Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Hospital VBP Program, HAC Reduction Program, and Hospital Readmissions Reduction Program FY 2025 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 uses two time periods, the baseline and performance periods, to calculate Improvement Points. 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 calculate Improvement Points.

The Hospital VBP Program allows hospitals to earn Improvement Points based on how it improved its own performance from the baseline period (an earlier time period) to the performance period (a more recent time 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.

Question 2: **When will we receive the fiscal year (FY) 2025 Hospital VBP Program reports?**

CMS made the FY 2025 Hospital VBP Program Percentage Payment Summary Reports (PPSRs) available in the *Hospital Quality Reporting (HQR) Secure Portal* in late 2024. More information on how to access your PPSR is available in this brief instructional video.

Question 3: **Will CMS publish a Hospital VBP Program FY 2025 Quick Reference Guide?**

The FY 2025 Hospital VBP Program Quick Reference Guide is available for download on the Hospital VBP Program Resources page on QualityNet. The link can be found on slide 30.

Question 4: **Why is it useful to access the FY 2021 payment tables when analyzing historical payment data or trends in Medicare reimbursement?**

Accessing the FY 2021 payment tables on the Provider Data Catalog, and Table 16B on the CMS.gov website, offers several uses for hospitals.

Table 16B provides the actual payment adjustment factors by CMS Certification Number for each participating hospital under the Hospital VBP Program for FY 2025. 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 Inpatient Quality Reporting Program, or being located in Maryland) helps hospitals identify compliance issues and clarify their eligibility status. 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 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), but we no longer see those data points. Are they still available on the Compare tool on Medicare.gov?**

Yes, on the Compare tool on Medicare.gov 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 in the HAC Reduction Program?**

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) Healthcare-Associated Infection (HAI) measures report a standardized infection ratio, or a SIR.

The SIRs are calculated as the ratio of a hospital's observed HAIs to its predicted HAIs. The 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 it 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 fiscal year 2025 HAC Reduction Program's 75th percentile in your hospital's hospital-specific report (HSR).

Question 9: **Why are my readmission measure results in the Hospital Readmissions Reduction Program dataset on the Provider Data Catalog different from the readmission measure results on Medicare.gov?**

Both metrics use the same readmission measure methodology and hospital performance period. However, the readmission measure results on the Compare tool on Medicare.gov, 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 the Hospital Readmissions Reduction Program. CMS's goal is to provide information on a broader set of hospitals on Medicare.gov.

The Hospital Readmissions Reduction Program includes subsection (d) hospitals, as well as hospitals in Maryland. By contrast, the measure results on Medicare.gov are calculated among a broader set of hospitals, including subsection (d) hospitals, Maryland hospitals, and non-subsection (d) hospitals, such as critical access hospitals, Veterans Affairs medical centers and hospitals, and hospitals in U.S. territories.

Most hospitals will have similar results for the Hospital Readmissions Reduction Program 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 Hospital Readmissions Reduction Program 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 the Hospital Readmissions Reduction Program in FY 2025?**

CMS publishes hospitals' payment reduction percentage in the FY 2025 IPPS/Long-Term Care Hospital Prospective Payment System Prospective Payment System (LTCH PPS) final rule Hospital Readmissions Reduction Program Supplemental Data File. This file is posted on the FY 2025 IPPS Final Rule page on CMS.gov, as shown in the slides. This file includes hospitals subject to Hospital Readmissions Reduction Program requirements 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 2025. Hospitals with a payment reduction percentage equal to 0 percent are not penalized in FY 2025.

Question 11: **For the Hospital VBP Program, why is Table 16A published since it only includes the proxy payment adjustment rate and isn't the final payment adjustment rate?**

CMS publishes Table 16A as part of the IPPS final rule to provide hospitals with proxy value-based incentive payment adjustment factors based on historical performance data.

These proxy factors are calculated using the Total Performance Scores (TPSs) from the previous fiscal year and a predetermined exchange function slope, giving hospitals an estimate of how their Medicare reimbursements may be adjusted under the Hospital VBP Program.

Since hospitals have the opportunity to review and correct their performance data, the actual payment adjustment factors are later provided in the PPSR and officially published in Table 16B. This process ensures hospitals receive an initial estimate to plan for financial impacts while allowing for final adjustments based on verified data.

Question 12: **Will we be able to download more current data for these programs?**

For the Hospital Readmissions Reduction Program, the most recent data available on the Provider Data Catalog is July 1, 2020– June 30, 2023 (the FY 2025 performance period).

For the HAC Reduction Program, the most recent data available on the Provider Data Catalog for CDC's NHSN HAI measures is January 1, 2022–December 31, 2023; for the CMS PSI 90 measure, it is July 1, 2021–June 30, 2023 (the FY 2025 measure performance periods).

For the Hospital VBP Program, the most recent data available on the Provider Data Catalog for the Clinical Outcomes domain is uly 1, 2020–June 30, 2023 for the mortality measures, and April 1, 2020–March 31, 2023 for the complication measure; for the Person and Community Engagement domain, Safety domain, and Efficiency and Cost Reduction domains, it is January 1, 2023 –December 31, 2023 (the FY 2025 measure performance periods).

More recent data for some measures may be available on the Compare tool on Medicare.gov.

Question 13: **How soon can we expect a response to a validation reconsideration in the HAC Reduction Program?**

Through the HAC Reduction Program validation reconsideration process, hospitals can request reconsideration of their final validation scores. CMS will provide written notification of the formal decision regarding the reconsideration request to the hospital contact(s) listed on the validation reconsideration request form. CMS anticipates that the

reconsideration process may take approximately 90 days from the receipt of the reconsideration request.

Question 14: **Does the Hospital Readmissions Reduction Program and the HAC Reduction Program also include critical access hospitals (CAHs)?**

CMS only includes subsection (d) hospitals in the HAC Reduction and Hospital Readmissions Reduction Programs. In general, subsection (d) hospitals are general acute care hospitals paid under IPPS.

CMS does **not** include the following non-subsection (d) hospitals and units in the HAC Reduction and Hospital Readmissions Reduction Programs:

- CAHs
- Rehabilitation hospitals and units
- LTCHs
- Psychiatric hospitals and units
- Children's hospitals
- PPS-exempt Cancer Hospitals
- Veterans Affairs hospitals
- Short-term acute care hospitals in U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)
- Religious nonmedical health care institutions

Question 15: **Are any changes to these programs expected? Are they related to any of the executive orders and federal staffing/program cuts?**

The Social Security Act set forth the statutory authority for the HAC Reduction (Section 1886(p)), Hospital Readmissions Reduction (Section 1886(q)), and Hospital VBP Programs (Section 1886(o)). Substantive changes to the Hospital VBP Program, the HAC Reduction Program, and the Hospital Readmissions Reduction Program requirements would occur through federal rulemaking. Each spring, CMS announces proposed changes to the program via the IPPS/LTCH PPS proposed rule. A 60-day

public comment period then begins to allow for stakeholder feedback. After considering and responding to public comments, CMS announces the final policies in the IPPS/LTCH PPS final rule. Please refer to the FY 2026 IPPS/LTCH PPS proposed rule for recently proposed policies.

Question 16: **From what date do you have 30 days to submit corrections?**

For the Hospital VBP Program, the HAC Reduction Program, and the Hospital Readmissions Reduction Program, the Review and Correction period begins the first full business day following when PPSRs or HSRs are made available on the HQR system. Hospitals were provided with 30 days to review and correct their data in 2024 prior to results appearing on the Provider Data Catalog in early 2025.

CMS notified hospitals of the exact dates of the Review and Correction period via the HVBP Notify: Hospital Inpatient Value-Based Purchasing (HVBP) Program Notifications QualityNet Listserv.

Question 17: **Are the HCAHPS results displayed as the linear result in the Provider Data Catalog?**

HCAHPS results are not displayed as a linear result in the Provider Data Catalog. Instead, they are reported as percentile scores, top-box percentages, and star ratings based on patient survey responses.

Question 18: **Hospital VBP Program, Hospital Readmissions Reduction Program, and HAC Reduction Program reports were usually updated once a year in July or August. Why were those reports available in February? Were there changes in performance periods?**

The FY 2025 Hospital VBP Program, Hospital Readmissions Reduction Program, and HAC Reduction Program reports were made available to hospitals in August 2024. Those FY 2025 results were then publicly reported on the Provider Data Catalog in February 2025. The performance periods in the reports that were sent to hospitals in August 2024 are the same as those on the Provider Data Catalog.

Question 19: **Where can we access the patient-level data that are used to determine the numerator and denominator of the readmission measures and Hospital VBP Program measures?**

Detailed patient-level data for the readmission, mortality, complication, and Medicare Spending Per Beneficiary (MSPB) measures are available

in your hospital's HSR for each program or measure. The HSR is a confidential report that CMS sends to hospitals at the beginning of the Review and Correction period. The HSR provides hospitals the opportunity to review their results. Detailed information about the Hospital VBP Program's HAI and HCAHPS measures is available through the HQR system's Performance Reports PPSR. Patient-level data is not available on the Provider Data Catalog.

For detailed information on specific data elements, please refer to the resources available on the QualityNet website.

You can directly download HSRs from the HQR system, and a login is required. Follow the steps below to access your HSR via the HQR system. You can view a brief instructional video on how to download your reports.

If you have any issues accessing your HSR, please contact CCSQ Service Center at qnetsupport@cms.hhs.gov, or by calling, toll free, 866-288-8912 (TRS 711), weekdays from 8:00 a.m. to 8:00 p.m. ET. For questions related to Health Care Quality Information System (HCQIS) Access Role and Profile (HARP) registration, please visit the HARP Help page or contact qnetsupport@cms.hhs.gov.

Question 20: **What is the difference between the Compare tool on Medicare.gov and the Provider Data Catalog?**

The Compare tool on Medicare.gov is a user-friendly tool designed for patients and caregivers to compare healthcare providers based on quality ratings, patient experiences, and performance metrics, helping them make informed decisions.

In contrast, the Provider Data Catalog is intended for researchers and analysts, offering comprehensive, downloadable datasets with detailed provider information for in-depth analysis. While the Compare tool on Medicare.gov simplifies provider comparisons with an easy-to-navigate interface, the Provider Data Catalog provides raw data for those needing more granular insights, such as Medicare reports and utilization statistics.

Question 21: **For the Hospital Readmissions Reduction Program, are you only including elective inpatient Medicare Fee-for-Service patients?**

Patients are included in the readmission measures if they meet, at minimum, the following criteria:

- Are age 65 and older
- Have been hospitalized for one of the following conditions or procedures included in the Hospital Readmissions Reduction Program during the performance period: Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, pneumonia, Coronary Artery Bypass Graft surgery, or Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty
- Are enrolled in Medicare Fee-for-Service Part A and Part B for the full 12 months before the index stay (the initial admission), as well as enrolled in Part A during the index stay

Patients enrolled in Medicare Advantage (MA) are not currently included in the readmission measures. However, in the FY 2026 IPPS/LTCH PPS proposed rule (pages 18283–18286), CMS proposed to expand the readmission measures' inclusion criteria to include MA beneficiaries beginning with the FY 2027 program year.

More information about which patients are included in the readmission measures is available in the Readmission Measures Methodology on the QualityNet website.