Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Reviewing Your Fiscal Year 2026 Hospital Value-Based Purchasing Program Mortality and Complication Measures Hospital-Specific Report Presentation Transcript

Speakers

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Brandi Bryant: Hello and thank you for tuning into *Reviewing Your Fiscal Year 2026 Hospital Value-Based Purchasing Program Mortality and Complication Measures Hospital-Specific Report*. My name is Brandi Bryant, and I will be your host for the webinar.

I would like to welcome our speakers for this webinar. Maria Gugliuzza is the Program Lead; Hospital Value-Based Purchasing (VBP) Program; Division of Value, Incentives, and Quality Reporting Program Support Contractor. Mike Miller is the Delivery Manager for the Hospital VBP Program, Hospital Quality Reporting.

Today we will cover the Hospital-Specific Reports for mortality and complication measures, specifically how the measures are calculated, how to access your reports, and how to submit a review and correction request if needed.

At the conclusion of the webinar, you should be able to recall the updates to the fiscal year 2026 Hospital VBP Program Mortality and Complication Measures HSR, access and review the HSR, and submit a review and correction request, if desired.

This slide displays a list of acronyms that will be referenced during the webinar. That concludes my introductions. I will now turn the webinar over to our first speaker. 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, and other HSRs that are on the horizon.

The purpose of the Hospital VBP Program Mortality and Complication Measures HSR is to provide the underlying claims data that were used to calculate the measure results. Using this data, hospitals may review and request corrections to the calculations of the performance period measure rate results prior to those rates being used to calculate a hospital's Total Performance Score.

The performance periods for each of the measures are listed on this slide. Please note that there are no new updates to the measures for FY 2026.

The Hospital VBP Program HSRs were delivered April 14. 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 14. Mike will provide instructions and more details regarding the review and correction process later in the presentation.

In these HSRs, only performance period data will be included. If your hospital would like to review your FY 2026 baseline period results, you can download the report through the CMS *HQR Secure Portal*.

This webinar and HSR bundle that you are currently receiving is for the Hospital Value-Based Purchasing Program. The Public Reporting Claims-Based Measures Hospital-Specific Reports are anticipated to be available in late April or early May. When the HSRs are available, CMS will provide a notification through the Hospital IQR and Hospital VBP Listserve notification groups. Full names are listed on this slide. If you are not signed up for those Listserve groups, you can sign up using the link available on this slide.

We anticipate the Medicare Spending per Beneficiary HSRs will be available to hospitals in May or June of 2025. CMS will provide notification of the HSR availability through the same Listserve notification groups.

If you have any questions regarding measures, HSRs, and the Hospital VBP Program, please submit your question using the Question and Answer Tool on QualityNet. If you experience issues accessing your HSR from the HQR system or requesting and reviewing your HARP permissions, contact the CCSQ Service Center at QNetSupport@cms.hhs.gov.

I will now pass the presentation over to Mike Miller. Mike, the floor is yours.

Mike Miller: Thank you. The Hospital VBP [Program] Hospital-Specific Reports, or HSRs, have been available for download since April 15. The reports are available by following the URL on this page. To download the report, a user will need an active HARP ID with the MFT role.

On the HQR website, enter your user ID and password.

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

Enter the code.

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

Select Program Reporting on the menu. Then, select Measure Details.

Select the release year of 2025, the program of HVBP, and then All Reports from the reports dropdown.

Once the report choices were selected, the Export button will allow you to choose what manner of file you would like to download. The.csv file is a so-called flat file with no formatting and is used to load the report information into databases for further study and comparisons. The majority of users will select the Excel file type. This is the traditional view of the report that has full formatting and is easier to read as an individual report. Regardless of the file type, what is downloaded to the user's computer is a zip file that contains the reports and the HSR User Guide, or HUG, for short. Once the reports are downloaded, they must be opened in Excel in order to view the data within it.

The HUG that is included in the report zip file is also available to the general public on the QualityNet website at this URL.

Now, I'd like to help explain the reports in more detail.

The Mortality HSR lists the hospital results in Table 1 with further details in the tables that follow. Table 1 provides the hospital results for the 30-day acute myocardial infarction, COPD, heart failure, and CABG mortality measures that will be used in the Hospital VBP Program.

These will calculate the achievement and improvement points for these outcome measures. The achievement threshold and the benchmark were calculated on fiscal year 2026 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 discharges used for the measure calculation. 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 fiscal year 2025 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 fiscal year 2026 baseline period.

Table 2 includes additional provider-level values that are used to calculate the performance period survival rate for the AMI, COPD, HF, and CABG mortality measures. Other than the number of eligible discharges and survival rate, information on this table will not be publicly reported. The following columns are found in Table 2. 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 in your hospital's effect on mortality. 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 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, or RSMR, is a mortality rate that has been adjusted for differences in case mix across hospitals and hospital-specific effect.

As shown in Footnote E, the 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 1 minus the RSMR.

The discharge tables contain discharge-level data for all Part A Medicare Fee for Service, or FFS, patient days with a principal qualifying diagnosis of AMI, COPD, HF, or CABG that have a discharge date in the reporting period for patients who are age 65 and above at the time admission. The ID number is provided as a way to reference records while avoiding sharing PII or PHI. The MBI, through Discharge Destination columns, contain data as it was pulled from hospital claims. The Index Stay column indicates whether the stay is included in measure calculations by a Yes or a 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 calculations, the Inclusion/Exclusion Indicator column has number or numbers 1 through 9 indicating the reason or reasons why the stay was excluded. The corresponding descriptions for these numbered reasons are defined in the user guide that accompanies the HSR.

In the Deaths Within 30 Days column, there are Yes or No values based on whether or not 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. 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 column represents the underlying risk of a mortality at the specific hospital after accounting for patient risk. The AVG_Effect column 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, equal the years above 65 for the Age_65 variable, and a contain 0 if otherwise.

Values will only display for each index day that is included in the measure calculations. The risk factor flags will be in cells beginning in Column O.

The replication steps for the mortality measures are listed here on this slide. 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 be requested through the QualityNet Inpatient Question and Answer Tool.

To begin the replication process, save a copy of the HSR and complete the calculations in Excel, working below the actual data. The replication steps should be completed on the discharge-level worksheet for each mortality measure. The first step for replicating your hospital's result 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: Years Over 65 (Continuous). The formulas used are highlighted in blue on the side of the slide.

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 BE. 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 BC8, to the sum of the risk factor flags for each index discharge calculated in the previous step. The calculation is shown in Column BF. Please note that this example is for the COPD mortality measure.

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 the 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. The example formula shown in blue was used to sum the values for the predicted deaths. 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 BD8. 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 stays to get the number of expected deaths within 30 days from admission. When this value was 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 their 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 here in Column BH. The result for these calculations are shown in BI.

The performance period survival rate is calculated as 1 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 calculation is shown in Column BH. The result of the calculation is shown in BI. Due to the differences in rounding between SAS and Excel, there may be minor differences at the fifth and sixth decimal places. When CMS calculates your hospital's rates, it uses SAS-FIA. The values in your HSR are based on those SAS calculations.

Now, I will discuss the fiscal year 2026 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 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 a minimum case size greater than 25 during the fiscal year 2026 baseline period. The benchmark was calculated as the mean of the top decile of complication rates among all hospitals with measure results and a minimum case size greater than 25 during the fiscal year 2026 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 that we 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. The Risk Standardized Complication Rate is the predicted admissions with a complication divided by the expected admissions with a complication, then multiplied by the National Observed Complication Rate.

The Complication HSR discharge table contains many of the same columns as the Mortality HSR discharge tables. A stay can appear multiple times on your Discharge tab if the patient had more than one complication for that discharge; however, it is only included once in the calculation of the measure. Similar to the [Hospital] IQR [Program] 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, either 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 a value of a double dash. 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 measure with one difference. In the first step, when you limit your replication calculations to rows where index day or Column G equals Yes, you must also then limit rows where additional complication record or Column H equals No. The rest of the replication process would follow the same steps as those outlined in the mortality measures.

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

The Hospital VBP [Program] review and correction period for fiscal year 2026 is April 15 through May 14, 2025. Please pay special attention to the review and correction period deadline. Requests sent after May 14 will not result in a correction.

The instructions for submitting a review or correction are detailed on this slide.

The HSRs contain PII and PHI. Emailing either PHI or PII 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 on your reports, 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, mortality measures, or the complication measures may also be submitted. Requests for a submission of new or corrected claims, however, are not allowed. A snapshot or copy of the administrative claims data, available approximately 90 days after the end of the applicable period, is taken in order to perform the calculations for these reports. For fiscal year 2026, the administrative claims data file used for calculations was captured on the last week of September 2024. 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 correct claims. If your facility submitted or wishes to submit a corrected claim after the snapshot is taken that is pertaining to an incorrect claim originally submitted prior to the snapshot taken, that claim will not be included in your measure results. Because claim data are generated by the hospital itself, hospitals in general have the opportunity to review and correct those data until the deadline.

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 for the snapshot. Thank you for your time. This concludes my portion of the presentation.

Brandi Bryant: Thank you, Mike. We will now answer some of the questions that were 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: My drop-down box does not provide the Hospital VBP Program as a selection. Is this because critical access hospitals do not participate?

Maria Gugliuzza: Thank you, Brandi. Only hospitals classified as subsection (d) hospitals are eligible to participate in the Hospital Value-Based Purchasing Program. These hospitals are governed by section 1886(d) of the Social Security Act, which applies to general acute care hospitals paid under the Inpatient Prospective Payment System. Subsection (d) hospitals include most hospitals in the 50 states and Washington, D.C., but this specifically excludes types such as psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. Because critical access hospitals, or CAHs are not included in subsection (d), they cannot access Hospital VBP Program reports. Therefore, as your hospital is a CAH, or a critical access hospital, you will not be able to view these reports.

Brandi Bryant: If our CAH received the fiscal year 2025 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report, or HSR, should we ignore it?

Maria Gugliuzza: Yes, you should disregard the FY 2026 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report if your hospital is a critical access hospital. CAHs are excluded from the Hospital Value-Based Purchasing Program, and CMS does not provide these reports to hospitals with CAH CMS Certification Numbers, CCNs. However, hospitals that were originally classified as acute care facilities, but later converted to CAHs, may have received the report.

In this case, you should not use the report for evaluation purposes, as CAHs are not included in the Hospital VBP Program. To verify your hospital's CAH status, check the CMS Certification Number and consult your Medicare Administrative Contractor, or MAC, to ensure your hospital is correctly classified as a CAH. If you still need clarification, please submit your questions through the QualityNet Question and Answer Tool for further assistance.

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

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