Hospital Value-Based Purchasing (VBP) Program: How to Read Your Fiscal Year (FY) 2022 Baseline Measures Report

Program Overview

The Hospital 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 and serves as an important driver in redesigning how the Centers for Medicare & Medicaid Services (CMS) pays for care and services 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 monitor their performance for all domains and measures required for the Hospital VBP Program.

FY 2022 Measurement Periods

The baseline and performance periods for FY 2022 measures are outlined in Table 1.

Table 1. FY 2022 Baseline and Performance Periods

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), and Heart Failure (HF)	July 1, 2012–June 30, 2015	July 1, 2017–June 30, 2020
Clinical Outcomes: 30-Day Mortality measure for Pneumonia (PN) (updated cohort)	July 1, 2012–June 30, 2015	September 1, 2017–June 30, 2020
Clinical Outcomes: Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complication measure	April 1, 2012–March 31, 2015	April 1, 2017–March 31, 2020
Person and Community Engagement: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) dimensions	January 1–December 31, 2018	January 1–December 31, 2020
Safety: Healthcare-Associated Infection (HAI) measures	January 1–December 31, 2018	January 1–December 31, 2020
Efficiency and Cost Reduction: Medicare Spending per Beneficiary (MSPB) measure	January 1–December 31, 2018	January 1–December 31, 2020

Baseline Measures Report

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

1. The **Clinical Outcomes Detail Report** provides details on the six 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 Detail Report** 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 Detail Report** 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.

4. The **Efficiency and Cost Reduction Detail Report** 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 not meeting the minimum number of cases/surveys 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 minimum number of cases/surveys are met during the performance period. Achievement points will be displayed on the Percentage Payment Summary Report (PPSR).

Section 1. Clinical Outcomes Detail Report

Section 1 displays your hospital's performance on the six Clinical Outcomes measures. Each measure is listed by the measure identifier, followed by the measure name.

> **Note**: The report mockups in this document are meant to be used as a visual representation (layout) of the report only and may not be an exact replication of actual report calculations.

Figure 1. Clinical Outcomes Detail Report

Report Run Date: Page 1 of 4

Hospital Value-Based Purchasing – Baseline Measures Report

Clinical Outcomes Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2022

Data As Of:

Mortality Baseline Period (AMI, HF, COPD,CABG): 07/01/2012 - 06/30/2015
Mortality Baseline Period (PN): 07/01/2012 - 06/30/2015

Mortality Measures	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	41	0.866859	0.861793	0.881305
MORT-30-CABG Coronary Artery Bypass Grafting (CABG) 30-Day Mortality Rate**	24	0.975450	0.968210	0.979000
MORT-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate**	0	-	0.920058	0.936962
MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	107	0.885776	0.879869	0.903608
MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	120	0.903072	0.836122	0.870506

Complication Baseline Period: 04/01/2012 - 03/31/2015

Complication Measure	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
COMP-HIP-KNEE Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty Complication Rate	318	0.028150	0.029833	0.021493

Calculated values were subject to rounding.
* A dash (-) indicates that the minimums were not met for calculation of the points or scores.
* A double asterisk (**) indicates that the hospital did not meet the minimum requirements for the measures in the Baseline Period.
Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

A dash (-) will be displayed in the Baseline Period Rate field when a hospital has a value of zero eligible discharges for the measure.

A double asterisk (**) after a measure name indicates that the hospital did not meet the minimum of 25 eligible discharges needed during the baseline period for improvement points to be scored. As a result, improvement points will not be calculated on your hospital's PPSR for the measure.

Explanation of Clinical Outcomes Detail Report Fields

The **number of eligible discharges** refers to the number of admissions for Medicare fee-for-service beneficiaries discharged from subsection (d) and Maryland acute care hospitals having a principal discharge diagnosis of AMI, COPD, HF, or PN; or a procedure code of primary THA and/or TKA; and meeting other measure inclusion criteria.

The **baseline rate** indicates a hospital's rate for each Clinical Outcomes measure during the baseline period. A minimum of 25 cases (i.e., a baseline period number of eligible discharges value greater than or equal to 25) is required to compute improvement points.

> **Note**: The 30-day mortality measure values display as survival rates instead of mortality rates. Higher values indicate better outcomes.

The **achievement threshold** marks the 50th percentile of all hospitals' performance for each measure during the baseline period.

The **benchmark** represents the mean of the top decile of all hospitals' performance for each measure during the baseline period.

Section 2. Person and Community Engagement Detail Report

Section 2 displays your hospital's performance on the eight dimensions of the Person and Community Engagement Detail Report. Each dimension is listed by the dimension title.

Figure 2. Person and Community Engagement Detail Report

Report Run Date:

Page **2** of **4**

Hospital Value-Based Purchasing – Baseline Measures Report

Person and Community Engagement Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2022

Data As Of:

Baseline Period: 01/01/2018 - 12/31/2018

HCAHPS Dimensions	Baseline Period Rate	Floor	Achievement Threshold	Benchmark
Communication with Nurses	75.6055%	15.73%	79.18%	87.53%
Communication with Doctors	82.2040%	19.03%	79.72%	87.85%
Responsiveness of Hospital Staff	57.4033%	25.71%	65.95%	81.29%
Communication about Medicines	63.4000%	10.62%	63.59%	74.31%
Cleanliness and Quietness of Hospital Environment	67.2014%	5.89%	65.46%	79.41%
Discharge Information	87.4032%	66.78%	87.12%	91.95%
Care Transition	48.9015%	6.84%	51.69%	63.11%
Overall Rating of Hospital	69.6047%	19.09%	71.31%	85.18%

HCAHPS Surveys Completed During the Baseline Period **1332**

Calculated values were subject to rounding.

A dash (-) indicates that the baseline period rate could not be calculated.

A double asterisk (**) after a dimension name indicates that the hospital did not meet the minimum of 100 completed HCAHPS Surveys needed during the baseline period for improvement points to be scored.

As a result, improvement points will not be calculated on your hospital's PPSR for the dimensions in the Person and Community Engagement domain.

Explanation of Person and Community Engagement Detail Report Fields

The **baseline period rate** refers to a hospital's rate for each Person and Community Engagement dimension during the baseline period. A minimum of 100 completed HCAHPS Surveys is required in the baseline period to compute improvement points on the PPSR.

The **floor** indicates the worst-performing hospital's performance rate during the baseline period, which defines the zero percentile for this dimension.

The **achievement threshold** marks the 50th percentile of all hospitals' performance on each dimension during the baseline period.

The **benchmark** represents the mean of the top decile of all hospitals' performance on each dimension during the baseline period.

Section 3. Safety Measures Detail Report

Section 3 displays your hospital's performance on the HAI measures.

Figure 3. Safety Measures Detail Report

Report Run Date: Page 3 of 4

Hospital Value-Based Purchasing – Baseline Measures Report

Safety Measures Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2022

Data As Of:

Baseline Period: 01/01/2018 - 12/31/2018

Healthcare Associated Infections	Number of Observed Infections (Numerator)	Number of Predicted Infections (Denominator)	Standardized Infection Ratio (SIR)	Achievement Threshold	Benchmark
CAUTI Catheter-Associated Urinary Tract Infection	3	3.971	0.755	0.727	0.000
CLABSI Central Line-Associated Blood Stream Infection	2	1.259	1.589	0.633	0.000
CDI Clostridium difficile Infection	3	8.772	0.342	0.646	0.047
MRSA Methicillin-Resistant Staphylococcus aureus Bacteremia**	2	0.992	-	0.748	0.000
SSI-Abdominal Hysterectomy	9	10.559	0.852	0.727	0.000
SSI-Colon Surgery**	N/A	N/A	-	0.749	0.000

Calculated values were subject to rounding.
* "N/A" indicates no data were available or submitted for this measure.
* A dash (-) indicates that the minimums were not met for calculation of the points or scores.

N/A indicates that no data were available or submitted for the measure during the baseline period.

A dash (-) indicates that the minimums were not met for the calculation of the SIR. A dash will be displayed in the SIR field when a hospital has an unrounded number of predicted infections value less than 1.000 or N/A for the measure.

A double asterisk (**) after a measure name indicates that the hospital did not meet the minimum unrounded number of 1.000 predicted infection(s), as calculated by the Centers for Disease Control and Prevention (CDC), needed during the baseline period for the calculation of a SIR and improvement points to be scored. As a result, improvement points will not be calculated on your hospital's PPSR for the measure.

Explanation of Safety Measure Detail Report Fields

The HAI measures include CAUTI, CLABSI, CDI, MRSA, SSI-Abdominal Hysterectomy, and SSI-Colon Surgery.

The **number of observed infections (numerator)** refers to the observed number of infections applicable to each measure.

The **number of predicted infections (denominator)** indicates the expected number of infections applicable to each measure. This value is calculated by the CDC based on the data that the hospital submits to the National Healthcare Safety Network for each measure.

The **SIR** represents the calculated number of observed infections divided by the number of predicted infections. For HAI measures, lower values correspond to higher quality. A minimum of 1.000 predicted infections is required to compute improvement points on the PPSR.

The **achievement threshold** marks the 50th percentile of all hospitals' performance during the baseline period. The **benchmark** is the mean of the top decile of all hospitals' performance during the baseline period.

Section 4. Efficiency and Cost Reduction Detail Report

Section 4 displays your hospital's performance on the MSPB measure of the Efficiency and Cost Reduction domain.

Figure 4. Efficiency and Cost Reduction Detail Report

Report Run Date: Page 4 of 4

Hospital Value-Based Purchasing – Baseline Measures Report

Efficiency and Cost Reduction Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2022

Data As Of:

Baseline Period: 01/01/2018 - 12/31/2018

Efficiency and Cost Reduction Measures	MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure	# of Episodes
MSPB-1 Medicare Spending per Beneficiary (MSPB)	$22,000.00	$20,000.00	1.100000	568

Calculated values were subject to rounding.

N/A indicates that no data were available for the measure during the baseline period.

A double asterisk (**) after a measure name indicates that the hospital did not meet the minimum of 25 episodes of care needed during the baseline period for improvement points to be scored. As a result, improvement points will not be calculated on your hospital's PPSR for the measure.

Explanation of Efficiency and Cost Reduction Detail Report Fields

The **MSPB amount (numerator)** is the hospital's Medicare spending per beneficiary dollar amount.

The **median MSPB amount** is the national median MSPB dollar amount.

The **MSPB measure** is the hospital's MSPB measure ratio calculated as MSPB amount divided by the median MSPB amount.

The **number (#) of episodes** is the number of MSPB episodes during the baseline period. A minimum of 25 episodes of care is required to compute improvement points on the PPSR.

Questions

For further assistance with the Hospital VBP Program, please contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor via the Hospital Inpatient Questions and Answers tool at https://cmsqualitysupport.service-now.com/qnet_qa or by calling, toll free, (844) 472-4477 or (866) 800-8765, weekdays from 8 a.m. to 8 p.m. ET.
For questions regarding technical issues, contact the *QualityNet* Help Desk at qnetsupport@hcqis.org.