Hospital VBP Program: How to Read Your FY 2026 Baseline Measures Report

Program Overview

The Hospital Value-Based Purchasing (VBP) Program is authorized by Section 1886(o) of the Social Security Act. The Hospital VBP Program is the nation's first national pay-for-performance program for acute care hospitals. The program serves as an important driver in redesigning how the Centers for Medicare & Medicaid Services (CMS) pays for care and services. It is based on the quality and value of care, not only the quantity of services provided.

Purpose of the Baseline Measures Report

The Hospital VBP Program Baseline Measures Report allows providers to review their performance for all domains and measures included in the Hospital VBP Program in comparison to the achievement threshold and benchmark performance standards that are used to determine achievement and improvement points.

Fiscal Year (FY) 2026 Measurement Periods

The baseline and performance periods for FY 2026 measures are outlined below.

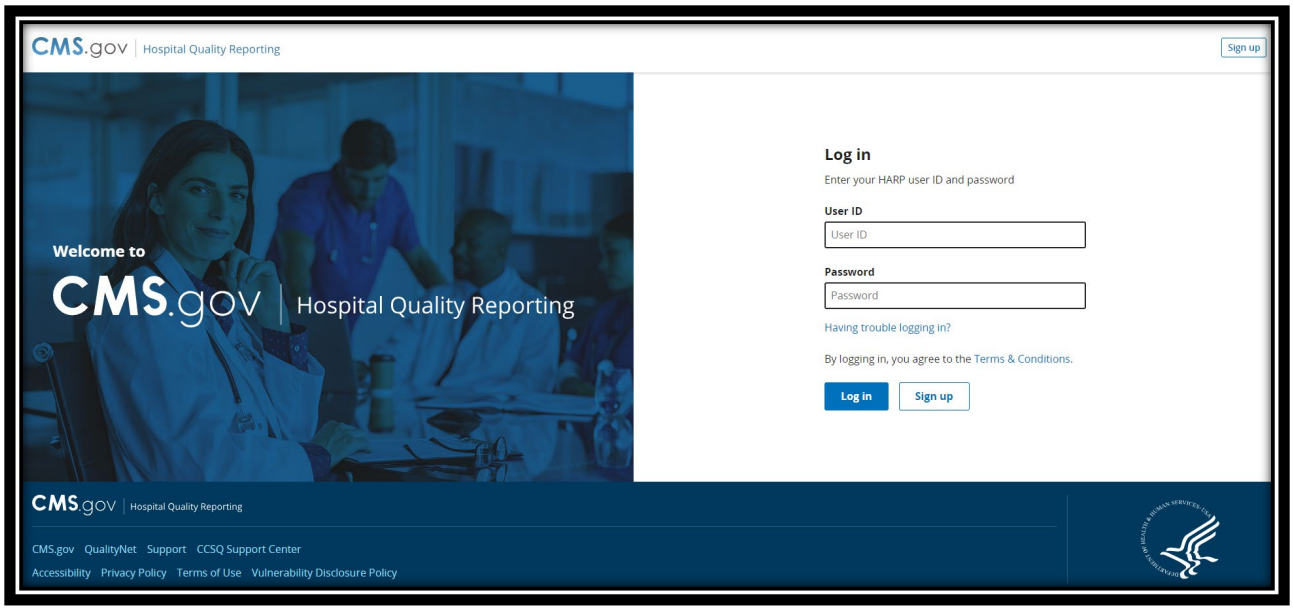
Domain/Measure Description	Baseline Period	Performance Period
Clinical Outcomes: 30-Day Mortality measures for: • Acute Myocardial Infarction (AMI) • Coronary Bypass Graft (CABG) Surgery • Chronic Obstructive Pulmonary Disease (COPD) • Heart Failure (HF • Pneumonia (PN)	July 1, 2016– June 30, 2019	July 1, 2021– June 30, 2024
Clinical Outcomes: Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complication measure	April 1, 2016– March 31, 2019	April 1, 2021– March 31, 2024
Person and Community Engagement: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey dimensions	January 1, 2022– December 31, 2022	January 1, 2024– December 31, 2024
Safety: Healthcare-Associated Infection (HAI) measures including: • Catheter-Associated Urinary Tract Infection (CAUTI) • Central line-associated Bloodstream Infection (CLABSI) • Harmonized Procedure Specific Surgical Site Infection (SSI) • Facility- wide Inpatient Hospital-onset MRSA Bacteremia • Facility-wide Inpatient Hospital-	January 1, 2022– December 31, 2022	January 1, 2024– December 31, 2024

onset Clostridium difficile Infection (CDI) Process of Care Measure: • Severe Sepsis and Septic Shock Management Bundle (Composite Measure) (SEP-1)		
Efficiency and Cost Reduction: Medicare Spending per Beneficiary (MSPB) Hospital measure	January 1, 2022–December 31, 2022	January 1, 2024–December 31, 2024

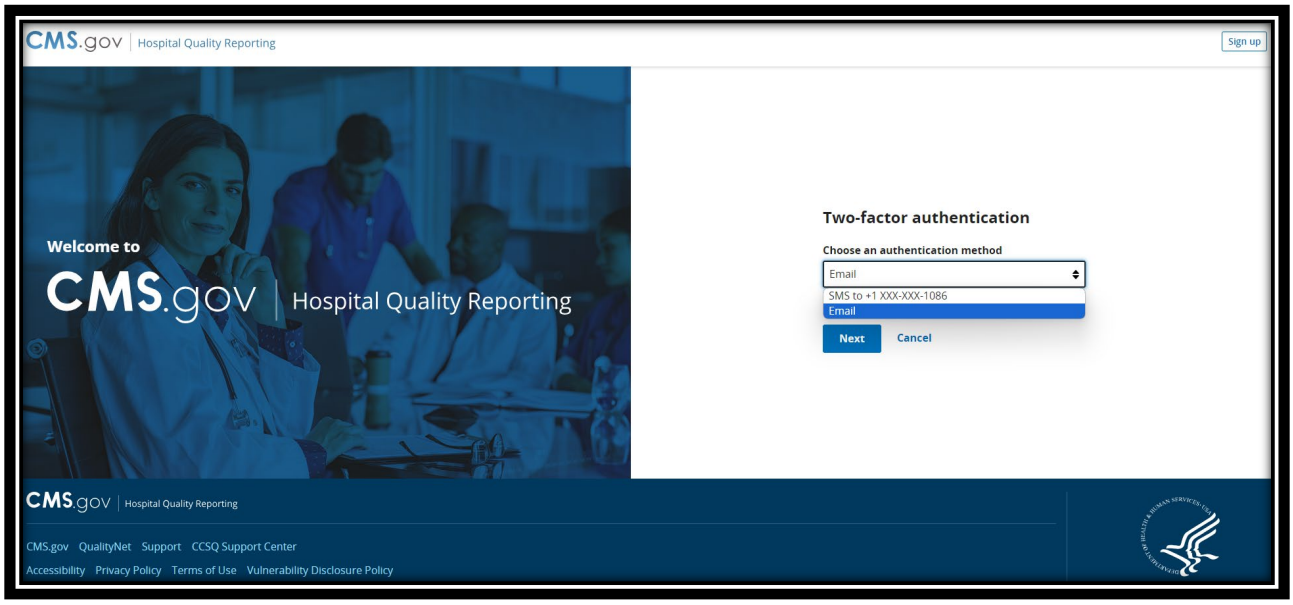
Accessing the Baseline Measures Report

Access your hospital's FY 2026 Hospital VBP Program baseline data by following these steps:

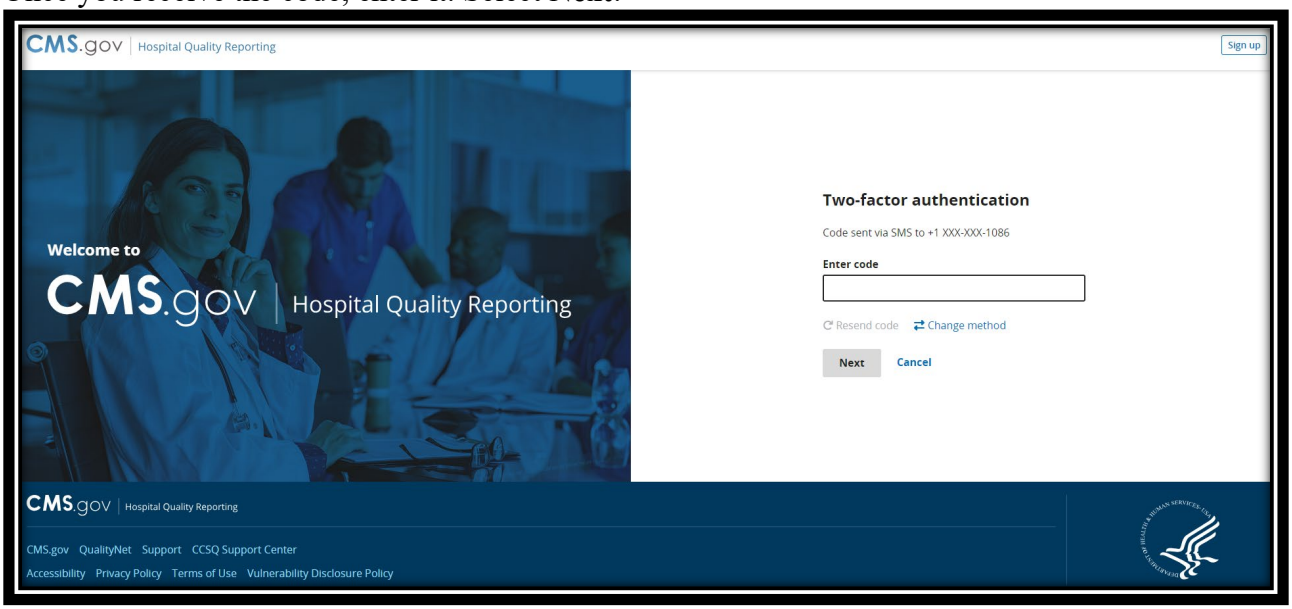
1. Navigate to the Hospital Quality Reporting (HQR) page for QualityNet at https://hqr.cms.gov/hqrng/login.
2. Enter your Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) User ID and Password. Then, select **Log in**.



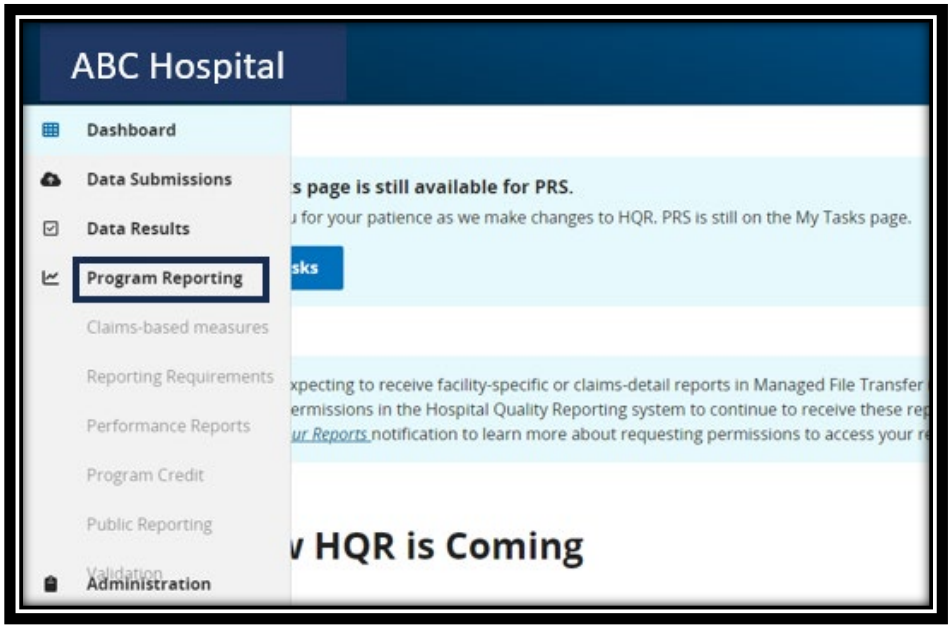
3. This will direct you to the **Two-Factor Authorization page**. Select the device you would like to use to retrieve the verification code. Select **Next**.



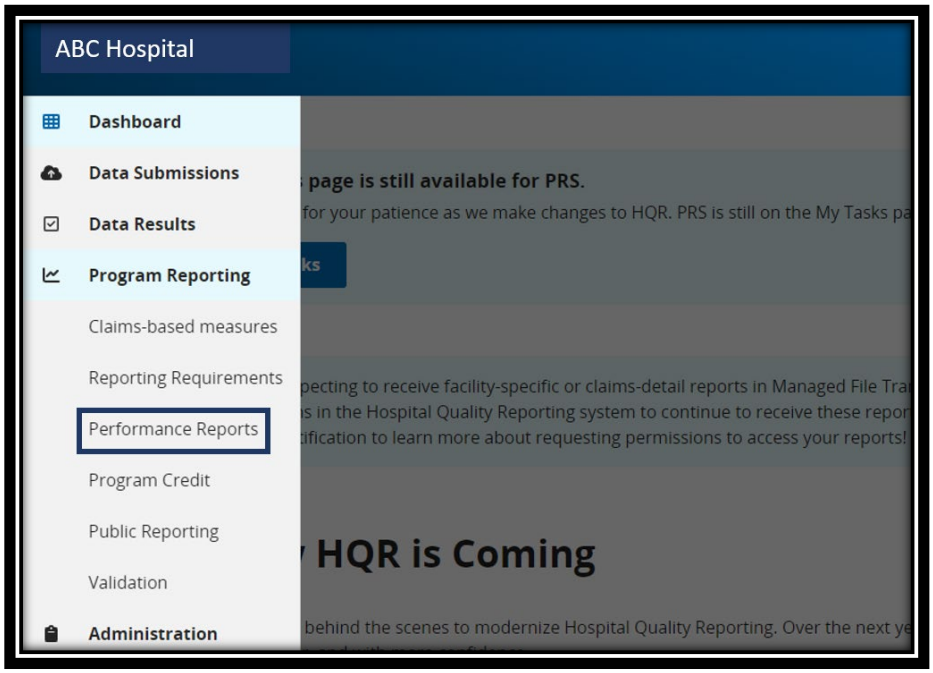
4. Once you receive the code, enter it. Select **Next**.



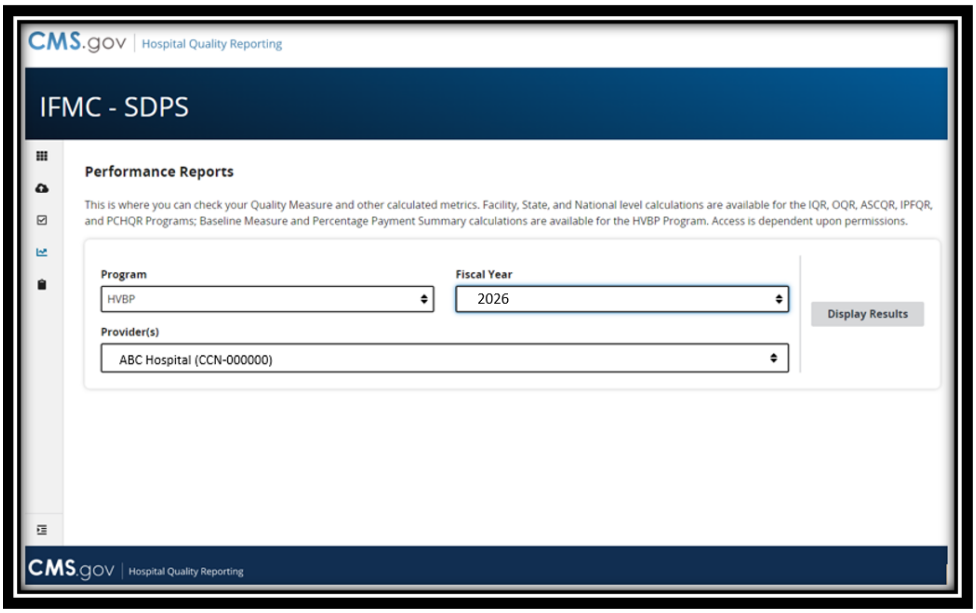
5. To expand the menu options on the HQR landing page, select **Program Reporting** from the left-side navigation menu.



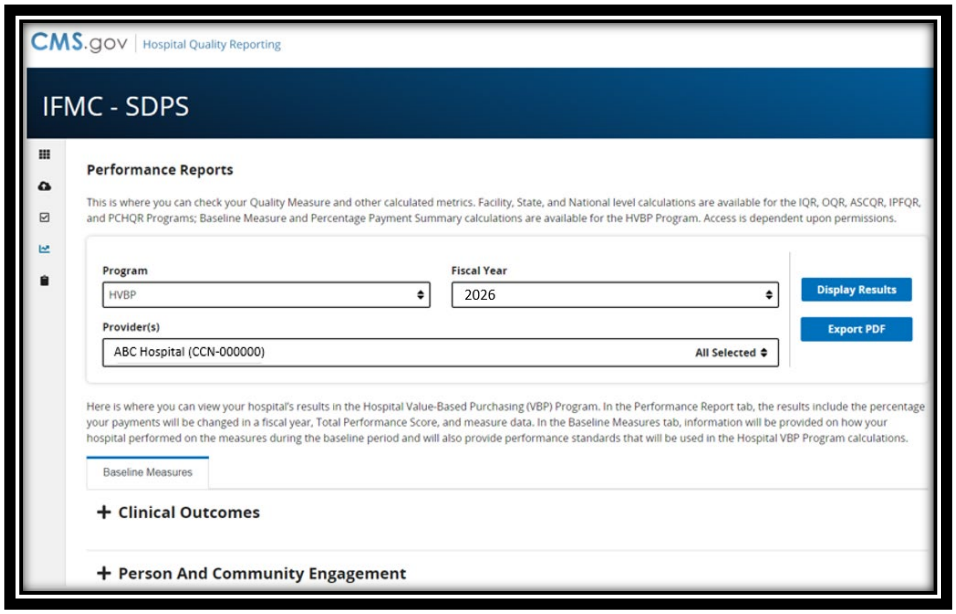
6. From the expanded Program Reporting drop-down menu, select **Performance Reports**.



7. Select **Hospital Value-Based Purchasing (HVBP)** from the Program selection menu; select **2026** from the Fiscal Year selection menu. Then, select your hospital from the Provider(s) selection menu if that option displays. Select **Display Results**.



8. To export the displayed data, select the **Export PDF** option available on the User Interface. The exported data will be available in a PDF format to save and print.



Baseline Measures Report

The hospital's **Baseline Measures Report** includes the following sections:

1. The **Clinical Outcomes domain** provides details on the Clinical Outcomes measures, including the number of eligible discharges and the baseline period rates. The achievement threshold and benchmark for each Clinical Care measure also display.
2. The **Person and Community Engagement domain** provides details on the eight HCAHPS dimensions, including baseline period rates, floor values, achievement thresholds, and benchmarks. The number of completed surveys also displays.

3. The **Safety Measures domain** provides details on the HAI measures, including Catheter-Associated Urinary Tract Infection (CAUTI), Central Line-Associated Bloodstream Infection (CLABSI), Clostridium difficile Infection (CDI), Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia, Surgical Site Infection (SSI)-Abdominal Hysterectomy, and SSI-Colon Surgery. These details include the number of observed infections, number of predicted infections, as well as standardized infection ratios (SIRs), achievement thresholds, and benchmarks.

   Note: The SSI measure is a single measure stratified by surgery site for colon surgeries and abdominal hysterectomies. For the purpose of the Hospital VBP Program, CMS scores the measure as a weighted average of each of the stratum's measure scores by predicted infections per stratum.

   This domain also contains one process of care measure Sepsis-1: Severe Sepsis and Septic Shock Management Bundle (Composite Measure). These details include the numerator, denominator, baseline period rate, achievement threshold, and benchmark.

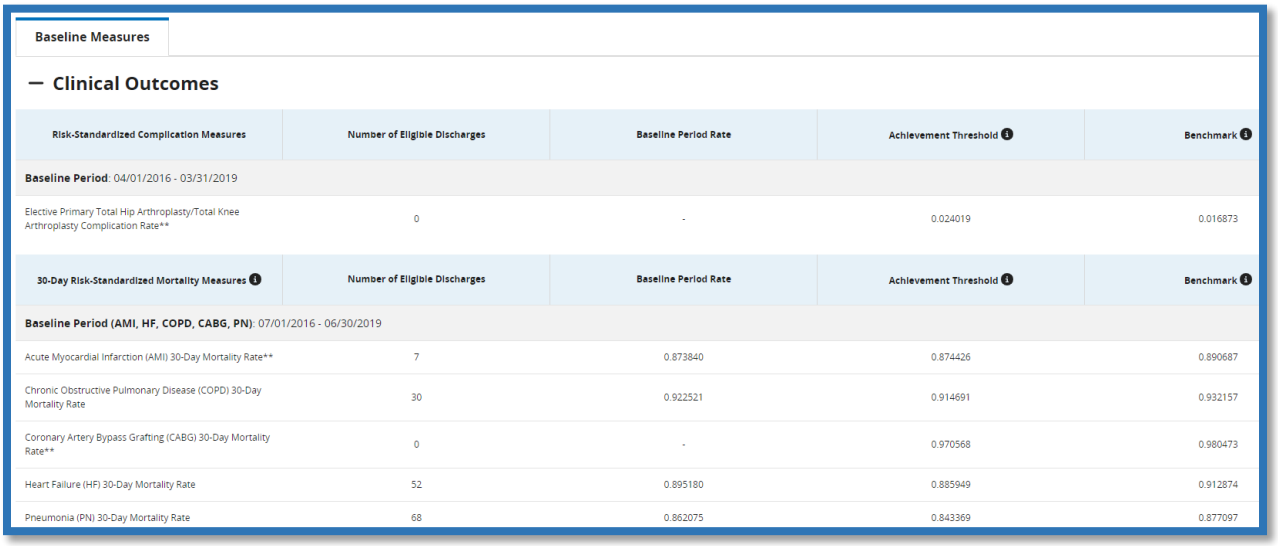
4. The **Efficiency and Cost Reduction domain** provides details on the MSPB measure, including the MSPB amount, median MSPB amount, MSPB measure ratio, and number of episodes of care in the baseline period.

Note: Hospitals that do not meet the minimum number of eligible discharges, surveys, predicted infections, underlying cases, or episodes of care for a measure during the baseline period will not receive improvement points for that measure. They are noted with a double asterisk (**). Hospitals can only earn achievement points for such measures if the minimums are met during the performance period. Achievement points will display on the Percentage Payment Summary Report (PPSR).

Note: Please use the report mockups in this document as a visual representation (layout) of the report only. These may not be an exact replication of actual report calculations.

Clinical Outcomes Domain

This displays your hospital's performance on the six Clinical Outcomes measures. Each measure is listed by the measure name.



Baseline Measures

— Clinical Outcomes

Risk-Standardized Complication Measures	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
Baseline Period: 04/01/2016 - 03/31/2019				
Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty Complication Rate**	0	-	0.024019	0.016873

30-Day Risk-Standardized Mortality Measures	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
Baseline Period (AMI, HF, COPD, CABG, PN): 07/01/2016 - 06/30/2019				
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate**	7	0.873840	0.874426	0.890687
Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	30	0.922521	0.914691	0.932157
Coronary Artery Bypass Grafting (CABG) 30-Day Mortality Rate**	0	-	0.970568	0.980473
Heart Failure (HF) 30-Day Mortality Rate	52	0.895180	0.885949	0.912874
Pneumonia (PN) 30-Day Mortality Rate	68	0.862075	0.843369	0.877097

Explanation of Clinical Outcomes Domain Report Fields

The **Number of Eligible Discharges** is a count of how many eligible discharges occurred at your hospital during the baseline period. A minimum of 25 eligible discharges during the baseline period is required for improvement point calculations.

The **Baseline Period Rate** is your hospital's rate on the measure during the baseline period. A dash (-) displays if your hospital had no eligible discharges during the baseline period.

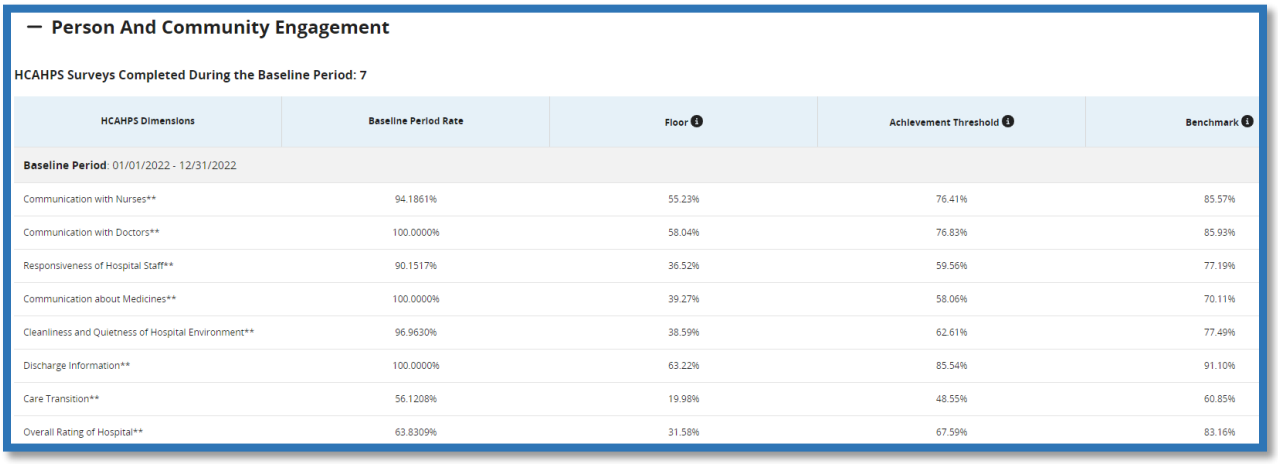
The **Achievement Threshold** is the 50th percentile (median) in the measure of hospitals during the baseline period. The achievement threshold is used in determining a hospital's achievement points.

Benchmarks are the mean of the top decile (average of the top 10%) in the measure of hospitals during the baseline period. The benchmark is used in determining a hospital's achievement points and improvement points.

Note: The **30-Day Risk Standardized Mortality measures** use survival rates instead of mortality rates, so higher values indicate better results.

Person and Community Engagement Domain

This displays your hospital's performance on the eight dimensions of the Person and Community Engagement domain. Each dimension is listed by the dimension title.



— Person And Community Engagement

HCAHPS Surveys Completed During the Baseline Period: 7

HCAHPS Dimensions	Baseline Period Rate	Floor	Achievement Threshold	Benchmark
Baseline Period: 01/01/2022 - 12/31/2022				
Communication with Nurses**	94.1861%	55.23%	76.41%	85.57%
Communication with Doctors**	100.0000%	58.04%	76.83%	85.93%
Responsiveness of Hospital Staff**	90.1517%	36.52%	59.56%	77.19%
Communication about Medicines**	100.0000%	39.27%	58.06%	70.11%
Cleanliness and Quietness of Hospital Environment**	96.9630%	38.59%	62.61%	77.49%
Discharge Information**	100.0000%	63.22%	85.54%	91.10%
Care Transition**	56.1208%	19.98%	48.55%	60.85%
Overall Rating of Hospital**	63.8309%	31.58%	67.59%	83.16%

Explanation of Person and Community Engagement Domain Report Fields

The **HCAHPS Surveys Completed During the Baseline Period** field shows the count of how many complete HCAHPS surveys were submitted for your hospital during the baseline period. A minimum of 100 complete HCAHPS surveys during the baseline period are required for improvement point calculations.

The **Baseline Period Rate** is your hospital's rate for the dimension during the baseline period. A dash (-) will be displayed if the baseline period rate could not be calculated for the dimension.

The **Floor** field shows the performance rate for the worst performing hospital during the baseline period, which defines the 0 percentile for the dimension. The floor is used in determining your hospital's Lowest HCAHPS Dimension Score in calculating your hospital's HCAHPS Consistency Score.

The **Achievement Threshold** field is the 50th percentile (median) in the measure of hospitals during the baseline period. The achievement threshold is used in determining a hospital's achievement points.

The **Benchmark** field is the mean of the top decile (average of the top 10%) in the measure of hospitals during the baseline period. The benchmark is used in determining a hospital's achievement points and improvement points.

Safety Domain

This displays your hospital's performance on the HAI measures and the Process of Care measure. Each measure is listed by the measure name.

— Safety

Healthcare Associated Infections	Number of Observed Infections (Numerator)	Number of Predicted Infections (Denominator)	Standardized Infection Ratio (SIR)	Achievement Threshold	Benchmark
Baseline Period: 01/01/2022 - 12/31/2022					
Catheter-Associated Urinary Tract Infection**	N/A	N/A	N/A	0.615	0.000
Central Line-Associated Blood Stream Infection**	N/A	N/A	N/A	0.760	0.000
Clostridium difficile Infection**	0	0.799	N/A	0.423	0.000
Methicillin-Resistant Staphylococcus aureus Bacteremia**	0	0.098	N/A	0.793	0.000
SSI-Abdominal Hysterectomy**	N/A	N/A	N/A	0.763	0.000
SSI-Colon Surgery**	N/A	N/A	N/A	0.747	0.000

Process of Care	Numerator	Denominator	Baseline Period Rate	Achievement Threshold	Benchmark
Baseline Period: 01/01/2022 - 12/31/2022					
SEP-1: Severe Sepsis and Septic Shock: Management Bundle**	N/A	N/A	-	0.597482	0.843620

Explanation of Safety Domain Report Fields

Healthcare Associated Infections

The **Number of Observed Infections (Numerator)** is the number of actual infections that were reported by your hospital in the National Healthcare Safety Network (NHSN). This value is the numerator for the SIR calculation. N/A will display if your hospital did not have data for the measure in NHSN.

The **Number of Predicted Infections (Denominator)** is the number of predicted infections that were calculated by the Centers for Disease Control and Prevention (CDC). This value is the denominator for the SIR calculation. A minimum of 1.000 predicted infections is the minimum for a SIR to be calculated. N/A will display if your hospital did not have data for the measure in NHSN.

The **SIR** is your hospital's number of observed infections (numerator) divided by your hospital's number of predicted infections (denominator) during the baseline period. The calculation of a SIR during the baseline period is required for improvement point calculations. A dash (-) displays if CMS could not calculate a SIR.

The **Achievement Threshold** is the 50th percentile (median) in the measure of hospitals during the baseline period. The achievement threshold is used in determining a hospital's achievement points.

The **Benchmark** is the mean of the top decile (average of the top 10%) in the measure of hospitals during the baseline period. The benchmark is used in determining a hospital's achievement points and improvement points.

Process of Care

The **Numerator** is patients who received **ALL** the following:

Within three hours of presentation of severe sepsis:

- Initial lactate level measurement
- Broad spectrum or other antibiotics administered
- Blood cultures drawn prior to antibiotics

AND received within six hours of presentation of severe sepsis, ONLY if the initial lactate is elevated:

- Repeat lactate level measurement

AND within three hours of initial hypotension:

- Resuscitation with 30 mL/kg crystalloid fluids

OR within three hours of septic shock:

- Resuscitation with 30 mL/kg crystalloid fluids

AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:

- Vasopressors are administered

AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L:

- Repeat volume status and tissue perfusion assessment is performed

The **Denominator** is inpatients age 18 and over with an *ICD-10-CM Principal or Other Diagnosis Code* of Sepsis, Severe Sepsis, or Septic Shock and not equal to U07.1 (COVID-19).

Included Populations: Discharges age 18 and over with an *ICD-10-CM Principal or Other Diagnosis Code* of Sepsis, Severe Sepsis, or Septic Shock as defined in Appendix A, Table 4.01.

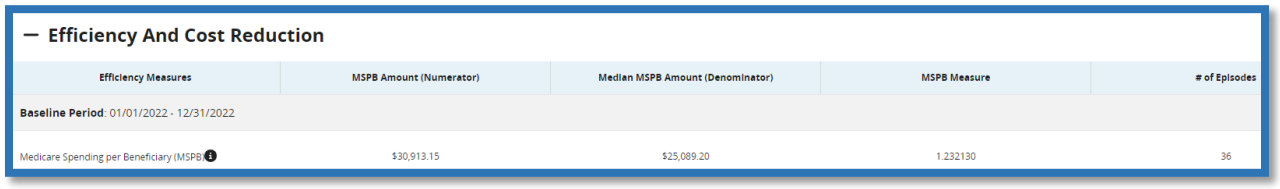
Excluded Populations:

- Patients with an ICD-10-CM Principal or Other Diagnosis Code of U07.1 (COVID-19)
- Directive for Comfort Care or Palliative Care within six hours of presentation of severe sepsis
- Directive for Comfort Care or Palliative Care within six hours of presentation of septic shock
- Administrative contraindication to care within six hours of presentation of severe sepsis
- Administrative contraindication to care within six hours of presentation of septic shock
- Length of Stay >120 days
- Transfer in from another acute care facility
- Patients enrolled in a clinical trial for sepsis, severe sepsis or septic shock treatment or intervention
- Patients with severe sepsis who are discharged within six hours of presentation
- Patients with septic shock who are discharged within six hours of presentation
- Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis

The **Achievement Threshold** is the 50th percentile (median) in the measure of hospitals during the baseline period. The achievement threshold is used in determining a hospital's achievement points.

The **Benchmark** is the mean of the top decile (average of the top 10%) in the measure of hospitals during the baseline period. The benchmark is used in determining a hospital's achievement points and improvement points.

Efficiency and Cost Reduction Domain



— Efficiency And Cost Reduction

Efficiency Measures	MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure	# of Episodes
Baseline Period: 01/01/2022 - 12/31/2022				
Medicare Spending per Beneficiary (MSPB)	$30,913.15	$25,089.20	1.232130	36

Explanation of Efficiency and Cost Reduction Measures Report Fields

The **MSPB Amount (Numerator)** is the average standardized spending level for your hospital divided by the average expected spending level for your hospital, multiplied by the average standardized spending over all episodes across all hospitals during the baseline period. N/A will display if your hospital had no eligible episodes of care during the baseline period.

The **Median MSPB Amount (Denominator)** is the episode-weighted median MSPB amount across all hospitals during the baseline period.

The **MSPB Measure** is calculated as the ratio of your hospital's MSPB amount (numerator) to the median MSPB amount (denominator). N/A will display if your hospital had no eligible episodes of care during the baseline period.

The **# of Episodes** is a count of the episodes of care that were evaluated for the MSPB measure during the baseline period. A minimum of 25 episodes of care are required for improvement point calculations.

The **Benchmark** and **Achievement Threshold** values are calculated for the MSPB measure using performance period data instead of baseline period data. As a result, these values will be available when the Percentage Payment Summary Report is added to the user-interface.

Questions

For further assistance with the Hospital VBP Program, please contact the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor via the QualityNet Question and Answer Tool or by calling, toll free, (844) 472-4477 or (866) 800-8765, weekdays from 8 a.m. to 8 p.m. Eastern Time (ET).

For questions regarding technical issues, contact the Center for Clinical Standards and Quality (CCSQ) Service Center at QnetSupport@cms.hhs.gov.