Medicare Quality Programs Performance Overview

Federal Fiscal Years (FFYs) 2022 – 2024 Program Performance
-Version 1-

Report Description

This report is a one-page summary of actual hospital quality performance and estimated impacts for each of the Centers for Medicare and Medicaid Services' (CMS') three Medicare fee-for-service (FFS) inpatient quality programs: Value-Based Purchasing (VBP); Readmissions Reduction Program (RRP); and Hospital Acquired Condition (HAC) Reduction, for federal fiscal years (FFYs) 2022 – 2024.

Adjustment factors provided in this report are the final factors as reported by CMS. Correction notices are reflected in this report.

CMS is neither penalizing nor rewarding hospitals for the FFYs 2022 and 2023 VBP programs due to the COVID-19 pandemic. Therefore, there are no FFYs 2022 or 2023 VBP performance data in this analysis. In addition, CMS is not penalizing hospitals for the FFY 2023 HAC program due to the COVID-19 pandemic. Therefore, there are no FFY 2023 HAC performance data in this analysis.

VBP

For each year, this report provides scores for the eligible domains: person and community engagement; clinical outcomes; safety; and efficiency and cost reduction.

VBP program adjustments apply to inpatient base operating dollars only, without adjustments for Disproportionate Share Hospitals (DSH), Indirect Medical Education (IME), outlier payments, etc.

A hospital's national percentile ranking based on score is provided in order to evaluate its performance against their peers. The 100th percentile rank represents the best performance, and the 1st percentile rank represents the worst. Hospitals that consistently perform better than their peers on all measures/domains are likely to gain under the VBP program, while hospitals that perform worse than their peers are likely to lose under the program.

If a hospital does not report data during a particular time period or is not eligible for a particular domain, then the hospital score and hospital percentile will indicate "N/A".

The separate domain scores are combined to calculate a total performance score (TPS) for each hospital. This report provides a hospital's TPS and national percentile ranking. The TPS is what CMS uses to redistribute the VBP dollars under the program.

Each year, CMS calculates a payment slope to determine the VBP program payments such that the program is budget neutral. The slope is dependent on the distribution of all TPSs and varies each year. Adjustment factors are calculated on each hospital's

program contribution and payout amounts. Adjustment factors are applied to base operating payments on a per-discharge basis to adjust for VBP program performance.

If a hospital is not eligible for the VBP program for a particular year, the column for that program year will not appear. If a hospital is not eligible for the VBP program in any year, the table and graph will be empty.

RRP

Under the RRP, a hospital's excess readmission rates are determined for multiple condition areas. Penalties are based on the excess readmission rates and the total amount of Medicare revenue received by the hospital for caring for those patients.

RRP adjustments apply to inpatient base operating dollars only, without adjustments for DSH, IME, outlier payments, etc.

This report includes hospital excess readmission ratios – i.e. the ratio of expected readmissions over predicted readmission for each condition as well as the revenue by condition for each of the years.

A budget neutral Socio-Demographic Status (SDS) adjustment is made in which hospitals are grouped into quintiles based on their ratio of full-benefit dual eligible patients to total Medicare FFS and Medicare Advantage (MA) patients; hospitals excess ratios are then compared to the condition-specific median excess ratio of all hospitals within their quintile to calculate excess readmission dollars. Hospitals in higher quintiles tend to have less stringent benchmarks than those in lower quintiles. There will be winners and losers within each quintile.

The excess ratio is multiplied by the revenue by condition to determine excess readmission dollars by condition. If the excess readmission ratio is less than the quintile excess median ratio, there is no penalty for that condition.

Excess readmission dollars by condition are summed to arrive at the total estimated excess readmission dollars, which in turn are used to derive the overall, final RRP adjustment factor.

The final RRP adjustment factor is applied to inpatient base operating revenue for each program year to determine an estimated annual impact.

The checkboxes above the graph can be used to toggle between Condition Revenue and Estimated Impact.

If a hospital does not have data for a particular measure, the report will indicate "N/A. If a hospital was not eligible for RRP for a particular year but still included in the RRP Supplemental File, the adjustment factor will be 1 and the excess ratios will all indicate "N/A". If a hospital is not eligible for RRP for a particular year and not included in the RRP Supplemental File, the column for that program year will not appear.

HAC Reduction Program

The HAC Reduction program section provides hospitals with a national percentile ranking based on score for each hospital for each program year. Measure scores are equally weighted to calculate total HAC scores.

The HAC program reduction of 1.0% is applied to total Medicare FFS payments, inclusive of operating, capital, uncompensated care payments, outlier payments, and payment adjustments such as DSH, IME, and VBP/RRP program adjustments. The impact of a HAC reduction (if applicable) on outlier payments is not included in the impacts in this report.

The report provides the hospital's final total HAC score, as well as the 75th percentile cut off score for each program year.

If a hospital's total HAC score is **above** the 75th percentile, the hospital receives a 1.0% reduction to its total Medicare inpatient revenue for that program year. If a hospital's total HAC score is **at-or-below** the 75th percentile, the hospital does not receive a HAC program penalty.

The report provides a hospital's estimated annual impact for each program year. If a hospital's total HAC score was below the 75th percentile, the estimated annual impact for that hospital will be $0. Otherwise, a negative estimated impact will be indicated.

HAC ratios for all program-eligible hospitals nationwide are assigned winsorized z-scores which represent how a hospital performed compared to the national average, in terms of standard deviations from the mean. Poor performance is indicated by a positive z-score and good performance is indicated by a negative z-score. Lower scores are better.

The checkboxes above the graph can be used to toggle between program years. If hospital lines do not appear in the graph, please refer to the table.

If a hospital does not have a total HAC score reported, the report will indicate "N/A" for the total HAC score.
Overall Impact

The overall estimated impact of the three Medicare quality programs for each of the program years is provided in a fourth section of the report. Payment adjustment factors for each of the programs are the actual, final factors for all three years. Dollar impacts are inclusive of changes due to correction notices and are estimated based on the financial information in the source data.

Data Sources

All dollar impacts in this report are estimated by applying final adjustment factors to Medicare FFS inpatient revenue estimates from the FFY 2024 Final Rule Inpatient Prospective Payment System (IPPS) impact file. FFY 2024 revenue is reduced by the appropriate market basket factor for FFYs 2022 and 2023. Hospitals for which FFY 2024 revenue is not available are not included in this report. Hospitals that are not eligible for at least one of the three programs in at least one of the three years are not included in this report.

The final VBP Adjustment Factors and slopes are taken from FFY 2024 IPPS Final Rule Table 16B. The FFY 2024 VBP domain scores are from the final updates of Care Compare for that program year.

Excess readmission ratios by condition, median quintile excess readmission ratios, full-benefit dual eligible ratios, quintile assignments, budget neutrality modifiers, and adjustment factors for the RRP program are from the FFYs 2022-2024 IPPS Final Rule RRP supplemental files.

Excess readmission dollars by condition are calculated using FFYs 2017-2022 Medicare Provider Analysis and Review file claims data and Diagnostic Related Groups (DRG) payment ratios from the appropriate IPPS Final Rule RRP Supplemental Files.

The FFYs 2022 and 2024 HAC Scores are from the final updates of Care Compare for that program year.