2025

HOSPITAL P4P

Pay for Performance (P4P) Program Technical Guide

IEHP
Inland Empire Health Plan

Contact: QualityPrograms@iehp.org

Published: March 25, 2025

TABLE OF CONTENTS

Program Overview

Program Measures

Measures

Risk-Based Measures

Appendix 1

Appendix 2

PROGRAM OVERVIEW

Inland Empire Health Plan (IEHP) is pleased to announce the eighth year of the Hospital Pay For Performance (P4P) Program for IEHP Medi-Cal contracted hospitals servicing Riverside and San Bernardino counties. This program underlines IEHP's commitment and support to our partners by providing financial rewards to hospitals that meet quality performance targets and demonstrate high-quality care to IEHP Members.

The 2025 Hospital P4P Program will award financial incentives for 15 individual measures, and includes 2 risk-based measures for which there is no payment outlay, as hospitals are held accountable for measure performance via forfeiture of dollars earned from other measures.

A. **Measures** feature clinical and transition of care quality indicators that highlight a hospital's commitment to excellence in patient outcomes as well as a data sharing measure to promote increased visibility and monitoring of key performance indicators, patient outcomes, and clinical excellence.

1. Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days
2. Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days
3. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio
4. Timely Postpartum Care
5. HQI Cares: Implementing BETA HEART®
6. Hospital Quality Rating
7. Patient Experience: Percentile Achievement
8. Hospital-Wide All-Cause Mortality
9. Quality Improvement Activity: Clinical Variation Reduction
10. Quality Improvement Activity: Patient Experience
11. Quality Improvement Activity: Readmission Reduction
12. Quality Improvement Activity: Safety and Adverse Events
13. Cal Hospital Compare "Health Organizations Leading SUD Care Honor Roll"
14. Adult Flu Vaccination
15. Manifest MedEx Active Data Sharing

B. **Risk-Based Measures**

16. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate
17. Post Discharge Follow-Up Appointment Within Seven Days of Discharge

☑ Participation Requirements

General:

- Hospitals located within Riverside and San Bernardino counties or other identified areas with emerging needs for IEHP Members must have an active IEHP contract for the Medi-Cal population and Covered California population at the beginning of the measurement year (2025).
- Hospitals must provide appropriate contact information for all hospital-based physician groups and engage in connecting key stakeholders from these hospital-contracted groups with IEHP as requested; including but not limited to topics regarding Covered California Network Adequacy.
- Hospitals must be in good standing with IEHP throughout the program year. This is defined as a Provider currently contracted with Plan for the delivery of services, not pursuing any litigation or arbitration or has a pending claim pursuant to the California Government Tort Claim Act (Cal. Gov. Code §§ 810, et. seq.), which is unresolved filed against Plan at the time of program application or at the time additional funds may be payable and has demonstrated the intent, in Plan's sole determination, to continue to work together with Plan on addressing community and member issues. Additionally, at the direction of the CEO or their designee, Plan may determine that a Provider is not in good standing based on relevant quality, payment, or other business concerns.
- Hospitals must provide Electronic Medical Record (EMR) access to IEHP for members with IEHP as the primary or secondary payor. This access facilitates treatment, payment, and operational processes, including but not limited to care coordination, utilization management (preauthorization, concurrent and retrospective review), and quality review. Access must be provided to IEHP by January 31, 2025, and continue through the entire measurement year (2025).
    - Due to their unique structure, Critical Access Hospitals are offered an alternative and must provide either EMR access (as above) and/or remain in good standing with IEHP's Integrated Transitional Care team throughout the program year. This is defined as a Hospital engaging in discussions, meetings and performance improvement related to member care transitions as requested and appropriate based on member volume and need.
- Hospitals that plan to discontinue a service line must be compliant with all requirements set forth by local, regional, and/or national governing agencies and regulatory bodies. Additionally, the Hospital must notify IEHP of the anticipated change at least 90 days prior to implementation.
- Hospitals are required to be in good standing with IEHP's Quality Management and Grievance and Appeals Departments. This includes but not limited to: Timely response for information/response related to Grievances, Potential Quality Issues, Corrective Action Plans, etc.

- For those measures that are evaluated on a quarterly basis, IEHP will re-evaluate performance for the entire measurement year, at the close of the 2025 reporting period.

Participation With/In Other Entity Reporting:

- Hospitals with Maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting, submit data timely as per CMQCC standards and have a signed CMQCC authorization release to share hospital-level results with IEHP.
- Hospitals must be in good standing with Dexur. Please reference Appendix 1 for additional details.
- Hospitals must be compliant with the requirements of the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF). Please visit the https://dxf.chhs.ca.gov/for-participants/ for additional information.
- Hospitals must participate in the ©Cal Hospital Compare "Healthcare Organizations Leading SUD Care - Hospital Self-Assessment" by June 27th, 2025. Please visit https://calhospitalcompare.org/ for details.
- Hospitals must have a current participation agreement (PA) in place with Manifest MedEx (MX). The executed PA using MX's post-merger PA structure must be in place at the beginning of each quarter to qualify for the quarterly incentive.

Data Submission:

- Hospitals must complete an update to their IEHP Hospital Profile as requested, approximately twice per year.
- Hospitals must submit their Inpatient, ED, and Ambulatory data to the Department of Health Care Access and Information (HCAI) and the Hospital Quality Institute (HQI) on an accelerated quarterly* basis in an editable file report.
- Hospitals must report healthcare-associated infection data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) on an accelerated monthly** basis and ensure rights are conferred to HQI.
- Hospitals must participate in disease-specific gap analyses and other strategic planning-related requests as requested by IEHP and relevant to hospital scope. This will be limited to no more than six requests throughout the calendar year.

** Quarterly reporting is effective 60 days (eight weeks) after the close of the measurement quarter.*
*** Monthly reporting is effective 60 days (eight weeks) after the close of the measurement month.*
Please reference table in Reporting Calendar portion of the guide for exact dates

☑ Program Terms and Conditions

- The Hospital must be in good standing with IEHP.
- Participation in the Hospital P4P Program, as well as acceptance of incentive payments, does not modify or supersede any terms or conditions of any agreement between IEHP and Providers, whether that agreement is entered before or after the date of this communication.
- There is no guarantee of future funding for, or payment under, any IEHP Provider incentive program. The Hospital P4P Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at IEHP's sole discretion.
- Criteria for calculating incentive payments are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the Hospital P4P Program, participants agree to fully and forever release and discharge IEHP from all claims, demands, causes of action, and suits, of any nature, relating to or arising from the offering by IEHP of the Hospital P4P Program.
- The determination of IEHP regarding performance scoring and payments under the Hospital P4P Program is final. If a potential discrepancy in performance scoring is identified, the responsibility will be on the Provider to demonstrate measure compliance.
- As a condition of receiving payment under the Hospital P4P Program, Providers must be credentialed and contracted with IEHP.
- P4P data is subject to retrospective validation and must pass all quality assurance checks. Recoupment of incentive payments may occur if the retrospective review fails medical record or other validation.
- Hospitals will not charge IEHP for medical records for routine operational activities including, but not limited to: HEDIS, Risk Adjustment and Financial Audit.

Incentive payments may be reduced or withheld as follows:

- (All Measures) Late or incomplete submissions: Late or incomplete submissions will generally not be accepted. If a late submission or resubmission is approved due to extenuating circumstances, hospitals may be penalized via a percent reduction in available/earned dollars. The specific percent reduction will be shared with the hospital at the time of approval for late submission or resubmission.
- (Manifest MedEx) Late or incomplete data feeds will generally not be accepted. If a late data feed or replay is approved due to extenuating circumstances, hospitals may be penalized via a percent reduction in available/earned dollars. The specific percent reduction will be shared with the hospital at the time of approval for late data feed or replay.

NOTE: If you disagree with your hospital's quarterly performance report, you may submit a request for dispute research by submitting dispute inquiries to QualityPrograms@iehp.org. All disputes for research must be submitted within 90 days of the distributed quarterly performance report.

Definitions:

Critical Access Hospital (CAH)

CAHs are specially designated hospitals located in rural areas. These may be more than 35 miles from the nearest hospital or more than 15 miles in areas with mountainous terrain or only secondary roads or designated by the State as a "necessary provider" of health care services to residents in the area. These facilities maintain no more than 25 inpatient beds that can be used for inpatient or swing-bed (skilled nursing facility level care), maintain an average length of stay of 96 hours or less for inpatients, and provide emergency services 24 hours a day, 7 days a week. Hospice agencies may contract with critical access hospitals to provide inpatient hospice care, included in the 25-bed maximum. Critical access hospitals may also operate a psychiatric and/or rehabilitation distinct part unit of up to 10 beds each. For purposes of the P4P program, Critical Access Hospital (CAH) designation is determined by Accreditation/Licensure. Hospitals must demonstrate qualification upon request by IEHP.

Financial Overview

The annual budget for the 2025 Hospital P4P Program is $64,800,000. The table below summarizes the Hospital P4P Program budget for the year, outlining dollars available per measure.

2025 HOSPITAL P4P PROGRAM	
Measure Name	**Financial Allocation**
Measures	
1. Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days	$3,000,000
2. Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days **NEW**	$3,000,000
3. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	$6,000,000
4. Timely Postpartum Care	$3,000,000
5. HQI Cares: Implementing BETA HEART®	$11,730,000
6. Hospital Quality Rating	$6,230,000
7. Patient Experience: Percentile Achievement	$3,000,000
8. Hospital-Wide All-Cause Mortality	$3,000,000
9. Quality Improvement Activity: Clinical Variation Reduction	$6,800,000
10. Quality Improvement Activity: Patient Experience	$4,000,000
11. Quality Improvement Activity: Readmission Reduction	$3,400,000
12. Quality Improvement Activity: Safety and Adverse Events	$3,400,000
13. Cal Hospital Compare "Health Organizations Leading SUD Care Honor Roll"	$340,000
14. Adult Flu Vaccination **NEW**	$1,900,000
15. Manifest MedEx Active Data Sharing	$6,000,000
Risk-Based Measures	
16. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery	*
17. Post-Discharge Follow-Up Within Seven Days of Discharge	*
Total Budget	**$64,800,000**

*These measures are not eligible for payment. Hospitals not meeting measure milestones and/or targets as outlined in individual measure specifications will be subject to payment withhold.

Payment Schedule

The chart below summarizes the Hospital P4P Program payment schedule. There are a total of five payments beginning August 2025, extending through August 2026.

PAYMENT SCHEDULE					
2025 Measurement Period					
Measure Name	Payout #1 **Aug. 2025**	Payout #2 **Nov. 2025**	Payout #3 **Feb. 2026**	Payout #4 **May 2026**	Payout #5 **Aug. 2026**
Measures					
1. Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
2. Follow-Up After Emergency Department Visit for People with Multiple High- Risk Chronic Conditions – Seven Days	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
3. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
4. Timely Postpartum Care		Quarter 1	Quarter 2	Quarter 3	Quarter 4
5. HQI Cares: Implementing BETA HEART®	Reference measure details for payment schedule				
6. Hospital Quality Rating	Reference measure details for payment schedule				
7. Patient Experience: Percentile Achievement		Quarters 1 & 2		Quarters 3 & 4	
8. Hospital-Wide All-Cause Mortality		Quarters 1 & 2		Quarters 3 & 4	
9. Quality Improvement Activity: Clinical Variation Reduction	Reference measure details for payment schedule				
10. Quality Improvement Activity: Patient Experience	Reference measure details for payment schedule				
11. Quality Improvement Activity: Readmission Reduction	Milestones 1-3		Milestone 4	Milestone 5	
12. Quality Improvement Activity: Safety and Adverse Events	Milestones 1-3		Milestone 4	Milestone 5	
13. Cal Hospital Compare "Health Organizations Leading SUD Care Honor Roll"			2025 Honor Roll Result		
14. Adult Flu Vaccination	Quarter 1			Quarter 4	
15. Manifest MedEx Active Data Sharing	Quarter 1	Quarter 2	Quarter 3	Quarter 4	

PAYMENT SCHEDULE					
2025 Measurement Period					
Measure Name	Payout #1 **Aug. 2025**	Payout #2 **Nov. 2025**	Payout #3 **Feb. 2026**	Payout #4 **May 2026**	Payout #5 **Aug. 2026**
Risk-Based Measures					
16. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Quarter 1*	Quarter 2*	Quarter 3*	Quarter 4*	
17. Post Discharge Follow-Up Within Seven Days of Discharge	Quarter 1*	Quarter 2*	Quarter 3*	Quarter 4*	

*These measures are not eligible for payment. Hospitals not meeting measure milestones and/or targets as outlined in individual measure specifications will be subject to payment withhold

2025 Hospital P4P Payment Calculation:

Incentive amounts for each measure are determined annually and may be set as follows:

- Flat rate
- Pool:
  - Divided among qualifying hospitals,
  - Based on IEHP Member admissions, or
  - Weighted based on additional factors
- Pay per encounter

Payments based on IEHP Member admissions are calculated as follows:

Step 1: Determine the Percentage of Total Admissions per Hospital
[Total IEHP Admissions for Hospital in the Quarter] ÷
[Total IEHP Admissions for All Eligible Hospitals in the Quarter]
= Percentage of Total Admissions

Step 2: Determine the Amount of P4P Dollars Available per Hospital
[Percentage of Total Admissions] X [Total Quarterly P4P Dollars Available]
= Total P4P Dollars Available per Hospital per Quarter

EXAMPLE: *Hospital X*

Step 1: Determine the Percentage of Total Admissions per Hospital
IEHP Admissions for Hospital X in Quarter 1 2024 = 3,000
Total IEHP Admissions for All Hospitals in Quarter 1 2024 = 16,000
3,000 ÷ 16,000 = 0.1875

Step 2: Determine the Amount of P4P Dollars Available per Hospital
0.1875 X $6,000,000 = $1,125,000 Available for Hospital X for All Measures per Quarter

Hospital Quality Star Rating Payment Calculation:

Payments for the Hospital Quality Rating are determined based on the following formula:

Step 1: Determine the Hospital Encounter Index

[IEHP admissions per hospital % converted into the 4-tier patient encounter load weighting scale]

Step 2: Determine the Hospital Payment Factor

[Hospital Quality Star Rating x Hospital Encounter Index]

Step 3: Determine the Weighted Incentive Payout per eligible hospital

[(Hospital Payment Factor ÷ Sum of eligible Hospital Payment Factors) × Measure Incentive Pool]

Reporting Calendar

The chart below summarizes the Hospital P4P Program reporting calendar. All items for any program year due between January 1, 2025, and January 31, 2026, are included.

Deliverables extending beyond January 31, 2026 will be itemized in the 2026 Hospital Pay for Performance Technical Guide.

2025 REPORTING CALENDAR				
JANUARY 2025				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Wednesday, January 1, 2025	2025	QIA: Patient Experience, Milestone #4	N/A	Vendor confirmation or Hospital submission to IEHP
Sunday, January 5, 2025	2024	Dexur HCAHPS Data	07/2024 - 12/2024	Hospital to submit to Dexur
Wednesday, January 15, 2025		Patient Experience: Percentile Achievement - OPTIONAL submission, please reference measure details	Q3 2024	Hospital to submit to IEHP
Friday, January 24, 2025		NHSN Accelerated Reporting (HQI & Dexur)	November 2024	Hospital to submit to NHSN
Friday, January 31, 2025	2025	Hospital Profile Update 1 of 2 due (participation requirement)	N/A	Hospital to update Hospital Profile in IEHP's Provider Portal
		HQI Cares: Annual Pulse Survey		Hospital to submit to HQI Cares Team
FEBRUARY 2025				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Wednesday, February 5, 2025	2024/2025	Dexur HCAHPS Data	08/2024 - 01/2025	Hospital to submit to Dexur
Wednesday, February 26, 2025	2025	HQI Cares Workshop I	N/A	N/A
Thursday, February 27, 2025				N/A

2025 REPORTING CALENDAR

FEBRUARY 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, February 28, 2025	2024	NHSN Accelerated Reporting (HQI & Dexur)	December 2024	Hospital to submit to NHSN
		Chart abstracted data to Dexur	Q3 2024	Hospital to submit per Supplemental Reporting Calendar
		SIERA Data Files to HQI	Q4 2024	
		SIERA or 837 data files to Dexur		
	2025	QIA: CVR, Option 1, Milestone #1 and #2A	Q1 2025	Hospital to submit to IEHP
		QIA: CVR, Option 2, Milestone #1 and #2		
		QIA: Readmission, Milestone #1 and #2		
		QIA: Safety and Adverse Events, Milestone #1 and #2		

MARCH 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Wednesday, March 5, 2025	2024/2025	Dexur HCAHPS Data	09/2024 - 02/2025	Hospital to submit to Dexur
Saturday, March 15, 2025	2024	Timely Postpartum Care	Q3 2024	IEHP Claims/Encounters
		Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q4 2024	CMQCC
		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions		IEHP Claims/Encounters
		Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
		Plan All-Cause Readmission Observed to Expected (O/E) Ratio		
		Post Discharge Follow-up Within Seven Days of Discharge		

2025 REPORTING CALENDAR

MARCH 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, March 28, 2025	2025	NHSN Accelerated Reporting (HQI & Dexur)	January 2025	Hospital to submit to NHSN
Monday, March 31, 2025	2025	QIA: Patient Experience, Milestone #5	N/A	Vendor confirmation or Hospital submission to IEHP
		QIA: CVR, Option 1, Milestone #2B	Q1 2025	Hospital to submit to IEHP
		QIA: CVR, Option 2, Milestone #3		
		QIA: Readmission, Milestone #3		
		QIA: Safety and Adverse Events, Milestone #3		
		Dexur: Goals/Interventions Due	N/A	Hospital to submit to Dexur

APRIL 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Tuesday, April 1, 2025	2024	Patient Experience: Percentile Achievement - OPTIONAL submission, please reference measure details	Q4 2024	Hospital to submit to IEHP
Saturday, April 5, 2025	2024/2025	Dexur HCAHPS Data	10/2024 - 03/2025	Hospital to submit to Dexur
Wednesday, April 23, 2025	2025	HQI Cares Workshop II	N/A	N/A
Thursday, April 24, 2025				
Friday, April 25, 2025		NHSN Accelerated Reporting (HQI & Dexur)	February 2025	Hospital to submit to NHSN

2025 REPORTING CALENDAR

MAY 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Monday, May 5, 2025	2024/2025	Dexur HCAHPS Data	11/2024 - 04/2025	Hospital to submit to Dexur
Friday, May 30, 2025	2024	Chart abstracted data to Dexur	Q4 2024	Hospital to submit per Supplemental Reporting Calendar
	2025	SIERA Data Files to HQI	Q1 2025	
		SIERA or 837 data files to Dexur		
		NHSN Accelerated Reporting (HQI and Dexur)	March 2025	Hospital to submit to NHSN

JUNE 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Thursday, June 5, 2025	2024/2025	Dexur HCAHPS Data	12/2024 - 05/2025	Hospital to submit to Dexur
Sunday, June 15, 2025	2024	Timely Postpartum Care	Q4 2024	IEHP Claims/Encounters
	2025	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q1 2025	CMQCC
		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions		IEHP Claims/Encounters
		Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
		Plan All-Cause Readmission Observed to Expected (O/E) Ratio		
		Post Discharge Follow-up Within Seven Days of Discharge		
Friday, June 27, 2025		NHSN Accelerated Reporting (HQI & Dexur)	April 2025	Hospital to submit to NHSN

2025 REPORTING CALENDAR				
JUNE 2025				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Friday, June 27, 2025	2025	Cal Hospital Compare "Healthcare Organizations Leading SUD Care – Hospital Self-Assessment"	Q3 2024-Q2 2025	Hospital to submit evidence of submission to IEHP
Monday, June 30, 2025		Hospital Profile Update 2 of 2 due (participation requirement)	N/A	Hospital to update Hospital Profile in IEHP's Provider Portal
		HQI Cares: Request for Domain Validation Due	N/A	HQI Cares Team
		QIA: CVR, Option 1, Milestone #3	Q2 2025	Hospital to submit to IEHP
		QIA: CVR, Option 2, Milestone #3		
		QIA: Readmission, Milestone #4		
		QIA: Safety and Adverse Events, Milestone #4		
		Dexur: Goals/Interventions Updates		Hospital to submit to Dexur
JULY 2025				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Saturday, July 5, 2025	2025	Dexur HCAHPS Data	01/2025 - 06/2025	Hospital to submit to Dexur
Friday, July 25, 2025		NHSN Accelerated Reporting (HQI & Dexur)	May 2025	Hospital to submit to NHSN

2025 REPORTING CALENDAR

AUGUST 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Tuesday, August 5, 2025	2025	Dexur HCAHPS Data	02/2025 - 07/2025	Hospital to submit to Dexur
Friday, August 29, 2025		NHSN Accelerated Reporting (HQI and Dexur)	June 2025	Hospital to submit to NHSN
		Chart abstracted data to Dexur	Q1 2025	Hospital to submit per Supplemental Reporting Calendar
		SIERA Data Files to HQI	Q2 2025	
		SIERA or 837 data files to Dexur		

SEPTEMBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, September 5, 2025	2025	Dexur HCAHPS Data	03/2025 - 08/2025	Hospital to submit to Dexur
Monday, September 15, 2025		Timely Postpartum Care	Q1 2025	IEHP Claims/Encounters
		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	Q2 2025	
		Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
		Plan All-Cause Readmission Observed to Expected (O/E) Ratio		
		Post Discharge Follow-up Within Seven Days of Discharge		
		Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate		CMQCC

2025 REPORTING CALENDAR

SEPTEMBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Wednesday, September 24, 2025	2025	HQI Cares Workshop III	N/A	N/A
Friday, September 26, 2025		NHSN Accelerated Reporting (HQI & Dexur)	July 2025	Hospital to submit to NHSN
Tuesday, September 30, 2025		QIA: CVR, Option 1, Milestone #3	Q3 2025	Hospital to submit to IEHP
		QIA: CVR, Option 1, Milestone #4	Q1 - Q3 2025	Hospital to submit application to TJC
		QIA: CVR, Option 2, Milestone #3	Q3 2025	Hospital to submit to IEHP
		QIA: Readmission, Milestone #4		
		QIA: Safety and Adverse Events, Milestone #4		
		QIA: Patient Experience, Milestone #6	N/A	Vendor confirmation or Hospital submission to IEHP
		QIA: Readmission Validation Complete	Q1 - Q3 2025	Validation completed by IEHP
		QIA: Safety and Adverse Events Validation Compete		
		Dexur: Goals/Interventions Updates	Q3 2025	Hospital to submit to Dexur

OCTOBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Sunday, October 5, 2025	2025	Dexur HCAHPS Data	04/2025 - 09/2025	Hospital to submit to Dexur
Friday, October 31, 2025		NHSN Accelerated Reporting (HQI & Dexur)	August 2025	Hospital to submit to NHSN
		QIA: Patient Experience, Milestone #7 and #8	NA	Vendor confirmation or Hospital submission to IEHP

2025 REPORTING CALENDAR

NOVEMBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Wednesday, November 5, 2025	2025	Dexur HCAHPS Data	05/2025 - 10/2025	Hospital to submit to Dexur
Friday, November 28, 2025		NHSN Accelerated Reporting (HQI and Dexur)	September 2025	Hospital to submit to NHSN
		Chart abstracted data to Dexur	Q2 2025	Hospital to submit per Supplemental Reporting Calendar
		SIERA Data Files to HQI	Q3 2025	
		SIERA or 837 data files to Dexur		

DECEMBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, December 5, 2025	2025	Dexur HCAHPS Data	06/2025 - 11/2025	Hospital to submit to Dexur
Monday, December 15, 2025		Timely Postpartum Care	Q2 2025	IEHP Claims/Encounters
		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	Q3 2025	
		Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
		Plan All-Cause Readmission Observed to Expected (O/E) Ratio		
		Post Discharge Follow-up Within Seven Days of Discharge		
		Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate		CMQCC

2025 REPORTING CALENDAR

DECEMBER 2025

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, December 26, 2025	2025	NHSN Accelerated Reporting (HQI & Dexur)	October 2025	Hospital to submit to NHSN
Wednesday, December 31, 2025		HQI Cares: Milestone #2	2025	HQI Cares Team
		QIA: CVR, Option 1, Milestone #3	Q4 2025	Hospital to submit to IEHP
		QIA: CVR, Option 2, Milestone #3		
		QIA: Readmission, Milestone #4		
		QIA: Safety and Adverse Events, Milestone #4		
		QIA: Patient Experience, Milestone #9 and #10	N/A	Vendor confirmation or Hospital submission to IEHP
		Dexur: Goals/Interventions Updates	Q4 2025	Hospital to submit to Dexur
		Dexur: Share CMS Preview Reports	2025	Hospital to submit to Dexur

JANUARY 2026

Date	P4P Program Year	Measure	Measurement Period	Data Source
Monday, January 5, 2025	2025	Dexur HCAHPS Data	07/2025 - 12/2025	Hospital to submit to Dexur
Friday, January 30, 2026	2025	NHSN Accelerated Reporting	November 2025	Hospital to submit to NHSN

Supplemental Reporting Calendar:

In addition to the above reporting calendar, hospital teams that are responsible for the submission of data files may reference the supplemental reporting calendar below.

These deliverables are noted in the overarching reporting calendar above and have been listed separately here for ease of reference.

DATA FILE DUE DATES^				
Due Date:	**NHSN Data to CDC** (HQI & Dexur)**	**SIERA Data Files to HQI* SIERA or 837 Files to Dexur**	**Chart Abstracted Data to Dexur**	**HCAHPS Data to Dexur**
	Accelerated Monthly Reporting Data Period	**Accelerated Quarterly Reporting Data Period**	**Quarterly Reporting Data Period**	**Monthly Reporting Data Period**
January 24, 2025	November 2024			Monthly - rolling 6 months of data Please see Appendix 1: Dexur Good Standing Criteria for details
February 28, 2025	December 2024	Q4 2024	Q3 2024 (IQR & OQR)	
March 28, 2025	January 2025			
April 25, 2025	February 2025			
May 30, 2025	March 2025	Q1 2025	Q4 2024 (IQR & OQR)	
June 27, 2025	April 2025			
July 25, 2025	May 2025			
August 29, 2025	June 2025	Q2 2025	Q1 2025 (IQR & OQR)	
September 26, 2025	July 2025			
October 31, 2025	August 2025			
November 28, 2025	September 2025	Q3 2025	Q2 2025 (IQR & OQR)	
December 26, 2025	October 2025			
January 30, 2026	November 2025		-	

**Quarterly reporting is effective 60 days (eight weeks) after the close of the measurement quarter.*
***Monthly reporting is effective 60 days (eight weeks) after the close of the measurement month.*

^Data submitted by the corresponding due date will be frozen and used for the associated measure outcomes and payments. Data submitted after the submission deadline will be accurately reflected on the Dexur Platform but may not match values in the HP4P scorecard for the associated measures.

IQR: Inpatient Quality Reporting
OQR: Outpatient Quality Reporting

Performance Targets

The chart below summarizes the Hospital P4P Program measures and the performance goals.

For measures with two-tier performance goals, 50 percent of the available measure dollars are rewarded for reaching Tier 1 level performance, and 100 percent are rewarded for Tier 2 level performance, unless otherwise specified. For measures with only one performance goal, 100 percent of the available measure dollars are rewarded for meeting the goal.

2025 MEASURE PERFORMANCE TARGETS			
Measures			
Measure Name		**Data Source**	**2025 Performance Targets**
1	Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance* Tier 2: 31.58% or above (75th percentile performance for IEHP network)
2	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance* Tier 2: 50.34% or above (75th percentile performance for IEHP network)
3	Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance* Tier 2: 0.7299 or below (90th percentile performance for IEHP network)
4	Timely Postpartum Care	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance* Tier 2: 83.75% or above (75th percentile performance for IEHP network)
5	HQI Cares: Implementing BETA HEART®	BETA & HQI Cares Team	See measure details for milestones
6	Hospital Quality Rating	CMS/Dexur	See measure details for performance target
7	Patient Experience: Percentile Achievement	Dexur	≥50th percentile performance in each recognized domain
8	Hospital-Wide All-Cause Mortality	Dexur	1) Less than or equal to 0.7% OR 2) Reduce hospital baseline rate by 10%
9	Quality Improvement Activity: Clinical Variation Reduction	Hospital/TJC	See measure details for milestones

2025 MEASURE PERFORMANCE TARGETS			
Measures			
	Measure Name	**Data Source**	**2025 Performance Targets**
10	Quality Improvement Activity: Patient Experience	Vendor/ Hospital	See measure details for milestones
11	Quality Improvement Activity: Readmission Reduction	Hospital/ Dexur	See measure details for milestones
12	Quality Improvement Activity: Safety and Adverse Events	Hospital/ Dexur	See measure details for milestones
13	Cal Hospital Compare "Health Organizations Leading SUD Care"	Cal Hospital Compare	Hospital recognition as a member of the 2025 Cal Hospital Compare Honor Roll for "Health Organizations Leading SUD Care" See measure details for achievement categories
14	2025 Adult Flu Vaccination	Manifest MedEx	See measure details for milestones
15	Manifest MedEx Active Data Sharing	Manifest MedEx	All conditions must be met: 1) Hospital is actively sharing data elements with MX per quarter 2) Hospital must submit all required P4P data elements for all hospital events throughout the entire measurement period
Risk-Based Measures			
16	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery	CMQCC	Less than or equal to 23.6%
17	Post-Discharge Follow-Up Within Seven Days of Discharge	IEHP Claims & Encounters	Maintain baseline performance from CY 2024

CMS: Centers for Medicare and Medicaid Services
CMQCC: California Maternal Quality Care Collaborative
TJC: The Joint Commission

*The hospital is assigned a Tier 1 goal at the 50th percentile for the IEHP network if minimum denominator requirements for the baseline period are not met.

2025 HOSPITAL P4P MEASURES

☑ Measure Name: *Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days*

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called Follow-Up Care for Mental Health and Substance Use Disorder Emergency Department – Seven Days is utilized to determine the percentage of emergency department (ED) visits for Members ages 6 years and older who had a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness, or intentional self-harm, and had a follow-up visit with a Provider within seven days.

Below is a list of practitioner types/visits that count towards this measure:

- PCP
- MD or DO specializing in psychiatry
- Licensed psychologist
- Certified clinical social worker
- RN certified as a psychiatric nurse
- Licensed or certified professional counselor with a master's degree or doctoral degree in marital and family therapy
- PA certified to practice psychiatry
- Certified Community Mental Health Center/Clinic
- Peer Support Services and Residential Treatment
- Behavioral Healthcare Setting and Psychiatric Collaborative Care Management

Refer to the Substance Disorders and Mental Health Diagnosis list located on the IEHP P4P Program website. These lists include diagnoses for substance use disorder, drug overdose, mental illness, or intentional self-harm.

Refer to the FUA and FUM code list located on the IEHP P4P Program website .

Numerator:

Members in the denominator who had an in-person or telemedicine follow-up visit within seven days of discharge from the ED with a practitioner who is addressing the substance use or mental illness disorder.

Denominator:

Members ages 6 years and older who had a discharge from an ED with a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness, or intentional self-harm.

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.
*This does not apply to Critical Access Hospitals (CAHs).

Note:

- Medi-Medi Members are excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

NEW

☑ Measure Name: *Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days*

This modified Healthcare Effectiveness Data and Information Set (HEDIS®) measure captures the percentage of Members, 18 years and older with multiple high-risk chronic conditions who visited the Emergency Department (ED) and had a follow-up service within seven days of the ED visit.

Members are included in this measure if they had an ED visit and have two or more diagnoses of the following chronic conditions prior to the ED visit:

- Acute Myocardial Infarction
- Atrial Fibrillation
- Asthma, Chronic Obstructive Pulmonary Disease, or unspecified Bronchitis
- Alzheimer's disease or other similar disorders
- Chronic Kidney Disease
- Depression
- Heart Failure
- Transient Ischemic Attack and Stroke

Numerator:

A follow-up service within seven days after the ED visit for members in the denominator. Include follow-up visits that occur on the date of the ED visit. Any of the following meet criteria for follow-up visits:

- Outpatient visit, Telephone visit, E-visit or Virtual check-in
- Transitional Care Management Services
- Case Management Visits
- Complex Care Management Services
- Outpatient or Telehealth Behavioral Health Visit
- Intensive Outpatient Encounter or Partial Hospitalization
- Community Mental Health Center Visit
- Electroconvulsive Therapy
- Substance Use Disorder Service
- Substance Use Disorder Counseling and Surveillance

Refer to the FMC Follow-Up code list located on the IEHP P4P Program website.

Denominator:

The number of ED visits from members 18 years and older with multiple high-risk chronic conditions on the date of the ED visit.

Minimum Denominator Requirement*:

The denominator must be 20 or above for this measure. *Critical Access Hospitals (CAHs) must have a minimum denominator of 5 or above for this measure.

Note:

- Medi-Medi Members are excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio*

This measure captures the number of acute inpatient stays during the measurement period that are followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of acute readmission for IEHP Members 18-64 years old. Acute inpatient stays include any observation days that exceed one day.

Methodology:

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called "Plan All-Cause Readmissions" (PCR) is utilized to determine the 30-day readmission rate for IEHP Hospitals. Data are reported in the following categories:

1) Count of Observed 30-Day Readmissions
2) Count of Expected 30-Day Readmissions
3) Count of Index Hospital Stays (IHS)
4) Observed-to-Expected Ratio

The Observed-to-Expected Ratio (O/E Ratio) is the final measure used to determine hospital performance.

Numerator: Count of Observed 30-Day Readmissions:

Count all acute readmissions for any diagnosis within 30 days of the Index Discharge Date. The readmission can occur at any hospital, including a hospital separate from the hospital being measured.

The following are excluded from the Count of Observed 30-Day Readmissions:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Nonacute inpatient stays
- Principal diagnosis of maintenance chemotherapy
- Principal diagnosis of rehabilitation
- Organ transplant
- Potentially planned procedures without a principal acute diagnosis

Denominator: Count of Expected 30-Day Readmissions:

The first step in calculating the Rate of Expected 30-Day Readmissions is to calculate the count of Expected 30-Day Readmissions. The count of Expected Readmissions is determined in two steps:

1) Calculate the Estimated Readmission Risk for each IHS by summing the following risk adjustment weights:
   - Age/gender
   - Surgeries
   - Discharge clinical condition
   - Comorbidities

2) Sum the Estimated Readmission Risk for all IHS in the reporting period

Next, the Expected 30-day Readmission Rate is calculated by taking the count of Expected 30-Day Readmissions and dividing it by the Count of Index Hospital Stays.

Index Hospital Stays (IHS):

Count of all acute inpatient discharges on or between January 1 and December 31 of the measurement year (2025). The index stay must occur at the hospital being measured.

The following are excluded from the Index Hospital Stay:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Member died during the stay
- Non-Acute inpatient stays
- Hospice care
- Same-day discharges. Observation stays will be excluded if the observation stay meets the same-day discharge criteria. Same-day discharge criteria is defined as having the same admit and discharge date.
- Outliers: Members with four or more index hospital stays between January 1 and December 31 of the measurement year (2025)

Observed-to-Expected Ratio:

The Rate of Observed 30-Day Readmissions divided by the Rate of Expected 30-Day Readmissions.

Minimum Denominator Requirement*:

The count of Index Hospital Stays must be 20 or greater for this measure to be eligible for payment.

*This does not apply to Critical Access Hospitals (CAHs).

Eligibility Criteria:

To be eligible for this measure, Members must be enrolled with IEHP 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date. No gap is allowed during the 30 days following the Index Discharge Date.

Notes:

- All hospital claims received by IEHP are included in the calculation of this measure regardless of payment decision (i.e., all payment statuses are counted, including denied status claims).
- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *Timely Postpartum Care*

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called Timely Postpartum Care is utilized to determine the percentage of live birth deliveries that had an outpatient postpartum visit on or between 7 and 84 days after delivery.

The eligible population in this measure meets all the following criteria:

- Continuous IEHP enrollment 43 days prior to delivery through 60 days after delivery.
- No allowable gaps in IEHP enrollment.

Numerator:

Members in the denominator who had a postpartum visit on or between 7 and 84 days after delivery.

Refer to the Timely Postpartum Care code list located on the IEHP P4P Program website.

Denominator:

Members who delivered a live birth during the measurement year (2025).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

*This does not apply to Critical Access Hospitals (CAHs).

Note:

- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *HQI Cares: Implementing BETA HEART® Program*

HQI Cares: Implementing BETA HEART® (healing, empathy, accountability, resolution, and trust) (in further text "HQI Cares") is a coordinated effort designed to guide healthcare organizations in implementing a reliable and sustainable culture of safety grounded in a philosophy of transparency. The goals of the program are to develop an empathic and clinically appropriate process that supports the healing of the patient and clinician after patient harm; ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust in all clinicians and patients.

HQI Cares is an interactive, and collaborative process supporting the organization, its staff, and patients. Hospitals progress through five individual yet integrated domains, each an essential component of the culture of safety and transparency:

1. **Safety Culture:** Administering a scientifically validated, psychometrically sound safety culture survey to measure staff perceptions of safety and engagement, as well as sharing and debriefing results. The Culture domain includes the implementation of a Just Culture of accountability and the sharing of lessons learned.

2. **Rapid Event Response and Analysis:** A formalized process for early identification of adverse events and rapid response to them. This includes applying cognitive interviewing tactics to collect information. The event analysis process includes obtaining input from patients and families, and integrates human factors science, systems analysis, and the principles of Just Culture. Organizations learn to differentiate between strong and weak performance improvement action items and apply strong actions that result in improved systems.

3. **Communication and Transparency:** The organization commits to honest and transparent communication with patients and family members harmed during care or after an adverse event. Participating organizational leaders, physicians and staff will take a communication assessment, identify, and designate a communication consult or resource team, and develop processes for ensuring empathic and transparent communication with patients and families that begins early and continues through the course of the event review. Findings from the event review and actions taken are shared with patients and families.

4. **Care for the Caregiver:** Development and implementation of an organizational proactive peer support program that ensures emotional support for members of the health care team involved in or impacted by an adverse event.

5. **Early Resolution:** A process for resolution when harm is deemed a result of inappropriate care or medical error. Resolution may include financial or non-financial means and is dependent upon the impact of the event and the actions needed to be taken, to the best of the organization's ability, to make the patient/family whole.

The five domains are introduced through distinct workshops attended by participating hospital teams. The order and timeframe for the implementation of domains will vary by organization. For domain completion (validation) requirements, visit: https://hqinstitute.org/hqi-cares-introduces-beta-heart/, and scroll to click on Program at a Glance and the BETA HEART® Guideline. For most hospitals, completing a domain will require a significant investment of time and effort. The HQI Cares program team and faculty are available to provide multi-faceted support to participating hospitals throughout the implementation.

Performance Requirements Overview – All eligible hospitals

Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

MILESTONE #	2025 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	DUE DATE
1	Participation Requirements	Sign Participation Agreement Addendum	11/29/2024
		Complete Annual Pulse Survey: 1) Hospital identifies HQI Cares Project Leader in the Hospital who will be the key contact for HQI Cares Program Team (HQI Cares) 2) Project Leader distributes pulse survey link to key leaders and staff in the organization, including: • Executive leadership team • Medical staff-select leaders, attending physicians and resident physicians (if residency program) • Vice presidents for clinical services • Safety, risk management, quality, legal and ethics personnel • Unit/departmental directors, managers, and educators • Patient and family advisors (if applicable) 3) Project Leader oversees completion of pulse survey from a minimum of 15-20 leaders and staff. Critical access hospitals must have a minimum of 10-15. • Pulse surveys are completed via Survey Monkey by individuals selected by the Project Leader	1/31/2025

MILESTONE #	2025 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	DUE DATE
1	Participation Requirements	**Workshop Attendance:** Hospital representatives must attend all three workshops.* 1) Critical access hospitals – Minimum of 2 attendees per workshop, per hospital. 2) All other hospitals – Minimum of 4 attendees per workshop, per hospital. Suggested participants (no longer required): an executive leader, a physician leader, a nursing leader, a risk manager and/or patient safety officer. Additional staff can attend and may include those with key roles in implementing domain-specific strategies addressed at each workshop (e.g., designated peer supporters, culture survey administration leads, communication resource team members, and others). Max of 6 participants, per facility *Note: Hospitals who share the same executive leadership will need to ensure that each hospital is represented with the minimum number of representatives per hospital, per workshop. This is a new written requirement for the 2025 program year.*	9/30/2025
2	Validation in Selected Domain(s)	Once domain elements are complete hospitals may request validation for up to **two** domains*. 1) Select domain for validation 2) Schedule validation of selected domain(s) with HQI Cares team 3) Participate in all aspects of domain validation process (document review, interviews, observation). Please refer to HQI Cares BETA HEART Guidelines for domain validation criteria 4) Obtain validation in selected domain(s) To be eligible for the P4P dollars associated with validation, validation must occur prior to 12/31/2025. **Participating hospitals will need to ensure that they allow ample time to coordinate validation planning and scheduling with the HQI Cares team. Requests for validation must be received by 06/30/2025.** ***To be eligible for incentive dollars associated with domain validation, the hospital must validate in a new domain(s). Additionally, the participating hospitals will need to revalidate meeting subsequent validation criteria for domains validated as part of the 2024 HP4P program. Please see exclusion criteria for additional details.**	12/31/2025

Exclusions -

Hospitals who achieved domain validation as part of the 2024 HP4P HQI Cares: Implementing BETA HEART® P4P Measure are not eligible to earn incentive dollars for revalidating in the same domain(s).

- To quality for incentive dollars, the hospital will need to select a new domain(s) for validation and are required to *revalidate meeting subsequent validation criteria* in any domain(s) achieved as part of the 2024 HP4P Program. If the hospital does not successfully revalidate meeting subsequent validation criteria for domains achieved as part of the 2024 program, the hospital will not be eligible for incentive dollars related to any new domains validated in 2025.

Payment Methodology – All eligible hospitals:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

BETA HEART® PAYMENT SCHEDULE				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution****
1	Sign Participation Agreement	$43,125	Q4 2024	August 2025
	Complete Annual Pulse Survey		Q1 2025	
	2025 Workshop Attendance***	$43,125	Q1 - Q3 2025	November 2025
2	Obtain Validation in selected Domain**	$172,500	Q1 - Q2 2025	August 2025
			Q3 - Q4 2025	February 2026
	Obtain Validation in selected additional Domain**	$86,250	Q1- Q2 2025	August 2025
			Q3 - Q4 2025	February 2026
Milestones Total		**$345,000**		

**Payments will be issued in either August 2025, or February 2026 dependent on the quarter the hospital obtained validation for their selected domain(s).

***While workshops are incentivized separately, they are also a milestone for validation. Hospitals requesting validation must have met this milestone to be eligible.

☑ Measure Name: *Hospital Quality Star Rating*

IEHP is committed to helping hospitals ensure exceptional quality outcomes for patients. One way to evaluate the overall quality of care provided by a hospital is to assess their Centers for Medicare & Medicaid Services (CMS) Hospital Quality Star rating. IEHP has established a goal that ≥75% of IEHP network hospitals will have a rating of 3 stars or higher by 2026.

The Hospital Quality Star Rating is a trusted, robust, validated methodology designed by the Center for Outcomes Research and Evaluation (CORE) project team in collaboration with CMS. This rating system was launched in July 2015 and since its inception has been modified into a statistically sound, comprehensive evaluation tool to summarize hospital performance that patients and consumers can easily interpret. Hospital quality outcomes and results are categorized into five major areas. These measure groups for the July 2025 star rating system are:

1. Mortality (7 measures) – examines death rates within 30 days of the date of hospital admission
2. Safety of Care (8 measures) – observes potentially preventable injury and complications during hospitalization
3. Readmission (11 measures) – monitors the return of patients following hospitalization
4. Patient Experience (8 measures) – observes the patient perspective on the hospital care received
5. Timely & Effective Care (13 measures) – assesses how often or quickly hospital care is provided

Alternative Hospital Quality Rating: Critical Access Hospitals and those hospitals with too few measures or measure groups reported to calculate a CMS Hospital Quality Star Rating, will receive a Quality Rating leveraging CMS Star Rating Patient Experience & Safety Domain Scores and All Payor data for the following measure groups via the Dexur platform:

1. Mortality (1 measure) – in-hospital mortality rates utilizing all payor encounters
2. Readmission (1 measure) – readmissions within 30 days to the same hospital utilizing all payor encounters
3. Patient Experience (8 measures) – observes the patient's perspective on the hospital care received (HCAHPS)
4. Safety of Care (6 measures) – observes potentially preventable injury and complications during hospitalization (HAIs)*

*Excludes Critical Access Hospitals

Note:

- For this inaugural year of the alternative Hospital Quality Rating, hospitals earning a CMS star rating are NOT eligible to leverage the alternative rating scale in lieu of their rating. As additional comparative data between the two ratings becomes available, this will be reevaluated.

Methodology:

CMS Hospital Quality Star Rating:

Hospitals receive a composite score through the weighted combination of individual measure results associated with their measure groups. However, only hospitals that have a minimum of three (3) measures within three (3) measure groups, with at least one (1) of those measure groups being Mortality or Safety of Care, are eligible to receive a quality star rating. Hospitals are assigned to peer clusters based on the number of their measure groups attaining the required measure reporting threshold minimum, then a clustering algorithm (k-means) is applied to categorize a hospital composite score on a 1 to 5 rating scale to derive the Hospital Quality Star Rating.

Alternative Hospital Quality Rating:

Critical Access Hospitals and hospitals with too few measures or measure groups reported to calculate a Hospital Quality Star Rating will be determined using the Quality Rating Score. The Hospital Quality Rating will be calculated using data from the Dexur platform. A 1 to 5 rating scale utilizing the same percentiles as the CMS Hospital Quality Star Rating will be used to derive the Hospital Quality Rating.

Performance Requirements Overview – All eligible hospitals

CMS Hospital Quality Star Rating:

Hospitals are eligible to earn incentive dollars for either achieving/maintaining a 3+ CMS Hospital Quality Star Rating or improving their CMS Hospital Quality Star Rating when compared to the 2024 July release.

Alternative Hospital Quality Rating:

Hospitals eligible for the alternative rating will be eligible to earn incentive dollars for achieving a 3+ Hospital Quality Rating.

Payment Methodology – All eligible hospitals:

The following table describes the payment amounts available for hospitals to earn for achieving a Quality Rating.

2025 CMS HOSPITAL QUALITY STAR RATING
Payment will be determined via the officially released 2025 CMS Hospital Quality Star Rating *OR* IEHP's Quality Rating for hospitals not earning a CMS Hospital Quality Star Rating. P4P payment distribution will be November 2025.

☑ Measure Name: *Patient Experience: Percentile Achievement*

Patient Experience is an important component of healthcare quality and continues to be a top priority for hospitals. A positive experience can lead to better health outcomes and patient loyalty. Many hospitals elected to participate in the 2024 Hospital P4P Quality Improvement Activity (QIA) specific to Patient Experience. Results from the QIA highlighted a need to continue to recognize and reward hospitals achieving outcomes-based improvements as a result of their performance improvement efforts in the following Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) domains of focus:

- Communication with doctors
- Discharge information
- Overall rating of the hospital
- Likelihood to recommend the hospital

This measure compares the top-box score (%) for each domain against the 50th percentile scores as referenced in nationally published HCAHPS Percentiles Table (referenced below).

Methodology:

The top-box score is the most positive response to the survey questions. Percentiles allow IEHP to compare a hospital's "top-box" score relative to national rates for each of the survey domains.

Top box scores for each domain will be converted into percentile rankings utilizing the nationally published HCAHPS Percentile Table (referenced below)*. Hospitals will receive incentive dollars for each domain achieving ≥50th percentile performance. Top-box scores will be obtained from the Dexur platform.

Numerator:

Numerator varies by survey domain as follows:

Communication with Doctors – The number of respondents selecting "Always" for all three questions that comprise the Communication with Doctors composite:

- How often doctors treated you with courtesy and respect
- How often doctors listened carefully to you
- How often doctors explained things in a way you could understand

Discharge Information – The number of respondents selecting "Yes" for all two questions that comprise the Discharge Information composite:

- Did staff communicate about the help they would need at home after they left the hospital
- Did patients receive written information about symptoms or health problems to look out for after they left the hospital

Overall Rating of Hospital – The number of respondents rating the hospital a '9' or '10'

Likelihood to Recommend – The number of respondents selecting "Definitely yes"

Denominator:

The total number of survey responses

Determining Percentile:

The outcome of the calculation of numerator divided by denominator is compared to the 50th Percentile top-box score from the HCAHPS Percentiles Table.

50th Percentile Performance Target:

TOP BOX SCORE				
Hospital Percentile	**Communication with Doctors**	**Discharge Information**	**Overall Rating**	**Likelihood to Recommend**
50th	79%	87%	71%	70%

**Percentiles are based off surveys of patients discharged between October 2022 and September 2023*

☑ Measure Name: *Hospital-Wide All-Cause Mortality*

In-hospital mortality is a key indicator of quality of care. There are several known factors that can directly and indirectly affect hospital mortality rates. Therefore, this metric assesses all-cause mortality rates, highlighting the overall performance of the hospital and encourages hospitals to track and trend performance and implement performance improvement based upon data outcomes.

Methodology:

Hospitals must actively participate with Dexur. Inpatient encounters from the following data sources are included in this measure:

- **System of Integrated Electronic Reporting and Auditing (SIERA) files** - Required files uploaded periodically by hospitals to the Department of Health Care Access and Information (HCAI) and, for purposes of this measure and the Hospital P4P program, submitted to Dexur.

-OR-

- **837 File** - Also known as Health Care Claim files. These are standard electronic formats used to submit insurance claims to payers in the healthcare industry. These files contain detailed billing information, payment remittance, including patient demographics, diagnosis codes, treatment details, and provider information.

The mortality rate will be Case Mix Adjusted to account for the patient's clinical acuity and severity of comorbidities.

Code Source:

The code set for this measure is adapted from the methodology outlined in the Hospital-wide (All-condition, All-procedure) Risk-standardized Mortality Measure, however, only in-hospital deaths during a single admission are tracked (rather than 30-day follow-up from admission), and the risk-standardization methodology is not performed.

Denominator:

Acute-care inpatient discharges, excluding patients for whom survival was not the primary goal (hospice, palliative care and DNR patients).

Numerator:

Acute-care inpatient discharges who *expired* in the hospital.

Inclusion/Exclusion Criteria:

Some patients are excluded from the calculation based on diagnoses of certain conditions associated with factors that make mortality less likely to be influenced by the quality of care

provided. Patients under hospice or palliative care or who have a do-not-resuscitate (DNR) order are excluded.

1. Calculate the denominator by identifying and *excluding* all inpatient discharges with a:
    - Type of care other than *acute care (Type of Care not equal to 1)* **OR**
    - Diagnosis ICD-10 code (in any position) indicating *palliative care (code Z51.5)* **OR**
    - Diagnosis ICD-10 code (in any position) indicating *do not resuscitate (code Z66)* **OR**
    - Source of admission indicating *hospice (Source of Admission Point of Origin = F)*

2. Calculate the numerator by identifying the discharges remaining after #1 *with* a discharge disposition indicating the patient expired *(Disposition = 20)*

Rate Calculation:

(Numerator ÷ Denominator) × 100

Note:

- Baseline performance for the Hospital-Wide All-Cause Mortality measure is 01/01/2023 – 12/31/2023.

☑ Measure Name: *Quality Improvement Activity: Clinical Variation Reduction*

Clinical variation reduction (CVR) is a process that identifies evidence-based practices/medicine for a specific disease process and then leverages them to develop a clinical pathway to guide clinicians in providing and directing care. Standardized care that reduces variations improves quality outcomes, increases collaboration, and can improve the patient experience. Overall, CVR efforts can have great impact on hospitals and patients by reducing potentially preventable complications, readmissions, and unexpected outcomes (Ardoin & Malone, 2019).

IEHP has collaborated with The Joint Commission (TJC) for utilization of their evidence-based certification standards as a means of establishing disease-specific program standards. Leveraging these standards will allow for the development of a robust quality-centric hospital network with as much reduction in variability as possible given the operational nuances and diversity within this network.

Methodology:

Hospitals may elect to participate in one of the below Quality Improvement Activities (QIA) if eligibility criteria is met.

QUALITY IMPROVEMENT ACTIVITY (QIA): CLINICAL VARIATION REDUCTION		
	Option 1	**Option 2**
Goal	Obtain certification in selected area from The Joint Commission.	Demonstrate continuous ongoing improvement and improved data outcomes for certification achieved as part of the 2024 HP4P Program.
Performance Requirements Overview – All eligible hospitals	Achieve TJC Certification in one* of the selected certifications: Advanced Certification in Perinatal Care *** Advanced Heart Failure*** Chronic Obstructive Pulmonary Disease** Hospital-based Palliative Care** Inpatient Diabetes** Pneumonia** Sepsis**	Submit to IEHP quarterly data progress related to hospital certification measure sets with an updated PDSA.
Exclusions	Hospitals are not eligible if they participated in the QIA during the HP4P Program Year 2024 or related to certifications that: 1. Are already in effect anytime in calendar year 2025, and/or 2. For which they have already formally applied for before 1/1/2025	Hospital is not eligible if the hospital did not participate and did not achieve TJC certification as part of the 2024 Hospital Pay for Performance Program.

*Hospitals must demonstrate to IEHP that there is a clinical need for selected certification. Please see appendix for additional details.
**Per The Joint Commission certification standards, hospital must be Accredited by The Joint Commission to participate in these certification programs.
***The Joint Commission requires that hospitals meet certain eligibility criteria. Please reach out to TJC for up-to-date requirements to ensure hospital eligibility.

Performance Requirements Overview – All eligible hospitals

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION - OPTION 1			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current certification steering team*	Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	2/28/2025
2A	Participation*	1) Hospital to select one certification for completion 2) Hospitals to demonstrate that there is a clinical need for the certification a. Hospital to send IEHP data, as outlined in Appendix 2 for the past 12 months (10/01/23-9/30/24) i. Data should not include PHI	2/28/2025
2B	Participation*	Once certification is approved by IEHP, hospital will complete a participation agreement with IEHP outlining their intent to participate in this QIA and engage with The Joint Commission for the formal certification process	3/31/2025
3	Quarterly Progress Updates*	1) Submit Quarterly progress updates including progress toward certification and updated data outcomes	6/30/2025 9/30/2025 12/31/2025
4	Apply for certification	1) Hospitals will apply for certification of selected measure through The Joint Commission	9/30/2025
5	Obtain Certification	1) Hospitals will obtain certification from The Joint Commission in selected area	3/31/2026^

^Administrative delays outside of the control of the Hospital will not impact ability to earn incentive dollars for this milestone

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION - OPTION 2			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Provide evidence of a current steering team*	Demonstrate evidence of a current committee, workgroup, or task force for ongoing improvement efforts associated with certification that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	2/28/2025
2	Participation*	Hospital to notify IEHP of measure participation and certification measure sets for QIA (minimum of four)	2/28/2025
3	Quarterly Progress Updates*	Demonstrate evidence that group met at least monthly (January through December 2025) via Quarterly updates: a. Summary report includes, at a minimum: i. Meeting Attendees ii. Summary of data reviewed (please do not include PHI) b. Update to PDSA cycle	03/31/2025 06/30/2025 09/30/2025 12/31/2025

*Please reference supplemental submission templates provided by IEHP

Additional Participation Requirements:

As a new requirement for program year 2025, in addition to specific milestones above, hospitals must actively participate in Advance Care Planning (ACP) health information exchange with CareDirectives or equivalent throughout the entire program year in order to receive incentives for this QIA. Participation will be reviewed at the close of each quarter to ensure ongoing adherence.

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION PAYMENT SCHEDULE - OPTION 1				
Milestone #	**2025 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Certification Steering Team	$80,000	Q1 2025	August 2025
2	Participation			
3	Quarterly Progress Updates	$20,000	Q2 2025 Q3 2025 Q4 2025	February 2026
4	Apply for certification	$20,000	Q3 2025	February 2026
5	Obtain Certification	$80,000	Q1 2026	May 2026
	Milestone Total:	**$200,000**		

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION PAYMENT SCHEDULE - OPTION 2				
Milestone #	**2025 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Certification Steering Team	$10,000	Q1 2025	August 2025
2	Participation			
3	Quarterly Progress Updates	$45,000	Q1 - Q2 2025	November 2025
		$45,000	Q3 - Q4 2025	May 2026
	Milestone Total:	**$100,000**		

Note:

- Option 1: All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined or achieve TJC certification, all incentives are subject to withhold from future incentive payments.
- Option 2: All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined, all incentives are subject to withhold from future incentive payments.

References:

Ardoin MD, D., & Malone, J. (2019). Reducing clinical variation to drive success in value-based care (part 1). HFMA. https://www.hfma.org/operations-management/care-process-redesign/reducing-clinical-variation-to-drive-success-in-value-based-care0/

☑ Measure Name: *Quality Improvement Activity: Patient Experience*

IEHP is focused on ensuring Members discharged from Network Hospitals receive care and services that reflect cultural humility, respect and human-centered hospital care that aligns with our Mission, Vision and Values.

This measure encourages member hospitals to participate in a NEW Quality Improvement Activity (QIA) focused on comprehensive and human-centered custom experience design. Through this endeavor, participating hospitals will be well-equipped to design and consistently deliver the personal, memorable, and high-quality health care experiences IEHP members desire and deserve.

Performance Requirements Overview – All eligible hospitals

Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE			
Milestone #	**2025 Incentive Milestone**	**Hospital Requirements**	**Completion Due Date**
1	Participation Requirement	1) Sign Participation Agreement	11/29/2024
2	Establish the Program*	1) Select and engage in the contracting process with a vendor who specializes in healthcare experience design*	
3		2) Complete contracting and onboarding process with approved vendor** Deliverable 1: Confirmation of fully executed contract with an approved experience design vendor Deliverable 2: Confirmation of completion of all vendor-required onboarding documents (i.e., participant profiles, intake assessments, etc.)	12/31/2024

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE			
4	Engage in the Process	1) Select a steering team of three to fully participate in the experience design QIA endeavor. Consider the following when curating your team of three: • **1 executive sponsor** (in addition to participating in this QIA, this member will also serve as the conduit to the executive team regarding the patient experience QIA, connect important organizational dots, and pave the way for rapid experience activation across the organization) • **1 most senior leader responsible for patient experience** • **1 operating leader** (consider COO, CNO, CMO, CHRO, or a director of a key hospital unit/service line with interest in patient experience design) *Ideally, at least one member of the steering team should be clinical (i.e., MD, RN)* Deliverable: Vendor or hospital submission of confirmed steering team members including name, title and credentials.	1/1/2025
5		2) Complete the vendor onboarding/orientation/launch process Deliverable: Vendor or hospital submission of outline for onboarding/orientation/launch process and evidence of completion	3/31/2025
6		3) Engage in at least two in-person design sessions with the vendor Deliverable: Vendor or hospital submission of agenda and presentation material outline. Confirmation of attendance by the three individuals identified in milestone 4 above.	9/30/2025
7		4) Engage in at least two *additional* virtual design sessions with the vendor Deliverable: Vendor or hospital submission of agenda and presentation material outline. Confirmation of attendance by the three individuals identified in milestone 4 above.	10/31/2025

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE			
8	Engage in the Process	5) Engage in at least two hospital-based experience design activations using new tools, skills, and methods provided by vendor Deliverable: Hospital submission of activation report-out summary and participating in activation by the three individuals identified in milestone 4 above.	10/31/2025
9		6) Engage monthly with the vendor Deliverable: Vendor or hospital submission of evidence of consistent design work during the months without formal design sessions. Confirmation of engagement by the three individuals identified in milestone above.	12/31/2025
10	Share Project Outcomes and Next Steps	1) Complete and provide a final summary of the work undertaken in 2025 2) Develop a hospital-specific action plan for 2026 Deliverable: Hospital submission of documented summary and action plan	12/31/2025

*IEHP will need to review and approve the selected vendor. To facilitate this process, hospitals must submit details as outlined in the participation agreement no later than 11/15/2024 to allow for approval in advance of the due date for milestone 1 and 2.

At minimum, the vendor must provide:

- Hospital-specific experience design services as defined as:
  The comprehensive and human-centered process of creating a positive experience for patients and their families through all aspects of their healthcare journey. It considers the patient's entire experience, including all interactions, touchpoints, and outcomes, before, during and after visits–as well as considering the team member and provider experience. The goal is to improve the patient's clinical experience and create a personal, memorable, and mutually beneficial experience.
- Curated experience design learning opportunities including in person and virtual design forums that include sessions that are both hospital-specific and collaborative in nature.
- A cohesive and coordinated approach to designing and improving the Experience: Shifting from siloed, discrete efforts to a unified, orchestrated approach for improving hospital culture and overall patient Experience.
- Education and guidance for bringing new-world solutions to existing patient experience efforts and preparing participants to serve as in-house experts in experience design.
- Experience design methods that equip participants with ready-to-implement tools and rapid experience activations that can be easily customized and uniquely applied to each participating hospital's areas of focus.
- Avenues for hospitals to complete all milestones as listed above.

** Contract term must be no less than 1 year and extend through 12/31/2025

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE PAYMENT SCHEDULE				
Milestone #	**2025 Incentive Milestones**	**Incentive Per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Sign Participation Agreement	$25,000	Q4 2024	January 2025
2-3	Establish the Program: Select and engage in the contracting process Complete contracting and onboarding process with the vendor	$100,000	Q4 2024	January 2025
4-9	Engage in the Process: Select a steering team of 3 to fully participate Complete the vendor onboarding/orientation/ launch process Engage in at least two in-person design sessions with the vendor Engage in at least two additional virtual design sessions with the vendor Engage in at least two hospital-based experience design activations Engage monthly with the vendor	$50,000	Q1 - Q4 2025	February 2026

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE PAYMENT SCHEDULE				
Milestone #	**2025 Incentive Milestones**	**Incentive Per Hospital**	**Performance Period**	**P4P Payment Distribution**
10	Share Project Outcomes and Next Steps	$25,000	Q4 2025	February 2026
	Milestones Total	**$200,000**		

Note:

- All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined, all incentives are subject to withhold from future incentive payments.

☑ Measure Name: *Quality Improvement Activity: Readmission Reduction*

Readmission reduction is a top priority for healthcare providers. IEHP is committed to ensuring that members successfully transition from one care setting to the next. A successful indicator of this transition is a low preventable readmission rate. This measure encourages hospital engagement in a QIA that focuses on reducing preventable readmissions and aligns with IEHP's Hospital Quality Rating goal as readmission measures account for 22% of the total score for the hospital's overall CMS Star Rating (Centers for Medicare & Medicaid Services, n.d).

Many hospitals elected to participate in the 2024 Hospital P4P QIA specific to Readmission Reduction and the results indicated the need to continue to recognize and award hospitals for their improvement efforts and performance.

Methodology:

The All-Cause Readmission rate will be Case Mix Adjusted to account for the patient's clinical acuity and severity of comorbidities.

Performance Requirements Overview – All eligible hospitals

Hospitals must actively participate with Dexur. Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current Readmission Reduction Workgroup*	1) Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader f. Care Manager/Patient Throughput leader	2/28/2025

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
2	Identify key priority areas for improvement*	1) Hospital to conduct an initial analysis of readmission data and performance for the Hospital-Wide All-Cause 30-Day Readmission rate during the time period of Q3 2023 - Q2 2024 via the Dexur Healthcare Quality Excellence Platform 2) Hospital to select area of readmission focus to implement a QIA project based upon identified hospital needs with a goal to increase measure percentile performance 3) Hospital to submit to IEHP Readmission Reduction area of focus for QIA	2/28/2025
3	Leverage analysis to implement performance improvement*	1) After hospital selection of readmission focus, hospital to submit action plan outlining QIA and initial implementation completion	3/31/2025
4	Demonstrate meeting and working of Readmission Reduction Workgroup*	1) Demonstrate evidence that group met at least monthly (April through December 2025) via Quarterly progress updates a. Summary report includes, at minimum: i. Meeting Attendees ii. Summary of data reviewed (please do not include PHI) b. Update to PDSA cycle *Validation of full implementation and QIA evolution will be completed by IEHP's Hospital Relations Team during Q3*	06/30/2025 09/30/2025 12/31/2025
5	Demonstrate a reduction in hospital selected readmission focus	1) Hospital to demonstrate an increase in percentile performance within the Hospital-Wide All-Cause 30-Day Readmission rate (i.e., hospital improving from 10th to 30th, 30th to 50th, 50th to 70th, and 70th to 90th^) Performance Period: Q1 2025 - Q4 2025	N/A - Data will be pulled from Dexur following Q4 2025 data submission

*Please reference supplemental submission templates provided by IEHP
^Hospitals who have achieved the 70th or 90th percentile in the QIA measure of focus are still eligible to participate upon IEHP review and approval. Hospitals will be required to participate in all milestones and show the evolution and progress of QIA. To be eligible for incentive dollars related to the outcome measure, the hospital must remain at the 70th or 90th percentile.

Additional Participation Requirements:

As a new requirement for program year 2025, in addition to specific milestones above, hospitals must actively participate in Advance Care Planning (ACP) health information exchange with CareDirectives or equivalent throughout the entire program year in order to receive incentives for this QIA. Participation will be reviewed at the close of each quarter to ensure ongoing adherence.

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION PAYMENT SCHEDULE				
Milestone #	**2025 Incentive Milestones**	**Incentive Per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Readmission Reduction Workgroup	$25,000	Q1 2025	August 2025
2	Identify key priority areas for improvement			
3	Leverage analysis to implement performance improvement			
4	Demonstrate meeting and working of Readmission Reduction Workgroup	$35,000	Q2 2025 Q3 2025 Q4 2025	February 2026
5	Demonstrate a reduction in preventable readmission rates	$40,000	Q1 - Q4 2025	May 2026
	Milestones Total	**$100,000**		

Note:

- All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined, all incentives are subject to withhold from future incentive payments.

References:

Centers for Medicare & Medicaid Services. (n.d) Overall Hospital Quality Star Rating. Hospitals - Overall hospital quality star rating | Provider Data Catalog. https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating

☑ Measure Name: *Quality Improvement Activity: Safety and Adverse Events*

Many hospitals elected to participate in the 2024 Hospital P4P QIA specific to Safety and Adverse Events. The results of the QIA indicated the need to continue to recognize and award hospitals for their improvement efforts and performance.

For this program year, the QIA will focus on reducing Healthcare-Associated Infections (HAIs). HAIs are infections that patients can acquire while receiving treatment for medical or surgical conditions. There are many risk factors that expose patients to HAIs including hospitalization, invasive procedures, and deviation from best practices. Additionally, HAIs are associated with morbidity and mortality rates indicating a serious threat to healthcare safety (CDC, 2024).

As IEHP is committed to ensuring that all patients receive safe, high-quality care, this measure is intended to encourage hospitals to participate in continuous quality improvement driving the reduction of HAIs.

Performance Requirements Overview – All eligible hospitals

Hospitals must actively participate with Dexur. Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current Safety and Adverse Event Workgroup*	1) Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader f. Infection Prevention leader	2/28/2025

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
2	Identify key priority areas for improvement*	1) Hospital to conduct an initial analysis of Hospital Acquired Infection (HAI) data and performance for the following HAIs during the time period of Q1 2023 - Q4 2023 via the Dexur Healthcare Quality Excellence Platform: i. Central line-associated bloodstream infections (CLABSI) ii. Catheter-associated urinary tract infections (CAUTI) iii. *Clostridium difficile* (C.diff) Laboratory-identified Events iv. Methicillin-resistant *Staphylococcus aureus* (MRSA) Blood Laboratory-identified Events v. Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy) vi. Surgical site infections from colon surgery (SSI: Colon) (CMS, n.d.) 2) Hospital to select one HAI for focused improvement that reflects performance below the 50th^ percentile and implement a QIA project based upon identified hospital needs with a goal to increase measure percentile performance 3) Hospital to submit to IEHP HAI for focused improvement for QIA	2/28/2025
3	Leverage analysis to implement performance improvement*	1) After hospital selection of HAI for focused improvement, hospital to submit action plan outlining QIA and initial implementation completion	3/31/2025
4	Demonstrate meeting and working of current patient safety and adverse event workgroup*	1) Demonstrate evidence that group met at least monthly (April through December 2025) a. Summary report includes, at minimum: i. Meeting Attendees ii. Summary of data reviewed (please do not include PHI) b. Update to PDSA cycle *Validation of full implementation and QIA evolution will be completed by IEHP's Hospital Relations Team during Q3*	06/30/2025 09/30/2025 12/31/2025

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
Milestone #	**2025 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
5	Demonstrate a reduction in the rate of safety and adverse events	1) Hospital to demonstrate an increase in percentile performance for the selected HAI measure (i.e., hospital improving from 10th to 30th, 30th to 50th, 50th to 70th, and 70th to 90th^) Performance Period: Q1 2025 - Q4 2025	N/A - Data will be pulled from Dexur following Q4 2025 data submission.

^Hospitals who have achieved the 70th or 90th percentile in all the QIA measures of focus are still eligible to participate upon IEHP review and approval. Hospitals will be required to participate in all milestones and show the evolution and progress of QIA. To be eligible for incentive dollars related to the outcome measure, the hospital must remain at the 70th or 90th percentile for the measure selected.

Additional Participation Requirements:

As a new requirement for program year 2025, in addition to specific milestones above, hospitals must actively participate in Advance Care Planning (ACP) health information exchange with CareDirectives or equivalent throughout the entire program year in order to receive incentives for this QIA. Participation will be reviewed at the close of each quarter to ensure ongoing adherence.

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS PAYMENT SCHEDULE				
Milestone #	**2025 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current patient safety and adverse event workgroup	$25,000	Q1 2025	August 2025
2	Identify key priority areas for improvement			
3	Leverage analysis to implement performance improvement			
4	Demonstrate meeting and working of current patient safety and adverse event workgroup	$35,000	Q2 2025 Q3 2025 Q4 2025	February 2026
5	Demonstrate a reduction in the rate of hospital acquired infections	$40,000	Q1 - Q4 2025	May 2026
	Milestone Total	**$100,000**		

Please reference supplemental submission templates provided by IEHP.

Note:

- All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined, all incentives are subject to withhold from future incentive payments.

References:

Centers for Disease Control and Prevention (CDC). (2024). About HAIs. https://www.cdc.gov/healthcare-associated-infections/about/index.html

Centers for Medicare & Medicaid Services. (n.d). Overall Hospital Quality Star Rating. Hospitals - Overall hospital quality star rating | Provider Data Catalog. https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating

☑ Measure Name: *Cal Hospital Compare "Healthcare Organizations Leading SUD Care – Hospital Self-Assessment"*

The opioid epidemic is one of the most severe public health crises in US history. Preliminary data from 2023 shows that nearly 22,500 people sought treatment for an opioid overdose in emergency rooms, and an additional 7,500 people died as a result from an overdose (CDPH, 2024). Cal Hospital Compare has developed the hospital self-assessment "Healthcare Organizations Leading Substance Use Disorder (SUD) Care" in which hospitals can evaluate their progress and performance in four domains of care (2024).

IEHP encourages hospital partners to review their current practices and continue to work toward excellence in the space of care delivery for opioid and substance use disorder.

Methodology:

As part of their participation in the 2025 IEHP P4P Program, hospitals participate in the Cal Hospital Compare "Healthcare Organizations Leading SUD Care – Hospital Self-Assessment" (2024). This assessment created by Cal Hospital Compare evaluates hospital performance during the period of July 2024-June 2025. Please visit https://calhospitalcompare.org for more information.

Goal:

Hospitals submit the "Healthcare Organizations Leading SUD Care" – Hospital Self-Assessment to Cal Hospital Compare and based upon identified achievement in Cal Hospital Compare Honor Roll, IEHP will award hospitals who achieve recognition in one of the following categories:

1. Superior Performance
2. Excellent Progress
3. Most Improvement
4. Sustained Improvement

Payment Methodology:

Hospital partners will be eligible for P4P dollars if elements in tiers below are met.

PERFORMANCE INDICATOR			
Milestone #	**Hospital Requirement**	**Milestone/Data Source**	**Completion Due Date**
1	As part of their participation in the 2025 IEHP HP4P Program, Hospital will submit a Self-Assessment	1. Hospital will submit to Cal Hospital Compare their "Healthcare Organizations Leading SUD Care – Hospital Self-Assessment" 2. Hospital will submit to IEHP confirmation of self-assessment completion.	6/27/2025
2	Hospital recognized as a member of the Cal Hospital Compare 2025 "Introducing Healthcare Organizations Leading SUD Care" Honor Roll	1. 2025 Cal Hospital Honor Roll results (IEHP to obtain results)	N/A

References:

Cal Hospital Compare. (2024). Healthcare Organizations Leading SUD Care - Hospital Self-Assessment. https://calhospitalcompare.org/wp-content/uploads/2024/07/Hospital-Self-Assessment_Healthcare-Orgs-Leading-SUD-Care_CHC_2025_FINAL-1.pdf

California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH - Substance and Addiction Prevention Branch). Accessed on 10/11/24. https://skylab.cdph.ca.gov/ODdash/.

NEW

☑ Measure Name: *Adult Flu Vaccination*

According to the CDC, the flu can cause illness, hospitalization, and mortality, yet many individuals can be protected from the flu through the flu vaccination (2024). Therefore, IEHP has established a measure that incentivizes hospitals for each adult influenza vaccination administered to inpatient IEHP members 19 years of age and older.

Methodology:

Hospital administration of flu vaccination will be captured through the Manifest MedEx HL7 VXU data feed. Hospitals may be asked to provide supplemental details.

Exclusions:

IEHP Members less than 19 years of age and/or Medi-Medi members.

Performance Requirement Overview – All eligible Hospitals:

Adult Flu Vaccination - Performance Window	
Data Capture Period	**Flu Vaccination Administration Period:**
Q1 2025	01/01/2025 - 03/31/2025
Q4 2025	10/01/2025 - 12/31/2025

Payment Methodology:

Adult Flu Vaccination Payment Schedule		
Payment per Service	**Performance Period**	**P4P Payment Distribution**
$25/Vaccination	Q1 2025	August 2025
	Q4 2025	May 2026

References:

Centers for Disease Control and Prevention (CDC). (2024). Benefits of the Flu Vaccine. https://www.cdc.gov/flu-vaccines-work/benefits/index.html

Note:

- Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Manifest MedEx Active Data Sharing

Manifest MedEx (MX) supports Health Information Exchange (HIE) connectivity across California. As the largest nonprofit health data network in California, Manifest MedEx connects hospitals, medical groups, IPAs, physician practices and health plans in the Inland Empire. Manifest MX is also a CalHHS Data Exchange Framework (DxF)-designated intermediary and helps organizations securely exchange data as required under the DxF.

Performance Requirements:

- Hospitals must demonstrate active data sharing with Manifest MX by submitting all data types listed below throughout the measurement period.
- Completeness of hospital data will be assessed monthly and quarterly to ensure data sharing is in place throughout the entire measurement period.
- Participants have 30 days from notification to resolve any identified issue and achieve passing status for the feed or segment.
    - Manifest MedEx will provide monthly reports as written notification of issues and relevant status updates.

This data sharing requirement aims to leverage new technology to support care transition processes between hospitals and providers. Compliance with this measure requires hospitals to report all discharges and admissions (including emergency room, acute, and subacute stays) to Manifest MX for all message types noted in the following table during the entire measurement period.

MX DATA CONTRIBUTION FOR HOSPITALS		
HL7 ADT data feed that complies with MX data sharing guidelines in production		
Admissions Data	*Discharge Data*	*Diagnosis Data*
HL7 ORU/MDM data feed that complies with MX data sharing guidelines in production		
Lab Orders *Pathology Documents*	*Lab Results* *Radiology Documents*	*Lab Documents* *Chart Notes**
HL7 RDE data feed that complies with MX data sharing guidelines in production		
Prescription Medications/Orders *Delivery Route*		*Medication Information (including SIG)* *Status*
HL7 VXU data feed that complies with MX data sharing guidelines in production		
*Immunization Data***		

** Chart notes include: History & Physical, discharge summary, consults, progress notes, surgical notes and procedure notes. These notes can be provided by HL7 Medical Document Management (MDM).*
*** Immunization data submitted to MX is separate from immunization reporting to California Immunization Registry (CAIR).*

Payment Methodology:

For general acute care hospitals, each feed listed in the MX Data Contribution Table above (ADT, ORU/MDM, RDE, VXU) is recognized as 25% of the total allocated incentive. Hospitals must pass in all feeds to achieve full incentive.

Due to the unique characteristics of critical access hospitals (CAH), the following adjustment is made to provide additional resources to support the establishment and maintenance of the required data feeds for this measure:

– A maximum of $25,000 is available for the measurement year, distributed at the end of the measurement year.
– Incentives are awarded as follows:
- $1,562.50 for each HIE feed (ADT, ORU/MDM, RDE, VXU) that
  - is newly established during the quarter, or
  - meets the quality threshold for the quarter

Technical Requirements:

Hospitals are required to send all fields listed in the technical specification documents on the IEHP.org website: https://www.providerservices.iehp.org/en/programs-and-services/provider-incentive-programs/pay-for-performance-program#hospital-P4P-program.

Acronym Dictionary:

ADT: Admission, discharge, transfer message
HL7: Health level 7 standards development organization
MDM: Medical Document Management
ORM: Order Interface
ORU: Observation result message
RDE: Pharmacy/treatment encoded order message
VXU: Immunization data

RISK-BASED MEASURES: *The following section of the guide outlines measures for which there is no payment outlay, but for which hospitals are held accountable for measure performance via forfeiture of dollars earned from other measures.*

☑ Measure Name: *Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate*

The California Maternal Quality Care Collaborative (CMQCC) calculates a standardized measure that assesses the rate of Cesarean births, focusing on the all-important first birth. This measure is known as the Nulliparous Term Singleton Vertex (NTSV) Cesarean Birth Rate. It identifies the proportion of live babies born at or beyond 37 weeks of gestation to women in their first pregnancy, which are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions) via Cesarean birth. The United States Department of Health and Human Services, in its Healthy People 2020 project, simplified the name for non-obstetric audiences to "Low-Risk Cesarean Birth Among First-Time Pregnant Women." This is somewhat imprecise, as some higher-risk patients remain in the denominator but have very little impact.

The Joint Commission subsequently adopted this metric in 2010 and now requires all hospitals with more than 300 births to report their results as part of the Perinatal Core Measure Set.

The metric has also been adopted by the Leapfrog Group and the Centers for Medicare and Medicaid Services. Several states also require hospital reporting as part of their Medicaid quality initiatives. The NTSV Cesarean Birth measure was re-endorsed as one of the National Quality Forum's (NQF) Perinatal and Reproductive Health measures in 2016, and the Joint Commission is now the steward of the measure.

Methodology:

Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and have a signed CMQCC authorization release in place to share hospital-level results with IEHP by February 15, 2025.

All hospitals participating in the IEHP Hospital P4P Program must report their rates according to the CMQCC reporting guidelines and timeframes and authorize CMQCC to give IEHP access to the reported rates. IEHP will receive hospital-specific rates from CMQCC according to the reporting timeline noted in the "Payment Methodology Section."

A lower rate in this measure indicates better performance.

Risk-Based Payment Methodology:

Hospitals must achieve an NTSV Cesarean Delivery rate of ≤23.6% or forfeit 5% of total dollars earned during that measurement quarter.

- Measure will be assessed and payment reduced quarterly.
- To accommodate for volume variance, performance will also be assessed annually.

Hospitals who meet the target utilizing annualized outcomes are eligible for repayment of the withhold.

☑ Measure Name: *Post Discharge Follow-Up Within Seven Days of Discharge*

This measure captures the number of discharges during the measurement period for high-risk members, 18 years of age and older, with a follow-up outpatient visit within seven days of hospital discharge.

Methodology:

To identify high-risk Members, IEHP employs the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx (MRx) model (CDPS+MRx), a combined diagnostic and pharmacy model, to identify high-, rising- and low-risk members. This is also referred to as the FAR tool. The system was developed by the University of California, San Diego, and has been adopted by the Department of Health Care Services (DHCS) of the State of California for use in its rate-setting methodology with Medi-Cal Managed Care Plans (MCPs).

CDPS+MRx uses clinical and pharmaceutical data from the prior 12 months to generate predictive risk scores for the next 12 months. The CDPS+MRx system measures the morbidity burden of patient populations based on age, gender, and diagnostic markers.

For member stratification, IEHP uses the CDPS+MRx risk scores, along with other inputs including Social Determinants of Health (SDOH) indices, and other clinical indicators to further stratify members into high, rising, and low-risk tiers.

Hospitals will not experience a decrease in their baseline PDFU rate from CY 2024. Indirectly, this will ensure that post-discharge follow-up appointments are being made as effectively as in previous calendar years for which there was upside financial incentive for this measure.

Numerator:

High-risk Members who had a follow-up visit with a practitioner within seven days of discharge. A practitioner for this measure is defined as:

- A Primary Care Provider or Specialty Care Provider
- A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care or specialty care medical services
- Note: Licensed practical nurses, registered nurses and pharmacists are not considered PCPs or Specialists

Refer to the PDFU code list located on the IEHP P4P Program website.

Denominator:

All acute and nonacute inpatient discharges during the measurement period for high-risk Members.

IEHP utilizes the HEDIS® modified measure denominator specifications for Transition of Care (TOC) to determine the initial denominator.

To be eligible for this measure, IEHP Members must be enrolled with IEHP on the date of discharge through 30 days after discharge (31 total days).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.
*Critical Access Hospitals (CAHs) must have a minimum denominator of 5 or more Members, in the performance quarter, to be assessed for the Post Discharge Follow-Up measure.

Notes:

- Only the last discharge is counted if the discharge is followed by a readmission within seven days of the initial discharge.
- Urgent Care visits are not accepted for this Post Discharge Follow-Up measure.
- Medi-Medi Members are also excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

The following are excluded from the measure:

1. Members discharged to Hospice
2. Members discharged to a Skilled Nursing Facility
3. Members presenting for Delivery

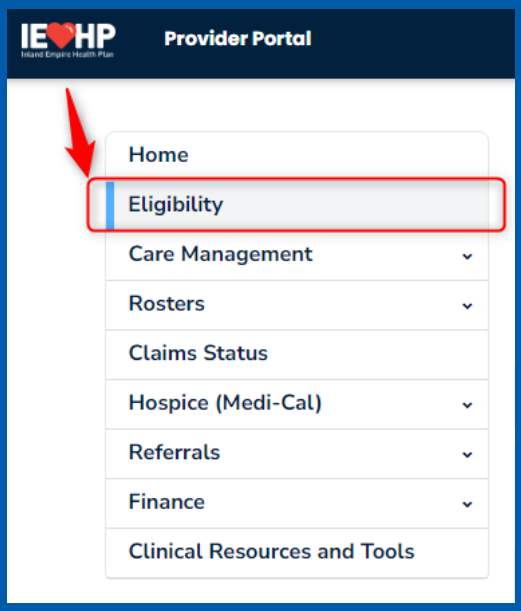
Risk-Based Payment Methodology:

Hospitals not maintaining baseline PDFU rates will be subject to a 5% reduction of total P4P dollars earned within that measurement quarter.

To view an IEHP Member's current high-risk score, hospitals can log into the secure IEHP Provider Portal and follow these steps:

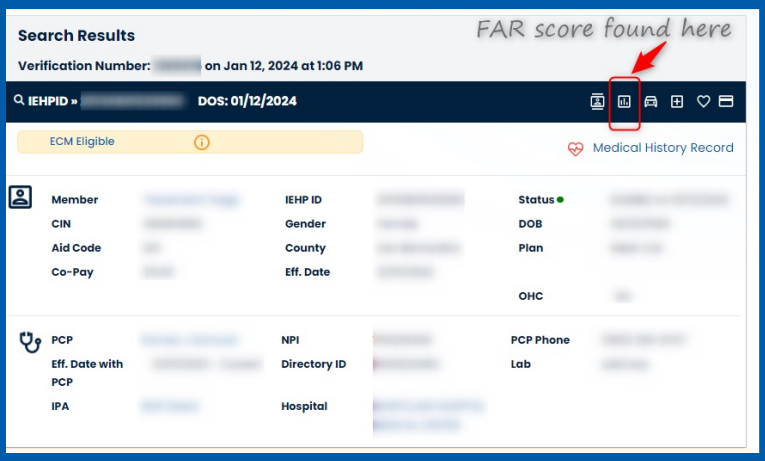
Step 1:

Locate IEHP member in eligibility on IEHP Secure Provider Portal



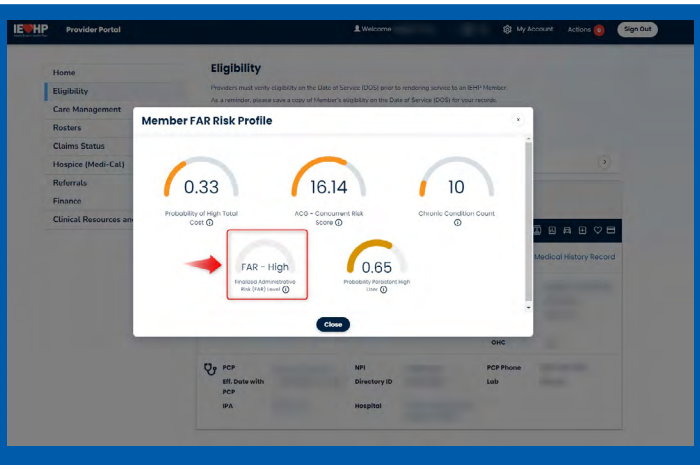
Step 2:

Click icon for "FAR score"



Step 3:

View "FAR score"



APPENDIX 1: *Dexur Good Standing Criteria*

Dexur Good Standing Criteria:

Hospitals must complete the following as per referenced timeframes and/or at least quarterly. Hospitals not meeting all criteria in a single quarter are at risk of forfeiture of all 2025 Hospital P4P incentives earned during that quarter for the following measures:

- Hospital Quality Rating
- Patient Experience: Percentile Achievement
- Hospital-Wide All-Cause Mortality
- Quality Improvement Activity: Readmission Reduction
- Quality Improvement Activity: Safety and Adverse Events

- Submit their SIERA data files to include Inpatient, ED, and Ambulatory data to Dexur on an accelerated quarterly* basis in an editable file report.
  - In lieu of SIERA data file submission, the hospital may submit the 837 Healthcare Claim file.
  - For optimal use of the Dexur platform, it is recommended to send 837 data monthly.
- Submit their chart abstracted and web-based measure data to Dexur on a quarterly basis.*
- Grant the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Group Access to Dexur to allow for downloadable HAI data.
- Submit individual survey-level HCAHPS responses through an automated process or by granting Dexur direct access to your HCAHPS vendor's reporting system.
  - This approach ensures detailed cohort-level analytics to enhance patient experience, align with plan goals, and maintain consistent monthly reporting.
  - Submit a rolling 6-month set of HCAHPS data on the 5th of every month.*
- Have a minimum of 3 active goals with at least one associated intervention per goal to improve CMS Star Rating/IEHP Quality Rating by March 31st, 2025.
  - Goals and interventions must be addressed by hospitals quarterly.
- Share all CMS Preview Reports with Dexur for purposes of reconciliation by 12/31/2025.

*Please see the reporting calendar and supplemental reporting calendar for data submission deadlines

APPENDIX 2: *QIA: Clinical Variation Reduction Data Elements*

The below data elements are to be utilized by Hospitals who are participating in the QIA: Clinical Variation Reduction (Option 1). These data requirements are to be utilized for submission of milestone #2A and milestone #3 associated with the QIA.

Data capture period:

Milestone 2A: Baseline - 10/01/2023 – 09/30/2024

Milestone 3:

- Q2 submission will include data from Q4 2024
- Q3 submission will include data from Q1 2025
- Q4 submission will include data from Q2 2025

DATA ELEMENTS	
Certifications	**i. Data should be provided in monthly or quarterly aggregates** **ii. Please do not include any PHI**
Advanced Certification in Perinatal Care	Measures associated with The Joint Commission Perinatal Care Measure Set: PC-01: Elective Delivery PC-02: Cesarean Birth PC-05: Exclusive Breast Milk Feeding PC-06: Unexpected Complications in Term Newborns
Advanced Heart Failure	Measures associated with The Joint Commission Heart Failure Measure Set: ACHF-01: Beta-Blocker Therapy ACHF-02: Post-Discharge Appointment ACHF-03: Care Transition Record Transmitted ACHF-04: Discussion of Advance Directives/Advance Care Planning ACHF-05: Advance Directive Executed ACHF-06: Post-Discharge Evaluation for Heart Failure Patients
Chronic Obstructive Pulmonary Disease	Readmission Rate** Mortality Rate**
Hospital-based Palliative Care	N/A Data will be retrieved directly from CareDirectives
Inpatient Diabetes	Measures associated with the CMS electronic clinical quality measures (eCQMs): HH-01: Hospital Harm- Severe Hypoglycemia HH-02: Hospital Harm- Severe Hyperglycemia Hospital must have elected to submit and have access to eCQM data for both of these measures

DATA ELEMENTS	
Pneumonia	Readmission Rate** Mortality Rate** Excess Days in Acute Care (CMS measure)
Sepsis	Measure associated with The Joint Commission Inpatient Quality Measure: SEP-1 Sepsis Mortality Rate

These measures were selected as they align with mutual hospital-health plan priorities and are likely available within most hospital settings.

Depending on the certification selected, the hospital may also be required to collect/report data directly to The Joint Commission as part of the certification process. These data elements may or may not match those listed in the table above. Please contact The Joint Commission for any questions.

**Hospital can determine data definition and source; however, data must be disease-specific and must include both hospital-specific outcomes and state or national benchmark.

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HOSPITAL RELATIONS SERVICE TEAM

hospitalrelationsserviceteam@iehp.org

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