Medicare Readmission Reduction and Hospital Acquired Condition Programs Overview

Illinois Health and Hospital Association

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Susan McDonough, MBA, MPA

Lauren Alvarenga, MPH, CPH

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Today's Objectives

- Overview of Medicare Readmission Reduction and Hospital Acquired Condition Programs

- Review Methodologies

- Review Illinois' performance in the two programs

- Review RRP and HAC Analyses

Medicare Quality Based Payment Reform (QBPR) Programs

- Mandated by the ACA of 2010
  - VBP Program (redistributive w/ winners and losers)
  - Readmissions Reduction Program (remain whole or lose)
  - HAC Reduction Program (remain whole or lose)

- National pay-for-performance programs

- Most acute care hospitals must participate; CAHs excluded

- Program rules, measures, and methodologies adopted well in advance (through 2027)

Medicare Quality Programs

- Payment adjustments based on <u>facility-specific</u> performance compared to <u>national</u> standards

- Performance metrics are determined using historical data

- Program components change every year
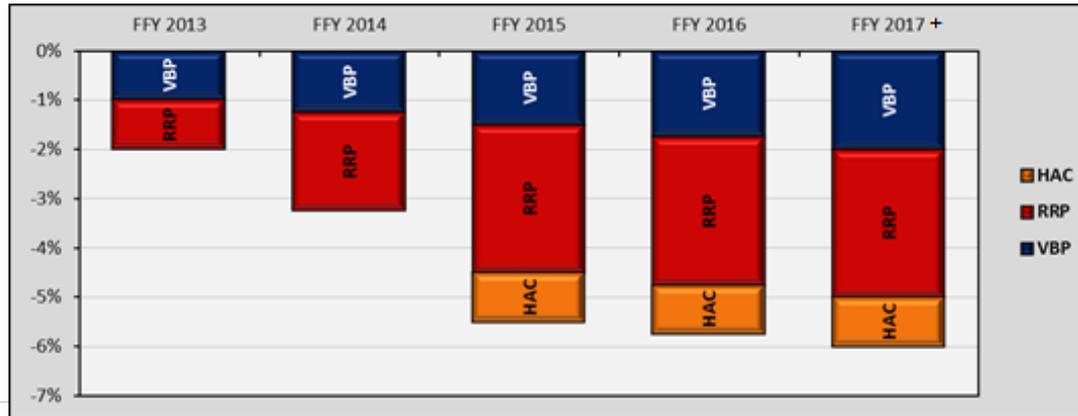
Quality Program Measure Populations FFY 2023

- Value-Based Purchasing (VBP)
  - All patients
    - Safety, Person and Community Engagement
  - Medicare FFS patients only
    - Clinical Outcomes, Efficiency and Cost Reduction

- Readmissions Reduction Program (RRP)
  - Medicare FFS patients only

- Hospital Acquired Conditions (HAC)
  - All patients
    - CAUTI, CLABSI, C-diff., MRSA, SSI Colon, SSI Abdominal Hysterectomy
  - Medicare FFS patients only
    - PSI-90

Medicare Readmission Reduction Program (RRP)

| National Quintile Assignments	Excess Readmission Ratios by Condition	Excess Readmission Revenue by Condition	Total Excess Readmission Revenue (all conditions)	RRP Adjustment Factor	Program Impact

- **Program became effective FFY 2013** (October 1, 2012)

- **Penalizes hospitals for exceeding expected readmission rates**
  - Expected rates based on national performance levels

- **Program expands over time with addition of new conditions**

- **Penalty capped at 3% for 2015 and thereafter**
  - 1% in FFY 2013;
  - 2% in FFY 2014;
  - 3% in FFY 2015+

- **Measures are established in advance through the IPPS rule**

RRP Program Timeframes

	2017	2018	2019	2020	2021	2022	2023	2024
		FFY 2022 Program Performance Period (All Conditions)		Excluded[#]		FFY 2022 Program Payment Adjustment		
			FFY 2023 Program Performance Period (All Conditions except PN)	Excluded[#]	FFY 2023 Program Performance Period (All Conditions except PN)		FFY 2023 Program Payment Adjustment	
			FFY 2024 Program	Excluded[#]	FFY 2024 Program Performance Period (All Conditions)			FFY 2024 Program Payment Adjustment

[#]These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for RRP.

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RRP Methodology

- Excess readmission ratios are calculated for multiple condition areas

Measure	FFY 2013 Program	FFY 2014 Program	FFY 2015 Program	FFY 2016 Program	FFY 2017+ Program
AMI	X	X	X	X	X
HF	X	X	X	X	X
PN	X	X	X	X	X*
COPD			X	X	X
THA/TKA			X	X	X
CABG					X

*expanded to include aspiration PN and sepsis with a secondary diagnosis of PN

- Improvement is not recognized
- Certain planned readmissions are not counted
- No offsets between categories
- Socio-Demographic Status (SDS) adjustment based on percent of full-benefit dual eligible patients

5/20/2022   Slide 8

RRP Methodology – FFY 2023 SDS Adjustment

- Groups based on ratio of full-benefit dual eligible relative to total Medicare patients:

$$\frac{\text{\# Full}-\text{benefit Dual Status}}{\text{\# Medicare Patients}}$$

- An individual is counted as a full-benefit dual patient if the patient was identified as such for the month he/she was discharged from the hospital
  - identified using the State Medicare Modernization Act (MMA) file of dual eligibility
- Data period for identifying patients is the same 3-year period as the performance period
  - i.e. July 1, 2018 – June 30, 2021 for FFY 2023
- Total number of Medicare patients is all Medicare FFS and Medicare Advantage stays using MedPAR files
- Hospitals are grouped into national quintiles based on full-benefit dual eligible ratio and compared to hospitals within their quintile

RRP Methodology

- Step 1: Place hospital into quintile

$$\frac{\text{\# Full}-\text{benefit Dual Status Patients}}{\text{\# Medicare Patients}} = \textbf{Full} - \textbf{benefit Dual Eligible Ratio}$$

$$\frac{14,322}{29,453} = \textbf{Full} - \textbf{benefit Dual Eligible Ratio}$$

$$48.6\% = \textbf{Full} - \textbf{benefit Dual Eligible Ratio}$$

Ratio of 48.6% puts this hospital in quintile 3

- Quintile placement on a national level
- Placement will change from year to year based on data period used and ratios of other hospitals
- Quintile 5 is highest, meaning the higher full-benefit dual eligible ratios
- Quintile 1 is lowest, meaning the lowest full-benefit dual eligible ratios
- Hospitals in higher quintiles will have <u>less</u> stringent benchmarks
- Hospitals in lower quintiles will have <u>more</u> stringent benchmarks

RRP Methodology (con't)

- <u>Step 2</u>: Calculate excess readmission ratios for each condition
  (subject to minimum case counts requirements)

  $$\frac{\text{Predicted AMI Readmission Rate}}{\text{Expected AMI Readmission Rate}} = \textbf{AMI Excess Ratio}$$

  $$\frac{20.300\ \%}{19.459\ \%} = \textbf{AMI Excess Ratio}$$

  $$\mathbf{1.0432} = \textbf{AMI Excess Ratio}$$

- Predicted readmissions = number of unplanned readmissions predicted for a hospital based on hospital's performance

- Expected readmission = expected U.S. readmission rate for each hospital's patient mix

- Ratio less than quintile median excess ratio

  - Lower than expected readmission rate

  - Better quality

- Ratio greater than quintile median excess ratio

  - Higher than expected readmission rate

  - Lower quality

  - Penalty applies

RRP Methodology (con't)

- <u>Step 3</u>: Calculate total excess payments for each condition

Total Payment for AMI Procedures $\times$ (**Median Quintile Excess Ratio** $-$ **AMI Excess Ratio**) $=$ **AMI Excess Dollars**

Historically, excess ratio was compared to a "1"

$\$6,000,000 \times (\mathbf{1.0233} - \mathbf{1.0432}) =$ **AMI Excess Dollars**

$\mathbf{\$119,400} =$ **AMI Excess Dollars**

- <u>Step 4</u>: Calculate total excess payments for all conditions

AMI Excess Payments + **HF Excess Payments** + **PN Excess Payments** + **COPD Excess Payments** + **THA TKA Excess Payments** + **CABG Excess Payments** = **Total Excess Dollars**

$\mathbf{\$119,400} + \mathbf{\$0} + \mathbf{\$0} + \mathbf{\$0} + \mathbf{\$0} + \mathbf{\$0} + \mathbf{\$0} =$ **Total Excess Dollars**

$\mathbf{\$1}19,400 =$ **Total Excess Dollars**

- Excess Ratios are multiplied by revenue in each condition area to find excess readmission revenue by condition
  - Sum of all conditions excess revenue = total excess readmission dollars
  - Revenue = exposure
  - More conditions = More exposure

RRP Methodology (con't)

- <u>Step 5</u>: Calculate Readmissions Adjustment factor (capped at .97, or 3%, for FFY 2015+)

$$\left[1 - \text{BN Adjuster} \times \frac{\text{Total Excess Dollars}}{\text{3 yr Total Medicare IPPS Operating Revenue}}\right] = \text{Readmissions Adj. Factor}$$

$$\left[1 - 0.99 \times \frac{\$119,400}{\$50,000,000}\right] = \text{Readmissions Adjustment Factor}$$

$$0.9976 = \text{Readmissions Adjustment Factor}$$
(applied on a per-claim basis)

-0.24% cut

- Total excess readmission revenue is used to calculate adjustment factors.
- The excess revenue is not your impact.
- Payments are adjusted on a per-claim basis to all Medicare FFS cases (not just RRP cases)
- Although the SDS adjustment is budget neutral nationally, there will be winners and losers within each quintile.

RRP Trends

Estimated U.S. Revenue by Condition in Billions

- AMI: $5.14
- HF: $7.83
- PN: $8.99
- COPD: $3.57
- THA/TKA: $8.54
- CABG: $3.17
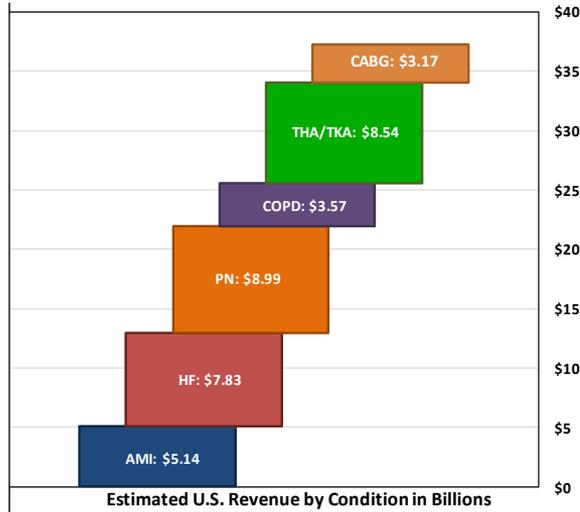
- Continually evolving

- As measures are added, exposure increases and hospitals are more likely to receive penalties

Adjustment Factor	Percent Cut	2019	2020	2021	2022
No Payment Penalty	0%	18.1%	17.5%	17.4%	18.0%
0.9951 to 0.9999	-0.01% to -0.5%	41.6%	42.5%	42.9%	44.5%
0.9901 to 0.9950	-0.5% to -0.999%	20.1%	18.9%	19.9%	19.7%
0.9851 to 0.9900	-1.0% to -1.499%	9.4%	10.6%	9.7%	9.4%
0.9801 to 0.9850	-1.5% to -1.999%	5.6%	4.8%	5.0%	4.0%
0.9751 to 0.9800	-2.0% to -2.499%	2.5%	2.7%	2.8%	2.2%
0.9701 to 0.9750	-2.5% to -2.999%	1.2%	1.2%	1.1%	0.9%
0.97	-3.0%	1.5%	1.8%	1.2%	1.3%

RRP Performance Scorecard

Actual FFY 2021 Performance

Actual Adj. Factor	Actual % Impact	Est. Revenue Subject to Adj.	Est. Impact	Max Penalty (3.0%)
0.9700	-3.00%	$30,888,000	($926,600)	($926,600)

National Budget Neutrality Modifier	% Full-Benefit Dual Eligible	National Quintile	SDS Impact (Breakout)
0.9613	33.87%	5	$0

Actual FFY 2022 Performance

Actual Adj. Factor	Actual % Impact	Est. Revenue Subject to Adj.	Est. Impact	Max Penalty (3.0%)
0.9784	⬆ -2.16%	$31,718,800	($685,100)	($951,600)

National Budget Neutrality Modifier	% Full-Benefit Dual Eligible	National Quintile	SDS Impact (Breakout)
0.9637	33.58%	5	$80,000

Condition Chart:
- ☐ Condition Revenue
- ☑ Est. Impact
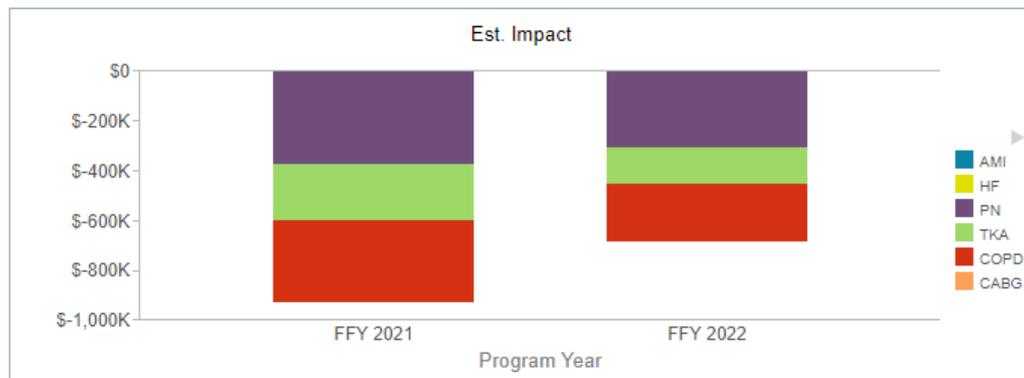
Actual FFY 2021 Performance

Condition	Condition Revenue	Est. Impact	Percent Impact
AMI	$126,800	$0	0.00%
HF	$3,802,200	$0	0.00%
PN	$7,035,700	($373,000)	40.25%
THA/TKA	$4,345,700	($221,600)	23.92%
COPD	$4,227,100	($332,000)	35.83%
CABG	$0	$0	0.00%

Actual FFY 2022 Performance

Condition	Condition Revenue	Est. Impact	Percent Impact
AMI	$94,500	$0	0.00%
HF	$2,994,300	$0	0.00%
PN	$6,398,600	($306,100)	44.68%
THA/TKA	$3,882,900	($148,000)	21.60%
COPD	$3,165,100	($231,000)	33.72%
CABG	$0	$0	0.00%

RRP Performance Scorecard (con't)

Condition:
- ☐ AMI
- ☐ CABG
- ☐ COPD
- ☐ HF
- ☑ PN
- ☐ THA/TKA

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Actual Performance: PN		
FFY Program	**2021**	**2022**
Eligible Discharges	814	697
DRG Ratio [A]	0.0766	0.0818
Excess Ratio [B]	1.2059	1.1392
Quintile Median [C]	1.0166	1.0167
Excess % [D = C - B]	0.1893	0.1225
Excess Amt. [E = A x D]	0.0145	0.0100
Total Excess Amt. [F = Sum(E)]	0.0360	0.0224
Excess % of Total [G = E/F]	40.25%	44.68%
Total Est. Impact [H]	($926,600)	($685,100)
Est. Impact by Condition [G x H]	($373,000)	($306,100)

An adjustment factor in blue indicates there would have been higher penalty if not capped at 3.0%

Readmissions Reduction Program: Hospital Case Study

- Hospital had several excess ratios below 1 in 2022

- Estimated negative annual impact is still high in ($30.,900) in 2022 in part due to being in quintile 2 for the SDS adjustment and having more stringent benchmarks (less than 1)

- Hospitals in higher quintiles will typically be compared to less stringent benchmarks and hospitals in lower quintiles will generally be compared to more stringent benchmarks.

	2020		2021		2022	
	Excess Ratio	Median Excess Ratio	Excess Ratio	Median Excess Ratio	Excess Ratio	Median Excess Ratio
AMI	0.8562	0.9957	0.9184 ▲	0.9918	0.9880 ▲	0.9955
HF	0.9314	0.9862	0.9275 ▼	0.9899	0.8892 ▼	0.9927
PN	0.9688	0.9844	0.9418 ▼	0.9872	0.9977 ▲	0.9865
THA/TKA	0.9094	0.9969	0.8165 ▼	0.9941	0.8651 ▲	0.9944
COPD	1.0492	0.9940	1.0647 ▲	0.9942	1.0372 ▼	0.9941
CABG	1.0060	0.9961	0.9256 ▼	0.9942	0.9834 ▲	0.9845

	2020	2021	2022
Quintile Assignment	2	2	2
Final RRP Adjustment Factor	0.9988	0.9987	0.9989
Estimated Annual Impact	($32,000)	($35,600) ▼	($30,900) ▲

IL's RRP Revenue by Condition
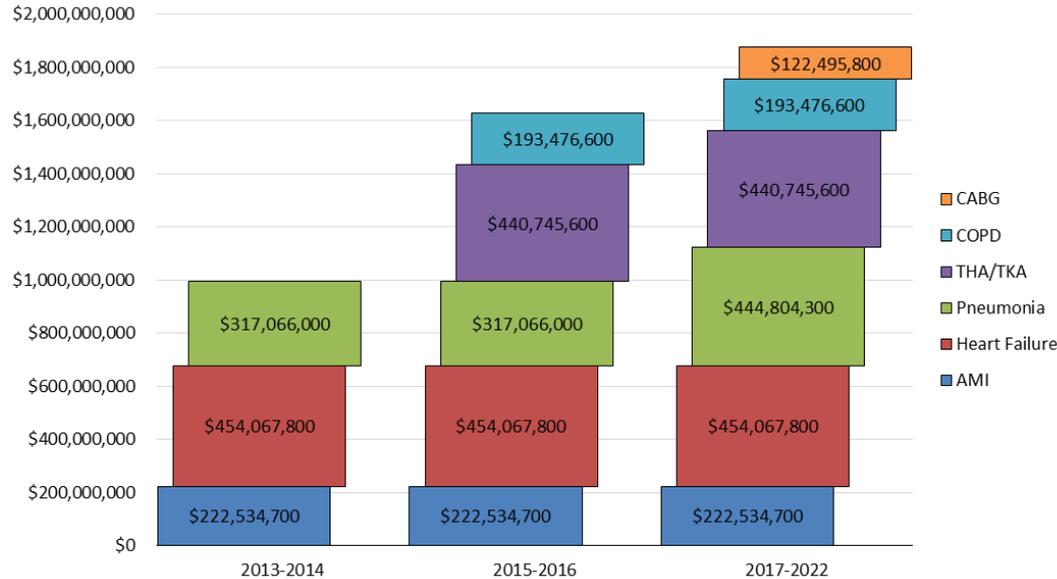
Condition/Procedure	2013-2014	2015-2016	2017-2022
AMI	$222,534,700	$222,534,700	$222,534,700
Heart Failure	$454,067,800	$454,067,800	$454,067,800
Pneumonia	$317,066,000	$317,066,000	$444,804,300
THA/TKA	N/A	$440,745,600	$440,745,600
COPD	N/A	$193,476,600	$193,476,600
CABG	N/A	N/A	$122,495,800
Total Program Exposure	**$993,668,500**	**$1,627,890,700**	**$1,878,124,800**
Increase in Exposure		**63.8%**	**15.4%**

IL's RRP Impact by Condition
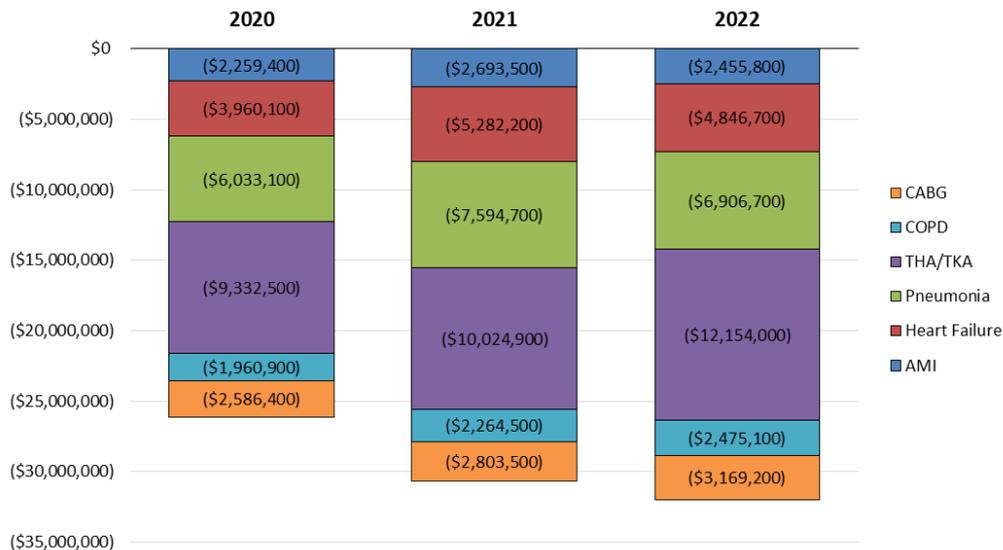
Condition/Procedure	2020	2021	2022
AMI	($2,259,400)	($2,693,500)	($2,455,800)
Heart Failure	($3,960,100)	($5,282,200)	($4,846,700)
Pneumonia	($6,033,100)	($7,594,700)	($6,906,700)
THA/TKA	($9,332,500)	($10,024,900)	($12,154,000)
COPD	($1,960,900)	($2,264,500)	($2,475,100)
CABG	($2,586,400)	($2,803,500)	($3,169,200)
Total Impact	**($26,132,400)**	**($30,663,300)**	**($32,007,500)**

Eligible providers and their characteristics are based on the FFY 2022 IPPS Final Rule Correction Notice.

IL's Readmission Rate Trends

	State Rates			
	2Q 2018 July 1, 2014 - June 30, 2017	2Q 2019 July 1, 2015 - June 30, 2018	2Q 2020 July 1, 2016 - June 30, 2019	2Q 2021 July 1, 2017 - Dec 1, 2019
READM_30_AMI: Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	15.9%	15.7% ▼	16.3% ▲	15.9% ▼
READM_30_HF: Heart Failure (HF) 30-Day Readmission Rate	21.6%	21.6% ▼	22.1% ▲	22.1% ▲
READM_30_PN: Pneumonia (PN) 30-Day Readmission Rate	17.0%	16.9% ▼	17.1% ▲	17.1% ▲
READM_30_HIP_KNEE: Elective Total Hip/Knee Surgery (THA/TKA) 30-Day Readmission Rate	4.1%	4.0% ▼	4.0% ▼	4.1% ▲
READM_30_COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	19.5%	19.4% ▼	19.8% ▲	20.2% ▲
READM_30_CABG: Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	13.3%	13.0% ▼	13.0% ▼	13.0% ▼

Readmission Rates

IL's Readmission Rank Trends

Readmission Ranks	State Rank			
	2Q 2018 July 1, 2014 - June 30, 2017	**2Q 2019** July 1, 2015 - June 30, 2018	**2Q 2020** July 1, 2016 - June 30, 2019	**2Q 2021** July 1, 2017 - Dec 1, 2019
READM_30_AMI: Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	31 of 51	32 of 51 ▲	42 of 51 ▲	38 of 51 ▼
READM_30_HF: Heart Failure (HF) 30-Day Readmission Rate	36 of 51	34 of 51 ▼	36 of 51 ▲	37 of 51 ▲
READM_30_PN: Pneumonia (PN) 30-Day Readmission Rate	37 of 51	36 of 51 ▼	41 of 51 ▲	40 of 51 ▼
READM_30_HIP_KNEE: Elective Total Hip/Knee Surgery (THA/TKA) 30-Day Readmission Rate	31 of 51	39 of 51 ▲	38 of 51 ▼	41 of 51 ▲
READM_30_COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	24 of 51	23 of 51 ▼	37 of 51 ▲	44 of 51 ▲
READM_30_CABG: Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	38 of 51	38 of 51	39 of 51 ▲	43 of 51 ▲

Medicare Hospital Acquired Condition (HAC) Reduction Program

Measure Scores	Domain Scores	Total HAC Score	Top Quartile/1.0% Penalty Determination	Annual Program Impact

- Program started FFY 2015 (October 1, 2014)
- Penalizes hospitals with the highest HAC rates
  - Rates are per 1,000 patients
  - Compared to all other eligible hospitals nationally
- 1% Penalty applied to all hospitals in the worst performing quartile
  - 25% of hospitals will receive a penalty
  - Applied to Total Medicare FFS Inpatient Dollars
- Parameters set in IPPS rulemaking at least one year in advance
- Penalty is in addition to existing HAC DRG demotion policy

HAC Program Timeframes

	2018	2019	2020	2021	2022	2023	2024
	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D

FFY 2022: PSI-90 Performance Period | Excluded#

FFY 2022: HAI Measures Performance Period | Excluded#

FFY 2022 Program Payment Adjustment

FFY 2023: PSI-90 Performance Period | Excluded# | FFY 2023: PSI-90 Performance Period

FFY 2023 Program Payment Adjustment

Excluded# | FFY 2023: HAI Measures Performance Period

Excluded# | FFY 2024: PSI-90 Performance Period

FFY 2024: HAI Measures Performance Period

FFY 2024 Program Payment Adjustment

#These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the HAC Program. In the FFY 2022 IPPS Final Rule, CMS also suppressed data from July 1, 2020 - December 31, 2020 due to the COVID-19 PHE for the HAC program.

HAC Reduction Program Methodology

- HAC measures:
  - PSI-90 Composite Measure, CAUTI and CLABSI, SSI (colon surgery and abdominal surgery), C-Diff and MRSA
- Separate performance scores are calculated for each HAC measure
  - Z-score
  - Based on national mean and standard deviation for all eligible hospitals
  - Improvement is not recognized
- Average of all eligible measures are calculated to determine a total HAC score (prior to FFY 2020, averages were calculated for two domains, then the domains were weighted together for a total HAC score)
- Total HAC Score determines worst performing quartile of hospitals to receive 1% payment penalty

# of HAI Measures with Scores	Weight applied to:	
	PSI 90	Each HAI
0	100%	N/A
1	50%	50%
2	33.3%	33.3%
3	25%	25%
4	20%	20%
5	16.7%	16.7%
Any number	N/A	100% (equally divided)

HAC Reduction Program: Z-score Methodology

- HAC program evaluates hospitals based on a **Z-score**
  - Measure ratios are winsorized to remove effects of outliers (top and bottom 5%)
  - Represents a hospital's distance from the national average for a measure, in terms of units of standard deviation
    - A **POSTIVE** z-score is above the average, and reflects **POOR** performance
    - A **NEGATIVE** z-score is below the average, and reflects **GOOD** performance
    - <u>Lower scores are better</u>
  - Z-scores are averaged together to determine Total HAC Score

$$Z - score = \frac{Hospital's\ Measure\ Performance\ -\ Mean\ Performance\ for\ All\ Hospitals}{Standard\ Deviation\ for\ All\ Hospitals}$$

HAC Reduction Program Measure Detail

HAI-6 SIR

5th: 0.00   Mean: 0.50   95th: 1.26   0.91
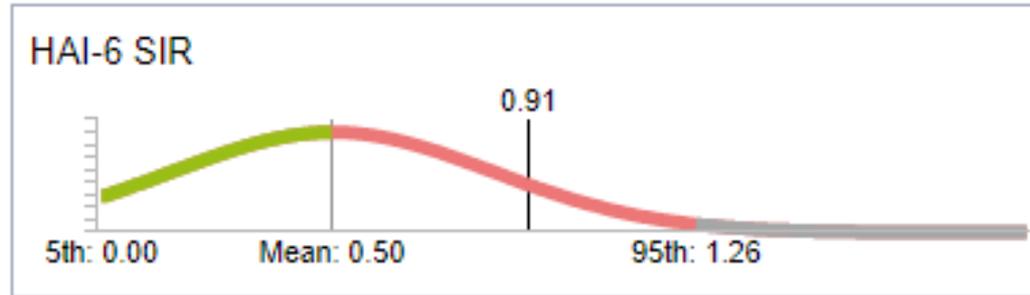
HAI-6: Clostridium difficile (C.diff.)

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	C.diff Z-Score
89.00	97.83	0.9100	0.9100	0.5019	0.3370	1.2110

HAC Reduction Program Performance Scorecard
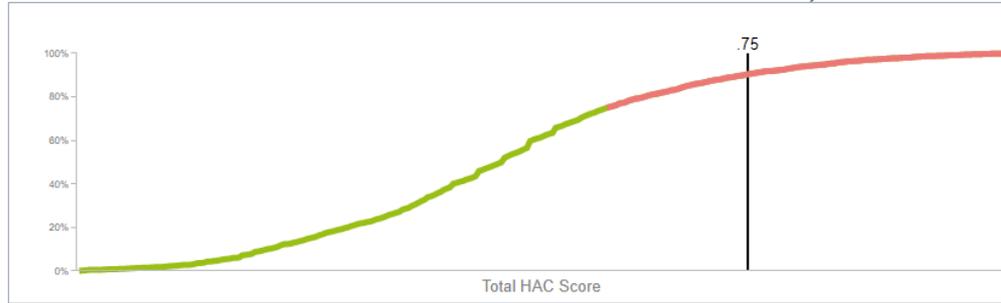
Estimated FFY 2023 Performance

Total HAC Score		75th Cutoff	Payment Penalty?	Est. Annual Impact
0.7503	⇧	0.3068	Yes	($1,549,200)

Estimated FFY 2023 Performance
Lower is Better

Measure	Base Score	Measure Z-Score	
AHRQ Claims Based			
PSI-90-Safety	1.1400	1.2526	⇧
CDC Chart Abstracted			
HAI-1	1.3000	0.4215	⇩
HAI-2	0.3670	-0.7701	⇩
SSI	1.0700	0.5222	⇧
HAI-5	2.2710	1.8645	⇧
HAI-6	0.9100	1.2110	⇧

HAC Data Source Summary

	2017	2018	2019	2020	2021	
	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	
Actual Program		**AHRQ PSI-90 Claims Based Measure (AHRQ Software: Modified Version 10.0)**		No longer included*		**FFY 2022 Payment Adjustment**
			CDC Chart Abstracted Measures (CLABSI, CAUTI, SSI, MRSA, C.diff)	No longer included*		
This Analysis		**AHRQ PSI-90 Claims Based Measure (AHRQ Software: Modified Version 10.0)**				
			CDC Chart Abstracted Measures (CLABSI, CAUTI, SSI, MRSA, C.diff)			

*These performance periods are impacted by the public health emergency so CMS is excluding claims data and chart-abstracted data reflecting services provided in Calendar Year 2020 in calculations for the HAC Program.

Hospital Acquired Condition: Hospital Case Study

FFY 2022

.26

Total HAC Score

	2020	2021		2022	
PSI-90 Score	-0.0183	-0.1267	▼	1.4252	▼
HAI-1 CLABSI Score	0.3678	-0.1342	▼	-1.291	▼
HAI-2 CAUTI Score	0.8354	0.2816	▼	1.0445	▼
SSI Colon/Abd. Score	-1.5000	0.0929	▲	-0.398	▼
HAI-5 MRSA Score	N/A	N/A	-	N/A	▲
HAI-6 C.Diff Score	1.9710	1.5775	▼	0.5193	▼
Total HAC Score	0.3312	0.3382	▲	0.2599	▼
75th Percentile Total HAC Score	0.3306	0.3383		0.2998	
Receives 1.0% Reduction?	Yes	No		No	
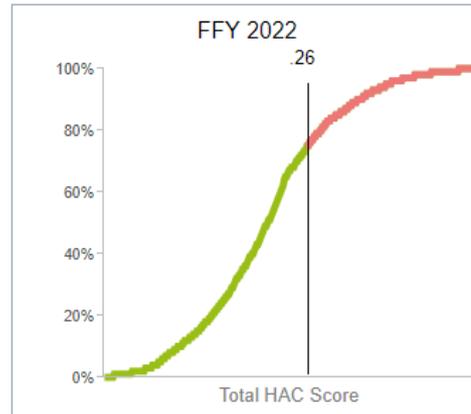
- Hospital does worse (Total HAC score increases) from 2020 to 2021.

- Hospital goes from penalty in 2020 to no penalty in 2021 (even with better performance in 2020 compared to 2021) because a hospital must keep up with other providers in the US in order to avoid getting a penalty.

- Even if all hospitals improve, 1.0% penalty is always applied to worst performing quartile.

IL's HAC Reduction Program Performance
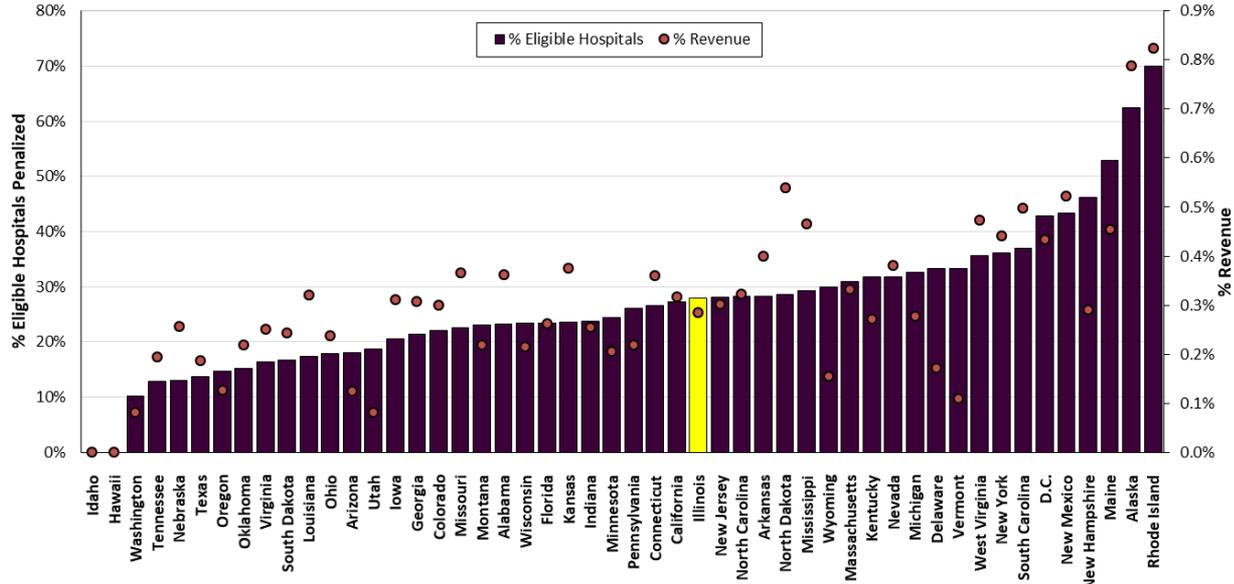
HAC Reduction Program Performance			
	FFY 2020	**FFY 2021**	**FFY 2022**
Statewide Impact	($16,594,900)	($16,291,700)	($15,818,900)
Number of Penalty Hospitals	32	36	35
Percent of Hospitals Receiving Penalty	25.6%	28.8%	28.0%
Percent of Total Revenue Affected	0.32%	0.30%	0.29%

Eligible providers and their characteristics are based on the FFY 2022 IPPS Final Rule Correction Notice.

Quality Program Reference Guide

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Quality Program Measure Trends

- **Chasing a moving target**

  - Measures/Domains

  - National Improvement Trends

  - Performance Standards/Z-scores

  - Start period and peer group in filter panel on left impacts all graphs and tables in report (except peer group for z-score graphs)

  - Comparison groups and measure only impact the current tab
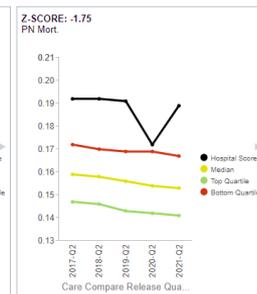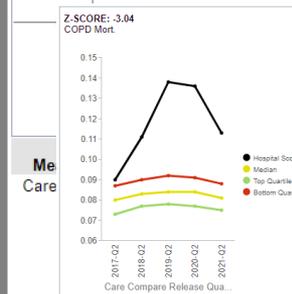
Hospital-Specific One-Pager Report
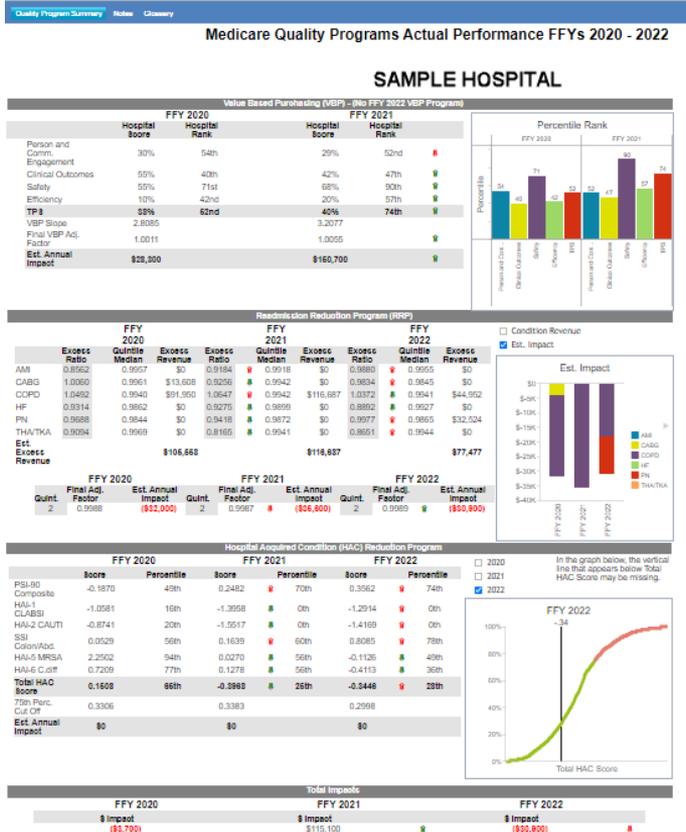
- 3-year trend for each hospital

- FFYs 2020-2022

- Actual performance on all 3 programs: VBP, RRP, HAC

Other Quality Data Sources

- Care Compare

- Quality Net

- Other

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Key Reminders for Hospitals

- Payments are at stake
- Historical data will continue to drive these programs
- Program targets move with national performance, so hospitals must keep pace with the pack
- Complexity of program measures
- Overlap with other quality based payment reform programs
  - VBP & HAC: CAUTI, CLABSI, Surgical Site Infection (SSI), MRSA and C-Diff Measures
  - VBP & RRP: THA/TKA, AMI, HF, PN, CABG, and COPD
- HACs will have a worst performing 25%

Thank you.

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Contact us

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