ACUTE CARE

QUALITY REPORTING GUIDE

MHA
MISSOURI HOSPITAL ASSOCIATION

Table of Contents

INTRODUCTION ... 3

GLOSSARY OF KEY TERMS ... 4

REGULATORY PROGRAMS ... 5

ACUTE CARE PAY FOR PERFORMANCE SYSTEM REPORTING SUMMARY ... 6

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM ... 7

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM ... 12

HOSPITAL VALUE-BASED PURCHASING ... 14

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM ... 15

HOSPITAL READMISSION REDUCTION PROGRAM ... 15

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS ... 16

MEDICARE PROMOTING INTEROPERABILITY PROGRAM ... 16

QUALITY PAYMENT PROGRAM ... 18

INITIATIVES ... 19

MISSOURI QUALITY TRANSPARENCY MEASURES ... 19

VOLUNTARY INITIATIVES ... 20

MISSOURI PERINATAL QUALITY COLLABORATIVE AND MATERNAL-CHILD LEARNING AND ACTION NETWORK ... 20

ACCREDITATION ... 21

THE JOINT COMMISSION ... 21

DNV ... 21

APPENDIX A — WEBSITE RESOURCES ... 22

APPENDIX B — MEDICARE QUALITY PROGRAM REFERENCE GUIDE ... 24

INTRODUCTION

The Missouri Hospital Association's Quality Reporting Guide is intended to provide support to acute care hospitals inpatient prospective payment systems when reporting hospital quality measures through the various reporting programs. Quality measure reporting is a priority for several reasons. By measuring the success of quality initiatives, we can better ensure patients in Missouri communities are receiving the quality health care they deserve. Moreover, the Centers for Medicare & Medicaid Services and other health care partners use quality measures in their various quality initiatives that include quality improvement, pay-for-reporting and public reporting. As a result, proper quality reporting can affect a hospital's financial stability.

This guide will be updated as appropriate to represent measure changes and updates. Please be sure to use direct sources of information for detailed and up-to-date program and measure specifics. Direct links to helpful websites and resources are located in Appendix A.

GLOSSARY OF KEY TERMS

AIM .... Alliance for Innovation on Maternal Health
CMS.................... Centers for Medicare & Medicaid Services
CY .... Calendar Year: describes a typical calendar year. This represents Jan. 1 through Dec. 31 of the given year.
DNV................... Det Norske Veritas: Global quality assurance and risk management company providing accreditation services for hospital and health care systems
eCQMs .... Electronic Clinical Quality Measures: refers to measures that are electronically submitted via the entity's certified electronic health record with the goal to improve quality and efficiency of patient care.
EHR................... Electronic Health Record
FFY..................... Federal Fiscal Year: describes the Medicare fiscal year. This represents Oct. 1 through Sept. 30 of the given year.
HAC .... Hospital-Acquired Conditions (Present on Admission Indicator) Program
HCAHPS .... Hospital Consumer Assessment of Healthcare Providers and Systems
HIDI .... MHA Hospital Industry Data Institute
HIQRP............. Hospital Inpatient Quality Reporting Program
HOQRP .... Hospital Outpatient Quality Reporting Program
HRRP .... Hospital Readmission Reduction Program
MC LAN .... Maternal-Child Learning and Action Network
NAS.................... Neonatal Abstinence Syndrome
NHSN .... National Healthcare Safety Network
OAS CAHPS.... Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems
PAMR................ Pregnancy-Associated Mortality Review Board
PPS .... Prospective Payment System: payment method where Medicare reimbursement is allocated based on a fixed amount.
PQC .... Perinatal Quality Collaborative
PY .... Payment Year: describes the year that a payment or reimbursement is received
QI........................ Quality Improvement
QPP.................... Quality Payment Program
SUD.................... Substance Use Disorder
TJC .... The Joint Commission
VBP .... Hospital Value-Based Purchasing

REGULATORY PROGRAMS

- **Hospital-Acquired Conditions Reduction Program** — Medicare pay-for-performance program that supports the CMS effort to link Medicare payments to health care quality in the inpatient hospital setting to encourage eligible hospitals to reduce HACs; requires a reduction in payments to applicable hospitals in worst-performing quartile of risk-adjusted HAC quality measures.
- **Hospital Consumer Assessment of Healthcare Providers and Systems** — Survey program administered to a random sample of inpatients to give insight on their health care experience. Results are publicly reported on https://www.medicare.gov/care-compare/?providerType=Hospital&redirect=true for the purposes of comparison, value-based purchasing and consumer education for health care decisions.
- **Hospital Inpatient Quality Reporting Program** — Equips consumers with hospital inpatient quality data for informed decisions and encourages the improvement of quality by hospitals and clinicians. Includes inpatient measures collected and submitted by acute care hospitals paid under prospective payment system and claims-based inpatient measures calculated by CMS. Failure to submit data results in a 25% reduction to the annual marketbasket update for hospitals paid under inpatient PPS.
- **Hospital Outpatient Quality Reporting Program** — Equips consumers with hospital outpatient quality data for informed decisions and encourages the improvement of quality by hospitals and clinicians. Includes outpatient measures collected and submitted by acute care hospitals paid under PPS and claims-based outpatient measures calculated by CMS. Failure to meet data submission requirements results in a 2% reduction in a provider's annual payment update under the outpatient PPS.
- **Hospital Readmission Reduction Program** — Reduction in payments to applicable hospitals for greater than expected readmissions.
- **Missouri Healthcare-Associated Infection Reporting System** — Missouri Department of Health & Senior Services program that requires Missouri hospitals to report health care-associated infections. Based on 2019 legislation, hospitals no longer are required to report to MHIRS so long as CMS requires reporting. This applies to all hospitals except ambulatory surgical centers and abortion facilities.
- **Promoting Interoperability Program** — Previously known as Medicare and Medicaid EHR Incentive Program; encourages clinicians, eligible hospitals and CAHs to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology.
- **Quality Payment Program** — Rewards high value, high quality Medicare clinicians with payment increases while reducing payments to clinicians not meeting performance standards.
- **Hospital Value-Based Purchasing** — Effort to improve health care quality by linking Medicare's payment system to patient outcomes, patient satisfaction, patient safety and efficiency.

ACUTE CARE PAY FOR PERFORMANCE SYSTEM REPORTING SUMMARY

Quality Reporting Program	Data Steward	Data Collection System	Reporting Frequency	Notes (For Hospital Use)
REQUIRED*				
HIQRP±	CMS	QualityNet, Vendor, NHSN	Quarterly	
HOOQR±	CMS	QualityNet, Vendor, NHSN	Quarterly	
HCAHPS±	CMS	QualityNet, Vendor	Quarterly	
VBP±	CMS	QualityNet, Vendor, NHSN	Quarterly	
HRRP±	CMS	CMS Claims	Quarterly	
HAC	CMS	QualityNet, Vendor, NHSN	Quarterly	
eCQM Program – Required for Promoting Interoperability Program	CMS	QualityNet, Vendor	Quarterly	
QPP — Required for eligible practitioners	CMS	Qualified registries, Medicare Part B claims, data submission, vendor	Quarterly or yearly, based on requirement of chosen metrics	
Missouri Quality Transparency Measures	MHA HIDI	HIDI, NHSN	Quarterly	
STRONGLY ENCOURAGED*				
AIM	Health Resources and Services Administration, ACOG	CMS claims, chart abstracted data	Monthly and quarterly	
Missouri Neonatal Abstinence Syndrome Collaborative	MHA	CMS claims, chart abstracted data	Monthly and quarterly	
ACCREDITATION*				
TJC National Quality Acute Care Hospital Accreditation Program – Required if accredited	TJC	TJC Direct Data Submission Platform	Quarterly	
DNV – Required if accredited	DNV			

*Based on facility's services and licensures. Please research your hospital's eligibility for each listed quality reporting program.
±Reported on Care Compare

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

The Hospital IQR program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.

In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care. Some of the hospital quality of care information gathered through the program is available to consumers on the Care Compare website at https://www.medicare.gov/care-compare/?providerType=Hospital&redirect=true.

Hospitals that do not submit quality data receive a reduced payment rate increase. For these hospitals, the annual payment update is reduced by one quarter.

Measure	Reporting Effective Date	Affects APU	Promoting Interoperability Program	Notes (For Hospital Use)
Clinical Process of Care Measures (Via Chart Abstraction)				
Sepsis and Septic Shock				
Severe sepsis and septic shock: management bundle measure	Oct. 2015	FY 2017		
Perinatal Care				
PC-01: Elective delivery prior to 39 completed weeks of gestation (aggregate data submission)	Removed effective CY 2024 reporting period	Removed effective FY 2026		
EHR-Based Clinical Process of Care Measures (eCQM) Reporting Requirements				
CY 2024/FY 2026 – Hospitals required to report four quarters of data for six eCQMs: three select-selected plus mandatory eCQMs of Safe Use of Opioids – Current Prescribing; Cesarean Birth; Severe Obstetric Complications				
Opioid-Related Measures				
Safe use of opioids – concurrent prescribing		FY 2024	Required CY 2023	
HH-ORAE: Hospital harm – opioid-related adverse events			Available for reporting CY 2024	
Stroke				
STK-2: Discharged on antithrombotic therapy			Yes	

Measure	Reporting Effective Date	Affects APU	Promoting Interoperability Program	Notes (For Hospital Use)
STK-3: Anticoagulation therapy for atrial fibrillation/flutter			Yes	
STK-5: Antithrombotic therapy by the end of hospital day 2			Yes	
Perinatal Care (PC)				
ePC-02: Cesarean birth			Mandatory for hospitals with obstetrics department CY 2024 reporting period/FY 2026 payment determination	
cPC-07: Severe obstetric complications			Mandatory for hospitals with obstetrics department CY 2024 reporting period/FY 2026 payment determination	
Venous Thromboembolism (VTE)				
VTE-1: Venous thromboembolism prophylaxis			Yes	
VTE-2: Intensive care unit VTE prophylaxis			Yes	
Medication-Related Adverse Events				
HH-01: Hospital harm – severe hypoglycemia			Available for reporting CY 2023	
HH-02: Hospital harm – severe hyperglycemia			Available for reporting CY 2023	
Additional eCQM Measures				
GMSC: Global malnutrition composite score			Available for reporting CY 2024	

Measure	Reporting Effective Date	Affects APU	Promoting Interoperability Program	Notes (For Hospital Use)
HH-PI: Hospital harm – pressure injury			Available for reporting CY 2025	
HH-AKI: Hospital harm – acute kidney injury			Available for reporting CY 2025	
ExRad: Excessive radiation dose or inadequate image quality for diagnostic CT in adults (hospital level – inpatient)			Available for reporting CY 2025	

Measure	Reporting Effective Date	Affects APU	Notes (For Hospital Use)
Claims and Electronic Data Measures			
Hybrid HWR: Hospital-wide readmission measure with claims and electronic health record data	Required July 2023 – June 2024	FY 2026	
Hybrid HWM: Hybrid hospital-wide all-cause risk standardized mortality measure	Required July 2023 – June 2024	FY 2026	
Claims-Based Measures			
Coordination of Care			
AMI Excess Days: Excess days in acute care after hospitalization for acute myocardial infarction	Will use three years of data	FY 2018	
HF Excess Days: Excess days in acute care after hospitalization for heart failure	Will use three years of data	FY 2018	
PN Excess Days: Excess days in acute care after hospitalization for pneumonia	July 2014 – June 2017	FY 2019	
Mortality Outcome Measures (Medicare Patients Only)			
MORT-30-STK: Hospital 30-day, all cause, risk standardized mortality rate following acute ischemic stroke		FY 2016	
Patient Safety Measures			
PSI-4: Death among surgical inpatients with serious treatment complications	On-going	On-going	
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA/TKA	April 2019 – March 2022; removed effective April 2025 – March 31, 2028, reporting period	FY 2024; removed effective FY 2030 payment determination	

Measure	Reporting Effective Date	Affects APU	Notes (For Hospital Use)
Payment Measures			
AMI Payment: Hospital-level, risk-standardized 30-day episode-of-care payment measure for AMI		FY 2016	
HF Payment: Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure		FY 2017	
PN Payment: Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia		FY 2017	
THA/TKA Payment: Hospital-level, risk-standardized payment associated with a 90-day episode of care for elective primary total hip arthroplasty and/or total knee arthroplasty	CY 2016	FY 2018	
MSPB: Updated Medicare spending per beneficiary	Removed CY 2026 reporting period	FY 2024; removed effective FY 2028 payment determination	
National Healthcare Safety Network Measures			
Influenza vaccination coverage among healthcare personnel	Jan. 2013	FY 2015	
COVID-19 vaccination coverage among health care personnel	Oct. 2021	FY 2023	
HAI Measures Required for Value-Based Purchasing (See Appendix B)			
CLABSI: Central line-associated bloodstream infection outcome			
CAUTI: Catheter-associated urinary tract infection outcome			
Colon and Abdominal Hysterectomy SSI: ACS-CDC harmonized procedure specific surgical site infection outcome (colon procedures and abdominal hysterectomy procedures)			
MRSA: Facility-wide inpatient hospital-onset methicillin-resistant staphylococcus aureus bacteremia outcome			
CDI: Facility-wide inpatient hospital-onset clostridium difficile infection outcome			
Structural Measures			
Maternal morbidity	Oct. 2021	FY 2023	
HCHE: Hospital commitment to health equity	CY 2023	FY 2025	
SDOH-1: Screening for social drivers of health	Required CY 2024	FY 2026	

Measure	Reporting Effective Date	Affects APU	Notes (For Hospital Use)
SDOH-2: Screen positive rate for social drivers of health	Required CY 2024	FY 2026	
Patient Experience of Care Survey Measure			
HCAHPS survey	On-going	On-going	
Patient-Reported Outcome Performance Measure			
THA/TKA PRO-PM: Hospital-level total hip arthroplasty and/or total knee arthroplasty patient reported outcome-based performance measure (PRO-PM)	Voluntary for procedures performed July 2023 – June 2024; required for procedures performed July 2024 – June 2025	Voluntary data submission will not affect APU; required for FY 2028 payment determination	

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

The Hospital OQR Program is a pay-for-quality data reporting program implemented by CMS for outpatient hospital services. The Hospital OQR Program was mandated by the Tax Relief and Health Care Act of 2006 which requires subsection (d) hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome and efficiency.

In addition to providing hospitals with a financial incentive to report their quality of care measure data, the Hospital OQR Program provides CMS with data to help Medicare beneficiaries make more informed decisions about their health care. Hospital quality of care information gathered through the Hospital OQR Program is available on the Care Compare website.

Failure to meet data submission requirements results in a 2% reduction in a provider's annual payment update under the OPPS.

The FY 2023 Hospital OPPS/ASC Payment System Final Rule aligned the patient encounter quarters for chart-abstracted measures with the calendar year. The transition year used three quarters of data for CY 2023 reporting period/CY 2025 payment determination.

CY 2024 Payment Determination	
Patient Encounter Quarter	**Clinical Data Submission Deadline**
Q2 2022 (Apr. 1 – June 30)	Nov. 1, 2022
Q3 2022 (July 1 – Sept. 30)	Feb. 1, 2023
Q4 2022 (Oct. 1 – Dec. 31)	May 1, 2023
Q1 2023 (Jan. 1 – Mar. 31)	Aug. 1, 2023
CY 2025 Payment Determination	
Patient Encounter Quarter	**Clinical Data Submission Deadline**
Q2 2023 (Apr. 1 – June 30)	Nov. 1, 2023
Q3 2023 (July 1 – Sept. 30)	Feb. 1, 2024
Q4 2023 (Oct. 1 – Dec. 31)	May 1, 2024
CY 2026 Payment Determination	
Patient Encounter Quarter	**Clinical Data Submission Deadline**
Q1 2024 (Jan. 1 – Mar. 31)	Aug. 1, 2024
Q2 2024 (Apr. 1 – June 30)	Nov. 1, 2024
Q3 2024 (July 1 – Sept. 30)	Feb. 1, 2025
Q4 2024 (Oct. 1 – Dec. 31)	May 1, 2025

Measure	Reporting Effective Date	Affects APU	Notes (For Hospital Use)
Chart-Abstracted Measures Collected and Submitted by Hospital			
ED Throughput			
OP-18: Median time from ED arrival to ED departure for discharged ED patients	Jan. 2012	CY 2013	
Stroke			
OP-23: Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT or MRI scan interpretation within 45 minutes of ED arrival	Jan. 2012	CY 2013	
Web-Based Measures (Via Hospital Quality Reporting Portal)			
OP-22: ED patient left without being seen	Jan. – June 2012 data	CY 2013	
OP-29: Endoscopy/polyp surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients	April 1, 2014	CY 2016	
OP-31: Cataracts –- improvement in patient's visual function within 90 days following cataract surgery	Voluntary reporting CY 2015		
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems			
OP-37a: OAS CAHPS – about facilities and staff	Mandatory CY 2024	CY 2026	
OP-37b: OAS CAHPS – communication about procedure	Mandatory CY 2024	CY 2026	
OP-37c: OAS CAHPS – preparation for discharge and recovery	Mandatory CY 2024	CY 2026	
OP-37d: OAS CAHPS – overall rating of facility	Mandatory CY 2024	CY 2026	
OP-37e: OAS CAHPS – recommendation of facility	Mandatory CY 2024	CY 2026	
Claims-Based Measures			
Imaging Efficiency Measures			
OP-8: MRI lumbar spine for low back pain	On-going	On-going	
OP-10: Abdomen compute tomography (CT) use of contrast material	Ongoing	On-going	

Measure	Reporting Effective Date	Affects APU	Notes (For Hospital Use)
OP-13: Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	CY 2010	CY 2012	
OP:39: Breast Screening Recall Rates	July 1, 2020 - June 30, 2021, data collection period	CY 2023	
Outcome Measures			
OP-32: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy	CY 2016	CY 2018	
OP-35: Admissions and emergency department visits for patients receiving outpatient chemotherapy	CY 2018	CY 2020	
OP-36: Hospital visits after hospital outpatient surgery	CY 2018	CY 2020	
National Healthcare Safety Network Measures			
OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel	CY 2022	CY 2024	
EHR-Based Clinical Process of Care Measures (eCQM)			
OP-40: ST-Segment Elevation Myocardial Infarction (STEMI)	Mandatory reporting CY 2024	CY 2026	

HOSPITAL VALUE-BASED PURCHASING

The VBP program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care at a lower cost during hospital stays by:

- eliminating or reducing the occurrence of adverse events (health care errors resulting in patient harm)
- adopting evidence-based care standards and protocols that result in the best outcomes for the most patients
- re-engineering hospital processes that improve patients' experience of care

Additional information regarding the Value-Based Purchasing Program is available on Appendix B.

CMS finalized within the FY 2024 final IPPS payment and policy updates that hospitals would be assessed a 2% reduction to its operating diagnosis-related group and then receive a value-based incentive payment based on measure performance.

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

Section 3008 of the 2010 Patient Protection and Affordable Care Act established the Hospital-Acquired Condition Reduction Program to provide an incentive for hospitals to reduce HACs. The program requires the Secretary of the Department of Health & Human Services to adjust payments to applicable hospitals that rank in the worst performing quartile of all subsection (d) hospitals with respect to HACs. As stated in ACA Section 3008, these hospitals may have their payments reduced to 99% of what would otherwise have been paid for such discharges. Effective FFY 2021, each measure will be weighted the same; there are no domains.

Payment Penalties

Federal Fiscal Year	
IPPS Policy	**2016 – 2021**
Hospital-Acquired Conditions	1% for bottom quartile hospital

Please see Appendix B for additional information regarding the Hospital-Acquired Condition Reduction Program.

HOSPITAL READMISSION REDUCTION PROGRAM

Section 3025 of the Affordable Care Act added Section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with readmissions that are higher than expected, effective for discharges beginning Oct. 1, 2012. Additionally, the 21st Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid beginning in FY 2019. The legislation requires estimated payments under the non-stratified methodology (i.e., FY 2013 to FY 2018) equal payments under the stratified methodology (i.e., FY 2019 and subsequent years) to maintain budget neutrality.

For FY 2024, CMS calculates the payment adjustment factor (PAF) and components results for each hospital based on their performance that occurred during the two and one-half year performance period (i.e., July 1, 2019, through Dec. 31, 2019, and July 1, 2020, through June 30, 2022). Beginning with FFY 2015, the maximum payment reduction is 3%.

CMS calculates an excess readmission ratio for each measure in HRRP, calculated using data for Medicare fee-for-service patients discharged during the performance period. Detailed information is available on QualityNet.

Additional information about the Hospital Readmission Reduction Program is available in Appendix B.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

The first 22 questions of the HCAHPS survey are used to grade a hospital's patient satisfaction domain within the Medicare Value-Based Purchasing system. This domain consists of nine dimensions. The dimensions and corresponding measures are outlined below:

Dimension	Questions
Communication with nurses / your care from nurses	1-4
Communication with doctors / your care from doctors	5-7
Cleanliness and quietness of hospital environment / the hospital environment	8-9
Responsiveness of hospital staff / your experiences in hospital	10-11
Communication about medicines / your experiences in hospital	12-14
Discharge information / when you left the hospital	15-17
Overall rating / overall rating of the hospital	18-19
Care transitions / understanding of your care when you left the hospital	20-22
Consistency score	Calculated

Within VBP, the person and community engagement domain has a weighting of 25%. Each of the dimensions has an equal weighting with consistency getting twice the weight (each dimension is 10% of the total score with consistency counting as 20%). Each measure is weighted equally under each dimension (i.e., communication with nurse questions is weighted as 2.5% of the total patient satisfaction score while each overall rating question is weighted as 5% of total score).

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

Electronic clinical quality measures are tools that help measure and track the quality of health care services that eligible professionals, eligible hospitals and critical access hospitals provide, as generated by a provider's electronic health record. Measuring and reporting eCQMs help to ensure that our health care system is delivering effective, safe, efficient, patient-centered, equitable and timely care. eCQMs measure many aspects of patient care, including patient and family engagement, patient safety, care coordination, population/public health, efficient use of health care resources and clinical process/effectiveness.

Health care providers are required to electronically report eCQMs, which use data from EHRs and/or health information technology systems to measure health care quality. To report eCQMs

successfully, health care providers must adhere to the requirements identified by the CMS quality program in which they intend to participate.

Each year, CMS makes updates to the eCQMs approved for CMS programs to reflect changes in evidence-based medicine, code sets and measure logic.

To successfully participate in the Medicare Promoting Interoperability Program, CMS requires EPs, eligible hospitals, CAHs and dual-eligible hospitals to report on eCQMs. These eCQMs are determined by CMS and require use of the 2015 Edition Cures Update criteria in order to meet the CEHRT definition. Review this site for more information on the program.

CY 2024 Reporting Criteria

Eligible hospitals and CAHs that report CQMs electronically for the Promoting Interoperability Program or participate in both the Promoting Interoperability Program and the IQR Program are required to report a total of six eCQMs for all four quarters of CY 2024:

- three of the 12 self-selected eCQMs
- Safe Use of Opioids – Concurrent Prescribing eCQM
- Cesarean Birth (required for hospitals with obstetrics departments)
- Severe Obstetric Complications (required for hospitals with obstetrics departments)

The submission period begins two months following the close of CY 2024 and ends Feb. 28, 2025. Information on eCQM specifications is available on the eCQI Information Resource Center.

Short Name	Measure Name
ePC-02	Cesarean birth (mandatory for hospitals with OB department)
ePC-07	Severe obstetric complications (mandatory for hospitals with OB department)
STK-02	Discharged on antithrombotic therapy
STK-03	Anticoagulation therapy for atrial fibrillation/flutter
STK-05	Antithrombotic therapy by end of hospital day 2
VTE-1	Venous thromboembolism prophylaxis
VTE-2	Intensive care unit venous thromboembolism prophylaxis
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing (mandatory)
HH-01	Hospital harm – severe hypoglycemia measure
HH-02	Hospital harm – severe hyperglycemia measure
HH–ORAE	Hospital harm – opioid-related adverse events
GMCS	Global malnutrition composite score

QUALITY PAYMENT PROGRAM

The Quality Payment Program is authorized under the Medicare Access and CHIP Reauthorization Act of 2015. Provisions of the QPP rewards high value, high quality Medicare clinicians with payment increases while at the same time reducing payments to those clinicians who aren't meeting performance standards.

Clinicians have two tracks to choose from in the Quality Payment Program based on their practice size, specialty, location or patient population:

- Merit-based Incentive Payment System or
- Advanced Alternative Payment Models

Detailed information about QPP is available on the CMS website.

INITIATIVES

MISSOURI QUALITY TRANSPARENCY MEASURES

The Missouri Quality Transparency Measure Initiative was launched in February 2015. The goal is to communicate the quality outcomes of both individual hospitals and Missouri hospitals as an aggregate. Throughout 2015, state-aggregate quality outcomes were publicly reported on www.focusonhospitals.com. By sharing this information, MHA's goal is to decrease variation among hospitals and identify best practices throughout the state. Beginning in February 2016, hospitals voluntarily reported their facility-specific quality measure data on www.focusonhospitals.com. If a hospital chooses to participate, its quarterly hospital-specific measure data is displayed.

Quality transparency measures for the initiative were selected using a standardized review that assessed each measure for criteria such as financial implications, regulatory effects and state-aggregate current performance. All measures follow national definitions and their conventional reporting rates. Categories include:

- managing chronic diseases
- preventing infections
- preventing harm
- managing readmissions

Detailed information on the measures is available on the MHA website, including:

- Missouri Price Quality Measure Technical Manual – provides specifications for Missouri price and quality measures that are included in the transparency initiative
- glossary – a snapshot of the measures that includes technical specifications, risk adjustment, rate explanation and importance

VOLUNTARY INITIATIVES

MISSOURI PERINATAL QUALITY COLLABORATIVE AND MATERNAL-CHILD LEARNING AND ACTION NETWORK

MHA leads and facilitates the Missouri Perinatal Quality Collaborative (PQC), which encompasses the Maternal-Child Learning and Action Network (MC LAN) and Missouri's inclusion in the American College of Obstetricians and Gynecologists Alliance for Innovation on Maternal Health patient safety bundles. Missouri birthing hospitals and associated stakeholders currently may participate in several patient safety bundles, with additional quality improvement collaboratives expected to launch in the future.

- **MO AIM:** Caring for Pregnant and Postpartum Persons with Substance Use Disorder
- **MO AIM:** Severe Hypertension in Pregnancy
- **MO AIM:** Obstetrical Hemorrhage
- **MO AIM:** Cardiac Conditions of Care
- **MO AIM:** Perinatal Mental Health
- **MO NAS:** Implementing Eat, Sleep, Console Assessment for Infants affected by SUD

Missouri's PQC/LAN offers opportunities for stakeholders across the care continuum to connect, receive education and training, access subject matter experts and resources, and submit data toward quality improvement activities. It is directly connected to the Missouri Pregnancy-Associated Mortality Review Board and develops actions in response to annual PAMR report recommendations. The following are a few examples.

- **Quality Improvement Collaboratives** – Participants receive intensive technical support and guidance to implement and advance evidence-based practices to improve health outcomes, clinical effectiveness and operational efficiency.
- **Virtual and In-person Learning** – Multiple options are available to connect with other stakeholders across the state and nation, with access to maternal-child field subject matter experts. Platforms are leveraged to support shared learning and cross-sector collaboration.
- **Reports, Toolkits and Other Resources** – Supportive materials are developed for high-need topics and are distributed broadly to improve knowledge, reduce stigma and facilitate rapid implementation of evidence-based processes.
- **Research and Pilot Activities** – Current examples include The Cuff Kit™ project with associated research study, a study of patients' perceptions of maternal mortality, and reviewing standards for postpartum care through one year post-birth.

This work, along with leveraging strong cross-sector partnerships, is designed to incrementally drive change to achieve the vision of "Healthy Moms, Healthy Babies, Healthy Missouri."

ACCREDITATION

THE JOINT COMMISSION

In 1987, The Joint Commission announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. ORYX® is The Joint Commission's performance measurement and improvement initiative, which integrates outcomes and other performance measure data into the accreditation process.

The ORYX® initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals. ORYX® measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts.

The initial phase of the ORYX® initiative provided healthcare organizations a great degree of flexibility in terms of the measures that could be reported. Over time, the ORYX® measures have evolved into standardized valid, reliable, and evidence-based quality measures.

The initial CMS/Joint Commission alignment efforts addressed chart-abstracted measures and subsequently both organizations have worked on aligning as closely as possible the electronic clinical quality measures (eCQMs).

The Joint Commission began accepting direct data submission of eCQM data from hospitals with the submission of CY 2017 eCQM data. The Direct Data Submission Platform enables an ORYX eCQM process that simplifies operations and reduces the burden for accredited hospitals while ensuring regulatory compliance and security. Beginning CY 2020 and forward for chart-based measure data, all hospitals utilize the DDS Platform for submission of data for accreditation.

Information regarding measures collected by TJC effective Jan. 1, 2024, can be found on the TJC website.

Source: *Specifications Manual for Joint Commission National Quality Measures, version 2024A1*.

DNV

On Sept. 26, 2008, CMS approved then DNV GL Healthcare by granting it deeming authority for hospitals. Hospitals accredited by DNV after that date are deemed to be in compliance with the Medicare conditions of participation. Participating hospitals can seek accreditation and certification in specialty programs such as cardiac, advanced orthopedic and stroke care. The company's name changed from DNV GL to DNV in 2021.

APPENDIX A — WEBSITE RESOURCES

QualityNet (https://qualitynet.cms.gov/) is a site developed by CMS to provide health care quality improvement information and resources. The site includes information on the following programs.

- Inpatient Quality Reporting — https://qualitynet.cms.gov/inpatient
- Outpatient Quality Reporting — https://qualitynet.cms.gov/outpatient
- Inpatient Psychiatric Facility Quality Reporting — https://qualitynet.cms.gov/ipf
- PPS-Exempt Cancer Hospital Quality Reporting — https://qualitynet.cms.gov/pch
- Value-Based Purchasing — https://qualitynet.cms.gov/inpatient/hvbp
- Hospital Readmissions Reduction — https://qualitynet.cms.gov/inpatient/hrrp
- Hospital-Acquired Condition Reduction — https://qualitynet.cms.gov/inpatient/hac

The Hospital Quality Reporting Secure Portal is the only CMS-approved web source for secure health care communications and data exchange between quality improvement organizations, hospitals, physician offices, nursing homes, end-stage renal disease facilities and data vendors.

Additional web resources include:

Resource	Website Address
CMS Hospital Inpatient Quality Reporting Program	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU
CMS Hospital Outpatient Quality Reporting Program	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram
CMS Hospital Value-Based Purchasing Program	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing
IQR Hospital Quality Reporting Important Dates and Deadlines	https://qualityreportingcenter.com/globalassets/2023/10/iqr/iqr-important-dates-deadlines--_october-2023508.pdf
OQR Hospital Important Data-Related Dates, CY 2025 Payment Determination	https://qualityreportingcenter.com/globalassets/2023/08/oqr/hosp_oqr_imptdates_cy25_pymt-final508.pdf
Hospital Consumer Assessment of Healthcare Providers and Systems	https://www.cms.gov/research-statistics-data-and-systems/research/cahps https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS
Outpatient and Ambulatory Surgery CAHPS	https://oascahps.org/
Quality Reporting Center — Tools and resources to assist hospital, inpatient psychiatric facilities, PPS-exempt cancer hospitals and ambulatory surgical centers with quality data reporting	https://www.qualityreportingcenter.com

Resource	Website Address
Agency for Healthcare Research and Quality — Agency charged with improving the safety and quality of America's health care system AHRQ provides information and tools regarding:	https://www.ahrq.gov/
• Patient Safety Indicators	https://qualityindicators.ahrq.gov/modules/psi_resources.aspx#techspecs
• Inpatient Quality Indicators	https://qualityindicators.ahrq.gov/modules/iqi_resources.aspx#techspecs
• Prevention Quality Indicators	https://qualityindicators.ahrq.gov/modules/pqi_resources.aspx#techspecs
• Pediatric Quality Indicators	https://qualityindicators.ahrq.gov/modules/pdi_resources.aspx#techspecs
Missouri Healthcare-Associated Infection Reporting System	https://health.mo.gov/data/mhirs/
Institute for Healthcare Improvement — Organization whose mission is to improve health and health care worldwide	http://www.ihi.org/
National Academies of Sciences, Engineering, Medicine Vital Signs Report	https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress
Medicare Beneficiary Quality Improvement Program	https://www.ruralcenter.org/tasc/mbqip
Centers for Disease Control and Prevention National Healthcare Safety Network	https://www.cdc.gov/nhsn/index.html
Electronic Clinical Quality Improvement (eCQI) Resource Center	https://ecqi.healthit.gov/

APPENDIX B — MEDICARE QUALITY PROGRAM REFERENCE GUIDE

Medicare Quality Programs Reference Guide

Value Based Purchasing (VBP) Overview: FFY 2024 Program

Measures, Performance Standards, Evaluation Periods, and Other Program Details for the FFY 2024 VBP Program

Safety

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
HAI_1*+ (CLABSI)	Central Line-Associated Blood Stream Infection (CLABSI) (ICU and Select Wards)	0.589	0.000	1 Predicted Infection Each
HAI_2*+ (CAUTI)	Catheter-Associated Urinary Tract Infection (CAUTI) (ICU and Select Wards)	0.650	0.000	
HAI_5*+ (MRSA)	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified Events	0.726	0.000	
HAI_6*+ (C.diff)	Clostridium difficile (C.diff.)	0.520	0.014	
Pooled Surgical Site Infection (SSI) Measure:**				
HAI-3*+ (SSI - Colon)	Surgical Site Infection - Colon	0.717	0.000	1 Predicted Infection on One of the Two Strata
HAI-4*+ (SSI - Abd. Hyst.)	Surgical Site Infection - Abdominal Hysterectomy	0.738	0.000	

Clinical Outcomes

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MORT–30–AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (converted to survival rate for VBP)	86.9247%	88.7868%	25 Cases Each
MORT–30–HF	Heart Failure (HF) 30-Day Mortality Rate (converted to survival rate for VBP)	88.2308%	90.7733%	
MORT–30–PN	Pneumonia (PN) 30-Day Mortality Rate (converted to survival rate for VBP)	84.0281%	87.2976%	
MORT–30–COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate (converted to survival rate for VBP)	91.6491%	93.4002%	
MORT–30–CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate (converted to survival rate for VBP)	96.9499%	98.0319%	
COMP–HIP–KNEE*	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2.5396%	1.81590%	

Person and Community Engagement

Measure ID	Measure Description	Floor[3]	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
	Communication with Nurses[+]	53.50%	79.42%	87.71%	100 Surveys
	Communication with Doctors[+]	62.41%	79.83%	87.97%	
	Responsiveness of Hospital Staff[+]	40.40%	65.52%	81.22%	
	Communication about Medicines[+]	39.82%	63.11%	74.05%	
	Hospital Cleanliness & Quietness[+]	45.94%	65.63%	79.64%	
	Discharge Information[+]	66.92%	87.23%	92.21%	
	Overall Rating of Hospital[+]	36.31%	71.66%	85.39%	
CTM-3	3-Item Care Transitions Measure[+]	25.64%	51.84%	63.57%	

Efficiency and Cost Reduction

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MSPB-1*	Spending Per Hospital Patient With Medicare	Median Ratio Across All Hospitals***	Mean Ratio of Lowest Decile of Hospitals***	25 Cases

Total Performance Score: Original Domain Weighting[5]

Safety 25%
Clinical Outcomes 25%
Person and Community Engagement 25%
Efficiency and Cost Reduction 25%

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024

Person and Community Engagement: Baseline Period[6]
Person and Community Engagement: Performance Period[7]
Clinical Outcomes (Mortality): Baseline Period[6]
Clinical Outcomes (Mortality): Performance Period[#]
Excluded[#]
Clinical Outcomes (Mortality): Performance Period[7]
Clinical Outcomes (COMP-HIP-KNEE): Baseline Period[6]
Clinical Outcomes (COMP-HIP-KNEE) Performance Period[#]
Excluded[#]
Clinical Outcomes (COMP-HIP-KNEE): Performance Period[7]
Safety: Baseline Period[6]
Safety: Performance Period[7]
Efficiency and Cost Reduction: Baseline Period[6]
Efficiency and Cost Reduction: Performance Period[7]
FFY 2024 Payment Adjustment

[#]These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the VBP Program.

The Affordable Care Act (ACA) of 2010 mandated the implementation of an inpatient hospital value-based purchasing (VBP) Program. The VBP Program is a pay-for-performance program that links Medicare payment to quality performance for acute care hospitals paid under the Inpatient Prospective Payment System (IPPS). Under the VBP Program, using quality data grouped into quality domains, hospitals can earn points towards a Total Performance Score (TPS). The TPS will serve as the basis for determining hospitals' VBP payments or gain/loss under the program. In calculating the TPS, the scoring methodology provides points to hospitals that achieve high quality standards as well as points to hospitals that improve in the quality measures evaluated. As required by the ACA, a pool of funds, to be redistributed to hospitals based on their TPS, will be funded through an across-the-board reduction to Medicare IPPS base operating payments. The reduction has been capped at 2.0%. Critical Access Hospitals (CAHs), hospitals in Maryland and Puerto Rico, and small hospitals with insufficient numbers of measures and/or cases are excluded from the program.

[1]The Achievement Threshold is the minimum performance standard for each measure and reflects the median performance score (50th percentile) for all hospitals in the nation during the baseline period. The threshold is used in combination with other factors to calculate hospital-specific achievement points.

[2]The Benchmark is the top performance standard for each measure and reflects the average performance score for the top 10% of all hospitals in the nation during the baseline period. The benchmark is used in combination with other factors to calculate hospital-specific achievement and improvement points.

[3]The Floor is for Person and Community Engagement measures only and each measure reflects the lowest measure score in the nation during the baseline period. The floor is used in combination with other factors to calculate hospital-specific consistency points.

[4]Hospitals must meet minimum case and survey counts to be included in the VBP Program. In addition to the case count criteria, hospitals must have a minimum of 2 measures to obtain a Clinical Outcomes Domain score, 2 measures to obtain a Safety domain score and 1 measure to obtain an Efficiency and Cost Reduction domain score.

[5]The Domain Weight is a weight applied to each domain to calculate a hospital-specific TPS. A hospital's weighted TPS is compared to TPSs for all hospitals to determine the hospital-specific gain or loss under the program. If hospitals do not meet the minimum requirements on one or more domain, the other domains are proportionately reweighted to determine a TPS. Hospitals are required to be scored on 3 of the 4 domains to be eligible for the program.

[6]The Baseline Period is a specified period for which quality data will be evaluated. The baseline period data is used for determining the floors, achievement thresholds, and benchmarks (excluding the efficiency measure) and is also used in combination with other factors to calculate hospital-specific improvement points.

[7]The Performance Period is a specified period for which quality data will be evaluated. The performance period data is used in combination with other factors to calculate hospital-specific achievement and improvement points.

*For these measures, lower scores are better.

**The final SSI measure score is an aggregate of the calculated scores for HAI-3 and HAI-4, which are then weighted based on the predicted infections for each measure. For purposes of domain eligibility, CMS considers the two SSI measures as a single measure.

***Performance standards for the MSPB-1 measure are based on the performance period and are not released in advance of the program.

[+]More than Medicare Fee-For-Service patients are included in measure population.

©November 2023 DataGen®, Inc.

Value Based Purchasing (VBP) Overview: FFY 2025 Program

Measures, Performance Standards, Evaluation Periods, and Other Program Details for the FFY 2025 VBP Program

Safety

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
HAI_1*+ (CLABSI)	Central Line-Associated Blood Stream Infection (CLABSI) (ICU and Select Wards)	0.589	0.000	1 Predicted Infection Each
HAI_2*+ (CAUTI)	Catheter-Associated Urinary Tract Infection (CAUTI) (ICU and Select Wards)	0.650	0.000	
HAI_5*+ (MRSA)	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-Identified Events	0.726	0.000	
HAI_6*+ (C.diff)	Clostridium difficile (C.diff.)	0.520	0.014	
Pooled Surgical Site Infection (SSI) Measure:**				
HAI-3*+ (SSI - Colon)	Surgical Site Infection - Colon	0.717	0.000	1 Predicted Infection on One of the Two Strata
HAI-4*+ (SSI - Abd. Hyst.)	Surgical Site Infection - Abdominal Hysterectomy	0.738	0.000	

Clinical Outcomes

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (converted to survival rate for VBP)	87.2624%	88.9994%	25 Cases Each
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate (converted to survival rate for VBP)	88.3990%	91.0344%	
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate (converted to survival rate for VBP)	84.1475%	87.4425%	
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate (converted to survival rate for VBP)	91.5127%	93.2236%	
MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate (converted to survival rate for VBP)	97.0100%	97.9775%	
COMP-HIP-KNEE*	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2.5332%	1.7946%	

Person and Community Engagement

Measure ID	Measure Description	Floor[3]	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
	Communication with Nurses+	53.50%	79.42%	87.71%	100 Surveys
	Communication with Doctors+	62.41%	79.83%	87.97%	
	Responsiveness of Hospital Staff+	40.40%	65.52%	81.22%	
	Communication about Medicines+	39.82%	63.11%	74.05%	
	Hospital Cleanliness & Quietness+	45.94%	65.63%	79.64%	
	Discharge Information+	66.92%	87.23%	92.21%	
	Overall Rating of Hospital+	36.31%	71.68%	85.39%	
CTM-3	3-Item Care Transitions Measure+	25.64%	51.84%	63.57%	

Efficiency and Cost Reduction

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MSPB-1*	Spending Per Hospital Patient With Medicare	Median Ratio Across All Hospitals***	Mean Ratio of Lowest Decile of Hospitals***	25 Cases

Total Performance Score: Original Domain Weighting[5]

- Safety 25%
- Clinical Outcomes 25%
- Person and Community Engagement 25%
- Efficiency and Cost Reduction 25%

(Scale: 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%)

Timeline (2015–2025)

- Person and Community Engagement: Baseline Period[6] (2019); Person and Community Engagement: Performance Period[7] (2023)
- Clinical Outcomes (Mortality): Baseline Period[6]; Clinical Outcomes (Mortality): Performance Period[7]
- Clinical Outcomes (COMP-HIP-KNEE): Baseline Period[6]; Baseline[6]; Clinical Outcomes (COMP-HIP-KNEE): Performance Period[7]
- Safety: Baseline Period[6] (2019); Safety: Performance Period[7] (2023)
- Efficiency and Cost Reduction: Baseline Period[6] (2021); Efficiency and Cost Reduction: Performance Period[7] (2023)
- FFY 2025 Payment Adjustment (2025)

[a]These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the VBP Program.

The Affordable Care Act (ACA) of 2010 mandated the implementation of an inpatient hospital value-based purchasing (VBP) Program. The VBP Program is a pay-for-performance program that links Medicare payment to quality performance for acute care hospitals paid under the Inpatient Prospective Payment System (IPPS). Under the VBP Program, using quality data grouped into quality domains, hospitals can earn points towards a Total Performance Score (TPS). The TPS will serve as the basis for determining hospitals' VBP payments or gain/loss under the program. In calculating the TPS, the scoring methodology provides points to hospitals that achieve high quality standards as well as points to hospitals that improve in the quality measures evaluated. As required by the ACA, a pool of funds, to be redistributed to hospitals based on their TPS, will be funded through an across-the-board reduction to Medicare IPPS base operating payments. The reduction has been capped at 2.0%. Critical Access Hospitals (CAHs), hospitals in Maryland and Puerto Rico, and small hospitals with insufficient numbers of measures and/or cases are excluded from the program.

[1]The Achievement Threshold is the minimum performance standard for each measure and reflects the median performance score (50th percentile) for all hospitals in the nation during the baseline period. The threshold is used in combination with other factors to calculate hospital-specific achievement points.

[2]The Benchmark is the top performance standard for each measure and reflects the average performance score for the top 10% of all hospitals in the nation during the baseline period. The benchmark is used in combination with other factors to calculate hospital-specific achievement and improvement points.

[3]The Floor is for Person and Community Engagement measures only and each measure reflects the lowest measure score in the nation during the baseline period. The floor is used in combination with other factors to calculate hospital-specific consistency points.

[4]Hospitals must meet minimum case and survey counts to be included in the VBP Program. In addition to the case count criteria, hospitals must have a minimum of 2 measures to obtain a Clinical Outcomes Domain score, 2 measures to obtain a Safety domain score and 1 measure to obtain an Efficiency and Cost Reduction domain score.

[5]The Domain Weight is a weight applied to each domain to calculate a hospital-specific TPS. A hospital's weighted TPS is compared to TPSs for all hospitals to determine the hospital-specific gain or loss under the program. If hospitals do not meet the minimum requirements on one or more domain, the other domains are proportionately reweighted to determine a TPS. Hospitals are required to be scored on 3 of the 4 domains to be eligible for the program.

[6]The Baseline Period is a specified period for which quality data will be evaluated. The baseline period data is used for determining the floors, achievement thresholds, and benchmarks (excluding the efficiency measure) and is also used in combination with other factors to calculate hospital-specific improvement points.

[7]The Performance Period is a specified period for which quality data will be evaluated. The performance period data is used in combination with other factors to calculate hospital-specific achievement and improvement points.

*For these measures, lower scores are better.

**The final SSI measure score is an aggregate of the calculated scores for HAI-3 and HAI-4, which are then weighted based on the predicted infections for each measure. For purposes of domain eligibility, CMS considers the two SSI measures as a single measure.

***Performance standards for the MSPB-1 measure are based on the performance period and are not released in advance of the program.

+More than Medicare Fee-For-Service patients are included in measure population.

©November 2023 DataGen®, Inc.

Value Based Purchasing (VBP) Overview: FFY 2026 Program

Measures, Performance Standards, Evaluation Periods, and Other Program Details for the FFY 2026 VBP Program

FFY 2026 is the first year of the Health Equity Adjustment (HEA) bonus points. More detail is on the VBP Program Methodology page.

Safety

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
HAI_1*[+] (CLABSI)	Central Line-Associated Blood Stream Infection (CLABSI) (ICU and Select Wards)	0.760	0.000	1 Predicted Infection Each
HAI_2*[+] (CAUTI)	Catheter-Associated Urinary Tract Infection (CAUTI) (ICU and Select Wards)	0.615	0.000	
HAI_5*[+] (MRSA)	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified Events	0.793	0.000	
HAI_6*[+] (C.diff)	Clostridium difficile (C.diff.)	0.423	0.000	
Pooled Surgical Site Infection (SSI) Measure:**				
HAI-3*[+] (SSI - Colon)	Surgical Site Infection - Colon	0.747	0.000	1 Predicted Infection on One of the Two Strata
HAI-4*[+] (SSI - Abd. Hyst.)	Surgical Site Infection - Abdominal Hysterectomy	0.763	0.000	
SEP-1	Severe Sepsis and Septic Shock: Management Bundle	0.597482	0.843620	25 Cases

Clinical Outcomes

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (converted to survival rate for VBP)	87.4426%	89.0687%	25 Cases Each
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate (converted to survival rate for VBP)	88.5949%	91.2874%	
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate (converted to survival rate for VBP)	84.3369%	87.7097%	
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate (converted to survival rate for VBP)	91.4691%	93.2157%	
MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate (converted to survival rate for VBP)	97.0568%	98.0473%	
COMP-HIP-KNEE*	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2.4019%	1.6873%	

Person and Community Engagement

Measure ID	Measure Description	Floor[3]	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
	Communication with Nurses[+]	55.23%	76.41%	85.57%	100 Surveys
	Communication with Doctors[+]	58.04%	76.83%	85.93%	
	Responsiveness of Hospital Staff[+]	36.52%	59.56%	77.19%	
	Communication about Medicines[+]	33.27%	58.06%	70.11%	
	Hospital Cleanliness & Quietness[+]	38.59%	62.61%	77.49%	
	Discharge Information[+]	63.22%	85.54%	91.10%	
	Overall Rating of Hospital[+]	31.58%	67.59%	83.16%	
CTM-3	3-Item Care Transitions Measure[+]	19.98%	48.55%	60.85%	

Efficiency and Cost Reduction

Measure ID	Measure Description	Achievement Threshold[1]	Benchmark[2]	Minimum Standards[4]
MSPB-1*	Spending Per Hospital Patient With Medicare	Median Ratio Across All Hospitals***	Mean Ratio of Lowest Decile of Hospitals***	25 Cases

Total Performance Score: Original Domain Weighting[5]

Domain	Weight
Safety	25%
Clinical Outcomes	25%
Person and Community Engagement	25%
Efficiency and Cost Reduction	25%

Timeline (2016–2026)

Period	Timing
Person and Community Engagement: Baseline Period[6]	2022
Person and Community Engagement: Performance Period[7]	2024
Clinical Outcomes (Mortality): Baseline Period[6]	2016–2019
Clinical Outcomes (Mortality): Performance Period[7]	2021–2024
Clinical Outcomes (COMP-HIP-KNEE): Baseline Period[6]	2016–2019
Clinical Outcomes (COMP-HIP-KNEE): Performance Period[7]	2021–2024
Safety: Baseline Period[6]	2022
Safety: Performance Period[7]	2024
Efficiency and Cost Reduction: Baseline Period[6]	2022
Efficiency and Cost Reduction: Performance Period[7]	2024
FFY 2026 Payment Adjustment	2026

The Affordable Care Act (ACA) of 2010 mandated the implementation of an inpatient hospital value-based purchasing (VBP) Program. The VBP Program is a pay-for-performance program that links Medicare payment to quality performance for acute care hospitals paid under the Inpatient Prospective Payment System (IPPS). Under the VBP Program, using quality data grouped into quality domains, hospitals can earn points towards a Total Performance Score (TPS). The TPS will serve as the basis for determining hospitals' VBP payments or gain/loss under the program. In calculating the TPS, the scoring methodology provides points to hospitals that achieve high quality standards as well as points to hospitals that improve in the quality measures evaluated. As required by the ACA, a pool of funds, to be redistributed to hospitals based on their TPS, will be funded through an across-the-board reduction to Medicare IPPS base operating payments. The reduction has been capped at 2.0%. Critical Access Hospitals (CAHs), hospitals in Maryland and Puerto Rico, and small hospitals with insufficient numbers of measures and/or cases are excluded from the program.

[1]The Achievement Threshold is the minimum performance standard for each measure and reflects the median performance score (50th percentile) for all hospitals in the nation during the baseline period. The threshold is used in combination with other factors to calculate hospital-specific achievement points.

[2]The Benchmark is the top performance standard for each measure and reflects the average performance score for the top 10% of all hospitals in the nation during the baseline period. The benchmark is used in combination with other factors to calculate hospital-specific achievement and improvement points.

[3]The Floor is for Person and Community Engagement measures only and each measure reflects the lowest measure score in the nation during the baseline period. The floor is used in combination with other factors to calculate hospital-specific consistency points.

[4]Hospitals must meet minimum case and survey counts to be included in the VBP Program. In addition to the case count criteria, hospitals must have a minimum of 2 measures to obtain a Clinical Outcomes Domain score, 2 measures to obtain a Safety domain score and 1 measure to obtain an Efficiency and Cost Reduction domain score.

[5]The Domain Weight is a weight applied to each domain and combined with HEA bonus points to calculate a hospital-specific TPS. A hospital's weighted TPS is compared to TPSs for all hospitals to determine the hospital-specific gain or loss under the program. If hospitals do not meet the minimum requirements on one or more domain, the other domains are proportionately reweighted to determine a TPS. Hospitals are required to be scored on 3 of the 4 domains to be eligible for the program.

[6]The Baseline Period is a specified period for which quality data will be evaluated. The baseline period data is used for determining the floors, achievement thresholds, and benchmarks (excluding the efficiency measure) and is also used in combination with other factors to calculate hospital-specific improvement points.

[7]The Performance Period is a specified period for which quality data will be evaluated. The performance period data is used in combination with other factors to calculate hospital-specific achievement and improvement points.

*For these measures, lower scores are better.

**The final SSI measure score is an aggregate of the calculated scores for HAI-3 and HAI-4, which are then weighted based on the predicted infections for each measure. For purposes of domain eligibility, CMS considers the two SSI measures as a single measure.

***Performance standards for the MSPB-1 measure are based on the performance period and are not released in advance of the program.

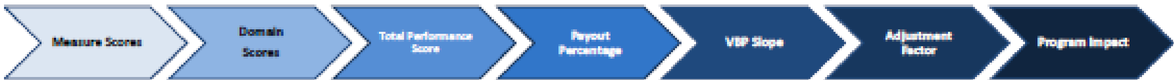
[+]More than Medicare Fee-For-Service patients are included in measure population.

©November 2023 DataGen®, Inc.

Value Based Purchasing (VBP) General Program Methodology

Hospital Scoring Methods and Other Program Details for the VBP Program

As required by the ACA, VBP eligible hospitals contribute a set percentage of their Medicare IPPS base operating payments to a national VBP pool of dollars. All VBP pool dollars are then paid out, in full, based on each hospital's performance. Hospitals are evaluated on a measure by measure basis and receive a score of 0-10 on each measure where they meet each measure's minimum requirement. Next, similar measures are grouped into domains and overall domain scores are calculated based on the average measure score in the domain. Domain scores are then combined to find a Total Performance Score (TPS). The TPS serves as the basis for determining hospitals' VBP payments or gain/loss. Using all program-eligible hospitals' Total Performance Scores, CMS calculates a VBP slope that redistributes all VBP contributions and makes the program budget neutral nationally. Each hospital's TPS multiplied by the slope determines payout percentages. The program methodology is shown below:



Measure Score Calculation

For each measure, hospitals can receive a score of 0-10 depending on where they fall in relation to national performance standards (achievement points) and/or how much they have improved from historical rates/ratios (improvement points). After achievement and improvement points are calculated, the higher of the two determines final points for each measure.

$$\textbf{Achievement Points (all program measures)} = \left[9 \times \left[\frac{\text{Performance Period Score - Achievement Threshold}}{\text{Benchmark - Achievement Threshold}}\right] + 0.5\right.$$

$$\textbf{Improvement Points (all program measures)} = \left[10 \times \left[\frac{\text{Performance Period Score - Baseline Period Score}}{\text{Benchmark - Baseline Period Score}}\right] - 0.5\right.$$

Final Points (all program measures) = Higher of Achievement or Improvement

$$\textbf{Final Points (SSI Measure)} = \left[\frac{\text{Final Points}_{[illegible]} \times \text{Predicted Infections}_{[illegible]} + \text{Final Points}_{[illegible]} \times \text{Predicted Infections}_{[illegible]}}{\text{Predicted Infections}_{[illegible]} + \text{Predicted Infections}_{[illegible]}}\right]$$

Person and Community Engagement - Consistency Points Calculation

In addition to individual measure scores, the Person and Community Engagement domain scores hospitals based on how consistently they perform across all measures within the domain. Each hospital can receive between 0-20 consistency points based on the measure with the lowest Consistency Multiplier calculated as shown below:

Consistency Points (person and community engagement) = [20 x Lowest Measure Consistency Points Multiplier] - 0.50

$$\textbf{Consistency Points Multiplier (person and community engagement)} = \left[\frac{\text{Performance Period Score - Floor}}{\text{Achievement Threshold - Floor}}\right]$$

FFY 2026+: Health Equity Adjustment (HEA) Bonus Points

FFY 2026+: Hospitals will be awarded for excellent care in underserved populations. If a hospital is in the top third, middle third, or bottom third of performance of all hospitals within a domain, the hospital will be awarded 4, 2, or 0 points, respectively. The sum of these points are called the "measure performance scaler". The maximum amount of points a hospital can receive is 16 (12 if they are eligible for only 3 of the 4 domains). The "underserved multiplier" is the number of inpatient stays for dual eligible patients out of the total inpatient Medicare stays during the calendar year 2 years prior to the start of the respective program year. Dual eligible patients are identified using the State Medicare Modernization Act file of dual eligible beneficiaries. CMS will use a logistic exchange function to calculate the underserved multiplier so that there would be a lower rate of increase at the beginning and the end of the curve. The measure performance scaler is multiplied by the underserved multiplier to determine the HEA bonus points.

Measure Performance Scalar = Domain₁ HEA points + Domain₂ HEA points... + Domain₄ HEA points

$$\textbf{Underserved Multiplier} = \frac{1}{1 + e^{-\left(-5 + 10 \cdot \frac{\text{Dual Rank}}{\text{Max Dual Rank}}\right)}}$$

Health Equity Adjustment (HEA) bonus points = Measure performance scaler x underserved multiplier

Domain Score and Total Performance Score (TPS) Calculation

Individual measure scores for similar measures are combined to find overall Domain scores. On each domain, a minimum number of measures must be scored in order to be eligible for the domain. Once domain scores are calculated, a total performance score is calculated, combining domain scores based on the program year's applicable domain weights. Hospitals are required to be scored on 3 of the 4 domains. Domain weights are reweighted proportionally when hospitals are not eligible for one or more domains.

FFY 2026+: The total performance score calculation will be the sum of the domain scores based on the program year's applicable weights and the health equity adjustment bonus points that the hospital earned.

$$\textbf{Overall Domain Score} = \left[\frac{\text{Sum of Final Points Earned on Each Scored Measure}}{\text{Maximum Possible Points on Each Scored Measure}}\right]$$

$$\textbf{Proportionally Reweighted Domain Weight (FFY 2015+)} = \left[\frac{\text{Original Weight of Domain}}{\text{Sum of Original Weights for all Scored Domains}}\right]$$

$$\textbf{Total Performance Score (TPS)} = [\text{Domain}_1 \text{ Score} \times \text{Domain}_1 \text{Weight} + \text{Domain}_2 \text{ Score} \times \text{Domain}_2 \text{Weight} \ldots \text{Domain}_N \text{ Score} \times \text{Domain}_N \text{ Weight}]$$

FFY 2026+ TPS = Total of Weight Domain Scores (above) + HEA bonus points

VBP Slope/Linear Function, Payout Percentage, Adjustment Factor, and Program Impact Calculation

Once TPS scores are calculated for all eligible hospitals, the VBP slope is calculated such that all program contributions are paid out, making the program budget neutral nationally. The VBP slope/linear function is used to determine each hospitals payout percentage (the amount of their contribution to the VBP pool they receive back) as well as final adjustment factors, and impacts.

VBP Linear Function (Payout Percentage) = [Total Performance Score x VBP Slope]

VBP Adjustment Factor = [1 + (Program Contribution Percentage x Payout Percentage) − Program Contribution Percentage]

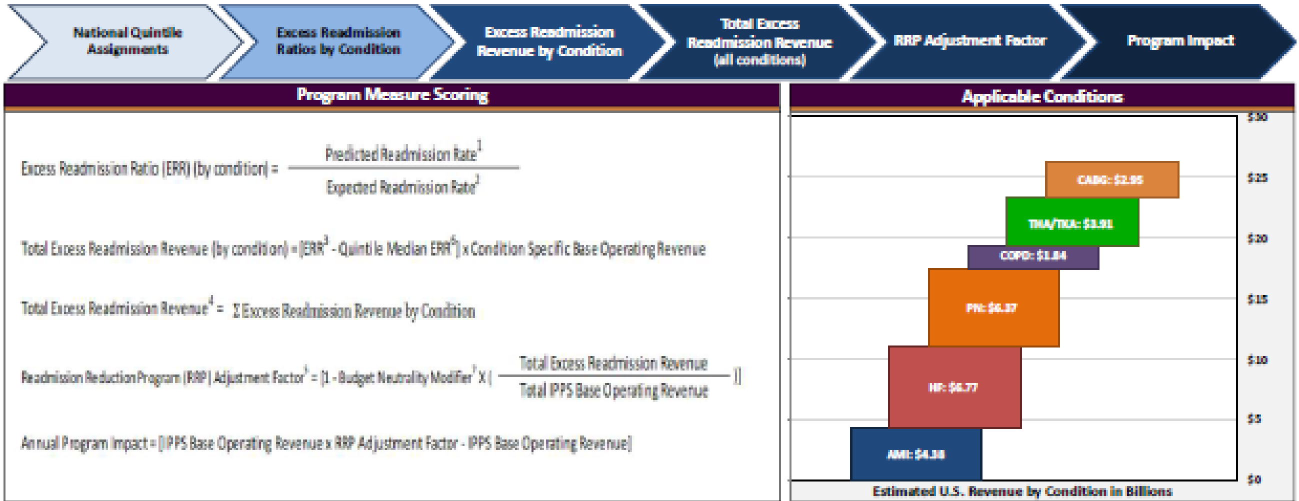
Annual Program Impact = [IPPS Base Operating Dollars x VBP Adjustment Factor − IPPS Base Operating Dollars]

©November 2023 DataGen®, Inc.

Readmission Reduction Program (RRP) Overview

Applicable conditions, performance timeframes, and other details for the FFY 2024, 2025, and 2026 programs

The Readmission Reduction Program (RRP) adjusts Medicare inpatient payments based on hospital readmission rates for several conditions. This program is punitive only and does not give hospitals credit for improvement over time. First, CMS assigns hospitals to national quintiles based on their ratio of full-benefit dual eligible patients to all Medicare patients. Then, CMS compares hospital risk-adjusted readmission rates to national rates to calculate excess readmission ratios for each condition. Next, CMS compares each excess ratio to the condition specific median excess ratio of the hospital's national quintile and applies the result to aggregate payments for each condition to find excess readmission dollars by condition. The sum of all excess readmission dollars for all applicable conditions divided by all inpatient operating revenue with a budget neutrality modifier applied determines program adjustment factors/impacts under the program. There is a socio-demographic status (SDS) in the RRP program. The program methodology is shown below:



Applicable Conditions

Readmission rates, aggregate payments by condition, and excess readmission dollars by condition are all defined by a predetermined list of procedure and/or diagnoses codes specific to each condition, excluding certain planned readmissions or regular, scheduled follow up care. The following patients are also excluded from the rates/revenue estimates used to calculate program adjustments for all measures: patients who are not enrolled in Medicare fee-for-service (FFS); patients under the age of 65; patients without at least 30 days enrollment post-discharge in a Medicare FFS plan; patients who were discharged against medical advice (AMA); certain patients who were transferred to/from another inpatient hospital.

A hospital must have an applicable period of three years of discharge data and at least 25 cases in order to calculate an excess readmission ratio for each applicable condition. Each additional condition added to the program increases the revenue exposed and the potential for excess readmissions that results in penalties under the program. The total estimated revenue across all hospitals for each condition is shown in the graph above to indicate the relative magnitude of each condition under the program.

Program Timelines

2019	2020	2021	2022	2023	2024	2025	2026
FFY 2024 Program Performance Period	Excluded* / FFY 2024 Program (All Conditions)	FFY 2024 Program (All Conditions)	FFY 2024 Program (All Conditions)		FFY 2024 Program Payment Adjustment		
	FFY 2025 Program (All Conditions)	FFY 2025 Program (All Conditions)	FFY 2025 Program (All Conditions)	FFY 2025 Program (All Conditions)		FFY 2025 Program Payment Adjustment	
		FFY 2026 Program Performance Period (All Conditions)	FFY 2026 Program Performance Period (All Conditions)	FFY 2026 Program Performance Period (All Conditions)	FFY 2026 Program Performance Period (All Conditions)		FFY 2026 Program Payment Adjustment

*These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for RRP.

Notes:

[1]Predicted Readmission Rate - Reflects the hospital's risk-adjusted, observed 30-day readmission rate following inpatient discharges for each applicable condition. Rates are risk adjusted for age, sex, comorbidities, and other patient characteristics that may contribute to higher readmission rates. These rates also exclude readmissions that are a result of planned follow up care, or unrelated readmissions that are never related to the index admission. Predicted rates reflect performance for the three year period shown above.

[2]Expected Readmission Rate - Reflects the U.S. 30-day readmission rate for each condition with hospital specific risk adjustments to estimate the expected U.S. readmission rate for each hospital's patient mix. Rates are risk adjusted for age, sex, comorbidities, and other patient characteristics that may contribute to higher readmission rates. These rates also include exclusions for readmissions that are a result of planned follow up care, or unrelated readmissions that are never related to the index admission. Expected rates reflect adjusted national performance for the three year period shown above.

[3]Excess Readmission Ratio - Calculated for each condition under the program, this ratio represents how each hospital's actual, observed readmission rate differs from the rate for all U.S. hospitals, adjusted for case-mix. An excess ratio greater than one indicates poorer performance than the country and results in payment penalties while an excess ratio less than one indicates better performance and has no effect on payment.

[4]Excess Readmission Revenue - Reflects the portion of revenue for each condition CMS believes was paid due to excess readmissions. Excess readmission revenue is a function of base operating revenue for the condition and the excess ratio on the condition. Base operating dollars reflect operating payments without adjustments for DSH, IME, or outlier payments.

[5]Readmission Reduction Program Adjustment Factor - Under the RRP program, adjustment factors are calculated by dividing total excess readmission dollars (all conditions) by total base operating dollars for all patients for the same three year performance period as measured by the readmission rates. Adjustment factors are used to reduce IPPS payments on a per-discharge basis for performance under the program. CMS currently sets an adjustment factor floor of 0.9700, or a 3.0% payment penalty.

[6]Quintile Median Excess Readmission Ratio - A hospital is placed into a quintile based on their ratio of full-benefit dual eligible patients to total Medicare patients (including Medicare Fee-For-Service and Medicare Advantage stays) over the three year program performance period. A median excess readmission ratio is calculated for each quintile for each condition. A hospital's own excess readmission ratio for each condition will be compared to the condition-specific quintile median excess readmission ratio to determine total excess readmission revenue.

[7]Budget Neutrality Modifier - A budget neutrality modifier is calculated such that the total Medicare savings using socio-demographic status adjustment methodology are equal to what the total Medicare savings would have been if the previous RRP methodology was used. This budget neutrality modifier is applied to each hospital's RRP adjustment factor.

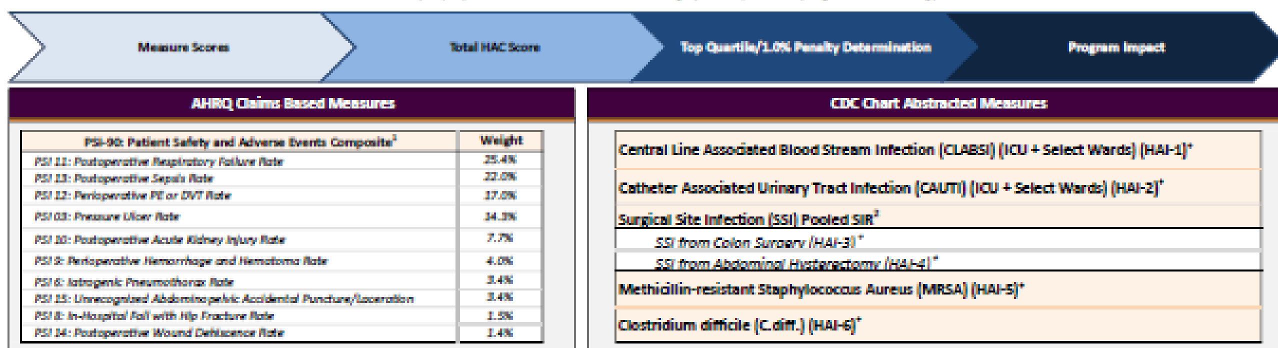
Readmission rates, aggregate payments by condition, and excess readmission dollars by condition are all defined by a predetermined list of procedure/diagnoses codes specific to each condition. For each condition, condition-specific exclusions and adjustments may apply. Full detail on measure methodology as well as applicable ICD-10 codes for each condition are provided here: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

©November 2023 DataGen®, Inc.

Hospital Acquired Condition (HAC) Reduction Program Overview

Applicable conditions, performance timeframes, and other details for the FFYs 2024, 2025 and 2026 programs

The Hospital Acquired Condition (HAC) Reduction Program sets payment penalties each year for hospitals in the top quartile (worst performance) of HAC rates for the country. The HAC reduction program is punitive only and does not give hospitals credit for improvement over time. Under the program, hospitals are compared to the nation measure by measure on their z-score. Available measure scores are equally weighted to determine a total HAC score. The total HAC score is used to determine the top quartile (worst performance) for payment penalty in each year. The HAC payment penalty is 1.0% of total Medicare Fee-For-Service (FFS) inpatient revenue and does not change year to year. The program methodology is shown below:



AHRQ Claims Based Measures

PSI-90: Patient Safety and Adverse Events Composite[1]	Weight
PSI 11: Postoperative Respiratory Failure Rate	25.4%
PSI 13: Postoperative Sepsis Rate	22.0%
PSI 12: Perioperative PE or DVT Rate	17.0%
PSI 03: Pressure Ulcer Rate	14.3%
PSI 10: Postoperative Acute Kidney Injury Rate	7.7%
PSI 9: Perioperative Hemorrhage and Hematoma Rate	4.0%
PSI 6: Iatrogenic Pneumothorax Rate	3.4%
PSI 15: Unrecognized Abdominopelvic Accidental Puncture/Laceration	3.4%
PSI 8: In-Hospital Fall with Hip Fracture Rate	1.5%
PSI 14: Postoperative Wound Dehiscence Rate	1.4%

CDC Chart Abstracted Measures

CDC Chart Abstracted Measures
Central Line Associated Blood Stream Infection (CLABSI) (ICU + Select Wards) (HAI-1)[+]
Catheter Associated Urinary Tract Infection (CAUTI) (ICU + Select Wards) (HAI-2)[+]
Surgical Site Infection (SSI) Pooled SIR[2]
SSI from Colon Surgery (HAI-3)[+]
SSI from Abdominal Hysterectomy (HAI-4)[+]
Methicillin-resistant Staphylococcus Aureus (MRSA) (HAI-5)[+]
Clostridium difficile (C.diff.) (HAI-6)[+]

Measure Scoring

HAC ratios for all program-eligible hospitals nationwide are assigned winsorized z-scores. A z-score represents how different a hospital performed compared to the national average, in terms of standard deviations from the mean: poor performance = positive z-score (worse than national average) and good performance = negative z-score (better than national average). Lower z-scores are better. Winsorization is intended to remove the effects of extreme outliers. CMS chose to do this by setting all z-score values below the 5th percentile to the 5th percentile value, and above the 95th percentile to the 95th percentile value.

In order to receive a score on a measure, hospitals must meet minimum requirements. In the FFY 2023 IPPS Final Rule, CMS finalized that for PSI-90 a hospital must have one or more component PSI measures that make up the PSI-90 measure with at least 25 eligible discharges and seven or more component PSI measures with at least 3 eligible discharges. For HAI, a hospital must have 1 or more predicted infections for each measure (1 or more pooled predicted infection for SSI).

Measure z-scores are weighted equally to calculate a total HAC score and are proportionally re-weighted when a hospital is missing one or more measures.

*Measures not meeting the minimum scoring requirements are dropped from the total HAC score calculation. Hospitals receive the maximum score for any HAI measure that is not submitted, unless provided with a waiver.

Other Program Calculations

$$\textbf{Pooled Standardized Infection Ratio (SIR)} \text{ (SSI measures only)} = \frac{\text{(Observed Infections for Abdominal Hysterectomy + Observed Infections for Colon)}}{\text{(Predicted Infections for Abdominal Hysterectomy + Predicted Infections for Colon)}}$$

$$\textbf{Total HAC Score}^{3} = \Sigma \text{ Measure Score x Measure Weight}$$

$$\textbf{Annual Program Impact}^{4} = \text{Total Medicare FFS Inpatient Dollars x 1.0\% - Total Medicare FFS Inpatient Dollars}$$

$$\textbf{Z-score}^{5} = \frac{\text{(Hospital's Measure Performance} - \text{Mean Performance for All Hospitals)}}{\text{Standard Deviation for All Hospitals}}$$

Program Timelines

Timeline: 2020 – 2026, by month (J F M A M J J A S O N D).

- Excluded[#] (Jul 2020 – Dec 2020)
- FFY 2024: PSI-90 Performance Period (Jan 2021 – Jun 2022)
- Excluded[#] (Jan 2021 – Dec 2021)
- FFY 2024: HAI Measures Performance Period (Jan 2022 – Dec 2022)
- FFY 2024 Program Payment Adjustment (Oct 2023 – Sep 2024)
- FFY 2025: PSI-90 Performance Period (Jul 2021 – Jun 2023)
- FFY 2025: HAI Measures Performance Period (Jan 2022 – Dec 2023)
- FFY 2025 Program Payment Adjustment (Oct 2024 – Sep 2025)
- FFY 2026: PSI-90 Performance Period (Jul 2022 – Jun 2024)
- FFY 2026: HAI Measures Performance Period (Jan 2023 – Dec 2024)
- FFY 2026 Program Payment Adjustment (Oct 2025 – Sep 2026)

[#]These performance periods are impacted by CMS' adoption in the FFY 2022 IPPS Final Rule to suppress data from July 1, 2020 - December 31, 2020 due to the COVID-19 PHE for the HAC program. CMS also suppressed CY 2021 data for the HAI measures in the FFY 2023 IPPS Final Rule.

Notes:

[1]The modified PSI-90 composite measure is calculated by combining performance on 10 individual Patient Safety Indicator (PSI) measures. While hospitals are scored on the overall PSI-90 composite measure, each component PSI and their weight towards the overall composite are shown above. Weights shown are based on version 12.0 of the AHRQ Quality Indicators software.

[2]The pooled Surgical Site Infection (SSI) measure is made up of two individual SSI measures: SSI - Abdominal Hysterectomy and SSI - Colon. For the pooled SIR measure, observed infections for both SSI measures are divided by predicted infections to calculate a pooled SIR. Hospitals are then evaluated and assigned measure points based on their pooled SIR.

[3]CMS applies an equal weight to each measure for which a hospital has a measure score.

[4]Unlike the Value Based Purchasing (VBP) and Readmission Reduction Program (RRP), penalties under the HAC program are applied to total Medicare inpatient fee-for-service payments, inclusive of operating, capital, uncompensated care payments, outlier payments, DSH, IME, and VBP/RRP program adjustments.

[5]Individual measure scores are assigned a z-score that represent how different a hospital performed relative to the national average in terms of standard deviation from the mean. Z-scores are winsorized to remove extreme outliers.

[+]More than Medicare Fee-For-Service patients are included in measure population.

©November 2023 DataGen®, Inc.