CMS Inpatient Value, Incentives, and Quality Reporting Programs Overview

IQR — What is the Hospital Inpatient Quality Reporting (IQR) Program?

Under the inpatient prospective payment system (IPPS), CMS provides hospitals a financial incentive to report on the quality of services and provide data to consumers to help them make informed healthcare decisions. Hospitals in the Hospital IQR Program must meet quarterly and annual quality measure submission deadlines and other requirements. Hospitals that do not participate, or that participate but do not comply with program requirements, will receive a one-fourth reduction of the applicable percentage increase in their annual payment update for the applicable Fiscal Year (FY).

eCQM — What are electronic clinical quality measures (eCQMs)?

An eCQM is a clinical quality measure (CQM) that is expressed and formatted to use data from electronic health records (EHRs) and/or health information technology systems to measure healthcare quality, specifically data captured in structured formats during patient care. The reporting of eCQMs allows hospital EHR systems to configure, extract, and submit CQMs. This reduces the need for manual abstraction and allows for consistency in measure reporting. Both the Hospital IQR and Medicare Promoting Interoperability Programs use eCQMs. Check requirements for both programs to confirm your hospital has successfully completed data submission to meet the respective requirements.

VBP — What is the Hospital Value-Based Purchasing (VBP) Program?

Under the Hospital VBP Program, payment is directly linked to the quality of care provided. The program was designed to promote better clinical outcomes for patients and improve their experience of care within the acute care setting. Measure data are evaluated and scored based on a specific methodology that compares baseline and performance periods and results in individual measure scores, domain scores, and an overall performance score for each hospital. This score equates to an incentive payment to the hospital based on the adjustment factor applied to the base Diagnosis-Related Group rate and affects payment for each discharge in the relevant FY. The resulting payment adjustment could increase or reduce hospital payments for that FY. Hospitals not participating in the Hospital IQR Program or not complying with program requirements are excluded from the Hospital VBP Program.

IPFQR — What is the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program?

The IPFQR Program is a pay-for-reporting program that requires inpatient psychiatric facilities (IPFs) to collect and submit quality data to CMS and meet procedural requirements by the annual submission deadline. IPFs in the IPFQR Program are excluded from payment under the IPPS because they submit claims to CMS under the inpatient psychiatric facility prospective payment system (IPF PPS). Eligible IPFs that do not meet one or more program requirements will be at risk of a 2.0 percentage point reduction of their annual payment update for the applicable FY.

PCHQR — What is the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program?

CMS has designated 11 hospitals nationwide as Prospective Payment System (PPS)-exempt Cancer Hospitals (PCHs). Those PCHs, under the PCHQR Program, are excluded from payment under the IPPS. The program is intended to encourage hospitals and clinicians to improve the quality of care provided to Medicare beneficiaries by ensuring they are aware of and reporting on best practices for their respective facilities and type of care. The PCHQR Program comprises multiple types of measures, including Safety and Healthcare-Associated Infection, Clinical Process/Oncology Care Measures, Intermediate Clinical Outcome, Patient Engagement/Experience of Care, Clinical Effectiveness, and Claims-Based Outcome measures.

PR — What is Public Reporting (PR)?

Information regarding the quality of care hospitals provide their patients is publicly reported on *Hospital Compare*, a consumer-oriented website. The information automatically appears from required measure data submitted by hospitals or collected from Medicare claims. Consumers use *Hospital Compare* to compare performance and cost for like conditions and procedures. Non-participating hospitals, such as critical access hospitals, have the option to publicly report their data. IPFQR Program measures will appear on *Hospital Compare* beginning with the July 2019 release. PCHQR Program measures are available for review via a link on the *Hospital Compare* Home page.

HAC — What is the Hospital-Acquired Condition (HAC) Reduction Program?

The HAC Reduction Program is a pay-for-performance program that supports CMS' effort to link Medicare payments to healthcare quality in the inpatient hospital setting. The HAC Reduction Program evaluates hospital performance by calculating a Total HAC Score from hospital performance on select measures of healthcare-associated infections and patient safety. Hospitals with a Total HAC Score in the worst-performing quartile among all subsection (d) hospitals have a 1% reduction applied to their Medicare fee-for-service (FFS) payments in the following Fiscal Year.

HRRP — What is the Hospital Readmissions Reduction Program?

HRRP is a pay-for-performance program that reduces payments to subsection (d) hospitals with excess readmissions. In accordance with the 21st Century Cures Act, hospital performance is assessed relative to other hospitals treating a similar proportion of Medicare patients who are also eligible for full Medicaid benefits (i.e., dual eligible). HRRP includes six condition/procedure-specific 30-day risk-standardized readmission measures. CMS assesses hospital performance using the excess readmission ratio, which is a relative measure of a hospital's readmission performance compared to the average hospitals that admitted similar patients. HRRP payment reductions are capped at 3%. CMS applies payment reductions to a hospital's Medicare FFS base operating DRG payments for the applicable Fiscal Year.