood that patients are sicker or are at the end of their lives, so that hospitals treating older, sicker patients are fairly compared to hospitals with a healthier case mix.