Hospital Value-Based Purchasing (VBP) Program

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

Hospital VBP Program Knowledge Refresher: FY 2026 Overview 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 baseline period rate, achievement threshold, and benchmark again? Which is our score compared to where we should be to achieve points?**

The baseline period rate represents a hospital's performance for each measure during the baseline period, which is used as input for scoring improvement points. The achievement threshold is the 50th percentile of all hospitals' performance on each dimension during the baseline period. The benchmark is the mean of the top decile of all hospitals' performance on each dimension during the baseline period. Achievement points are points awarded to a hospital by comparing its performance on a measure during the performance period with all hospitals' performance during the baseline period.

Question 2: **When will fiscal year (FY) 2026 baseline reports become available?**

The reports are currently available to run in the Hospital Quality Reporting (HQR) System. CMS made the reports available to hospitals in March 2024.

Question 3: **Will the baseline measures report go through the new Managed File Transfer inbox, or will we need to manually run the report in the HQR System?**

To access the report, users will need to have the Performance Reports permission for HVBP Access and navigate to the *HQR Secure Portal* login page at https://hqr.cms.gov/hqrng/login. Enter your Health Care Quality Information Systems Access Roles and Profile (HARP) User ID and Password. Then, select Login. The Two-Factor Authorization page will appear. Select the device you would like to use to retrieve the verification code, and select Continue. Once you receive the code, enter it, and select Continue. Read the Terms and Conditions statement. Select Accept to proceed, and the HQR landing page will appear. (If you select Cancel, the program closes.)

On the HQR landing page, select Program Reporting from the left navigation menu to expand the menu options. From the expanded Program Reporting drop-down menu, select Performance Reports. Select HVBP from the Program selection menu. Select Baseline Measures from the Report selection menu. Select 2026 from the Fiscal Year selection menu. Select the hospital from the Provider menu. Then, select Display Results.

Hospitals can refer to the *How to Read Your FY 2026 Baseline Measures Report* document on the QualityNet website at qualitynet.cms.gov.

To access the document, select the Hospitals – Inpatient option. Then, select HVBP from the Hospital Inpatient Quality Program options. Select the Resources link on the menu bar. Then, select FY 2026 on the left navigation pane.

Question 4: **What happens if a facility does not meet the minimum number of 100 completed Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) surveys?**

If the hospital does not submit at least 100 surveys during the baseline period, the hospital would not have an opportunity to receive improvement points. If the hospital did not submit at least 100 surveys during the performance period, the hospital would not be eligible to receive achievement points or improvement points. Also, the hospital would not receive a Person and Community Engagement domain score.

However, the hospital could still receive a Total Performance Score (TPS) if the hospital met the minimum measure requirements in the other three remaining domains. In addition, hospitals can still earn improvement points by comparing a hospital's performance on a dimension during the performance period with its own performance on the same dimension during the baseline period.

Question 5: **When will the FY 2025 performance reports become available?**

We anticipate the FY 2025 Percentage Payment Summary Reports (PPSRs) to become available around August 1, 2024.

Question 6: **Our hospital opened in late 2021, and we will begin submitting data with Quarter (Q)1 2022 discharges. Will we be eligible for the FY 2026 Hospital VBP Program, assuming we met minimum case and measure requirements?**

The Hospital VBP Program can still include a newly opened hospital that just has performance period data if the hospital meets the minimum measure, domain criteria, and all Hospital Inpatient Quality Reporting (IQR) Program requirements. In this scenario, CMS would not score the hospital on improvement because the hospital only submitted performance period data. However, the hospital still could earn achievement points to calculate a TPS.

Question 7: **Are critical access hospitals (CAHs) exempt from the Hospital VBP Program?**

Yes, only subsection (d) hospitals paid through the Inpatient Prospective Payment System (IPPS) are included in the Hospital VBP Program. CAHs are not eligible to participate in the Hospital VBP Program.

Question 8: **How are the achievement thresholds and benchmarks communicated to the hospitals?**

The quick reference guide, available on the QualityNet and Quality Reporting Center websites, contains the performance standards for the FY 2026 Hospital VBP Program. The performance standards are published in the IPPS rules and on the QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp/performance. In addition, if the performance standards for any measure need a technical update, a QualityNet news article will be posted and a Hospital VBP Program Listserve will be sent. The performance standards will also be listed on your hospital's baseline measures report.

Question 9: **I did not receive an email stating baseline reports were available, but I saw a notice for them on the QualityNet website home page.**

CMS sends notifications and reminders for the Hospital VBP Program through the two QualityNet Listserve notification groups.

They are the Hospital Inpatient Value-Based Purchasing and Improvement notification group and the Hospital Inpatient Quality Reporting and Improvement notification group. If you aren't signed up for those notification groups, you can register on the QualityNet website: https://qualitynet.cms.gov/listserv-signup

Question 10: **How can we calculate mortality survival rates to calculate Hospital VBP Program points?**

The survival rate equals 1 minus the mortality rate:
Survival Rate = 1 - mortality rate.

For example, if your mortality rate was 0.10 or 10 percent, your survival rate would be 0.9 or 90 percent (1 - 0.1). Visit QualityNet for details: https://qualitynet.cms.gov/inpatient/measures/mortality/methodology

Question 11: **Could you please review improvement points?**

CMS may award a hospital improvement points if the hospital's performance period rate is better than its own baseline period rate. The maximum point value for improvement points is 9 points. If a hospital's performance period rate is at or better than the benchmark and better than its own baseline period rate, it will receive a maximum 9 improvement points. For more information on calculations, please refer to the *What's My Payment?* webinar.

Question 12: **What criteria are used for scoring Healthcare-Associated Infection (HAI) measures in the Safety domain?**

HAI measures in the Safety domain are scored using the standardized infection ratio (SIR). The SIR is calculated by dividing the number of observed infections reported to NHSN by the number of predicted infections calculated by the CDC. Hospitals need at least one predicted infection to determine an SIR. The CDC uses the SIR rather than the actual number of infections to ensure standardized evaluation across different hospital settings. For questions regarding the calculation or data submitted, hospitals can contact the NHSN Help Desk via email at NHSN@cdc.gov.

Question 13: **Are the HAI measures in the Hospital VBP Program calculated by NHSN criteria in the same way as HAI measures in the Hospital-Acquired Condition (HAC) Reduction Program are calculated?**

The HAI measures in both the Hospital VBP Program and the HAC Reduction Program are calculated using the same NHSN criteria. However, the two programs differ in their performance periods: The Hospital VBP Program uses one year, and the HAC Reduction Program uses two years. CMS assess each hospital's performance based on a SIR, which compares the actual number of HAIs to the predicted number using the CDC's risk-adjustment methodology.

The methodology varies across measures: CLABSI and CAUTI are adjusted at both the hospital and patient-care-unit levels, while SSI are evaluated at the procedure level, specifically infections from abdominal hysterectomies and colon surgeries. MRSA and CDI are risk-adjusted at the hospital level. However, if a hospital's predicted count of infections is less than one or community-onset CDI rates are statistical outliers, an SIR won't be calculated.

In the HAC Reduction Program, CMS determines the Total HAC Score using Winsorized z-scores, with each measure weighted equally. The

weight depends on the total number of measures a hospital has. For instance, if a hospital has scores for both the CMS PSI 90 measure and one HAI measure, each would carry 50% of the final Total HAC Score. Further information about the calculation methodologies can be found on the CDC website or in NHSN Technical Reports available via QualityNet. For more information regarding the HAI measures in the HAC Reduction Program, visit this QualityNet page: https://qualitynet.cms.gov/inpatient/hac/measures

Question 14: **How do I receive the benchmark and achievement threshold values for the Medicare Spending per Beneficiary (MSPB) measure?**

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 PPSR is added to the user interface in the HQR system.

Question 15: **What is the payment year that corresponds to FY 2026?**

The payment adjustment is effective for discharges from October 1, 2025, to September 30, 2026.

Question 16: **What is the time frame that CMS uses to calculate minimum requirements?**

The minimum requirements must be met during the baseline and performance periods to receive improvement and/or achievement points.

Question 17: **What is floor value?**

For the HCAHPS Survey measure, the "floor" is the performance rate for the worst performing hospital during the baseline period, which defines the 0 percentile for this dimension. To calculate consistency points, a hospital's performance on its lowest dimension is compared to the "floor."

Question 18: **Where can we enter our current or projected performance for measures? Where can we see what our achievement points and other values will be?**

The formulas are available in the *How to Read your Percentage Payment Summary Report* document on QualityNet.

Question 19: **Who can access QualityNet? Who gives permission to access?**

CMS retired the *QualityNet Secure Portal* and replaced it with hqr.cms.gov for HQR. The HARP system provides a single user ID and password to sign into several CMS applications, including HQR.

For questions related to the HQR System, please contact the Center for Clinical Standards and Quality (CCSQ) Service Center at QNetSupport@cms.hhs.gov or call (866) 288.8912 (TTY: 877.715.6222) weekdays 8 a.m.–8 p.m. ET.

Question 20: **Will hospitals be penalized in FY 2026 if they don't meet either the benchmarks or achievement thresholds?**

In FY 2026, hospitals that participate in the Hospital VBP Program could face reductions in Medicare reimbursements if they don't meet established quality performance standards. The program scores hospitals based on achievement (comparison to others) and improvement (progress from the baseline period), with these scores contributing to a TPS that ultimately determines if hospitals receive a payment increase or reduction. Within the Clinical Outcomes Domain, hospitals earn points based on their measure rates in the baseline and performance periods, while the Person and Community Engagement Domain requires a minimum performance "floor" for consistency. The achievement threshold is set at the median (50th percentile) of all hospital rates in the baseline period, with benchmarks reflecting the top 10% of hospitals during that period. Hospitals failing to meet these performance benchmarks and thresholds are at risk of lower TPS and, consequently, reduced Medicare payments.

Question 21: **What if we don't have My Tasks on our landing page?**

For questions related to the HQR System, please contact the CCSQ Service Center at QNetSupport@cms.hhs.gov or call (866) 288.8912 (TTY: 877.715.6222) weekdays from 8 a.m. to 8 p.m. ET.

Question 22: **What happens to a hospital when they are acquired by another health system?**

The Hospital VBP Program awards or penalizes hospitals according to the CMS Certification Number (CCN).If the CCN number hasn't changed, the payment adjustment factor is multiplied against the MS-DRG payment amount. For more specific information, we recommend contacting your Medicare Administrative Contractor.

Question 23: **For data requirements, do those standards apply to the baseline period, the performance period, or both? For example, do you need to have at least one predicted infection in the baseline and performance period to receive a score?**

Data requirements apply to both the baseline and performance period. Hospitals not meeting the minimum number of eligible discharges, surveys, predicted infections, underlying cases, or episodes of care for a measure during the baseline period will not be scored improvement points for that measure and will be indicated with a double asterisk (**). Only achievement points can be earned for such measures, if the minimums are met during the performance period. Achievement points will be displayed on the PPSR.

Question 24: **If a hospital is under Hospital IQR Program payment reduction, does ineligibility for the Hospital VBP Program payment adjustment last only as long as the Hospital IQR Program payment reduction?**

Yes. For each year, Hospital IQR Program eligibility relates directly to Hospital VBP Program eligibility. Excluded or ineligible hospitals will not have their payments adjusted, and it includes the 2-percent withhold to payments and the opportunity to receive incentive payments for each fiscal year.

Question 25: **What is the minimum number of cases for the SEP-1 (Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) measure in the Safety domain?**

Hospitals will have to meet the minimum of 25 cases accepted and used in the denominator for the entire performance period.

Question 26: **If a hospital decides not to submit SEP-1 measure data for the Hospital IQR Program because they have fewer than five patients in the denominator for one quarter, could that cause them to not meet the minimum denominator requirement for the performance period?**

Yes. The minimum case count for the Sepsis measure is 25 cases used and accepted in the denominator for the entire performance period.

Question 27: **Can you share what the methodology is for the HCAHPS Survey? Where does the survey data come from?**

The HCAHPS survey, also known as the CAHPS Hospital Survey, is a standardized tool used to measure patients' perspectives on hospital care. The methodology for this survey includes the following key components:

1. **Survey Design**: The HCAHPS survey contains 29 questions that cover various aspects of a patient's experience, such as communication with nurses and doctors, staff responsiveness, hospital cleanliness and quietness, communication about medications, discharge information, and overall rating of the hospital.

2. **Survey Administration**: Hospitals partner with CMS-approved vendors or administer the survey directly, following CMS guidelines. The survey can be conducted through several methods: mail, telephone, mail followed by telephone, or interactive voice response (IVR).

3. **Data Collection**: The survey is sent to a random sample of adult patients between 48 hours and six weeks after discharge. Patients eligible for the survey must have stayed at least one night in the hospital for non-psychiatric treatment.

4. **Data Submission and Processing**: Hospitals or vendors submit the completed survey data to CMS. CMS processes the data, applies survey adjustments for factors like patient mix, and calculates scores.

5. **Scoring and Reporting**: CMS scores the responses based on composite and individual measures. The scores are then publicly reported on the Care Compare website, providing transparency about patient experiences and allowing consumers to compare hospitals.

6. **Role in Programs**: HCAHPS scores are used in quality incentive programs like the Hospital VBP Program, where they contribute to a hospital's TPS, impacting the facility's Medicare payments.

These results offer valuable insights into patient satisfaction and areas for improvement in hospital services, helping hospitals enhance care quality and patient experience. For more information on the HCAHPS Survey measure methodology please see HCAHPSOnline.org.

Question 28: **For the Person and Community Engagement domain, please confirm which value is used for each domain (linear or top box score)?**

The HCAHPS Survey measure, or Person and Community Engagement Domain Dimension Score is awarded for each HCAHPS dimension,

based on the greater of the improvement or achievement points.

A dash in a field appears if a hospital received neither achievement nor improvement points. Hospitals earn consistency points only on their lowest scored HCAHPS Survey measure dimension.

For the Person and Community Engagement domain, CMS utilizes the "top-box" scores from the HCAHPS survey. The "top-box" score reflects the percentage of patients who chose the most positive response for each survey item, indicating the highest level of satisfaction. These top-box scores are then used to evaluate hospital performance in this specific domain.

Question 29: **What are the data sources (claims) used for risk adjustment for each case in the Hospital VBP Program 30-day mortality measures? I believe that the hospital inpatient claims are extracted from the UB40. What other forms are used? Is the CMS-1500 form used for risk adjustment?**

For the Hospital VBP Program's 30-day mortality measures, several sources of data are used to adjust for risk across different cases. Here's a detailed look at how these sources contribute to the risk adjustment:

1. **Medicare Fee-for-Service Claims**: This includes hospital inpatient claims, which are primarily derived from the UB-04 forms (not UB40, which is a common misconception). The UB-04 form captures detailed information about the inpatient stay, such as diagnosis codes, procedure codes, admission and discharge statuses, and other relevant clinical data.

2. **Enrollment Data**: Information from Medicare enrollment databases is used to ascertain demographic factors like age, gender, and eligibility status (e.g., eligibility for Medicare due to disability), which are crucial for risk adjustment.

3. **Condition Categories**: These are derived from the claims data and are used to identify comorbidities and other conditions that might impact a patient's risk of mortality.

The CMS-1500 form, which is used for physician office billing, is not directly utilized for the risk adjustment in the 30-day mortality measures of the Hospital VBP Program. This form primarily relates to outpatient services and professional fee claims and does not typically contribute to the inpatient risk models used in these specific mortality measures.

Therefore, while hospital inpatient claims and other Medicare enrollment data play significant roles in risk adjustment for these measures, the CMS-1500 forms do not.