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).

eCQMs — What are electronic clinical quality and hybrid measures?

Electronic clinical quality measures (eCQMs) are measures specified in a standard electronic format that use data electronically extracted from electronic health records (EHRs) and/or health information technology (IT) systems to measure the quality of healthcare provided. The annual submission of eCQM data for the acute care hospital setting is an aligned requirement for the Hospital IQR and Medicare Promoting Interoperability Programs. Hybrid measures are quality measures that merge EHR data elements with claims data to calculate measure results. Hospitals participating in the Hospital IQR Program are encouraged to voluntarily submit hybrid measure data. Beginning with the FY 2026 payment determination, hospitals will be required to submit data for the hybrid hospital wide readmission and mortality measures.

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 (DRG) 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.

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 quarterly and annual submission deadlines. IPFs in the IPFQR Program are excluded from payment under the IPPS because they submit claims to CMS under the inpatient psychiatric facilities 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 patients by ensuring they are aware of and reporting on best practices for their respective facilities and type of care. The PCHQR Program has multiple types of measures, including Safety and Healthcare-Associated Infection (HAI), Clinical Process/Oncology Care Measures, Intermediate Clinical Outcome, Patient Engagement/Experience of Care, and Claims-Based Outcome.

PR — What is Public Reporting?

Information regarding the quality-of-care that hospitals provide their patients is publicly reported on *Care Compare,* a consumer-oriented CMS website. The information is derived automatically from required measure data submitted by hospitals and other facilities or collected from Medicare claims. Consumers use *Care Compare* to compare performance and cost for like conditions and procedures. Prior to the public release of data, hospitals are given the opportunity to review their data during a 30-day preview period. eCQM data will appear on the Provider Data Catalog link on the *Care Compare* home page beginning with the January 2023 release. PCHQR Program measures are available for review via the Provider Data Catalog link on the *Care Compare* Home page.

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

The HAC Reduction Program is a Medicare value-based purchasing program designed to promote better clinical outcomes by encouraging hospitals to implement best practices to reduce their rates of HAIs and improve patient safety. The HAC Reduction Program evaluates hospital performance by calculating a Total HAC Score from hospital performance on select measures of HAIs 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 for the applicable FY.

HRRP — What is the Hospital Readmissions Reduction Program (HRRP)?

HRRP is a Medicare value-based purchasing 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 unplanned readmission measures. CMS assesses hospital performance using the excess readmission ratio, which is a measure of a hospital's relative performance compared to an average hospital 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 FY.