Publicly Reported DRA HAC Measures

Frequently Asked Questions

2025

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General Information

1. What is a hospital-acquired condition?

A hospital-acquired condition (HAC) is one of several medical conditions a patient can develop during a hospital stay that was not present on admission (POA), such as a pressure sore or surgical site infection. The Centers for Medicare & Medicaid Services (CMS) has used the HAC designation since October 1, 2008, as required by Section 5001(c) of the Deficit Reduction Act (DRA) of 2005.

2. What is the history of reporting DRA HAC measures?

Section 5001(c) of the DRA of 2005 requires the Secretary of the U.S. Department of Health and Human Services to identify HACs that (1) are high cost, high volume, or both; (2) result in higher claim payments to hospitals because of the presence of the HACs as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines. For discharges on or after October 1, 2008, hospitals no longer receive additional payment for cases in which one of the identified HACs occurred but was not POA. Instead, the case will be paid for as though the HAC was not present. This is known as the DRA HAC payment provision (see Question 3).

CMS selected 10 categories of HACs to which the DRA HAC payment provision would apply in the fiscal year (FY) 2009 Inpatient Prospective Payment System (IPPS)/ Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule (pages 48471-48491). In the FY 2013 IPPS/LTCH PPS final rule (pages 53285-53292), CMS added four more HAC categories, for a total of 14 categories. In September 2024, CMS calculated and publicly reported 4 of the 14 DRA HAC measures on the CMS website (see Question 6). CMS will continue to publicly report the same four DRA HAC measures in the third quarter (Q3) of 2025. See Question 16 for details on the differences between the Publicly Reported DRA HAC Measures in 2024 versus in 2025.

3. What is the DRA HAC payment provision?

Under the DRA HAC payment provision, established by Section 5001(c) of the DRA of 2005, hospitals no longer receive additional payment for cases in which one of the identified HACs occurred but was not POA. Instead, the case is paid as though the HAC was not present. This payment provision applies only to secondary diagnosis codes within 1 of the 14 identified HAC categories, given that the identified HACs are designated as a complication or comorbidity (CC) or as a major complication or comorbidity (MCC) when reported as a secondary diagnosis. However, if other CC/MCC conditions not subject to the DRA HAC payment provision are present—that is, other CC/MCC conditions which are not within 1 of the 14 identified HAC categories—then payments will not be adjusted.

4. What are the Publicly Reported DRA HAC Measures?

CMS calculates and reports rates for four of the HACs included in the DRA HAC payment provision; these measures are referred to as the Publicly Reported DRA HAC Measures. CMS calculates and reports these measures only for informational and quality improvement purposes; the results of the measure calculations do not affect payment. The Publicly Reported DRA HAC Measures are distinct from the HAC Reduction Program (see Question 5).

5. What is the HAC Reduction Program?

The Hospital-Acquired Condition (HAC) Reduction Program is a separate Medicare value-based purchasing program that reduces payments to hospitals based on their performance on measures of hospital-acquired conditions (HACs). The program supports the long-standing efforts of CMS to provide incentives for hospitals to improve health care quality in the hospital inpatient setting.

Section 1886(p) of the Social Security Act set forth the statutory requirements for the HAC Reduction Program. The Act requires the Secretary of the U.S. Department of Health and Human Services to reduce payments to hospitals that rank in the worst-performing quartile (that is, above the 75th percentile) of all subsection (d) hospitals (that is, general acute care hospitals paid under the Inpatient Prospective Payment System [IPPS][1]) with respect to measures of HACs.

Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (that is, hospitals in the worst-performing quartile) receive a payment reduction of 1 percent on overall Medicare fee-for-service (FFS) Part A payments.

The HAC Reduction Program includes six HAC quality measures:

- One claims-based composite measure of patient safety:
  - CMS Patient Safety and Adverse Events Composite (CMS Patient Safety Indicator [PSI] 90)
- Five chart-abstracted or laboratory-identified healthcare-associated infection measures submitted to the Centers for Disease Control and Prevention's National Healthcare Safety Network:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Colon and Abdominal Hysterectomy Surgical Site Infection (SSI)
  - Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia
  - *Clostridium difficile* Infection (CDI)

  For more information, see the HAC Reduction Program section of the QualityNet website.

[1] Maryland hospitals are exempt from payment reductions under the HAC Reduction Program per an agreement between CMS and Maryland.

Public Reporting

6. Which DRA HAC measures will CMS publicly report in 2025?

For 2025, CMS will publicly report the following DRA HAC measures:

- Foreign Object Retained After Surgery
- Blood Incompatibility
- Air Embolism
- Falls and Trauma (includes fractures, dislocations, intracranial injuries, crushing injuries, burns, and other injuries)

7. Why is CMS reporting these DRA HAC measures?

CMS is publicly reporting these DRA HAC measures to identify complications and undesirable conditions that patients experience in hospitals and that hospital-level changes in practice could reasonably prevent. Ensuring safety and quality is a CMS priority and a key goal of quality improvement. The DRA HAC measures remain an important aspect of CMS's commitment to safety and quality.

8. Why is CMS reporting only four DRA HAC measures?

CMS selected the four DRA HAC measures—Foreign Object Retained After Surgery, Blood Incompatibility, Air Embolism, and Falls and Trauma—because no current measures in other CMS quality programs cover these topics.

Previously, CMS calculated and reported four other DRA HAC measures: (1) Stage III and IV Pressure Ulcers, (2) Manifestations of Poor Glycemic Control, (3) Catheter-Associated Urinary Tract Infections, and (4) Vascular Catheter-Associated Infections. CMS also previously calculated and reported PSI 11 (Postoperative Respiratory Failure Rate).

CMS no longer reports these other measures to reduce redundancy among its quality reporting programs. For example, the CMS PSI 90 measure covers two of the concepts (pressure ulcers and postoperative respiratory failure rate) noted previously. Measures from the Centers for Disease Control and Prevention's National Healthcare Safety Network also cover two of the concepts (central line-associated bloodstream infections and catheter-associated urinary tract infections).

9. Can hospitals preview their results before public reporting?

Yes, CMS gives hospitals 30 days to preview their results and to submit questions about result calculations before public reporting on the CMS website in Q3 2025. This 30-day period is known as the Publicly Reported DRA HAC Measures Preview Period. At the beginning of the Preview Period in June 2025, CMS makes each hospital's Hospital-Specific Report (HSR) available for download in the Hospital Quality Reporting (HQR) system (login required). (See

Question 10 for access instructions.) CMS notified hospitals of the exact dates of the 2025 Preview Period via email.

During the Preview Period, hospitals may not submit corrections related to the underlying claims data or add new claims to the data extract used to calculate the results of the DRA HAC measures. If a hospital identifies an issue with their claims data during the Preview Period, see Question 12 for instructions.

Please direct any questions or concerns about your hospital's calculations to the QualityNet Question and Answer Tool no later than 11:59 p.m. PT on the final day of the Preview Period. Select "Ask a Question" and choose "DRA HAC—Deficit Reduction Act Hospital-Acquired Conditions" in the Program list. Select "DRA HAC Preview Period Request" in the Topic list and enter "DRA HAC Preview Period Inquiry" on the Subject line.

Note: The HSR contains discharge-level data protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of personal identifiable information (PII) or protected health information (PHI) should only be in accordance with, and to the extent permitted by, the HIPAA Privacy and Security Rules and other applicable law. When referring to the contents of the HSR, ONLY use the ID Number associated with the claim(s) in question. Do NOT send PII/PHI in your question.

Note: Hospitals with no eligible discharges will not receive an HSR. CMS will exclude these hospitals from public reporting.

10. How can my hospital access its HSR?

The HSRs for the Publicly Reported DRA HAC Measures can be downloaded directly from the HQR system (login required). The HSRs are accessible for users within your organization with a Health Care Quality Improvement System (HCQIS) Access Roles and Profile (HARP) account with access to Managed File Transfer (MFT). To access your hospital's HSR:

1. Log into the HQR system using your HARP ID credentials.
2. From the left-hand navigation menu, select "Program Reporting,"
3. Then select Measure details.
4. Next, select "Measures detail dashboard"
5. On the Measure detail dashboard, select the program in which you are interested in (e.g., Publicly Reported DRA HAC Measures)
6. Select the release year you are interested (2025). If applicable, select the name of facility you are interested in and its CMS Certification Number (CCN).
7. Your hospital's performance results will appear. Click on the header of each section to expand the data table within each section (e.g., click on "Performance summary" to expand the Performance summary data table).

To download your hospital's patient- or performance-level CSV files and performance-level PDFs, select "Export," and then choose the option you are interested in. The files will be downloaded through your browser. Once downloaded, open the ZIP file to view your hospital's information.

You can also view a brief instructional video on how to download the HSR on YouTube, and if you do not have a HARP account, you may register for a HARP ID on the CMS website.

If you have any issues accessing your hospital's HSR, please contact the Center for Clinical Standards and Quality (CCSQ) Service Center at qnetsupport@cms.hhs.gov, or by calling, toll free, 866-288-8912 (TRS 711), weekdays from 8:00 am to 8:00 pm ET. For questions related to HARP registration, please visit the HARP Help webpage or contact qnetsupport@cms.hhs.gov.

Note: Hospitals with no eligible discharges will not receive an HSR. CMS will exclude these hospitals from public reporting.

11. What should a hospital do if a HAC is coded incorrectly?

A hospital has 60 days after the date of notice of the initial assignment of a discharge to a Medicare Severity Diagnosis Related Group (MS-DRG) to request a review of that assignment, as explained by CMS in the FY 2008 IPPS/LTCH PPS final rule (page 47216) and under 42 CFR 412.60(d). The hospital may submit additional information in its request. The hospital may request that its fiscal intermediary or Medicare Administrative Contractor (MAC) review the MS-DRG assignment, consistent with Section 412.60(d) of the Code of Federal Regulations.

The results of the Publicly Reported DRA HAC Measures will only reflect edits that comply with the time limits and reopening and revision requirements described in the Medicare Claims Processing Manual: Chapter 1—General Billing Requirements and Chapter 34—Reopening and Revision of Claim Determinations and Decisions.

Note that MACs must process all corrections to the underlying Medicare fee-for-service (FFS) claims data by the date when CMS takes its annual "snapshot" of the claims data. CMS takes these snapshots each year to perform measure calculations for quality reporting programs. CMS took a snapshot of the data on October 22, 2024, to perform calculations for the 2025 Publicly Reported DRA HAC Measures. The next snapshot will be taken on September 30, 2025, for the 2026 Publicly Reported DRA HAC Measures.

The HSR will not reflect any corrections to the claims data processed after the claims snapshot. CMS cannot recalculate any results in the HSR to reflect corrected claims.

12. What should a hospital do if it identifies an issue with its claims data during the Preview Period?

Hospitals may not submit corrections related to the underlying claims data or add new claims to the data extract used to calculate the results of the Publicly Reported DRA HAC Measures during the Preview Period. However, if your hospital identifies an issue with its claims data

during the Preview Period, it may submit a *Withholding/Footnoting Data from Public Reporting* form to ask CMS to apply a footnote to the publicly reported results.

CMS reviews each request and determines whether or not the request is approved. If CMS approves your hospital's request, CMS will apply a footnote to your hospital's applicable measure results in the first quarter it is operationally feasible. The footnote will remain in the applicable year's dataset on the CMS website. If the data discrepancy remains in the next year's dataset, the hospital must request the footnote again during the applicable Preview Period.

CMS will not consider forms received after the end of the Preview Period. Please note the request form must be submitted to the email indicated on the form (QRFormsSubmission@hsag.com).

The *Withholding/Footnoting Data from Public Reporting* form and additional information about the form are available on the QualityNet website.

13. When will CMS publicly release the results of the DRA HAC measures?

CMS will publicly report the hospital-level results of the DRA HAC measures on the CMS website in Q3 2025. CMS will publicly report the rate of each DRA HAC measure for each hospital with eligible discharges.

Measure Methodology and Calculation Information

14. Which hospitals are included in the DRA HAC calculations?

Subsection (d) hospitals (that is, general acute care hospitals paid under the Inpatient Prospective Payment System, as well as Maryland hospitals) must submit complete POA Indicator coding to CMS. Although other types of hospitals can report these codes, CMS calculates the Publicly Reported DRA HAC Measures only for subsection (d) hospitals, including Maryland hospitals. This is because the DRA HAC measures depend on complete and accurate coding of POA Indicator fields.

The CMS webpage on HAC POA Indicators provides a list of hospital types exempt from the DRA HAC payment provision.

15. How does CMS calculate the DRA HAC measures?

CMS used claims for Medicare FFS discharges between July 1, 2022, and June 30, 2024, to calculate the DRA HAC measures for 2025. See Question 16 for more details on the discharge period for the 2025 Publicly Reported DRA HAC Measures. Only final action claims are used; pre-review claims and informational claims are not considered.

CMS reports the DRA HAC measures as observed rates (per 1,000 discharges). CMS divides the count of observed HAC occurrences identified at a hospital (numerator) by the number of eligible discharges at that hospital (denominator) and multiplies by 1,000.

Eligible discharges in the DRA HAC denominator include claims for Part A Medicare FFS discharges, sometimes called "traditional" Medicare or "original" Medicare, during the discharge period. That includes patients of all ages. CMS excludes discharges of patients who are enrolled in Medicare managed care plans (that is, Medicare Advantage). This exclusion is determined by checking the patient's enrollment status during the month of hospital admission. If a patient is enrolled in managed care during that month, the discharge will not be included in the calculation. Additionally, patients who are treated only in the emergency room or remain under observation without being formally admitted as inpatients are not counted in the DRA HAC measures. If, however, a patient initially treated in the emergency department is later admitted as an inpatient, that inpatient stay may be included, provided it meets all other required inclusion criteria.

HAC occurrences are included in the DRA HAC numerator only if they are associated with the POA Indicator codes "N" or "U."

The available POA Indicator codes are as follows:

- Y: Diagnosis was present at time of inpatient admission
- N: Diagnosis was not present at time of inpatient admission
- U: Documentation was insufficient to determine whether diagnosis was present at time of inpatient admission
- W: Clinically undetermined whether diagnosis was present at time of inpatient admission
- 1: Diagnosis exempt from POA Indicator reporting

The DRA HAC measures do not exclude any HACs based on how they occurred – there are no restrictions based on diagnosis or procedure coding. For example, a rib fracture resulting from cardiopulmonary resuscitation (CPR) would be included in the numerator of the Falls and Trauma DRA HAC measure, even if the CPR was necessary, because the rib fracture diagnosis is a qualifying, observed HAC that was not present on admission.

Every hospital is responsible for completing its claims according to CMS's coding guidelines. The coding guidelines for diagnoses, the assignment of POA Indicator codes for each diagnosis, and procedures are typically updated on an annual basis, and are available on the CMS ICD-10 Codes website (see the "ICD-10 CM & PCS files" drop-down selections). As discussed in Question 4, the DRA HAC measures are reported only for informational and quality improvement purposes; the results of the measure calculations do not affect payment.

16. How will the results of the DRA HAC measures posted in 2025 differ from the results posted in 2024?

The 2025 Publicly Reported DRA HAC Measures used an updated 24-month discharge period, covering discharges between July 1, 2022, and June 30, 2024. The 2024 Publicly Reported DRA HAC Measures used a 24-month discharge period covering discharges between July 1, 2021, and June 30, 2023.

17. Does CMS adjust these measures based on a hospital's patient case mix?

CMS does not adjust the results of the DRA HAC measures based on patient case mix. CMS considers many of these HACs to be serious, reportable events that should not occur, regardless of a patient's condition.

18. How does CMS assess multiple HACs in the same claim when calculating hospital rates?

If a discharge record contains qualifying secondary diagnoses for multiple identified HAC categories, CMS will count the discharge record once for each unique HAC category. However, if a discharge record contains multiple qualifying secondary diagnoses for the same identified HAC category, CMS will only count the discharge record one time.

19. Where can I find the ICD-10 codes used for the 2025 Publicly Reported DRA HAC Measures?

For the complete lists of ICD-10 codes, see the FY 2022, FY 2023, and FY 2024 ICD-10 HAC Lists on the CMS website. The range of discharge dates referenced by each ICD-10 HAC List is detailed in Table 1.

Table 1. ICD-10 HAC Lists Used for the 2025 Publicly Reported DRA HAC Measures

ICD-10 HAC list	Applicable Range of Discharge Dates
FY 2022 ICD-10 HAC List	Discharges between July 1, 2022 and September 30, 2022
FY 2023 ICD-10 HAC List	Discharges between October 1, 2022 and September 30, 2023
FY 2024 ICD-10 HAC List	Discharges between October 1, 2023 and June 30, 2024

Please direct any questions or feedback regarding the ICD-10 HAC Lists to the CMS HAC Feedback mailbox (HACFeedback@cms.hhs.gov).

20. Where can I find more information?

Visit CMS's HAC POA Indicator page for more information on the DRA HAC POA Indicators.

Please direct any **general questions** on the Publicly Reported DRA HAC Measures to the QualityNet Question and Answer Tool. Select "Ask a Question" and then "DRA HAC—Deficit Reduction Act Hospital-Acquired Conditions" in the Program list.

Please direct any **questions or feedback regarding the ICD-10 HAC Lists** to the CMS HAC Feedback mailbox (HACFeedback@cms.hhs.gov).

Please direct any **questions regarding accessing your hospital's HSR** to the CCSQ Service Center at qnetsupport@cms.hhs.gov, or by calling, toll free, 866-288-8912 (TRS 711), weekdays from 8:00 am to 8:00 pm ET. For questions related to HARP registration, please visit the HARP Help webpage or contact qnetsupport@cms.hhs.gov.