

VALUE-BASED PURCHASING: FREQUENTLY ASKED QUESTIONS

CMS Final Rule

June 2011

INTRODUCTION

The federal government’s long-held philosophy of paying hospitals for providing services to Medicare patients is changing. It is no longer enough for hospital providers to simply report and document that services were provided. With the issuance of CMS’ final rule addressing the Value-Based Purchasing (VBP) methodology, hospitals will be required to prove that the quality of care provided (and their patients’ perceptions of that care) meet or exceed national standards. To get paid requires more than just “doing”; it requires “doing it well.” Hospitals that fail to meet those standards will see payment reductions.

On May 2, the Centers for Medicare & Medicaid Services (CMS) put on display its highly anticipated final rule addressing implementation of a Medicare Value-Based Purchasing System, which was published in the *Federal Register* on May 6. This is a continuation of what is expected to be a series of rules designed to convert the Medicare program from simply a payer of services provided to a payer of *quality* services provided. While the final rule indicates that these payment adjustments are effective beginning Oct. 1, 2012, given the long-range CMS plans of integrating mortality measures (in FFY2014) and additional measurements in the future, this is expected to be a permanent Medicare payment adjustment for hospitals. Other quality measurements such as hospital-acquired conditions rates will eventually factor into the payment formulas as well. With CMS’ emphasis on quality of care, it is expected that other provider services, including post-acute and outpatient services, will see their current Medicare payments similarly adjusted.

In February, IHA prepared a “Frequently Asked Questions (FAQ)” document based on the CMS VBP proposed rule. In accordance with publication of the final rule, IHA presents this updated “FAQ” document for your information. Many provisions contained in the final rule are unchanged from those in the proposed rule; differences are pointed out below. Appendix A includes select comments from the health care field, along with CMS’ responses.

IHA will be sending members estimates of financial impacts and composite scores, based on the most current data available at this time. Among the more significant variables estimated in the analysis are:

- Each hospital’s specific 1% base DRG amount (the source is the latest data file from CMS).
- A linear function slope = 2.0. (In the estimates sent to you after the proposed rule was published, the slope was estimated at 2.35. As the slope decreases (or flattens), the dispersion between the highest “winner” and the highest “loser” shrinks.

- Based on current IHA estimates prepared in accordance with the VBP model in the 2007 CMS Report to Congress, the 1% total payment pool for Illinois hospitals is approximately \$41 million.

While the financial impact of this rule does not affect hospitals until FFY2013, preparations for implementation should begin now. Implementation should include internal processes such as evaluating how your hospital currently rates in terms of process measures and patient satisfaction, and estimating the financial impact on Medicare revenues. Since this is a patient care quality-driven rule, physicians' and case managers' input is also important.

QUESTIONS & ANSWERS REGARDING THE VALUE-BASED PURCHASING RULE

Integration of payment and quality

(Q) Where can I find the rule?

(A) The rule can be accessed through the following link:

<http://www.regulations.gov/#!documentDetail;D=CMS-2011-0003-0322> (Click on PDF.)

(Q) What is the rationale behind the implementation of Value-Based Purchasing?

(A) The hospital value-based purchasing program continues a longstanding effort by CMS to forge a closer link between Medicare's payment systems and improvement in health care quality, including the quality and safety of care in the inpatient hospital setting. In recent years, CMS has undertaken several initiatives, including demonstrations and quality reporting programs, to lay the foundation for rewarding health care providers and suppliers for the quality of care provided. This is achieved by tying a portion of Medicare payments to performance on quality measures. The transition of these initiatives to value-based purchasing is intended to transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive. The hospital VBP program is one of multiple reforms that are dramatically changing how Medicare pays hospitals. Other changes include incentives for implementing electronic health records and additional payment adjustments based on hospitals' rates of hospital-acquired conditions and readmissions.

(Q) What is the basis for CMS' authority to establish and implement this program?

(A) The Deficit Reduction Act of 2005 instructed CMS to design a plan for the structure and implementation of a Value-Based Purchasing system. In accordance with that directive, CMS published a report to Congress on its plans for the VBP system in November 2007. Section 3001 of the Affordable Care Act requires CMS to implement a hospital value-based purchasing program that rewards hospitals for the quality of care provided as demonstrated by their performance or improvement on measures of care quality beginning in FFY2013. The VBP implementation is

one step further than the current payment adjustment system that simply reduces payments to providers for failing to report on selected quality measures.

(Q) What is the general framework of the system?

(A) CMS' rule includes measures for the hospital value-based purchasing program, performance standards for the program, a scoring scheme, and a methodology for translating these scores into VBP-based incentive payments for hospitals in FFY2013. Under the program, CMS would evaluate a hospital's performance during a specific performance period based on achievement or improvement as compared to performance standards established for the program. Hospitals that achieve certain performance standards during this performance period or that improve their performance when compared to a baseline period would receive incentive payments ("re-distributions") for Medicare acute care discharges occurring on or after Oct. 1, 2012.

(Q) Which providers are affected?

(A) At this time, only inpatient, acute care hospitals paid under Medicare's Prospective Payment System are subject to the incentives provided under the Value-Based Purchasing System. It is expected that other hospitals (such as Critical Access Hospitals, Children's Hospitals or Long-Term Care Hospitals), as well as post-acute providers (such as Rehabilitation Hospitals, Skilled Nursing Facilities or Home Health Agencies) will be brought into the system in the future. Also, hospitals that are subject to the Hospital Inpatient Quality Reporting system payment reduction for a fiscal year are excluded from the definition of "hospital" for purposes of the Value-Based Purchasing program in that year. **In addition, hospitals with an insufficient volume of cases (less than 10) to calculate a meaningful process or HCAHPS score are excluded.**

(Q) What quality measurements will be used?

(A) CMS is using select measurements that have been publicly reported on *Hospital Compare*. In the first year, the measurements will include 12 process measurements on heart failure, heart attack, pneumonia, and surgical care, and eight measurements from HCAHPS (patient satisfaction). In the second year, CMS will add 13 new measurements which will be derived from claims data such as 30-day mortality rates; hospital-acquired conditions; and quality and patient safety measurements using the Agency for Healthcare Research and Quality methodology. Please refer to the attached matrix (Appendix B) for the proposed measurements for Value-Based Purchasing.

Scoring Methodology

(Q) What are the major components that will determine a specific hospital's rewards or penalties under this system?

(A) Initially, a hospital's financial impact will be determined based on an analysis of four components: (1) Base operating DRG payments to determine its contribution to the VBP "pool" of dollars available; (2) Process Measures Score (PM); (3) Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) Score; and (4) Overall Composite Score. The overall VBP score is comprised of 70% of the Process Measures score and 30% of the HCAHPS score. **Despite a significant number of comments to the contrary, CMS is retaining the 70% - 30% split in the final rule.** So for any hospital, .7 x PM score plus .3 x HCAHPS score equals the VBP composite score. Beginning in FFY2014, a hospital's specific outcome scores reflecting mortality rates for heart attack, heart failure and pneumonia will be incorporated.

(Q) How is the VBP system financed by hospitals?

(A) As required by the Affordable Care Act, the hospital VBP program will be budget-neutral, with all funds distributed in the same year they are collected. A pool of funds to be redistributed to hospitals based on quality performance will be funded through an across-the-board reduction to the IPPS standardized DRG amounts. The DRG percentage reduction is 1.0% in FFY2013, increasing by 0.25% each year until the reduction reaches a maximum of 2.0% for FFY2017 and subsequent years. Hospitals' notification of their 1% reduction amount will be included in the FY2013 Medicare IPPS final rule, expected to be published no later than Aug. 1, 2012.

(Q) What comprises the IPPS standardized amounts that fund the pool?

(A) The 1% of IPPS payments specific to a hospital is made up of base operating DRG payments taken from an estimate of FFY2013 payments. Those total estimated payments are reduced by the additional payments hospitals receive for outliers, capital, low-volume adjustments, indirect medical education or disproportionate share, as none of these adjustments are included in the 1% pool. CMS indicates that it will include a definition of the base payment amount in future rulemaking.

(Q) What are "Topped Out" Measures and how do they impact a hospital's score?

(A) CMS assigns scores to "Topped Out" measures. In theory, as a hospital's performance on a measure improves, the values of both the benchmark and the attainment threshold would increase. For these measures, all but a few reporting hospitals achieve similarly high performance level results. CMS believes that including the topped out measures would mask true performance comparisons among hospitals. In the final rule, CMS identifies 10 measures (compared to seven in the proposed rule) as "topped out:" AMI-1, Aspirin at Arrival; AMI-2, Aspirin Prescribed at Discharge; AMI-3, ACEI or ARB at Discharge; AMI-4, Smoking Cessation; AMI-5, Beta Blocker at Discharge; HF-2, Evaluation of LVS Function; HF-3, ACEI or ARB for LSVD; HF-4, Smoking Cessation; PN-4, Smoking Cessation; and SCIP-Inf-6, Surgery Patients With Appropriate Hair Removal).

(Q) How are the Process Measures scored?

(A) The scoring for Process Measures will consist of comparing two scores—one for attainment and one for improvement. To calculate the attainment score, a hospital’s performance in the scoring year is compared to the national benchmark (mean performance score for top 10%) and national threshold (50th percentile for all) for each measure. A hospital achieves an attainment score when its performance in the scoring year is above the national threshold for a certain measure; the closer the performance is to the national benchmark, the higher the attainment score. If a hospital’s performance during the scoring year is above the national benchmark, the hospital will receive a score of 10. If a hospital’s performance during the scoring year is below the national threshold, the hospital will achieve a score of 0. If a hospital’s performance is between the national benchmark and threshold, a score between 1 and 9 is calculated and assigned, according to a linear function.

To achieve the improvement score, a hospital’s performance for a certain measure must improve from the base year to the scoring year. For each measure, an improvement score of 0-9 is calculated by comparing a hospital’s performance in the scoring year to the range between the national benchmark (median performance score for top 10%) and the hospital’s performance in the base year. A hospital scoring equal to or lower than its baseline period score on a measure would receive 0 points for improvement.

The final Process Measures score by line item is the higher of the attainment score or the improvement score. The total score for the Process Measures equals the sum of all your hospital’s Final Scores divided by the total of all computed line items.

Examples of the various scoring calculations begin on page 26,520 (page 31 of 58) of the rule.

(Q) How are the HCAHPS measures scored?

(A) The methodology for calculating attainment and improvement scores for the HCAHPS indicators is similar to the methodology for the Process Measures described above. One additional consideration in the HCAHPS scoring is “consistency,” which measures whether hospitals are meeting the achievement thresholds established for all measures in this category. Hospitals that do not report at least 100 surveys during the performance period are excluded from the VBP program.

Hospitals would receive the higher of the attainment score or the improvement score for each measurement. In the final rule, CMS has agreed with many of the comments that percentages, instead of percentiles, should be used in the scoring determination, similar to the methodology used in the process measures scoring. A hospital will receive 1-9 points if it exceeds the threshold; if its score on one of the measures is below the threshold, it receives a score of 0 for that category. For

improvement, a hospital would receive a score of 0-9 based on comparison of its performance results with its baseline.

Consistency points, ranging from 0-20, will be given to a hospital based on how many of its scores meet or exceed the thresholds. But in a change from the proposed rule, CMS has defined a consistency “floor” as the lowest national score. In other words, if all of a hospital’s HCAHPS scores are above the achievement threshold, it will receive the maximum 20 consistency points. However, if only one of the hospital’s HCAHPS scores is the lowest nationally, the hospital would not receive any consistency points. Any hospital’s HCAHPS scores that range from above the national floor to the threshold will receive between one and 19 consistency points. Following are the published national floors for the eight HCAHPS measures:

Communication with Nurses	38.98%
Communication with Doctors	51.51%
Responsiveness of Hospital Staff	30.25%
Pain Management	34.76%
Communication About Medicines	29.27%
Cleanliness and Quietness of Hospital Environment	36.88%
Discharge Information	50.47%
Overall Rating of Hospital	29.32%

(Q) How is a specific hospital’s composite score determined?

(A) An overall VBP score is calculated by combining a hospital’s process measure score and HCAHPS indicator score. An overall VBP score is made up of 70% of the total process measure score and 30% of the total HCAHPS score.

(Q) How will hospitals be notified of their pool contribution amounts, their composite score and their portion of the pool redistribution?

(A) Hospital scores on Process Measures and HCAHPS will be available on the *Hospital Compare* website. The final rule indicates that hospitals will receive notification of their 1% IPPS reduction amount in the FFY2013 acute inpatient Medicare final rule, usually published no later than Aug. 1. CMS intends to implement this reduction for claims processed beginning Jan. 1, 2013. Hospitals would be notified of **estimates** of their redistribution payment via *QualityNet* no later than Aug. 1, 2012, with **final** amounts communicated on Nov. 1, 2012.

(Q) Is there more information on the linear function scoring methodology used when a hospital’s performance scores falls between the benchmark and the threshold? How are scores within a specific range (such as 0-9) assigned?

(A) Discussion of the linear function definition and application, as well as CMS' rationale for choosing this methodology, begins on page 26,531 (page 42 of 58) of the rule.

(Q) Do we know how a specific hospital's redistribution amount will be calculated?

(A) The specifics of the methodology are not clear; we know that the linear method will be used. Hospitals with composite scores below 0 will receive no award, while those above 0 will receive some award. There will be both "winners" and "losers" when the individual award amount is compared to the dollars put in the pool.

(Q) Will hospitals have the opportunity to review and appeal results before Medicare makes a final determination on the award?

(A) For the first year, hospitals will be notified of their estimated performance scoring and value-based incentive amounts 60 days prior to the beginning of FFY2013. However, CMS will be unable to make a final determination at that time since it is including claims through March 31, 2012. As a result, the agency proposes to provide final notification to providers on Nov. 1, 2012. CMS will make adjustments to payments in its claims processing system in January 2013, but those adjustments will be applied retroactively to discharges occurring on or after Oct. 1, 2012. The operational aspects of the claims adjustments will be announced in the FFY2013 final inpatient rule. While the final rule is silent on subsequent fiscal year determinations, Medicare is expected to make final determinations 60 days before the beginning of the federal fiscal year.

CMS has indicated that it will have an appeals process and will publish the specific details in a future rule.

(Q) How and where will hospitals be able to view their results and incentive determination?

(A) CMS will notify providers of estimated and final scores and financial determinations through each hospital's *QualityNet* account. Every hospital that currently submits performance measurement data has a *QualityNet* account where CMS provides all measurement results and previews of *Hospital Compare* information. If a hospital is unsure about its primary and backup account holders for *QualityNet*, it should contact its hospital's quality improvement staff. The *QualityNet* approach for review of performance results and previews of public information has been used for several years. Primary and backup account holders are encouraged to check their *QualityNet* mail boxes several times a week so they don't miss any important information.

(Q) Is the process that CMS is applying with the Hospital VBP program similar to other VBP programs for other providers?

(A) CMS is seeking to eventually include value-based purchasing in all of their provider programs. The final rules on a VBP for End Stage Renal Dialysis (ESRD) were made available on Dec. 29, 2010. While there were similarities, such as awards based on achievement and improvement measurements and scoring methodologies, differences included a penalty but no reward incentive in the ESRD program.

Impact of Post-Payment Reviews

(Q) How will post-payment audits of future Medicare claims affect the VBP payment process?

(A) As the VBP incentive payment is expected to be an “add-on” payment to the base DRG payment amount, any claim denials resulting from audits, such as the Recovery Audit Contractor review, will effectively return these dollars back to the Medicare program, along with the initial DRG payment. Conversely, it is expected that if a post-payment review results in the determination of an “underpayment to the hospital,” additional VBP dollars would be reimbursed as well. It is not known at this time whether a hospital will receive a “credit” for denied claims against the original amount charged to that hospital as part of the pooled amount, and CMS does directly address this issue in the final rule.

Contact IHA staff

(Q) Can I contact IHA if I have any further questions or comments?

(A): Please contact either of the following individuals:

- Cathy Grossi, Vice President, Quality Care Institute (630-276-5706 or cgrossi@ihastaff.org or
- Tom Jendro, Senior Director of Finance (630-276-5516 or tjendro@ihastaff.org)

Selected comments from the field and CMS' responses:

1. ***Comment:*** What is the relationship between the Hospital Inpatient Quality Reporting (IQR) program and VBP? How will payment penalties correlate (if at all) and will the IQR program even continue?

Response: Because the Affordable Care Act did not specifically repeal the IQR program, it will continue to exist alongside the VBP program. However, hospitals that are subject to a payment reduction for failing to meet the reporting requirements of the IQR program are not classified as “hospitals” under the Value-Based Purchasing program for that year. Additionally, with the assessing of payment penalties for hospitals’ failure to implement health information technology by 2015, the amount of the 2% payment reduction for failing to report under the IQR will be revised.

2. ***Comment:*** CMS should implement a 12-month performance reporting period for the mortality measures to be implemented in 2014, as opposed to the 18-month period specified in the proposed rule. (IHA-specific comment)

Response: CMS is amending the performance reporting period to begin on July 1, 2011 and ending June 30, 2012 for the three proposed 30-day mortality measures to be implemented in 2014.

3. ***Comment:*** CMS should exclude the measure for “Doctor Communication” from the Patient Experiences of Care survey, as physicians are paid under a separate fee schedule and the hospital IPPS should not be affected by physicians not financially vested in the system.

Response: Doctors’ communication represents a key aspect of care from the perspective of patients. Furthermore, many hospitals employ physicians, allowing the hospital to exert more control in those situations.

4. ***Comment:*** CMS should exclude Hospital-Acquired Conditions (HAC) measures from the 2014 VBP program, as hospitals could experience double payment penalties—one from the VBP program and one as mandated by the ACA (IHA-specific comment).

Response: CMS views the ACA-mandated HAC reductions and the VBP HAC reporting as related, but still two separate programs. No changes to the proposed rule were implemented in the final rule, although CMS will continue to monitor the interactions of various programs mandated by the ACA and that affect quality of care.

5. ***Comment:*** The proposed HAC measures only consider the first nine diagnoses on the patient claim.

Response: CMS is undergoing extensive system changes with implementation of the ICD-10 codes that will allow processing of up to 25 diagnoses and 25 procedure codes.

6. **Comment:** CMS should include the measures that are categorized as “topped out,” because it is still possible for hospitals to show improvement on them. (IHA-specific comment)

Response: CMS believes that once a measure is “topped out,” there is no room for improvement for the vast majority of hospitals. Therefore, these measures remain excluded.

7. **Comment:** Are 30-day readmission rates included in the Hospital VBP program?

Response: Readmissions measures are specifically excluded from the VBP program by the Affordable Care Act.

8. **Comment:** Measure scores for all three reporting domains (process, patient experience and outcomes) should be based on “all-patient” data, not limited solely to Medicare patients.

Response: Measures in the clinical process and patient experience domains are scored using all-patient data, while, due to data limitations, measures in the outcome domain are scored only for Medicare patients.

9. **Comment:** Care coordination measures are not included in the measurement set.

Response: This suggestion will be considered as VBP measurements are expanded in the future.

10. **Comment:** The 30% weighting of the Patient Experiences of Care is too high, due to its subjectivity. (IHA-specific comment)

Response: CMS disagrees and is maintaining the 30% weighting in the final rule.

11. **Comment:** CMS should drop the consistency score from the HCAHPS measures calculation altogether. (IHA-specific comment)

Response: CMS has not dropped the consistency variable from the calculations, although it has modified the scoring methodology.

12. **Comment:** CMS set the minimum number of cases for performance measurement reporting in the proposed rule at 10; many comments were received by the agency that this number is too low to provide any reliable scoring and that the number should be increased. (IHA-specific comment)

Response: CMS has finalized its proposed rule policies to exclude from a hospital’s total performance score any measure for which it reported fewer than 10 cases and to exclude from the VBP program any hospital to which less than four of the clinical processes apply.

13. Comment: The selection of a linear exchange function to determine the distribution of VBP payments was supported by the majority of the commenters, including MedPAC. However, many comments focused on the need for transparency as to the slope of the linear function; a maximum, performance-based adjustment amount applied to a hospital's base DRG amount, the budget neutrality factor and the methodology for distributing the payments to hospitals.

Response: CMS acknowledges the support of the linear function. With regards to the request for information concerning the other variables, CMS states that it will:

- Recalculate the linear slope for FFY2013 to a factor necessary to ensure that total aggregate payments under the system are equal to 1% of the base operating DRG amounts. CMS indicates that it will propose a definition of “base operating payment” in future rulemaking. CMS is unable to calculate the slope at this time until it has data from the performance period (July 2011 through March 2012) available.
- Provide information to hospitals (again, through future rulemaking) as to how the VBP payments will be distributed.
- Finalize the exchange function rule as proposed.

14. Comment: CMS should provide frequent updates of VBP financial information to hospitals. (IHA-specific comment)

Response: CMS will provide yearly updates.

15. Comment: CMS should establish an appeal process, whereby hospitals can challenge the calculation of the incentive payment, the composite score or the reduction to the DRG payment amounts.

Response: CMS will formalize this process in future rulemaking.

16. Comment: HCAHPS output scores are biased against those providers that use telephone or IVR system communication. Patients may not fully understand the questions. Also, older facilities tend to receive less favorable scores. (IHA-specific comment)

Response: CMS believes that it has satisfactorily removed the effects of bias from the survey results.

APPENDIX B

FINAL VALUE BASED PURCHASING RULE

Performance Measurements

Federal Fiscal Year 2013 - Discharges July 1, 2011 – March 31, 2012	Payers Included		Source of Data		Achievement Threshold	Benchmarks
	Medicare Only	All Payers	Clinical Abstract	Claims		
MEASUREMENT						
<i>Heart Attack</i>						
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival		X	X		0.6548	0.9191
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival		X	X		0.9186	1.0000
<i>Heart Failure</i>						
HF-1 Discharge Instructions		X	X		0.9077	1.0000
<i>Pneumonia</i>						
PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital		X	X		0.9643	1.0000
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient		X	X		0.9277	0.9958
<i>Surgical Care Improvement Program</i>						
SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision		X	X		0.9735	0.9998
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients		X	X		0.9766	1.0000
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time		X	X		0.9507	0.9968
SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose		X	X		0.9428	0.9963

SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period		X	X		0.9399	1.0000
SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered		X	X		0.9500	1.0000
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery		X	X		0.9307	0.9985

MEASUREMENT	Payers Included		Source of Data		Achievement threshold	Benchmarks
	Medicare Only	All Payers	Clinical Abstract	Claims		
<i>HCAHPS Patient Experience of Care Measures</i>						
Communication with Nurses		X	X		75.18%	84.70%
Communication with Doctors		X	X		79.42%	88.95%
Responsiveness of Hospital Staff		X	X		61.82%	77.69%
Pain Management		X	X		68.75%	77.90%
Communication About Medicines		X	X		59.28%	70.42%
Cleanliness and Quietness of Hospital Environment		X	X		62.80%	77.64%
Discharge Information		X	X		81.93%	89.09%
Overall Rating of Hospital		X	X		66.02%	82.52%
Outcome Measures for Federal Fiscal Year 2014						
<i>30-day Mortality Rate</i>						
Acute Myocardial Infarction (AMI)	X			X		86.9098%
Heart Failure (HF)	X			X		90.4861%
Pneumonia (PN)	X			X		90.2563%
<i>Hospital Acquired Condition Measures</i>						
Foreign Object Retained After Surgery	X			X		
Air Embolism	X			X		
Blood Incompatibility	X			X		
Pressure Ulcer Stages III & IV	X			X		
Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	X			X		
Vascular Catheter-Associated Infections	X			X		
Catheter-Associated Urinary Tract Infection (UTI)	X			X		
Manifestations of Poor Glycemic Control	X			X		

<i>AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures</i>						
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Complication/patient safety for selected indicators	X			X
Mortality for selected medical conditions	X			X