

# FY 2025 Final Rule Summary

## Inpatient Prospective Payment System (IPPS)

August 9, 2024

On August 1, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the final rule for fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS). The full document is located [here](#). The format of the following information is intended to serve as a summary of the proposed changes and readers are encouraged to view the document in its entirety for further details.

### Payment Rates

Under the Inpatient Prospective Payment System (IPPS) CMS sets rates for most acute care hospital inpatient stays, excluding those defined by law. The base payment rates are established based on the patient's diagnosis and severity of illness. The hospital will receive one payment for the case per the assigned classification of the patient at discharge. IPPS uses Medicare Severity Diagnosis-Related Groups (MS-DRGs) classification system for determining the corresponding payment rate. Rates assigned to the MS-DRGs are required to be updated annually based on several factors related to the price for goods and services used by the hospitals to treat Medicare beneficiaries as well as other factors, all known as the "market basket."

### FY 2025 Payment Rates

Beginning with a base rate, CMS applies other factors which, when calculated, determine the overall payment for the patient's care per their diagnosis and severity of illness relative to the geographic location of the hospital. For FY 2025, which begins October 1, 2024, CMS is finalizing to increase payment rates for hospitals that have successfully participated in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users by approximately 2.9 percent. This is reflected in the projected hospital market basket update of 3.4 percent and a 0.5 percent reduction of the productivity adjustment.

### Claims Data

When calculating the payment rates for FY 2025, CMS utilizes the most recently completed claims data which is two years prior. For FY 2025, CMS is finalizing their proposal to return to the use of most recent claims data when calculating and setting rates for the upcoming fiscal year, this means utilizing FY 2023 claims data for the upcoming payment period.

CMS estimates a 3.2 billion increase in FY 2025 payments. This estimate is based on the proposed FY 2025 applicable percentage increase to IPPS rates in conjunction with other proposed changes, including operating payments, uncompensated care payments, capital payments, and the September 30, 2024 expiration of the temporary changes in the low-volume hospital and the Medicare Dependent Hospital (MDH) programs.

Overall, CMS projects the operating payment rate increase with the other finalized changes to IPPS payment polices will be approximately \$2.9 billion. CMS projects Medicare uncompensated care payments to disproportionate share hospitals (DSH) will decrease in FY 2025 by approximately \$0.2 billion. Primarily driven by the continuation of new technology add-on payments, CMS estimates that additional payments for inpatient cases involving new medical technologies will increase by \$0.3 billion in FY 2025. Additional

payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals are set to expire on December 31, 2024. These payments have been extended by legislation in the past, but if they do expire, CMS estimates payments to these hospitals would decrease by \$0.4 billion in FY 2025.

### Low Wage Index

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42326 through 42332), CMS adopted a policy to increase the wage index for certain hospitals with low wage index values. This is known as the low wage index hospital policy. The intention was for this policy to be effective for four years. However, due to the COVID-19 public health emergency (PHE), CMS was unable to comprehensively evaluate the effect the low wage index hospital policy had on hospitals' wage increases. Before reaching conclusions about the efficacy of the low wage index hospital policy, CMS believes it is necessary to wait until they have usable data from fiscal years. Therefore, CMS is finalizing their proposal to extend the low wage index hospital policy and the related budget neutrality adjustment for three years, beginning in FY 2025. The first full fiscal year of wage data after the COVID-19 PHE is the FY 2024 wage data, which CMS expects to be available for FY 2028 policy making.

## **Add-On Payments for New Services and Technologies for FY 2025**

### Changes for the Add-On Payments for New Services and Technologies

New Technology Add-on Payment (NTAP) applies for certain new medical services and technologies under the IPPS. Even if a medical product receives "new" FDA approval or clearance, it may not be considered "new" for the purposes of NTAP if it is "substantially similar" to another FDA approved or cleared medical product that has been on the market for 2-3 years. The newness period begins when the medical product is available in the US market. This is typically the date of FDA approval or clearance. For FY 2025, CMS is proposing to change the cutoff date for determining whether a technology would be within its 2-3 year newness period from April 1 to October 1. CMS has received 10 FDA approved or cleared NTAP applications for FY 2025. If all 10 applications are determined to meet specified criteria for NTAP and are determined not to be "substantially similar" to any other FDA approved or cleared NTAP technologies that are within their 2-3 year newness period, CMS proposes IPPS spending to increase by approximately \$380 million in FY 2027. CMS expects that any new technologies that were ineligible to apply for NTAP in FY 2025 may now apply in FY 2026.

### New Applications

Each year CMS reviews applications received per the deadline for new technology requesting an add-on payment to the DRG. There are specific criteria which must be met to qualify for the additional payment:

- (1) the medical service or technology must be new;
- (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and
- (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.

### Newness Criterion

The newness criterion, technology is no longer considered "new" for the purposes of the add-on payment if it is substantially like one or more existing technologies, even if it recently received FDA approval or

clearance. In addition, if it has been on the market for more than 2 to 3 years, it is no longer considered “new”.

To differentiate how CMS defines what is new technology and the criteria it must meet to evaluate if potentially like existing technology CMS created the following guidelines. If technology meets all the following it is considered similar to existing technology and not “new” for an add-on payment:

- (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome;
- (2) whether a product is assigned to the same or a different MS-DRG; and
- (3) whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

### Cost Criterion

The second criterion is related to cost. CMS will evaluate whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the MS-DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant MS-DRGs if the new medical service or technology occurs in many different MS-DRGs). CMS does provide access to the data files utilized for this analysis.

Applicants are expected to submit a significant sample of data to demonstrate the technology meets the high-cost threshold. The sample size is expected to be significant to allow for CMS to be able to do an initial validation and analysis of the data.

### Substantial Clinical Improvement Criterion

The third and final criterion is the technology must represent an advancement that significantly improves the diagnosis or treatment relative to already existing technologies. Some of the criteria which may support the clinical improvement include:

- The new medical service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments;
- The new medical service or technology offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable, or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods, and there must also be evidence that use of the new medical service or technology to make a diagnosis affects the management of the patient;
- The use of the new medical service or technology significantly improves clinical outcomes relative to services or technologies previously available as demonstrated by one or more of the following: a reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication; a decreased rate of at least one subsequent diagnostic or therapeutic intervention; a decreased number of future hospitalizations or physician visits; a more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time; an improvement in one or more activities of daily living; an improved quality of life; or, a demonstrated greater medication adherence or compliance; or

- The totality of the circumstances otherwise demonstrates that the new medical service or technology substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.
- Evidence from published or unpublished sources with the United States or elsewhere may be sufficient to establish the improvement.
- The medical condition diagnosed or treated by the new medical service or technology may have a low prevalence among Medicare beneficiaries.
- The new medical service or technology may represent an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of a subpopulation of patients with the medical condition diagnosed or treated by the new medical service or technology.

For FY 2025, CMS is finalizing their proposal to approve 11 technologies for 12 NTAPS under the alternative pathway and 5 technologies under the traditional pathway. In addition, CMS is finalizing to continue the add-on payment for 24 technologies and discontinue add-on payments for 7 new technologies after consideration of public comments received. The new technology add-on payments for FY 2025 for technologies are listed in the following Table II.E.-01, for the full table refer to the final rule publication.

<b>TABLE II.E.-01: CONTINUATION OF TECHNOLOGIES APPROVED FOR FY 2024 NEW TECHNOLOGY ADD-ON PAYMENTS STILL CONSIDERED NEW FOR FY 2025 BECAUSE THE 3-YEAR ANNIVERSARY DATE WILL OCCUR ON OR AFTER APRIL 1, 2025</b>							
	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAP Amount for FY 2025	Coding Used to Identify Cases Eligible for NTAP
3	<i>GORE® TAG® Thoracic Branch Endoprosthesis</i>	05/13/2022	10/1/2022	5/13/2025	87 FR 48966 through 48969 88 FR 58800	\$27,807.00	02VW3DZ in combination with 02VX3EZ
5	<i>iFuse Bedrock Granite Implant System</i>	5/26/2022	10/1/2022	5/26/2025	87 FR 48969 through 48974 88 FR 58800	\$9,828.00	XNH6058 or XNH6358 or XNH7058 or XNH7358 or XRGE058 or XRGE358 or XRGF058 or XRGF358
17	<i>DETOUR System</i>	6/7/23	10/1/2023	6/7/2026	88 FR 58930 through 58932	\$16,250.00	X2KH3D9, X2KH3E9, X2KJ3D9, or X2KJ3E9
18	<i>DefenCath™ (taurolidine/heparin)</i>	11/15/23	1/1/2024	11/15/2026	88 FR 58942 through 58944	\$3,656.10	XY0YX28
19	<i>EchoGo Heart Failure 1.0</i>	11/23/23	10/1/2023	11/23/2025	88 FR 58932 through 58935	\$1,023.75	XXE2X19

The discontinuation of new technology add-on payments for technologies is listed in the following Table II.E.-02, for the full table refer to the final rule publication.

<b>TABLE II.E.-02: DISCONTINUATION OF TECHNOLOGIES APPROVED FOR FY 2024 NEW TECHNOLOGY ADD-ON PAYMENTS NO LONGER CONSIDERED NEW FOR FY 2025 BECAUSE 3-YEAR ANNIVERSARY DATE WILL OCCUR PRIOR TO APRIL 1, 2025</b>					
	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
1	<i>Intercept® Fibrinogen Complex (PRFC)</i>	5/5/2021	10/1/2021	5/5/2024	86 FR 45149 through 45150 86 FR 67875 87 FR 48913 88 FR 58800

## Applications for Alternative Pathway for Breakthrough Devices

### DETOUR System by Endologix, LLC

Endologix, LLC applied for new technology add-on payment for the DETOUR System for FY 2024. Per the applicant, the DETOUR System is a fully percutaneous approach to femoral-popliteal bypass. Under fluoroscopic guidance, a TORUS Stent Graft System is deployed from the popliteal artery into the femoral vein, and from the femoral vein into the superficial femoral artery (SFA) in a continuous, overlapping fashion through two independent anastomoses. The applicant stated the intended result is a large lumen endograft bypass, that delivers unobstructed, pulsatile flow from the SFA ostium to the popliteal artery.

The DETOUR System received Breakthrough Device designation from FDA on September 2, 2020, for percutaneous revascularization of symptomatic femoropopliteal lesions 200mm to 460mm with a chronic total occlusion 100mm to 425mm, and/or moderate-to-severe calcification, and/or in-stent-restenosis in patients with severe peripheral arterial disease.

Endologix LLC received FDA approval of the DETOUR System on June 7, 2023. CMS is finalizing their proposal to continue the NTAP for the Detour System for FY 2025. CMS finalized an NTAP amount of \$16,250.00 per case and estimates 600 cases for FY 2025. CMS estimates total NTAP for the DETOUR System at \$9,750,000.00 for FY 2025.

## Changes for the Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program was created to provide value-based incentive payments in a fiscal year to hospitals based on their performance on measures established in a performance period for such fiscal year. CMS estimates no net financial impact to the Hospital VBP Program for FY 2025. By law, the amount available for value-based incentive payments under the program for each year must equal the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount available for value-based incentive payments for FY 2025 discharges is approximately \$1.7 billion.

For FY 2025, CMS is finalizing the following:

- Modify scoring of the Person and Community Engagement Domain for the FY 2027 through FY 2029 program years to only score six unchanged dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
- Adopt the updated HCAHPS Survey in the Hospital VBP Program beginning with the FY 2030 program year after the updated survey would have been publicly reported under the Hospital Inpatient Quality Reporting (IQR) Program for 1 year.
- Modify scoring on the HCAHPS Survey beginning with the FY 2030 program year to incorporate the updated HCAHPS Survey measure into nine survey dimensions.
- Provide previously and newly established performance standards for FY 2027 through FY 2030 program years for the Hospital VBP Program.

CMS did not propose any changes to previously adopted quality measures for the Hospital VBP. Readers should refer to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49110 through 49111) for summaries of previously adopted measures for FY 2025. The following Table V.L.-01 summarizes the previously adopted Hospital VBP Program measure set for FY 2025.

**TABLE V.L.-01: SUMMARY OF PREVIOUSLY ADOPTED MEASURES FOR THE FY 2025 PROGRAM YEAR**

Measure Short Name	Domain/Measure Name	CBE #
<b>Person and Community Engagement Domain</b>		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	0166 (0228)
<b>Safety Domain</b>		
CAUTI	National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI	National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility wide Inpatient Hospital onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility wide Inpatient Hospital onset <i>Clostridioides difficile</i> Infection (CDI) Outcome Measure	1717
<b>Clinical Outcomes Domain</b>		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
COMP-HIP-KNEE	Hospital Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
<b>Efficiency and Cost Reduction Domain</b>		
MSPB	Medicare Spending Per Beneficiary (MSPB) Hospital	2158

## Replaced Devices Offered without Cost or with a Credit

In FY 2008, CMS implemented the policy to reduce reimbursement to a hospital for device placement for certain MS-DRGs where the implantation of the device subsequently failed or was recalled. At that time, CMS reduced the amount paid to the hospital when they received a credit equal to 50 percent or more of the cost of the device. In FY 2012 this was clarified to mean if a hospital received a credit equal to 50 percent or more of the cost of the replacement device and issued instructions to hospitals accordingly.

For FY 2025, CMS is finalizing their proposal to revise the title of MS-DRG 276 from “*Cardiac Defibrillator Implant with MCC*” to “*Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator.*” CMS further finalized their proposal to continue to include existing MS-DRGs currently subject to the policy. The final list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit is included in this final rule and will be issued to providers in the form of a Change Request (CR).

## Additional Information for Hospitals

### Transforming Episode Accountability Model (TEAM)

The FY 2025 IPPS proposed rule contains payment and policy changes for operating and capital-related costs of acute care hospitals. The proposed Transforming Episode Accountability Model (TEAM) is a 5-year mandatory model starting January 1, 2026, and ending December 31, 2030. Through financial accountability, TEAM is intended to improve patient care for the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacements (LEJRs), major bowel procedures, surgical hip/femur fracture treatments (SHFFTs) and spinal fusions. Instead of paying providers and suppliers individually for each item or service, TEAM expects to hold hospitals and suppliers accountable for all items and services provided during the entire episode of care. This will result in a reduction of fragmented, unnecessary, or duplicative care and incentivize providers to better coordinate, which will result in improved patient care. With limited exceptions, all acute care hospitals that are located within the Core-Based Statistical Areas that CMS selects for model implementation are required to participate in TEAMS. CMS estimates that TEAM will save Medicare \$481 million across the 5 testing years. Because this is a multi-faceted model, CMS is finalizing some TEAM policies as proposed (including model performance period and start date, TEAM participant requirements, monitoring model activities, noncompliance repercussions and model termination); and others with modification (such as refining the definition of TEAM participant to account for hospitals eligible to volunteer for the model). There are also certain proposed TEAM policies that CMS are not finalizing, and will instead go through future rulemaking to implement new policies before the model start date.

### Severity Level Changes for ICD-10-CM Z Codes Describing Homelessness

CMS examined resource data generated from claims in the September 2023 update of the FY 2023 MedPAR file for seven ICD-10-CM codes that describe inadequate housing and housing instability. After considering the impact of this data and guiding principles, CMS is finalizing their proposal to change the severity level of Z59.10 *Inadequate housing, unspecified*, Z59.11 *Inadequate housing environmental temperature*, Z59.12 *Inadequate housing utilities*, Z59.19 *Other Inadequate housing*, Z59.811 *Housing instability, housed, with risk of homelessness*, Z59.812 *Housing instability, housed, homelessness in past 12 months*, and Z59.819 *Housing instability, housed, unspecified* from NonCC to CC for FY 2025.

Health equity is a focus of the current Administration and a goal in understanding and recognizing the impact homelessness has on resources in the acute inpatient hospital setting. In response to the President's January 20, 2021, Executive Order 13985 on "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," CMS is continuing to monitor SDOH Z code reporting, including reporting based on SDOH screening performed because of new quality measures in the Hospital Inpatient Quality Reporting Program. CMS may consider proposing changes for other SDOH codes in the future and is interested in receiving feedback on how to foster documentation and reporting of SDOH diagnosis codes to reflect each health care encounter and improve the reliability and validity of coded data in support of efforts to advance health equity more accurately.

CMS is accepting feedback and other information to inform future rulemaking regarding SDOH Z code reporting. Submissions must be received by October 20, 2024, and directed to MEARIS™ at:

<https://mearis.cms.gov/public/home>

## Hospital Readmissions Reduction Program (HRPP) Request for Comment

The Hospital Readmissions Reduction Program (HRPP) was implemented to reduce excess readmissions effective for discharges from applicable hospitals beginning on or after October 1, 2012. The program uses six claims-based measures to track unplanned inpatient admissions within 30 days following discharge. Medicare payments under IPPS for discharges may be reduced for certain excess readmissions.

CMS used the data collected from these measures and notes a reduction in inpatient readmission rates for the conditions and procedures included in the program. However, studies have found an increase in other types of post-discharge events, such as patients visiting the emergency department (ED) or receiving observation services as an outpatient after being discharged from an inpatient stay. CMS is concerned that the hospital quality reporting and value-based purchasing programs are not providing adequate incentive for hospitals to improve quality of care by accounting for additional types of post-discharge events, other than inpatient readmissions.

In the FY 2025 proposed rule, CMS requested public comment on how these programs could further encourage hospitals to improve discharge processes. CMS noted introducing measures currently in quality reporting programs into value-based purchasing, to link outcomes to payment incentives as an option. CMS was specifically interested in comments on input in adopting measures which better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

Among the public comments provided, some commenters recommended to track ED visits and observation services through the HRRP, which would provide better analysis of post-discharge care; while others recommended only tracking post-discharge observation services but not ED visits. Some commenters expressed concerns the readmission measures may not account for factors out of the patient's or hospital's control, such as patient's condition severity, social determinants of health and admissions unrelated to the initial admission. And still other commenters urged CMS to "ensure that measures capturing readmissions would not unfairly penalize hospitals that disproportionately serve populations with health related social needs."

CMS is not finalizing any changes to the Hospital Readmissions Reduction Program (HRPP) for FY 2025. CMS believes continuing all six of the current claim-based measures will not create or reduce any information collection burden for hospitals, because they will continue to be collected using Medicare FFS claims that hospitals are already submitting to the Medicare program for payment purposes.

CMS stated they would consider all feedback as part of future rulemaking, and referred readers to their updated Z code payment policy for homelessness and housing instability for FY 2025 (see section "Changes to Code Severity (MCCs, CCs or non-CCs)").

## Hospital-Acquired Condition (HAC) Reduction Program

Section 1186 of the Act establishes an incentive to reduce the number of hospital-acquired conditions (HACs) by a 1 percent payment reduction to applicable hospitals, effective October 1, 2014. This adjustment applies to hospitals which rank in the worst performing 25 percent of all applicable hospitals (compared to the national average) of acquired conditions during the specified period and all hospital discharges for the specified year.

CMS did not make any proposals or updates for the HAC Reduction Program for FY 2025. Readers should refer to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50707 through 50709) for a general overview and



detailed discussion of the statutory basis of the HAC Reduction Program. Readers should refer to 42 CFR 412.170 through 412.172 for codified HAC Reduction Program requirements. The previously finalized measures for the HAC Reduction Program are shown in the following table V.M.-01.

<b>TABLE V.M.-01: HAC REDUCTION PROGRAM MEASURES FOR FY 2025 AND SUBSEQUENT YEARS</b>		
<b>Short Name</b>	<b>Measure Name</b>	<b>Consensus Based Entity (CBE) #</b>
CMS PSI 90*	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531
CAUTI**	CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI**	CDC NHSN Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	1717
CLABSI**	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia**	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	1716

\*Technical specifications for the CMS PSI 90 measure can be found on the QualityNet website available at:

<https://qualitynet.cms.gov/inpatient/measures/psi/resources>

\*\*Technical specifications for the CDC National Healthcare Safety Network (NHSN) HAI measures can be found at the CDC's NHSN website at

<http://www.cdc.gov/nhsn/acute-care-hospital/index.html> and on the QualityNet website available at: <https://qualitynet.cms.gov/inpatient/measures/hai/resources>