Comprehensive Hospital Increase Reimbursement Program (CHIRP) Requirements
State Fiscal Year (SFY) 2025

Program Overview

CHIRP is a directed payment program that provides for increased Medicaid payments to hospitals for inpatient and outpatient services provided to Medicaid enrollees. The target beneficiaries are adults and children enrolled in the STAR and STAR+PLUS Medicaid managed care programs.

Quality Goals

CHIRP aims to advance the goals of the Texas Managed Care Quality Strategy. Participating hospitals will report quality measures that tie to the following quality strategy goals.

1. Promote optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health.
2. Provide the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.
3. Keep patients free from harm by building a safer healthcare system that limits human error.
4. Promote effective practices for people with chronic, complex and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
5. Attract and retain high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team-based, collaborative, and coordinated care.

Program Structure

CHIRP includes three components. Hospitals apply for participation in CHIRP and can opt into Components 2 and 3.

1. Component 1: Uniform Hospital Rate Increase Program
2. Component 2: Average Commercial Incentive Award
3. Component 3: Alternate Participating Hospital Reimbursement for Improving Quality Award

Component 1

Component 1 includes structure and outcome measures. It requires yearly submission of status updates for the structure measures and data for the outcome measure.

All hospitals must participate in Component 1.

All measures in Component 1 must be reported as a condition of participation.

Component 2

Component 2 includes structure, process, and outcome measures. It requires yearly submission of status updates for the structure measures and data for the process and outcome measures.

Component 2 measures are grouped into modules around a similar hospital service type. These groupings are called modules. Hospitals must report all the measures in the modules for their hospital class. Some modules also require that a hospital provide a specific type of service.

All Component 2 measures for which a hospital is eligible must be reported as a condition of participation.

Component 3

Component 3 includes process and outcome measures. It requires yearly submission of data for the process and outcome measures.

HHSC determines, on an annual basis, the classes of hospitals that are eligible to participate in Component 3. For SFY 2025, HHSC anticipates that urban and children's hospitals will be eligible to participate in Component 3.

All Component 3 measures are pay-for-performance.

Reporting Requirements

Hospitals must report data for all modules and measures for which they are eligible as a condition of participation in the program. Hospitals that fail to submit the required data by the deadlines communicated by HHSC will be removed from CHIRP and will have all funds they were previously paid during the program period recouped.

SFY 2025 semiannual reporting is planned to take place during Reporting Period 1 (October 2024) and Reporting Period 2 (April 2025).

- Reporting Period 1 (October 2024): Hospitals will report progress on structure measures.
- Reporting Period 2 (April 2025): Hospitals will report data for outcome and process measures for January 1, 2024, to December 31, 2024, and will report baseline data for January 1, 2023, to December 31, 2023, for pay-for-performance measures under the new Component 3.

Reporting must follow the detailed measure specifications for each measure as included in the SFY 2025 Measure Specifications (Excel file).

For structure measures, hospitals must submit responses to qualitative reporting questions that summarize their progress toward implementing the structure measure. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

For outcome and process measures, a hospital must submit specified numerator and denominator data and respond to qualitative reporting questions as specified by HHSC. Hospitals must report data for most measures stratified by the specified reporting payer type.

Reported qualitative and numeric data will be used to monitor hospital-level progress toward state quality objectives.

Component 1 & 2 Hospital-Reported Measures

Component 1

Hospital Classes: All Hospitals

Minimum Volume Requirements: None

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward[1]	Reporting Payer Type
C1-105	Health Information Exchange (HIE) Participation	Structure	NA	NA	NA
C1-127	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient	Outcome	2456	HHSC	All-payer
C1-163	Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices	Structure	NA	HHSC	NA

[1] See Appendix C for a list of acronyms for measure stewards.

Component 2 Maternal Care

Hospital Classes: Children's Hospitals, State-Owned Hospitals that are not Institutions for Mental Disease (IMDs), Urban Hospitals

Minimum Volume Requirements: >=30 Medicaid Managed Care patients (includes STAR and STAR+PLUS) live births CY2023

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-128	AIM Collaborative Participation	Structure	NA	NA	NA
C2-129	Severe Maternal Morbidity	Outcome	NA	AIM	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer
C2-130	PC-02 Cesarean Birth	Outcome	0471e	TJC	- STAR - Other Medicaid - Uninsured - All-Payer

Component 2 Hospital Safety

Hospital Classes: State-Owned Hospitals that are not Institutions for Mental Disease (IMDs), Urban Hospitals

Minimum Volume Requirements: >=1 Medicaid Managed Care patients (includes STAR and STAR+PLUS) in CY2023 for at least one of the measures in the program component module.

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-132	Catheter-Associated Urinary Tract Infection (CAUTI)	Outcome	0138	CDC	All-payer
C2-133	Central Line Associated Bloodstream Infection (CLABSI)	Outcome	0139	CDC	All-payer
C2-164	PSI 13 Postoperative Sepsis Rate	Outcome	NA	CMS	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer

Component 2 Pediatric

Hospital Class: Children's Hospitals

Minimum Volume Requirements: >=1 Medicaid Managed Care patients (includes STAR and STAR+PLUS) in CY2023 for at least one of the measures in the program component module.

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-115	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	0418	CMS	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer
C2-158	Pediatric CLABSI	Outcome	NA	CHSPS	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer
C2-159	Pediatric CAUTI	Outcome	NA	CHSPS	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer
C2-165	Trauma Informed Care Training	Structure	NA	NA	NA

Component 2 Psychiatric Care Transitions

Hospital Classes: Children's, State-owned Hospitals that are not Institutions for Mental Disease (IMDs), Urban Hospitals, Non-State Owned IMDs, State-owned IMDs

Minimum Volume Requirements: >=30 Medicaid Managed Care (includes STAR and STAR+PLUS) Psychiatric Discharges in CY2023

Psychiatric discharges include revenue codes:

- 114 Private medical or general-psychiatric
- 124 Semi-private 2 bed (medical or general)-psychiatric
- 134 Semi-private 3 and 4 beds-psychiatric
- 144 Private (deluxe)-psychiatric
- 204 Intensive care-psychiatric
- 1001 Behavioral health accommodations - residential treatment - psychiatric

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-141	Written transition procedures that include formal managed care organization (MCO) relationship or Emergency Department Encounter Notifications (EDEN) notification/ admission, discharge, and transfer (ADT) Feed for psychiatric patients	Structure	NA	NA	NA

Component 2 Care Transitions

Hospital Classes: State-Owned Hospitals that are not Institutions for Mental Disease (IMDs), Urban Hospitals

Minimum Volume Requirements: >=30 Medicaid Managed Care (includes STAR and STAR+PLUS) Non-Psychiatric Discharges in CY2023.

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-142	Written transition procedures that include formal MCO relationship or EDEN notification/ ADT Feed for psychiatric patients	Structure	NA	NA	NA

Component 2 Rural Hospital Best Practices

Hospital Classes: Rural Hospitals

Minimum Volume Requirements: >=1 Medicaid Managed Care patient (includes STAR and STAR+PLUS) in CY2023 for at least one of the measures in the program component module.

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
C2-104	Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Process	0028e	NCQA	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer
C2-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418	CMS	- STAR/STAR+PLUS - Other Medicaid - Uninsured - All-Payer

Component 3

P4P Achievement Calculation

HHSC allocates each hospital a portion of the total funds available under Component 3 as described by 1 Tex. Admin. Code § 353.1306. A hospital's allocation is the maximum funding the hospital can earn under Component 3.

Each hospital is assigned outcome and process measures based on the hospital's class. Each outcome and process measure has a performance target and a point value. Each outcome measure has a point value of four, and each process measure has a point value of two.

Hospitals whose 12-month performance meets or exceeds a measure's performance target earn the measure's full point value. Hospitals whose performance partially meets a measure's performance target earn half of the measure's point value.

The sum of the point values of a hospital's assigned measures is the total points the hospital can earn.

There are four payment tiers:

Tier	% of Points Earned (out of 18 total)	Payment
1	≥ 50% (9 pts)	100%
2	≥ 40% (8 pts)	80%
3	≥ 20% (4 pts)	40%
4	< 20% (0 – 3 pts)	0%

A hospital's payment tier is determined by the percentage of total available points the hospital earned.

If a hospital has no denominator volume for a measure in the performance period, the total points will be reduced by the point value of the measure for which they have no denominator volume.

Any funds a hospital does not earn will be redistributed in accordance with 1 Tex. Admin. Code § 353.1306.

Component 3 - Achievement Targets

Measure Type	Full Achievement	Partial Achievement
High Benchmark (90th percentile or national goal)	Performance is better than or equal to the high benchmark OR Performance meets or exceeds a 5% gap closure over baseline	Performance is worse than the high benchmark and better than baseline
Average Benchmark (50th percentile or average)	Performance is better than or equal to the average benchmark and better than baseline OR Performance meets or exceeds a 5% gap closure over baseline	If baseline is better than the benchmark: Performance is better than the benchmark and worse than or equal to baseline OR If baseline is worse than the benchmark: Performance is worse than the benchmark and better than baseline
Actual/ Expected (A/E) Ratio	Performance is below or equal to .8 OR Performance is below 1 and better than the baseline OR Performance meets or exceeds a 5% gap closure over baseline	Performance is below 1 and equal to or worse than baseline OR Performance is equal to or above 1 and shows improvement over baseline

Improvement Over Self (IOS) Process Measures	Performance meets or exceeds a 10% gap closure over baseline	Performance shows improvement over baseline

Component 3 Urban Hospital Measures & Goal Calculation

Measure ID	Measure Name	Measure Type	Measure Steward (CBE ID)	Goal Calculation Type	Benchmark	Reporting Payer Types	Payer-Type for P4P
C3-130	PC-02 Cesarean Birth	Outcome	TJC (#0471)	High Benchmark	23.6%[2]	STAR Other Medicaid Uninsured All-Payer	STAR
C3-132[3]	Catheter-Associated Urinary Tract Infection (CAUTI)	Outcome	CDC (#0138)	A/E Ratio	NA	All-payers (Facility-level)	All-payers (Facility-level)
C3-164	PSI 13 Postoperative Sepsis Rate	Outcome	AHRQ	Average Benchmark	4.87 per 1000 discharges[4]	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS

[2] Healthy People 2030 Target (https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06)

[3] Hospitals will report either C3-130 or C3-132. Hospitals with >30 STAR and STAR+PLUS births will report C3-130. All other hospitals will report C3-132.

[4] Patient Safety Indicator (PSI) Benchmark Data Tables, V2023_PSI 13 Medicaid rate (https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2023/Version_2023_Benchmark_Tables_PSI.pdf)

Measure ID	Measure Name	Measure Type	Measure Steward (CBE ID)	Goal Calculation Type	Benchmark	Reporting Payer Types	Payer-Type for P4P
C3-173	Plan All-Cause Readmission	Outcome	NCQA #1768	Average Benchmark	12.6 per 100 discharges [5]	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS
C3-170	Food Insecurity Screening and Follow-up Plan	Process	HHSC	IOS only	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS
C3-171	IMM-2 Influenza Immunization	Process	TJC	IOS only	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS
C3-174	Safe Use of Opioids – Concurrent Prescribing	Process	CMS #3316e	IOS only	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS

[5] THLC CMS Core Measures Dashboard Adult-Medicaid Rate for PCR Total All Ages (18 – 64), Observed 2021 (https://thlcportal.com/measures/cmscoremeasuredashboard)

Component 3 Children's Hospitals Measures & Goal Calculation

Measure ID	Measure Name	Measure Type	Measure Steward	Goal Calculation Type	Benchmark	Reporting Payer Types	Payer-Type for P4P
C3-158	Pediatric CLABSI	Outcome	CHSPS	Average Benchmark	1.411 per 1000 central-line days[6]	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	All-payers (Facility level)
C3-175	Pediatric All-Condition Readmissions	Outcome	Center of Excellence for Pediatric Quality Measurement	Average Benchmark	Pending [7]	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS
C3-176	Follow-up After ED Visit for Mental Illness[8]	Outcome (Intermediate)	NCQA	Average Benchmark	56.57%[9]	NA	STAR
C3-170	Food Insecurity Screening and Follow-up Plan	Process	HHSC	IOS	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS

[6] Solutions for Patient Safety 2023 (https://static1.squarespace.com/static/62e034b9d0f5c64ade74e385/t/64ef7a12869c0427f3983bcf/1693415954751/CLABSI.jpg)
[7] Texas STAR rate for 2022 as calculated by the EQRO
[8] Data for C3-NEW Follow-up After ED Visit for Mental Illness will be tracked by the Texas External Quality Review Organization
[9] THLC Medical Quality of Care Measures STAR FUM 30 Day Age 6 – 17 2022 (https://thlcportal.com/measures/medical)

Measure ID	Measure Name	Measure Type	Measure Steward	Goal Calculation Type	Benchmark	Reporting Payer Types	Payer-Type for P4P
C3-171	IMM-2 Influenza Immunization	Process	TJC	IOS	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS
C3-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	CMS	IOS	NA	STAR/STAR+PLUS Other Medicaid Uninsured All-Payer	STAR and STAR+PLUS

Attribution Methodology

Hospitals must follow these steps to identify the specific population that should be included in the numerator and denominator for hospital-reported process and outcome measures.

Step 1: Determine the DPP-attributed population.

Step 2: Determine the measure-specific denominator population.

Step 3: Stratify the measure-specific denominator population by required reporting payer type.

Attribution Step	**Details**
Step 1: Attributed Population Definition	Using a retrospective attribution methodology, the CHIRP-attributed population includes the individuals that a participating Hospital, as approved in the enrollment application, is accountable for under CHIRP, as defined by the Attributed Population Inclusion Criteria. "
Step 1: Attributed Population Inclusion Criteria	The Hospital's attributed population includes any individual who meets the criteria below: a) For measures C2/C3-130 PC-02 Cesarean Section & C2-129 Severe Maternal Morbidity: One delivery during the measurement period b) For all other measures: One encounter during the measurement period
Step 1: Allowable Exclusions	None
Step 2: Measure-Specific Denominator Population Definition	The measure-specific denominator population (Step 2) includes the individuals or encounters from the CHIRP-attributed population (Step 1) that meet all criteria in the Measure Specifications.

Attribution Step	Details
Step 3: Reporting Payer Types	Measures must be stratified by the required reporting payer. Some measures may only require reporting the all-payer rate. Others require reporting all the payer types below. • Medicaid Managed Care: exclusive to STAR and STAR+PLUS • Other Medicaid: STAR Kids, STAR Health, and Medicaid Fee-For-Service • Uninsured: includes No insurance; County-based or other public medical assistance • All Payer: includes Medicaid Managed Care, Other Medicaid, Uninsured, and all other payer types such as CHIP, Medicare, Medicare/Medicaid Dual Eligibles, Commercial Insurance, Qualified Medicare Beneficiaries, and Non-Texas Medicaid individuals/encounters C2/C3-130 PC-02 Cesarean Sections reports Medicaid Managed Care exclusive to STAR. STAR+PLUS will be included in the Other Medicaid rate.
Step 3: Payer-Type Assignment Methodology	For measures that report a payer type other than all-payer, the assignment methodology depends on the unit of measurement for the denominator. The unit of measurement is defined in the Measure Specifications file. 1. Individual: If a person can be counted once in the denominator, then the unit of measurement is an individual. The payer type assignment will be determined by either the most recent payer type on record at the end of the measurement period OR as any individual with a Medicaid Managed Care-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid Managed Care. The same assignment methodology for determining Medicaid Managed Care must be applied consistently across the measurement period. 2. Encounter: If a person can be counted in the denominator more than once, then the unit of measurement is an encounter. The payer type assignment will be determined by the payer type on record for the qualifying encounter (e.g., visit or admission).

Additional Reporting Information

Data Sources and Data Elements

Depending on the measure steward and the publicly available measure specifications source, the measure specifications may have been written based on electronic health record (E.H.R.) and claims data sources available to healthcare providers or health plans. For any measures where the measure specifications were originally written based on data sources available to health plans, HHSC has adapted the measure specifications for DPP participating providers as possible.

For DPP reporting purposes, DPP participating providers are responsible for adhering to measure specifications and should use the most complete data available to ensure that the rates reported are representative of the entire population served. In cases where a variance from a designated measure specification is required due to variances in data sources, DPP participating providers may opt to use local or proprietary data elements (codes or values) mapped to the standard data elements (codes or values) included in the measure specifications.

DPP participating providers that use local or proprietary data elements must maintain documentation of the relevant clinical concepts, definitions, or other information as applicable that crosswalks to the standard data elements. DPP participating providers should keep a record of such variances to make note of and ensure consistency of such variances when reporting each measurement year.

Data Measurement Periods

The data measurement period required for a given reporting period is identified under Data Measurement Period in the Measure Specifications file. Additionally, measure-specific denominator specifications may place additional limitations on the measurement period used for denominator inclusion. This may include using only a portion of the measurement period for denominator inclusion or identifying encounters and/or diagnosis that occur before the measurement period for denominator inclusion (a lookback period).

All measures are specified for a 12-month Data Measurement Period, unless otherwise specified under Measurement Period.

Sampling Methodology Requirements

DPP participating providers should use the most complete data available to ensure that the rates reported are representative of the entire population served. All cases that meet the eligible population requirements for the measure must be included.

For measures where all required data elements are not available electronically (E.H.R., claims data, or registry) or are of poor quality, providers may conduct a sample to determine rate for a given measurement year. DPP participating providers should follow the sampling methodology included in the measure specifications, or if no sampling methodology is specified, providers should follow the HHSC sampling methodology identified below:

HHSC Sampling Methodology

DPP participating providers should use available administrative data to determine the denominator population. Sampling should be systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The resulting sample should be representative of the entire eligible population for the measure. At the time of reporting, DPP participating providers will indicate if a sampling methodology is used. DPP participating providers should maintain records of sampling methodology and random selection.

HHSC Minimum Sample Size for All-Payer

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases.

- For a measurement period where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 411 cases.

It is recommended to select an oversample of 10-15% of the sample size for substitution in the event that cases in the original sample are excluded from the measure.

HHSC Minimum Sample Size for Component 3 Measures

If a measure in Component 3 results in a Medicaid managed care sample size that is less than 76 cases, hospitals must randomly pull additional managed care cases until the minimum of 76 cases is met.

Appendix A: Summary of all measures by hospital class

Measure	Urban and state-owned that are not IMDs[10]	Children's
Structure Measures	C1-105 HIE Participation C1-163 NMDOH Screening & Follow-up C2-128 AIM Participation C2-141 Transition procedures for psych C2-142 Transition procedures for non-psych	C1-105 HIE Participation C1-163 NMDOH Screening & Follow-up C2-128 AIM Participation C2-141 Transition procedures for psych C2-165 Trauma Informed Care Training
Process Measures	C3-170 Food insecurity screening C3-171 IMM-2 Influenza Immunizations C3-174 Safe Use of Opioids	C2/C3-115 Depression Screening & Follow Up C3-170 Food insecurity screening C3-171 IMM-2 Influenza Immunizations
Outcome Measures	C1-127 Unintentional Medication Discrepancies C2-129 Severe Maternal Morbidity C2/C3-130 PC-02 Cesarean Section C2/C3-132 CAUTI C2-133 CLABSI C2/C3-164 PSI 13 Postoperative Sepsis Rate C3-173 All-cause readmissions	C1-127 Unintentional Medication Discrepancies C2-129 Severe Maternal Morbidity C2-130 PC-02 Cesarean Section C2/C3-158 Pediatric CLABSI C2-159 Pediatric CAUTI C3-176 Follow-up after ED Visit for Mental Illness C3-175 Pediatric All-Conditions Readmissions

Component	Rural	State-owned IMDs and non-state owned IMDs
Structure Measures	C1-105 HIE Participation C1-163 NMDOH Screening & Follow-up	C1-105 HIE Participation C1-163 NMDOH Screening & Follow-up
Process Measures	C2-104 Tobacco Screening & Cessation Counseling C2-115 Screening for Depression & Follow-up Planning	C2-141 Transition procedures for psychiatric patients
Outcome Measures	C1-127 Unintentional Medication Discrepancies	C1-127 Unintentional Medication Discrepancies

[10] State-owned hospitals that are not IMDs are not eligible for Component 3

Appendix B: Summary of Program Changes

The requirements document now includes technical instructions that were previously included in the measure specifications Excel file including Component 2 module eligibility, the attribution methodology, and additional reporting information. This content was not updated as compared to SFY 2024, unless otherwise noted below.

1. Component 1: No changes to the measures or reporting requirements in Component 1.
2. Component 2: No changes to the measures that are reported in Component 2.
    a. The following measures will be reported with a new payer-type stratification (Medicaid managed care, other Medicaid, uninsured, and all-payer), instead of all-payer only.
        i. C2-158 Pediatric CLABSI
        ii. C2-159 Pediatric CAUTI
        iii. C2-164 PSI 13 Postoperative Sepsis Rate
    b. Measure C2-130 PC-02 Cesarean Birth will be reported with a payer-type stratification of STAR instead of STAR and STAR+PLUS. STAR+PLUS will be included in the other Medicaid rate.
3. Component 3 is a new pay-for-performance component.
    a. This requirements document establishes the achievement and goal-setting policies as well as new sampling requirements for pay-for-performance measures.
    b. Some measures are already included in Component 2. The following measures are new to the CHIRP program.
        i. C3-173 All-cause readmissions (Urban hospitals)
        ii. C3-170 Food insecurity screening (Urban and children's hospitals)
        iii. C3-171 IMM-2 Influenza Immunizations (Urban and children's hospitals)
        iv. C3-174 Safe Use of Opioids (Urban hospitals)
        v. C3-175 Pediatric All-Condition Readmissions (Children's hospitals)
        vi. C3-176 Follow-up after ED Visits for Mental Illness (Children's hospitals)

Appendix C: List of Acronyms for Measure Stewards

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
AIM	Alliance for Innovation on Maternal Health
CDC	Centers for Disease Control and Prevention
CHSPS	Children's Hospital's Solutions for Patient Safety
CMS	Centers for Medicare & Medicaid Services
NCQA	National Committee for Quality Assurance
TJC	The Joint Commission