Hospital Inpatient Quality Reporting (IQR) Program

Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

FY 2024 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

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Donna Bullock: Hello. Welcome to the *Fiscal Year 2024 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Proposed Rule Overview for Hospital Quality Reporting Programs* webinar. My name is Donna Bullock. I am with the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation will be posted to the Inpatient-Archived Event section of the Quality Reporting [Center] website in the upcoming weeks. That website is www.QualityReportingCenter.com. If you registered for this event, a link to the slides was sent out a few hours ago. If you did not receive that e-mail, you can download the slides, also from the Quality Reporting Center website. This webinar has been approved for one continuing education credit. Further information will be provided at the end of the presentation.

Our speakers for today's event are Julia Venanzi, Program Lead for the Inpatient, Quality Reporting, and Hospital Value-Based Purchasing Programs; William Lehrman, Government Task Leader for the Hospital Consumer Assessment of Healthcare Providers and Systems Survey; Jessica Warren, Program Lead for the Medicare Promoting Interoperability Program; Jennifer Tate, Program Lead for the Hospital-Acquired Condition Reduction Program; and Lang Le, Program Lead for the Hospital Readmissions Reduction Program. All are with the Centers for Medicare & Medicaid Services. Alex Feilmeier is the Program Manager for the Value, Incentives, and Quality Reporting Center Validation Support Contractor.

This presentation will provide an overview of the fiscal year 2024 IPPS/ LTCH PPS proposed rule, as it relates to the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, the Hospital Readmissions Reduction Program, and the Medicare Promoting Interoperability Program.

At the end of this event, participants will be able to locate and identify proposed program changes, identify the time period for submitting public comments to CMS, and will be able to submit formal comments to CMS regarding the fiscal year 2024 proposed rule.

Because CMS must comply with the Administrative Procedures Act, they are not able to provide additional information, clarification, or guidance related to the proposed rule. As such, there will not be a question-and-answer session at the conclusion of this event. CMS encourages stakeholders to submit comments or questions through the formal comment submission process, as described later in this webinar.

This slide lists some of the acronyms and abbreviations that will be used in today's presentation...

As does this slide.

I would now like to turn the presentation over to Julia to provide the overview of the IQR proposed changes. Julia, the floor is yours.

Julia Venanzi: Thanks, Donna. I'm Julia Venanzi, Program Lead for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Today, I'll start by reviewing the Hospital IQR Program proposals from this year's proposed rule.

Starting first with a high-level summary of the proposals under the Hospital IQR Program, we are proposing to adopt three new measures, to remove three measures, and then to modify three existing Hospital IQR measures. We are also making a number of administrative proposals, including some changes to the HCAHPS Survey collection and validation targeting criteria. Lastly, we are seeking comment on the potential use of two geriatric health related measures and the possible creation of a geriatric care designation

Starting first with the three new measure adoptions, I wanted to first pull up the previously finalized electronic clinical quality measure requirements, or eCQM, requirements.

In last year's final rule, we finalized a requirement for hospitals to submit on six total eCQMs, beginning with the calendar year 2024 reporting year and for subsequent years. Of those six eCQMs, three are decided by CMS. Those are the Safe Use of Opioids eCQM, the C-section eCQM, and the Severe Obstetric Complications eCQM. For the remaining three eCQMs, hospitals have a choice to self-select three eCQMs from a list of eCQMs. The three new measure proposals for this year, all three of those will be added to that list from which hospitals can self-select to report them. As a reminder, eCQMs use data collected in hospital EHRs. These measures are designed to be calculated using the hospital's EHR and then submitted to CMS on annual basis. Reporting happens in the beginning of the year following the reporting period. For example, calendar year 2024 data will be submitted at the end of February in 2025.

Moving now to the specifics of the three new eCQMs that we are proposing, all three of these eCQMs focus on patient safety. The first eCQM is the Hospital Harm–Pressure Injury eCQM. Hospital-acquired pressure injuries are serious events and one of the most common in hospital patient harms. Pressure injuries commonly lead to further patient harm, including local infection, osteomyelitis, anemia, and sepsis, in addition to causing pain and discomfort to patients. Development of a pressure injury can also increase a patient's length of stay and can increase the risk of readmission. Given these risks and harms, the pressure injury eCQM assesses the proportion of hospital inpatients who are 18 and older who develop new pressure injuries during their inpatient hospitalization. This eCQM would require hospitals to systematically assess patients to identify new pressure injuries, which is an important step towards early identification of possible causes, initiation of treatment, and the potential development of preventive strategies. Full measure specifications for this eCQM as well as the two other newly proposed eCQMs can be found on the pre-rulemaking page of the eCQI Resource Center.

The second newly proposed eCQM is the Hospital Harm–Acute Kidney Injury eCQM.

Acute kidney injuries, stage 2 or greater, is defined as a substantial increase in serum creatine value or by the initiation of kidney dialysis. Up to two-thirds of ICU patients will develop acute kidney injury, which can result in the need for dialysis and is associated with an increased risk of mortality. This eCQM assesses the proportion of inpatient hospitalizations for patients aged 18 and older who have an acute kidney injury, stage 2 or greater, during their hospital stay. This eCQM is critical since early identification and management of at-risk patients is critical. Not all AKI is avoidable, but a substantial proportion of AKI cases are preventable and treatable at an early stage.

Moving to the last newly proposed eCQM, the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults. Diagnostic imaging using CT occurs in more than a third of acute care hospitalizations in the U.S., and over 90 million CT scans are performed annually in the U.S. There is also an observed variation in the radiation doses used to perform these exams, which represents a risk to patients, as high radiation doses are a risk factor for cancer. This eCQM provides a method to standardize the monitoring of the performance of diagnostic CT to discourage unnecessarily high radiation doses, while still preserving image quality. The eCQM assesses the percentage of eligible CT exams that are out-of-range, based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds that are based on the clinical indication for the exam.

Moving now to the three proposals to modify existing Hospital IQR Program measures, the first two refinements are to add Medicare Advantage patients to the Hybrid Hospital-Wide Mortality and Hybrid Hospital-Wide Readmissions measures. We are proposing to expand the measure cohort to include these MA patients since MA beneficiary enrollment has been rapidly increasing as a share of overall beneficiaries. In 2022, nearly half of Medicare beneficiaries—or over 28 million people—were enrolled in MA plans, and it is projected that this enrollment will continue to grow.

We believe that the addition of MA beneficiaries to Fee for Service, which is what is currently used, would significantly increase the size of the measure's cohort, enhance the reliability of the measure scores, lead to more hospitals receiving results, and increase the chance of identifying meaningful differences in quality for some of the lower-volume hospitals. Including MA beneficiaries in these two measures would help ensure that hospital quality is measured across all Medicare beneficiaries. If finalized as proposed, this modification would be included in the measure calculation for these two measures, beginning in the fiscal year 2027 payment determination which uses discharge data from July 1, 2024, through June 30, 2025.

Moving now to the third proposed modification of existing Hospital IQR measures, here we are proposing to modify the COVID-19 Vaccination Coverage Among Healthcare Personnel measure to replace the term "complete vaccination course" with the term "up to date" in order for us to be able to incorporate booster doses. This change in definition includes the bivalent booster which became available after we finalized the previous version of this measure, as well as allowing flexibility for any additional changes to the CDC's definition of "up to date." If finalized as proposed, this proposal would take place beginning with data that are reported for the fourth quarter of 2023, impacting the fiscal year 2025 payment determination.

So, moving now to the three proposed measure removals, the first two removals, the risk-standardized complication rate following total hip or knee arthroplasty and the Medicare Spending per Beneficiary, are related to replacing older versions of these measures in the Hospital Value-Based Purchasing Program. The Hospital VBP Program has a statutory requirement to public report measures for one full year in the Hospital IQR Program before they are able to move them into the Hospital VBP Program. So, whenever we want to substantively modify a Hospital VBP measure, we have to put the updated version in Hospital IQR first, public report it for a year, and then move it to the Hospital VBP Program.

The updated versions of these measures have now been in IQR for a year, so we are now proposing to move them from IQR and move them over to the Hospital VBP Program. The third removal is our proposal to remove the PC-01, Elective Delivery, measure. We are proposing to remove this measure since it is topped out. The measure has been topped out for a number of years, but we previously did not propose it for removal given that we did not, at the time, have any other maternal health related measures in the IQR measure set. Last year, we finalized the addition of the C-section and Severe Obstetric Complications eCQMs, as well establishing the birthing friendly designation, so we now feel it is appropriate to propose removal of PC-01. This helps us balance provider burden, while also making sure that we still include measures on this important topic.

Moving next to administrative proposals, I did want to know that we are also proposing to codify our measure retention and measure removal policies in the Code of Federal Regulations this year. I'll note that we are not proposing any changes to these previously finalized policies, only that we are proposing to codify them. We believe that codifying these requirements will make it easier for interested parties to find these policies and will further align with the regulations that we have codified for other quality reporting programs.

Before I turn it over to colleagues to talk about the HCAHPS and validation related proposals, I wanted to mention a measure-related Request for Information that we included in the rule this year. We are seeking comment on the potential use of two American College of Surgeons' attestation measures, the Geriatric Hospital measure and the Geriatric Surgical measure. In addition to seeking comment on whether or not we should potentially include these two measures in the Hospital IQR Program in the future, we are also seeking comment on possibly establishing a geriatric care designation, similar to the birthing friendly hospital designation that we finalized last year.

Hospitals are increasingly treating older patients who have complex medical, behavioral, and psychosocial needs that are often inadequately addressed by the current healthcare infrastructure. Although existing Hospital IQR Program quality measures include patients who are 65 years and older, some of these measures may be narrow in scope and may not fully capture the spectrum of geriatric care needs. To that end, we are considering these two measures, and the potential creation of a geriatric care designation. Specifically, we are seeking comments on how to best capture the role of patient caregivers, special considerations that we should include for rural hospitals, as well potential other quality measures that we can include in a designation in the future. I will now pass things off to Bill Lehrman to talk about the HCAHPS related proposals. '

William Lehrman: Hello, this is William Lehrman. I'm the Government Task Leader for the HCAHPS Survey at CMS. In this portion of the presentation, I'd like to say a few words about some of the changes to the HCAHPS Survey that are being proposed in the current IPPS rule to take effect in January of 2025.

So, we're using the IPPS rules to propose several changes in how the HCAHPS Survey is administered. Again, even though we're doing this in 2023, these proposed changes, if finalized, would take effect with patients discharged in January 2025 and forward, and I'd like to briefly run through the major changes that we're proposing.

So, the first change is to add three new modes to survey administration. These three new modes begin with a web survey. They are then followed by either a mail survey, telephone survey, or a mail and telephone survey. These are web-first surveys. These will give hospitals three more options for administering the survey. It's important to note that the current, mail only, telephone only, and mail/phone, what we call mixed mode survey modes, will remain available in hospitals, even when we add the three new web-first surveys.

We're doing this, not only because we've been requested to look at this a lot for many quarters, but we did the mode experiment involving over 40 hospitals and over 30,000 patients in 2021 to test how well these new modes would work. Among other things, we found that they worked well. They helped increase response rates, and they also resulted in a more representative set of patients responding to the HCAHPS Survey.

The second change that is being proposed is to allow a proxy response to the HCAHPS Survey for the patient. Currently, and up until now, only the patient himself or herself was allowed to answer the survey. We decided, based upon our research and observations, that it might be a good idea to no longer prohibit proxies from answering the survey. We also encourage the patient himself or herself to respond to the HCAHPS Survey, but, beginning of 2025, we will no longer prohibit a proxy to respond for the patient.

Another important change is to extend the data collection period from 42 days to 49 days for all survey modes. Up until now, patients had 42 days, from the time they were contacted with the survey, to complete the survey. In order to allow time for a web-based survey to be effective, we're adding seven days to the data collection period. So, we're going from 42 to 49 days. This will allow time for patients who will receive a web-based survey to answer that survey before the follow-up or secondary survey mode is administered. Again, we're basing this change upon evidence that we collected during our July 2021 HCAHPS mode experiment. It showed that there's a significant increase in both response rates in the extra seven days, the last seven days, days 43 to 49, and also an increase in representativeness of the type of patients who respond to HCAHPS Survey.

Another change that we're proposing in this year's IPPS rule is to limit the maximum number of supplemental items that may be added to the end of the HCAHPS Survey. Currently, there is no limit on supplemental items, but we know through empirical investigations and from experience with other surveys that, the longer the survey is, the less likely people are to respond to it.

Though, we are placing a limit of 12 supplemental items that may be added to the HCAHPS Survey, following all of the official HCAHPS Survey items. This would also bring the HCAHPS Survey into closer alignment with the policies of other CAHPS Surveys run by CMS.

In an effort to ensure that patients receive a survey in the language, they prefer, beginning with 2025 discharges, hospitals are being asked to select a patient's preferred language, spoken while in the hospital, that is the language the patient prefers to speak while that patient is in the hospital. For patients whose preferred language is Spanish, rather than English or something else, we will, we propose, to require that the official Spanish translation of the HCAHPS Survey is administered. We're making this proposal in order to ensure that Spanish-preferring patients will receive the survey in their preferred language.

Another change we're proposing in the IPPS proposed rule is to remove two current options from the HCAHPS Survey. We propose to remove the Active Interactive Voice Response Mode, or IVR mode, also known as touch-tone IVR. We are removing this mode because, two things. First, we're adding three new web-based modes, and, secondly, touch-tone IVR has not been popular as a method for administering the HCAHPS Survey. We also propose to remove the option called Hospitals Administering HCAHPS for Multiple Sites. That is, in other words, hospitals currently have the option to, in effect, act as their own sort of a vendor for themselves and for other hospitals. Again, this has not been a popular option in HCAHPS, and it's not, in fact, been used by any hospitals since 2019. Because these options complicate HCAHPS administration, training, and affiliated activities, and because they're very seldom used, in fact, currently, not used at all, we propose to remove these options beginning in January 2025.

In addition to these proposed changes to the administration of the HCAHPS Survey, we have also issued in the rule a Request for Information about the potential addition of patients with a primary psychiatric diagnosis to the HCAHPS Survey. This is a solicitation for the public to comment on this idea.

As you know, HCAHPS was designed, tested, and validated for patients in the medical, surgical, and maternity service lines in short-term, acute care hospitals. Patients with a primary psychiatric diagnosis are currently not eligible for HCAHPS. However, if a patient had a secondary psychiatric diagnosis and a primary diagnosis in medical, surgical, or maternity care, they wouldn't be eligible. We are seeking public input on the potential inclusion of the patient with the primary psychiatric diagnosis admitted to short-term acute care hospitals. Specifically, there are three things we're asking the public to comment upon, which are listed on the slide, which I encourage you to read. If you have a comment on them, you submit them to this rule through the regular comment process. We encourage hospitals to carefully consider their choice of survey mode. We have been investigating the impact of the survey mode on the response rate and representativeness of patients who respond to the survey. High response rates for all patient groups promote CMS's health equity goals. The HCAHPS team's research indicates that there are pronounced differences in response rates by mode of survey administration for some patient characteristics. Black, Hispanic, Spanish-language preferring, younger, and maternity patients are more likely to respond to a telephone survey. While older patients are more likely to respond to a mail survey. We encourage hospitals to consider the patient population when they decide to choose or change their mode of survey implementation. We encourage hospitals to also watch a podcast on our HCAHPS online website about how to improve that representativeness for the HCAHPS Survey, in particular by choosing a mode of survey administration that resonates with a patient's population. Thank you. Now, I'll pass this along to Alex.

Alex Feilmeier: Thank you, Mr. Lehrman. I'm Alex Feilmeier, Program Manager of the CMS Value, Incentives, and Quality Reporting Validation Support Contractor, and I have a couple of proposals to present that would impact CMS's inpatient data validation efforts.

The first proposal is to add targeting criteria that would impact both the Hospital IQR Program and HAC Reduction Program. Beginning with the validation of calendar year 2024 reporting period data, for the fiscal year

2027 payment year, CMS is proposing to add a new criterion to the previously established targeting criteria used to select up to 200 additional hospitals for validation. CMS is proposing to modify the validation targeting criteria to include any hospital with a two-tailed confidence interval that is less than 75 percent and which submitted less than four quarters of data, due to receiving an Extraordinary Circumstance Exemption for one or more quarters.

These hospitals would not fail the validation related requirements for the annual payment update determination in the Hospital IQR Program or the validation related requirements for the payment adjustment in the HAC Reduction Program for the payment year for which the ECE provides hospitals with an exception from data reporting or validation requirements. These hospitals could be selected for validation in the following year. We're proposing this additional criterion because such a hospital would have less than four quarters of data available for validation. Its validation results could be considered inconclusive for payment purposes. These proposals would align the targeting criteria and across the Hospital IQR, HAC Reduction, and Hospital Outpatient Quality Reporting Programs. Our proposals would also allow us to appropriately address instances in which hospitals that submit fewer than four quarters data due to receiving an ECE for one or more quarters might face payment implications under the current validation policies. Ultimately, this proposal provides an added benefit of the doubt, if you will, to any hospitals that have an ECE.

Another proposal for future inpatient data validation efforts is a proposal to add a process to the HAC Reduction Program that would allow reconsideration of validation results. Prior to establishing policies for the HAC Reduction Program to collect, validate, and publicly report quality measure data independently, instead of through the Hospital IQR Program like it used to, hospitals that failed their annual payment update requirement related to validation had the opportunity to request a reconsideration of their final scores for the HAI measures. CMS is proposing that, beginning with fiscal year 2025 program year, that is calendar year 2022 discharges, hospitals that fail validation would be

allowed to request reconsideration of their validation results before its use in the HAC Reduction Program scoring calculations. The validation reconsideration process would be conducted once per program fiscal year after the validation of HAIs for all four quarters of the relevant fiscal years data period and after the confidence interval has been calculated.

CMS is proposing to limit the scope of HAC Reduction Program data validation reconsideration reviews to information already submitted by the hospital during the initial validation process. Medical records that were not submitted during the initial validation process would not be abstracted. The review scope would be expanded only if it were found during review that the hospital correctly and timely submitted the requested medical records, in which case data elements would be abstracted from the medical records submitted by the hospital as part of the review of its reconsideration requests. After the reconsideration process was completed, the hospital's confidence interval would be recalculated based on the results of the reconsideration of hospital cases and determination made on whether the hospital passed or failed the validation requirements for the HAC Reduction Program. These proposals would more closely align validation reconsideration processes across the Hospital IQR and HAC Reduction Programs. If finalized, additional information on the process specifics will be posted on the CMS QualityNet website. That's all I have for data validation proposals for this year. So, I'll pass the presentation off to Jessica Warren. Thank you.

Jessica Warren: Thank you so much, Alex. This is Jessica Warren, and I'm from the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

The first proposed change we're going to talk about is a change to the EHR reporting period. As a refresher, our current policy for calendar year 2024 is a minimum of any continuous 180-day period within calendar year 2024. Proposed for calendar year 2025 is continuing with the 180-day period within calendar year 2025.

A reminder that we do encourage eligible hospitals and CAGs to use longer periods up to and including the full calendar year 2025, and this is for new and returning participants in the Medicare Promoting Interoperability Program.

Another proposed change for eligible hospitals and CAHs with regards to the EHR reporting period is that we are proposing to applied EHR reporting period in calendar year 2025, with the fiscal year 2027 payment adjustment year. This is for all new and returning eligible hospitals. Eligible hospitals that have not successfully demonstrated they are a meaningful user in a prior year would attest during the same submission period as those who did successfully demonstrate meaningful EHR use in the prior year. Essentially, what we're saying is that ,whether you are a new or returning eligible hospital, the same submission period would be required. That submission period is typically from January 1 through July 28 or another date specified by CMS.

Next, we'll talk about proposed changes to the SAFER Guides measures. Up until this point, we accepted both Yes and no as acceptable responses for the SAFER Guides requirement. The only answer that was not accepted would be a blank. What we are proposing now is that an answer of Yes would be required to be considered a meaningful user, and a responsive No would result in the eligible hospital or CAH not meeting the measure requirements. Therefore, they would not be meeting the definition of a meaningful EHR user, and, if you are not a meaningful EHR user, you could be subject to a downward payment adjustment.

The next proposal that we'll talk about is the adoption of three new eCQMs, beginning with calendar year 2025 and then with the Hospital IQR Program. So, we are proposing to adopt the following three new eCQMs. The first would be Hospital Harm–Pressure Injury eCQM. The next is Hospital Harm–Acute Kidney Injury eCQM. The last would be Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography. This will be explained in further detail within the Hospital IQR Program presentation.

This concludes the proposals for the Medicare Promoting Interoperability Program. Next up, we have Julia Venanzi. Thank you.

Julia Venanzi: Thanks, Jessica. I will now cover the Hospital VBP-related proposals for this year.

To start, first, with a high-level summary of proposals, we are proposing one new measure in the Hospital VBP Program, as well as proposing to make modifications to two of the existing Hospital VBP measures. We are also proposing a change to the scoring methodology in order to include health equity adjustment bonus points. We're also proposing the same HCAHPS changes that Bill just mentioned under IQR, as the HCAHPS measure is currently in both programs. Lastly, we're doing our annual proposals to establish certain performance standards for certain measures.

Starting first with our proposal to adopt the Severe Sepsis and Septic Shock bundle measure into the Hospital VBP Program. This measure is the chart-abstracted measure that is also currently collected under the Hospital IQR Program, sometimes referred to the SEP-1 measure. We're proposing to add this measure into the Safety domain in the Hospital VBP Program. We're proposing to add this measure into the Hospital VBP Program, in addition to the Hospital IQR Program, to further incentivize improvement on the measure. When we began publicly reporting this measure on Hospital Care Compare in July 2018, at that time, the average performance on the measure was 49 percent. The most recent refresh of data showed that the average performance rate reached 57 percent. Our hope is that, by moving this measure into the Hospital VBP Program, we will continue to see improvement in performance rates on this measure. I will just note that data collection would be the same for the measure under both programs. So, there is no additional data collection burden associated with moving this measure into the Hospital VBP Program, in addition to keeping it in IQR.

This slide shows the proposed and previously finalized measures for the calendar year 2024 performance period, which is associated with the fiscal year 2026 determination for Hospital VBP.

You can see this includes the proposed addition of the sepsis measure under the Safety domain.

So, moving now to the two proposed refinements, as mentioned earlier, these two modified measures are being moved over from the Hospital IQR Program in order to replace older versions that are currently in the Hospital VBP Program. The first refined measure is the modified MSPB measure. The modifications include updating the measure to allow readmissions to trigger new episodes to account for episodes and costs that are currently not included in the measure that could be within the hospital's reasonable influence and the addition of a new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to the episode start date. Lastly, there is an update to the MSPB amount calculation methodology in order to change one of the steps in the measure calculation from the sum of observed costs, divided by the sum of expected costs, to the mean of observed costs, divided by expected costs. If finalized, as proposed, this refined version of the measure would begin with the fiscal year 2028 payment determination in the Hospital VBP Program.

The second proposed modification is adding 26 additional mechanical complication ICD codes to the Risk-Standardized Complication Rate Following a Total Hip or Knee Arthroplasty measure. If finalized as proposed, this refined version of the measure would begin with the fiscal year 2030 payment determination, which uses data collected from April 1, 2025, through March 31, 2028.

Moving now to our scoring proposal, achieving health equity, addressing health disparities, and closing the performance gap in the quality of care provided to populations that have been disadvantaged, marginalized, and the underserved by the health care system continue to be priorities for CMS, as outlined in the CMS National Quality Strategy. In order to continue progress on those goals, we are proposing a scoring change under the Hospital VBP Program that would allow the opportunity to gain up to 10 health equity adjustment bonus points towards the Total Performance Score in a given year.

The bonus points would be calculated based on the performance on existing Hospital VBP measures, as well as the proportion of patients that a hospital treats that are dually eligible within a given performance period. These points would be available to all hospitals, but the amount of points would scale up as hospitals perform better on the existing measures, as well as when hospitals have a higher proportion of patients that are dually eligible. If finalized, the scoring change would begin with the fiscal year 2026 payment determination. I will also note that a similar policy was finalized in the calendar year 2023 physician fee schedule rule for the Medicare Shared Savings Program, and that a similar policy is being proposed in the Skilled Nursing Facility Value-Based Purchasing Program that is currently in their respective comment period for their proposed rule.

So, this slide is a high-level overview of what the current scoring methodology looks like. Hospitals are first scored on individual measures within each of the four domains. There are improvement and achievement points calculated for each measure if they meet measure minimums. Next, the higher of the achievement or improvement score is selected for each measure. The higher score is then totaled to calculate the unweighted domain weight in each of the four domains. Those domains are then weighted equally at 25 percent. Then, the domain scores are summed to create the Total Performance Score, or TPS. A linear exchange function is then applied to the TPS in order to produce payment adjustment percentages, aka the bonus or penalty for a hospital for that given year.

So, under this new scoring proposal, all of the steps would stay the same. Those are now grayed out on this slide, but four new steps would be added to the process. Those are shown by the bolded boxes in Steps 5 through 8. So, these new scoring steps come in after the weighted domain scores are calculated. From there, we are proposing to calculate what we're calling a Measure Performance Scaler. This is the piece of the equation where we are representing a hospital's performance on existing measures. So, the Measure Performance Scaler is the sum of the points awarded to a hospital for each domain, based on the hospital's performance on the measures in that domain.

So, we look at the weighted domain scores and award a value of 4, 2, or 0 points based on whether the hospital's performance is in the top third, middle third, or bottom third of performance on that measure. Hospitals can receive a maximum of 16 Measure Performance Scaler points. For example, if they performed in the top third of all hospitals across all four domains, they could receive up to 16 points. Then, in Step 6, we would calculate what we're calling the Underserved Multiplier, which is the proportion of total inpatient Medicare stays for patients with dual eligible status over the total number of inpatient Medicare stays during that performance period. We've had a pilot just to curve to those proportions. So, in Step 7, we are multiplying, basically, Step 5 and Step 6 together in order to get the total number of health equity adjustment bonus points. In Step 8, we then add the health equity adjustment bonus points to the sum of the weighted domain scores, the sum from Step 4, to give us the Total Performance Score. From there, we continue on the calculation of the payment adjustment percentage, just like we did previously. There is a more detailed walkthrough of each of these steps, as well as sample calculations, within the proposed rule text. In addition to this proposal, we are also seeking comment on a number of questions related to this proposal. At this time, we chose to use proportion of patients who are dually eligible, but in the RFI section of this proposed rule, we also sought comment on using other population-level factors, like Area of Deprivation Index or receipt of low-income subsidies in the future. We look forward to feedback on these questions.

Lastly, I just wanted to note that we are returning to normal scoring after two years of COVID-19 related suppression of certain measures from scoring in fiscal year 2024. With that, we will be posting our regular Table 16 updates with this year's proposed rule. I will now pass things over to Jennifer Tate to talk through the HAC Reduction Program proposals.

Jennifer Tate: Hi. Thank you, Julia. Good day. My name is Jennifer Tate, and I am the HAC Reduction Program Lead.

This section of the presentation focuses on proposed policies for the Hospital-Acquired Condition Reduction Program in the FY 2024 IPPS/ LTCH PPS proposed rule.

In the proposed rule, we are proposing two updates to the HAI validation process used by the HAC Reduction Program. The first proposal is to add a validation reconsideration process. The second proposal is to update the targeting criteria to include hospitals with a granted ECE that received a failing validation score. Please refer to the validation section of this presentation for more information on the validation reconsideration process and the updated targeting criteria. We also requested public comment on the potential adoption of six patient safety eCQMs in the HAC Reduction Program.

We are conducting a review of patient safety as part of our ongoing efforts to enhance the HAC Reduction Program. We are inviting the public to comment on whether to potentially adopt six patient safety focused eCQMs to promote further alignment across our quality reporting and value-based purchasing programs. The adoption of eCQMs in the program will support the CMS Meaningful Measures 2.0 priority to move fully to digital quality measurement.

This slide shows six eCQMs. We are seeking public comment on the potential inclusion in the HAC Reduction Program. Five are Hospital Harm eCQMs that include opioid-related events, acute kidney injury, and pressure injuries. We also see public comment on including the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eCQM in the HAC Reduction Program.

Next, we will review the performance periods for the FY 2024 and FY 2025 program years for the HAC Reduction Program. As previously finalized, CMS is excluding the Q3 and Q4 2020 claims data from all future program calculations. In addition, CMS is excluding calendar year 2021 HAI data from the FY 2024 program year calculations.

These data exclusions resulted in abbreviated CMS PSI 90 and HAI measure performance periods for the fiscal year program year. Please note that the typical two-year performance periods will resume in the fiscal year 2025 program year, as displayed in the graphic on the next slide.

This figure describes the effective performance periods for the FY 2024 and FY 2025 program years. The excluded data are shown in red. This includes the exclusion of Q3and Q4 2020 claims data from future program calculations, along with the exclusion of calendar year 2021 HAI data from the fiscal year 2024 program year calculations. The remaining effective performance periods for both program years are shown in blue for the CMS PSI 90 measure and in gray for the HAI measures. So, to summarize, for FY 2024, the performance period for the CMS PSI 90 measure will be January 1, 2021, through June 30, 2022. The performance period for the HAI measures will be January 1, 2022, through December 31, 2022. For FY 2025, the performance period or the CMS PSI 90 measure will be July 1, 2021, through June 30, 2023. The performance period for HAI measures will be January 1, 2022, through December 31, 2023.

For more information on the HAC Reduction Program, you can visit our CMS.gov website and the QualityNet.gov site, using the links on the slide. You can also submit questions about the HAC Reduction Program via the QualityNet Question and Answer Tool by using the link and instructions on the slide. Thank you, I will pass the presentation to Lang Le to discuss the Hospital Readmissions Reduction Program.

Lang Le: Hi, my name's Lang Le. I am the CMS Program Lead for the Hospital Readmissions Reduction Program.

For this year's proposed rule, there are no proposals or updates in the proposed rule for the Hospital Readmissions Reduction Program. All previously finalized policies on this program will continue to apply.

On this slide, we list a few HRRP resources. Each bullet point has a link to the program resources page that we recommend you utilize.

I'm passing the program to Donna Bullock to speak about the fiscal year 2024 IPPS/LTCH proposed rule. Thank you.

Donna Bullock: Thank you, Lang. We will now go over how to locate the programs within the proposed rule and how to submit comments.

This slide provides a link to the proposed rule on the *Federal Register* website and lists the pages for each of the different programs.

CMS is accepting comments until 5 p.m. Eastern Daylight Time on June 9, 2023. Comments can be submitted electronically, by regular mail, or by express or overnight mail. We encourage you to review the proposed rule for specific instructions about each submission method, and submit your comments using only one of the methods. CMS will respond to the comments in the final rule, scheduled to be issued by August 1, 2023.

This webinar has been approved for one continuing education credit. The link to the survey will be displayed in the chat box. You will need to complete the survey in order to obtain continuing education credit. However, the survey link, along with additional information about how to obtain continuing education credit, will also be available in a summary e-mail that will be sent to you within two business days after the webinar. If you did not register for this event, please obtain that e-mail from someone who did register. For more information about our continuing education process, please click the link on this slide.

This concludes today's event; however, there are additional slides in the Appendix section that you can use as a resource and review at your convenience. Thank you for joining us today. Enjoy the rest of your day.