Hospital Value-Based Purchasing (VBP) Program

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

Hospital VBP Program, HAC Reduction Program, and Hospital Readmissions Reduction Program FY 2024 Provider Data Catalog Update Question and Answer Summary Document

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

Question 1: **Can you explain the difference between baseline period and performance period?**

The Hospital VBP Program is unique in that it allows hospitals to earn improvement points. Hospitals earn improvement points based on how it improved its own performance from the baseline period to the performance period.

Hospitals can also earn achievement points. CMS awards these points to a hospital by comparing performance on a measure during the performance period with all hospitals' performance during the baseline period.

The Hospital VBP Program uses two time periods, the baseline and performance periods, to calculate improvement scores. The baseline period rate represents a hospital's performance for each measure during the baseline period. The performance period rate is compared to the baseline period to score improvement points. The Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey, healthcare-associated infection (HAI) measures, and Medicare Spending per Beneficiary measure are calendar year measures that use a performance period of calendar year 2022 and a baseline period of calendar year 2019. The mortality measures and complication measure use multi-year baseline and performance periods that are listed on slide 25.

Question 2: **When will we receive the fiscal year (FY) 2024 Hospital VBP Program reports?**

CMS made the FY 2024 Hospital VBP Program Percentage Payment Summary Reports (PPSRs) available in the *Hospital Quality Reporting (HQR) Secure Portal* in August of 2023.

Question 3: **Will CMS publish a FY 2024 Quick Reference Guide?**

The FY 2024 Hospital VBP Program Quick Reference Guide is available for download on QualityNet. The link can be found on slide 32.

Question 4: **What is the advantage of accessing the FY 2021 payment tables?**

Accessing the FY 2021 payment tables, including Table 16B on the CMS.gov website, offers several significant advantages.

Table 16B provides the actual payment adjustment factors by CMS Certification Number for each participating hospital under the Hospital VBP Program for FY 2021. This information enables hospitals to understand the precise adjustments made to their base operating Medicare Severity Diagnosis-Related Group (MS-DRG) payments, facilitating better financial planning and management. Hospitals can use these adjustment factors to forecast revenue and make informed budgeting decisions, which is crucial for maintaining financial stability.

Furthermore, the payment adjustment data allows hospitals to assess their performance relative to the metrics used by CMS, highlighting areas needing improvement and guiding quality enhancement initiatives. This level of detail promotes transparency and accountability, enabling hospitals to benchmark their performance against others and strive for better outcomes. Additionally, understanding the reasons for exclusion from the Hospital VBP Program (such as not being a subsection (d) hospital, failing to meet minimum domain requirements, being subject to payment reductions under the Hospital IQR Program, or being located in Maryland) helps hospitals identify compliance issues and clarify their eligibility status. Since the FY 2021 payment adjustment factors will remain valid until the FY 2024 Payment Tables are updated in 2026, hospitals can use this data for long-term strategic planning. In summary, accessing Table 16B provides hospitals with critical information necessary for financial management, performance evaluation, strategic planning, and operational transparency.

Question 5: **Previously, we were able to compare our data to the state and national averages for HCAHPS, but we no longer see those data points. Are they still available on Care Compare?**

Yes, on Care Compare, you can search for your hospital. On your hospital's page, select View Survey Details on the Patient Survey Rating section. For each dimension, you should see your hospital's HCAHPS rate, the national average, and your state's average.

Question 6: **Where can I find the slides for this webinar?**

A transcript of the presentation, the slides, a summary of the questions asked, and the responses will post to the Quality Reporting Center (www.QualityReportingCenter.com) in the upcoming weeks.

Question 7: **What is the difference between a hospital's measure results and measure scores?**

Measure results are the output of a measure's calculations and the first step of the scoring methodology. The HAC Reduction Program uses measure results from six total measures. Each of the five Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) HAI measures report a standardized infection ratio, or SIR. The SIRs are calculated as the ratio of a hospital's observed HAIs to its predicted HAIs. The CMS Patient Safety and Adverse Events Composite (CMS Patient Safety Indicator [PSI] 90) measure reports a composite value, which is a weighted average of the risk- and reliability-adjusted rates of 10 component PSI measures.

Measure scores, or Winsorized *z*-scores, are used to calculate the Total HAC Score. The HAC Reduction Program completes Winsorization to limit the impact of outlier measure results, and then calculates Winsorized *z*-scores. The *z*-scores indicate how different a hospital's measure result is from the average measure result across all hospitals in the HAC Reduction Program. The weighted sum of a hospital's measure scores is then used to calculate the Total HAC Score.

More information about the HAC Reduction Program's methodology can be found on the QualityNet website.

Question 8: **Can I calculate the 75th percentile of Total HAC Scores from publicly reported data on the Provider Data Catalog?**

The 75th percentile of Total HAC Scores cannot be calculated using the dataset available on the Provider Data Catalog because not all hospitals' results are publicly reported. However, you can find the FY 2024 HAC Reduction Program's 75th percentile in the Hospital-Specific Report (HSR) user guide, which is publicly available on the QualityNet website.

Question 9: **Why are my condition- or procedure-specific readmission measure results in the HRRP dataset on the Provider Data Catalog different from the readmission measure results on Medicare.gov?**

Both condition- or procedure-specific readmission metrics use the same readmission measure methodology and hospital performance period. However, the readmission measure results on the Medicare.gov website (Care Compare), which are also in the Unplanned Hospital Visits dataset on the Provider Data Catalog, are calculated using a different set of hospitals than the results for HRRP. HRRP includes subsection (d) hospitals, as well as hospitals in Maryland.

By contrast, the measure results on Medicare.gov are calculated among a larger hospital population, including subsection (d) hospitals, Maryland hospitals, and non-subsection (d) hospitals, such as critical access hospitals and hospitals in U.S. territories. Most hospitals will have similar results for HRRP and Medicare.gov, but they may not align exactly due to the different hospitals included in the calculations.

Additionally, Medicare.gov reports the rate of readmission after discharge while the HRRP results report the excess readmission ratio. The rate of readmission is a risk-standardized readmission rate, which is equal to the excess readmission ratio multiplied by the national observed readmission rate. The excess readmission ratio is equal to a hospital's predicted readmission rate divided by its expected readmission rate.

Question 10: **How do I determine if my hospital was penalized for HRRP in FY 2024?**

CMS publishes hospitals' payment reduction percentage in the FY 2024 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Final Rule HRRP Supplemental Data File. This file is posted on the FY 2024 IPPS/LTCH PPS Final Rule page on CMS.gov. This file includes hospitals subject to HRRP that have measure results for at least one measure in the program. Hospitals with a payment reduction percentage greater than 0 percent are penalized in FY 2024. Hospitals with a payment reduction percentage equal to 0 percent are not penalized in FY 2024.

Question 11: **How do these programs relate to critical access hospitals (CAHs)? Are CAHs required to participate?**

CMS includes all subsection (d) hospitals (short-term acute care hospitals paid under the IPPS) in the Hospital VBP Program, HAC Reduction Program, and HRRP. CMS does **not** include the following non-subsection (d) hospitals and units in these programs: CAHs, rehab hospitals and units, Long-Term Care Hospitals (LTCH), psychiatric hospitals and units, children's hospitals, Prospective Payment System (PPS)-exempt Cancer Hospitals, Veterans Affairs medical centers and hospitals, short-term acute care hospitals in U.S. Territories, and religious non-medical health care institutions.

Question 12: **Can you elaborate on the difference between the HAC Reduction Program and the HAC Present on Admission (POA) provision?**

HACs are one of several medical conditions that a patient can develop during a hospital stay that was not present on admission, such as pressure sores or a surgical site infection.

Section 5001(c) of the Deficit Reduction Act of 2005 (DRA) requires the Secretary of the US. Department of Health and Human Services, to identify HACs that are 1) high cost, high volume, or both; 2) result in higher claim payments to hospitals because of the presence of the HACs as a secondary diagnosis; and 3) could reasonably have been prevented through the application of evidence-based guidelines. For discharges on or after October 1, 2008, hospitals no longer receive additional payment for cases in which one of the identified HACs occurred but was not POA. Instead, the case will be paid for as though the HAC was not present. This is known as the DRA HAC provision.

CMS calculates and reports rates for four of the HACs included in the DRA HAC payment provision. These measures are referred to as the Publicly Reported DRA HAC Measures. CMS calculates and reports these measures only for informational and quality improvement purposes; the results of the measure calculations do not affect payment. The publicly reported DRA HAC measures are distinct from the HAC Reduction Program's measures.

The HAC Reduction Program is a separate pay-for-performance program under Medicare that supports CMS's long-standing effort to link Medicare payments to health care quality in the inpatient hospital setting. The HAC Reduction Program includes six measures of HACs that are separate from the four Publicly Reported DRA HAC Measures.

The HAC Reduction Program adjusts payments to hospitals that rank in the worst performing quartile (are above the 75th percentile) of all subsection (d) hospitals with respect to these six measures of HACs.

Question 13: **Are hospitals reimbursed for readmissions or is the only fiscal impact the reduction in the HRRP?**

HRRP is a Medicare value-based purchasing program established to reduce payments to subsection (d) hospitals (short-term acute care hospitals) with excess readmissions. For hospitals that receive a payment reduction under HRRP, CMS applies the payment adjustment factor to all Medicare Fee for Service (FFS) base operating diagnosis-related group (DRG) payments during the FY.

Question 14: **If the number of readmissions is too few to report, are these excluded from reporting?**

For HRRP hospitals and Maryland hospitals with 25 eligible discharges or more across the six condition- and procedure-specific readmission measures, CMS will report the following data elements for each of the readmission measures on the Provider Data Catalog: number of eligible discharges; number of readmissions for hospitals with 11 or more readmissions for that given measure; predicted readmission rates; expected readmission rates; and excess readmission ratios.

For more information on data elements on the Provider Data Catalog, please refer to the HRRP Frequently Asked Questions on the Resources page on the QualityNet website.

Question 15: **Are the benchmarks published?**

For definitive information on Hospital VBP Program requirements, performance standards, and quality measures, refer to CMS final rules.

Question 16: **I found my hospital on the HAC spreadsheet. However, my hospital was not listed in the downloaded Hospital VBP Program spreadsheet.**

All open subsection (d) hospitals (general acute care hospitals paid under the IPPS) are included in the HAC Reduction Program dataset posted on the data catalog on Data.cms.gov. For the Hospital VBP Program, the Social Security Act, Section 1886(d)(1)(B), outlines that all subsection (d) hospitals in the 50 states and the District of Columbia are included.

However, certain hospitals are excluded from this program: those exempt from the IPPS, those subject to payment reductions under the Hospital Inpatient Quality Reporting (IQR) Program, those cited for deficiencies posing immediate jeopardy to patient health or safety, those with insufficient domain numbers, those with approved disaster/ extraordinary circumstance exceptions, and short-term acute care hospitals in Maryland. If your hospital does not fall under any of the exclusions mentioned above, please contact the Hospital VBP Program team using the QualityNet Question and Answer Tool.

Question 17: **Why are the performance periods for Publicly Reported DRA HAC Measures data different from the HAC Reduction Program?**

The Publicly Reported DRA HAC Measures are distinct from the HAC Reduction Program. The Publicly Reported DRA HAC Measures calculate and report rates for four of the HACs included in the DRA HAC payment provision.

These claims-based measures are reported only for informational and quality improvement purposes; the results of the measure calculations do not affect payment.

Conversely, the HAC Reduction Program assesses performance based on claims-based and chart-abstracted or laboratory-identified measures of HACs. A hospital's performance on the six HAC Reduction Program measures may affect payment.

The 2023 Publicly Reported DRA HAC measures, posted publicly in quarter 3 2023, used a 24-month discharge period, covering discharges between July 1, 2020, and June 30, 2022.

The performance periods for the FY 2024 HAC Reduction Program include HAI data from January 1, 2022, to December 31, 2022, and CMS PSI 90 data from January 1, 2021, to June 30, 2022.

Question 18: **Slide 47 states that CMS will only report the number or readmissions if there are more than 11 readmissions. Is that 11 readmissions each month or a longer period of time?**

On the Provider Data Catalog, CMS will report the number of readmissions for each of the readmission measures from Maryland hospitals and hospitals in the HRRP if the hospital has 25 or more eligible discharges during the performance period and 11 or more readmissions during the entire performance period. The FY 2024 performance period is July 1, 2019, to December 1, 2019, and July 1, 2020, to June 30, 2022.

Question 19: **If you itemized the percentage at risk or award per measure within a domain, what percentage is allocated to each measure?**

For the FY 2024 Hospital VBP Program, CMS requires hospitals to have scores in at least three of the four domains to receive a Total Performance Score. The four domains include Clinical Outcomes, Person and Community Engagement, Safety, and Efficiency and Cost Reduction, each originally weighted at 25 percent. If a domain is excluded, the proportionate domain reweighting formula is applied, where the original weight of each remaining domain is divided by the sum of the eligible domain weights.

For example, if the Efficiency and Cost Reduction domain is excluded, the remaining domains (Clinical Outcomes, Person and Community Engagement, and Safety) each have their weights adjusted to approximately 33.33 percent.

The percentage allocated to each measure within a domain is then determined by dividing the new domain weight by the number of measures in that domain. This reweighting ensures the total weight across all domains sums to 100 percent, maintaining the integrity of the Total Performance Score calculation.

Question 20: **Can a hospital receive an incentive payment for better performance in any of the programs?**

Hospitals can receive incentive payments for better performance in several programs. The HRRP offers incentives for maintaining low readmission rates, while the HAC Reduction Program rewards hospitals with the lowest incidence of hospital-acquired conditions. The Hospital VBP Program rewards hospitals based on the quality of care provided, aiming to improve patient outcomes and reduce healthcare costs. The Hospital VBP Program is funded through a percentage withhold from participating hospitals' DRG payments. A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year under the Hospital VBP Program. Incentive payments are redistributed based on the hospital's Total Performance Score in comparison to the distribution of all hospitals' Total Performance Scores and the total estimated DRG payments for that fiscal year.

Question 21: **What Medicare payment types can receive payment adjustments?**

CMS first applies payment adjustments for the Hospital VBP Program, HRRP, the disproportionate-share hospital adjustment, and the indirect medical education adjustment to the base-operating DRG payments. CMS then applies the payment adjustment for the HAC Reduction Program to the overall Medicare payment amount.

The Value-Based Incentive Payment Adjustment Factor determines changes to hospitals' Medicare payments under the IPPS for FY 2024 based on their performance in the Hospital VBP Program. This factor, applied to the base operating DRG amount, reflects the net change in payment. If the factor is greater than 1, payments increase; if equal to 1, payments remain unchanged; and if less than 1, payments decrease.

Question 22: **Can you explain the difference between the predicted readmission rate and the expected readmission rate?**

The predicted readmission rate is the predicted 30-day readmission rate for a hospital, based on *that hospital's* performance for its specific patient case mix (its hospital-specific effect on readmissions). The expected readmission rate is the expected 30-day readmission rate for a hospital.

That is based on readmission rates at *an average hospital* with a patient case mix similar to that hospital's (if patients with the same characteristics had been treated at an average hospital rather than at that individual hospital). More information is available on the Readmission Measures Methodology page on the QualityNet website.

Question 23: **What is the difference between the Provider Data Catalog and Care Compare website?**

Care Compare provides a single user-friendly interface that patients and caregivers can use to make informed decisions about healthcare based on cost, quality of care, volume of services, and other data. The Provider Data Catalog better serves innovators and stakeholders who are interested in detailed CMS data and use interactive and downloadable datasets like those currently available on Data.Medicare.gov.

Question 24: **Is there a calendar that notes when each of these reports is available for download?**

The HAC Reduction Program HSRs are available for hospitals annually, typically in the third quarter of the year. HRRP HSRs are also available for hospitals annually, typically in the third quarter of the year. The Baseline Measures Report for the Hospital VBP Program is issued on an annual basis, typically in February or March. The PPSR is released annually around August or September.

Question 25: **Do HRRP measures only include Medicare Part A and Part B payer? Are Medicare Advantage payers included in the hybrid measures?**

CMS includes Medicare FFS stays in all components of the payment reduction calculations under HRRP. CMS includes Medicare FFS and Medicare Advantage stays in the calculation of the dual proportion (the proportion of Medicare FFS and Medicare Advantage stays for which the beneficiary was dually eligible for Medicare and full Medicaid benefits). Similarly, CMS only includes Medicare FFS patients in the Hybrid Hospital-Wide Readmission (HWR) measure calculations. CMS does not include Medicare Advantage patients in the Hybrid Hospital-Wide Readmission measure.

However, in the FY 2024 IPPS/LTCH PPS final rule, CMS finalized its proposal to include Medicare Advantage patients in the Hybrid HWR and Hospital-Wide Mortality measures, beginning with admissions data from July 1, 2024 through June 30, 2025, affecting the FY 2027 payment determination.

More information on the condition- and procedure-specific readmission measures is available on the Readmission Measures Methodology page on the QualityNet website.

More information on the hybrid measures is available on the Hybrid Measure Methodology page on the QualityNet website.

Question 26: **Are the claims-based readmission and mortality disease-specific categories only Medicare patients?**

The claims-based condition- and procedure-specific readmission and mortality measures included in the Hospital VBP Program and HRRP include only Medicare FFS patients.

Question 27: **Why do the 2024 measures include data from 2021 and 2022? Should it be 2023 data?**

The FY 2024 HAC Reduction Program payment reductions are applied to hospitals' overall Medicare FFS payments from October 1, 2023, to September 30, 2024. The performance periods for the FY 2024 HAC Reduction Program include HAI data from January 1, 2022, to December 31, 2022, and the CMS PSI 90 data from January 1, 2021, to June 30, 2022. For HAI measures, hospitals have 4.5 months after the end of the quarter to submit, review, and correct data. Therefore, data for quarter 4 2022 are finalized May 15, 2023.

Similarly, for the CMS PSI 90 measure, there is a lag between the end of the performance period and when the data are ready to use for program calculations. This lag allows time for hospitals to submit claims for these stays. CMS takes an annual snapshot of hospital claims data to calculate results for claims-based measures for quality reporting programs, including the CMS PSI 90 measure. To calculate results for the FY 2024 program year, CMS took a snapshot of the data on the last business day of September 2022. The most recent claims snapshot for the claims-based measures was on the last business day of September 2023 to calculate results for the FY 2025 program year.