Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2022 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

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Candace Jackson: Good afternoon and welcome to the *FY 2022 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Proposed Rule Overview for Hospital Quality Programs* webinar. My name is Candace Jackson, and 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, along with the question- and-answer summary, will be posted to the inpatient website, www.QualityReportingCenter.com in the upcoming weeks. If you are registered for this event, the link to the slides was sent out a few hours ago. If you did not receive that email, you can download the slides. Again, that is at www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey for today's event, please stand by after the event. We will display a link for the survey that you would need to complete for continuing credit. The survey will no longer be available if you leave the event early. If you do need to leave prior to the conclusion of the event, a link to the survey will be available in the summary email one to two business days after the event. If you have questions as we move through the webinar, please type the questions into the Ask a Question window with the slide number associated, and we will answer as many questions as time allows after the event.

I would now like to welcome our speakers for this webinar. Julia Venanzi is the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs Program Lead. Dylan Podson is a Social Science Research Analyst for the Medicare and Medicaid Promoting Interoperability Programs. Jennifer Tate is the Hospital-Acquired Condition Reduction Program Program Lead. 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.

The purpose of this webinar is to provide an overview of the Fiscal Year 2022 IPPS/Long-Term Care Hospital PPS Proposed Rule as it relates to the Hospital IQR, Hospital VBP, HAC Reduction, Hospital Readmissions Reduction, and the Promoting Interoperability Programs.

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

We would like to note that, due to the Administrative Procedures Act, CMS will not be able to provide additional information, clarification, or guidance related to the proposed rule. CMS encourages stakeholders to submit comments or questions through the formal comment submission process as described in this webinar.

This slide displays a list of the acronyms and abbreviations that we will use throughout the presentation.

I will now turn the presentation over to Julia. Julia, the floor is yours.

Julia Venanzi: Thank you, Candace. I'd like to welcome everyone to our webinar today. Thank you for taking the time out of your day to join us. I really appreciate this opportunity to share our proposals for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Before I get into the Hospital IQR Program proposals for this year, I want to first touch on two cross-program Requests for Information that are included in this year's proposed rule. These two RFIs focus on two priority CMS goals. The first is advancing digital quality measurement, and the second is improving health equity.

The first RFI asks for stakeholder input on CMS's goal to advance towards digital quality measurements. We're also seeking input on the potential use of the Fast Healthcare Interoperability Resources standard, or FHIR standard, for eCQMs that are currently being used in our program. We are also asking for feedback on how to define digital quality measures in this context within our program.

The second RFI is focused on improving health equity within CMS programs. In this RFI, we seek stakeholder input on future expansions of CMS's current use of disparity methods including potential future stratification of program data by race, ethnicity, and other demographics, as well as the potential creation of a hospital equity score to be used in hospital programs. We encourage all stakeholders to submit comments and feedback on these two RFIs. We'll then use this information feedback to help guide us in potential future rulemaking.

I'll move now to the Hospital Inpatient Quality Reporting Program, or Hospital IQR Program, proposals in this year's proposed rule, starting first with a high-level overview of all the proposals and then going into more detail.

This year in the Hospital IQR Program, we are proposing to first adopt five new measures; second, to remove five existing measures from the measure set; third, to make an update to the existing certification requirements for electronic clinical quality measures (eCQMs) and hybrid measures. Fourth, we're proposing to make some changes to the existing validation process. Lastly, we are proposing some minor terminology updates.

To start first with the measure proposals, this year we are proposing to adopt the following five measures: the Maternal Morbidity Structural measure, the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure, the COVID-19 Vaccination [Coverage] Among Healthcare Personnel measure, then, lastly, two medication-related adverse event eCQMs – a severe hyperglycemia measure and a severe hypoglycemia measure.

So, first to start out with the Maternal Morbidity Structural measure, we're proposing to adopt this measure beginning with a shortened time period associated with the calendar year 2021 reporting period and the fiscal year 2023 payment determination. This structural measure was developed by CMS to determine the number of hospitals currently participating in a structured state or national Perinatal Quality Improvement Collaborative and, second, to determine whether hospitals are implementing the safety practices or bundles included as part of these QI initiatives.

In this measure, we define a state or national Perinatal Quality Improvement Collaborative as a statewide or multi-state network working to improve women's health and maternal health outcomes by addressing the quality and safety of maternity care. Hospital participation in quality improvement collaboratives have been shown to be effective in appropriately managing maternal morbidity conditions that may lead to mortality or other adverse consequences. For the calendar year 2021 reporting period and the fiscal year 2023 payment determination, we are proposing a shortened reporting period from October 1, 2021, through December 31, 2021. Then, beginning with the calendar year 2022 reporting period, which is associated with the fiscal year 2024 payment determination, and for subsequent years, we're proposing that the reporting period would be January 1 through December 31. We propose to collect this data once a year via the QualityNet website in a very similar way to how we have collected previous structural measures in the program.

Next is our second measure proposal to add the Hospital-Wide All-Cause Risk Standardized Mortality measure, which I will shorten and call the Hybrid Hospital-Wide Mortality measure. So, the Hybrid Hospital-Wide Mortality measure is an outcome measure that captures hospital-level risk standardized mortality within 30 days of hospital admission for most conditions and procedures. It does not have a traditional numerator and denominator, is instead reported as a single summary score, which is derived from the results of risk-adjustment models for 15 mutually exclusive service line divisions, with a separate risk model for each of those 15 service line divisions. This measure utilizes both claims and EHR data in a very similar way to the Hospital-Wide Readmissions measure that we adopted in the Hospital IQR Program in the Fiscal Year 2020 IPPS Final Rule. I will note here that we have previously included condition-specific mortality measures in the Hospital IQR and Hospital Value-Based Purchasing Programs, but, with this measure, we are looking to measure hospital performance across a broader set of patients and across more areas of the hospital.

One benefit of this broader measure is that this measure also captures the performance for smaller volume hospitals that would have otherwise not had sufficient cases to receive measure scores for the other condition- or procedure-specific mortality measures. We are proposing to start with a voluntary reporting period that includes four quarters of data and runs from July 1, 2022, through June 30, 2023. During the voluntary period, data will not be publicly reported and hospitals that do voluntarily submit data will receive confidential Hospital-Specific Reports. We are then proposing that mandatory reporting would begin with the reporting period which runs from July 1, 2023, through June 30, 2024, affecting the fiscal year 2026 payment determination and for subsequent years. We will begin publicly reporting this data in the July 2025 refresh of Care Compare beginning again with data from July 1, 2023, through June 30, 2024.

Next, I'll move to our third measure proposal, the COVID-19 Vaccination Coverage Among Healthcare Personnel measure. We believe it is important to incentivize and track healthcare provider vaccination in acute care facilities to protect healthcare workers, patients, and caregivers, and to help sustain the ability of hospitals to continue to serve their communities throughout this Public Health Emergency and beyond. This measure will assess the proportion of a hospital's healthcare workforce that has been vaccinated against COVID-19. The numerator of this measure is the cumulative number of healthcare personnel eligible to work in the healthcare facility for at least one day during the submission period and who received a completed vaccination course against COVID-19 since the date the vaccine was first available or on a repeated interval if re-vaccination is recommended. The denominator of the measure is the number of healthcare personnel eligible to work in the healthcare facility for at least one day during the submission period, excluding persons with contraindications to the COVID-19 vaccination as described by the CDC. Similar to the flu vaccination coverage measure that is currently in the Hospital IQR Program, this data will be collected via the CDC's National Healthcare Safety Network.

Given the urgency of this measure, we are proposing a shortened reporting period from October 1, 2021, through December 31, 2021, for the calendar year 21 and fiscal year 2023 payment determination. Then, for calendar year 2022 and subsequent years, we're proposing data collection for a full year of data.

So, our fourth and fifth measure proposals are for two Hospital Harm eCQMs. As a reminder, hospitals are able to self-select which eCQMs they would like to report from a list of eCQMs. So, we are just proposing to add these two eCQMs to that list. The first measure, the Severe Hypoglycemia eCQM, identifies the proportion of patients who experienced a severe hypoglycemic event within 24 hours of the administration of an anti-hyperglycemic agent which indicates harm to a patient. The measure is intended to facilitate safer patient care not only by promoting adherence to recommended clinical guidelines but also by incentivizing hospitals to track and improve their practices of appropriate dosing and adequate monitoring of patients receiving glycemic control agents. The second eCQM, Severe Hyperglycemia, assesses the number of inpatient hospital days with a severe hyperglycemic event among the total qualifying hospital days for patients 18 years and older who have a diabetes diagnosis and who either received at least one anti-diabetic medication during the hospital admission or who had an elevated blood glucose level during their hospital admission. These two measures were developed in a manner that allows them to be reported independently, but they can be considered balancing measures if a hospital does choose to report on both of these measures at the same time.

Now, I'll move to talk about our measure removal proposals. I'm not going to spend a lot of time today talking through each of the individual removal factors that we mentioned in the rule, but I wanted to note that we are proposing to remove the following five measures. The first is a claims-based measure, CMS Patient Safety Indicator 4, or CMS PSI 4, Death Among Surgical Inpatients with Serious Treatable Complications. Then, there are four eCQMs. First, the ED-2 eCQM is Admit Decision Time to ED Departure for Admitted Patients.

Next is PC-05, which is Exclusive Breast Milk Feeding. Third is the STK-3 measure, which is Anticoagulation Therapy for Atrial Fibrillation or Flutter. Then, fourth is the STK-6 measure which is Discharged on Statin Medication.

Before I move on to our other non-measure-related proposals, I wanted to mention some Hospital IQR [Program]-specific Requests for Information that we include in the proposed rule. I'll note that these are distinct from the two-cross program RFIs that I mentioned earlier on. So, specific to the Hospital IQR Program, we are seeking stakeholder feedback on the potential future adoption of two measures. The first is a 30-Day All-Cause Mortality measure for patients admitted with a COVID-19 infection, and the second is the Hospital-Level Risk Standardized Patient Reported Outcome measure following Elective Hip or Knee Replacement. We are also seeking stakeholder feedback on two potential Hospital IQR [Program]-specific changes to address health equity. The first is the potential future expansion of the Hybrid Hospital-Wide Readmission measure data and stratification by certain demographics, and second is the potential future adoption of a structural measure to assess hospital leadership engagement in health equity data. We look forward to hearing stakeholder input on both of these topics.

So, now I'll move to non-measure related proposals, the first of which is our proposal to require the 2015 Edition Cures Update for Certified EHR Technology beginning with the calendar year 2023 and fiscal year 2025 payment determination for both eCQMs and hybrid measures. Previously, we finalized a requirement to require eCQMs and hybrid measures to be certified to the 2015 Edition Certification. In May 2020, the Office of the National Coordinator, or ONC, updated that edition so we are now proposing to change our requirement to align with that updated 2015 Edition Cures update.

Lastly, I will move briefly to two minor administrative proposals. We're proposing to remove references to QualityNet.org and instead update the reference to point to the updated QualityNet URL, as well as updating terminology around the QualityNet Security Official in order to align closer with the Hospital Quality Reporting System.

So, I will now quickly turn it over to Alex to review the Hospital IQR Program validation proposal before we move on to other program proposals.

Alex Feilmeier: Thanks, Julia. Previously, CMS finalized several policies to incrementally align the validation processes for chart-abstracted measure data and eCQM data in the Hospital IQR Program. CMS is proposing changes to the data validation educational review process to extend the effects of the educational review policy beginning with validation affecting the fiscal year 2024 payment determination and for subsequent years. Under the current process, for the last quarter of validation for chart-abstracted measures, because of the need to calculate the confidence interval in a timely manner and due to the insufficient time available to conduct educational reviews, the existing reconsideration process must be used to dispute an unsatisfactory validation result, but, under the new proposed process, the quarters used for validation are now early enough to calculate the confidence interval for the fourth quarter of validation in a timely manner. So, CMS proposes to extend the effects of educational reviews for fourth quarter if an error is identified during the educational review process for that fourth quarter of data. The corrected quarterly score would be used to compute the final confidence interval used for payment determination. It is important to note that all previously finalized policies with respect to educational reviews would still apply. That's all I have, so I'll pass it off to Dylan Podson.

Dylan Podson: All right. Thank you, Alex, and good day everyone. My name is Dylan Podson, and I'm one of the Program Leads for the Medicare Promoting Interoperability Program. Today, we'll touch upon the IPPS proposals at a high level to point out what makes them unique for this year. Before we begin, as a bit of a gentle reminder, this information shared today is specific to Eligible Hospitals (EHs) and Critical Access Hospitals (CAH) participating in the Medicare Promoting Interoperability Program, which means that these details will not cover missed eligible clinicians nor the PFS rule.

So, with that said, onto the general changes themselves, which are presently available for public comments. First off is one to maintain the EHR reporting period for 2023 as a minimum of any continuous 90-day period both for new and returning eligible hospitals and CAHs. However, with that said, please note this topic also includes the proposal to transition and increase this minimum period from 90 up to a 180-day period for calendar year 2024, so two related but different proposals there to take note of. Next, we have a proposal regarding the Query of Prescription Drug Monitoring Program measure, also fondly known as the PDMP measure, which would increase the available bonus points associated with the measure from five up to 10 points total. We would like to highlight that this PDMP measure would remain optional for 2022 and worth bonus points as it is currently being used. So, we would continue it as optional; however, we would just be increasing the bonus points available for completing the optional measure from five to 10. The next highlight would be concerning the Public Health and Clinical Data Exchange Objective where we propose to require a total of four specific measures to report on for a total of 10 points. The four required measures that would be expected under this proposal would be the Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Laboratory Result Reporting. Those four under this proposal would be required. As for the remaining two measures, to round out the six total, they would be considered optional and available to select one of them for an additional five bonus points. Although there are two optional measures remaining, reporting on two of them would not gain you any additional bonus points as if you had just selected one. In summary, only five bonus points total for reporting on one additional measure beyond the four that are required.

Starting off for this slide, we have the proposal to adopt and introduce a new Health Information Exchange Bi-Directional Exchange measure as an element to the Health Information Exchange Objective. This new Bi-Directional Exchange measure would be worth a total of 40 points and act as an alternative reporting option to the two existing Support Electronic Referral Loops measures.

In other words, a provider would select either the Bi-Directional Exchange measure, which is being proposed here, or per the more traditional method, report for the two current referral loops measures. Doing more than is currently proposed or reporting on both of the methods here described above would not result in additional bonus points. It's simply one or the other. The next proposal is for another new measure addition, named the Safety Assurance Factors for EHR Resilience Guides measure, or what is commonly referred to as the SAFER Guides measure for short. Plotted under the Protect Patient Health Information Objective, this Yes or No attestation measure would require that all providers respond to the question with either a Yes or a No, having completed the review for an annual assessment of all nine SAFER Guides. To reiterate, the proposal does not indicate that a provider would fail the program by attesting No to the measure, if they respond with a No. However, the question must be answered one way or the other for completeness to satisfy program requirements.

Next, in alignment with the Hospital Inpatient Quality Reporting Program, we've mirrored their proposed changes which would add two new eCQMs to the Medicare Promoting Interoperability Program available measure set in calendar 2023 as well as subsequently removing four from the available measure set in program year 2024. This was already described on a few slides earlier in the presentation.

So, starting off on this slide related to an EHR data retention change, we propose to update the Provide Patients Electronic Access to Their Health Information measure which would now, under the proposal, require Eligible Hospitals and CAHs to maintain electronic health information from all patient encounters that have occurred on or after January 1, 2016. Following that, we propose to remove attestation statements 2 and 3 from the Medicare Promoting Interoperability Program's annual prevention of information blocking requirement for 2022. So, while the same attestation would still be an annual requirement, feedback and discussions have specifically concluded that these extraneous and slightly duplicative statements would only cause further confusion for participating stakeholders and, therefore, as proposed here, we believe that they may be removed for simplicity's sake.

The next proposed change to the program's overall scoring methodology would be to increase the minimum scoring threshold from its current level of 50 points up to 60 points, an increase of 10 points. This means that a provider would then need to accumulate a total of 60 points or higher across the various scored measures in order to be considered a meaningful user and to avoid a potential downward payment adjustment. The scoring would be calculated in the same manner. There aren't any other changes in that regard; however, instead of that threshold needing to be met of 50 points, the proposal here is that it would be bumped up to 60 points. Lastly for this slide, although it's already been presented earlier today by the Hospital IQR Program, this is just a bit of a gentle alignment reminder. We would like to continue reiterating to providers that under ONC's 21st Century Cures Act final rule, the new 2015 Edition Cures Update would be required for CEHRT beginning in calendar year 2023 for all participating providers. This is something I'm sure you've heard in various presentations or news blips in the past, hopefully from CMS and the Promoting Interoperability Programs. However, we like to keep hammering this home. In the meantime, either the 2015 Edition CEHRT, 2015 Edition Cures Update, or a combination of the two would be acceptable for implementation use through December 31, 2022. Only after December 31, 2022, that is beginning calendar year 2023, would the new 2015 Edition Cures Update be the only required option.

On this slide, we tried to show a bit of a visual overview of the proposed performance-based scoring methodology for the EHR reporting period in calendar year 2022 for the Medicare Promoting Interoperability Program. I'd like to note that the asterisk and asterisks indicated here on the table are related to a proposed change made to the relevant objective for the relevant measure, and we would encourage reviewers to keep this summary chart on hand and available as a cross-reference when reading through the proposed changes. We found that it's a bit easier, especially with all the heavy text in the *Federal Register*, to kind of jump back and forth between the proposals and this table, kind of eyeing up what's changed what's remained the same and what new options are available.

As one final friendly reminder regarding the IPPS/LTCH PPS proposed rule, as I'm sure you've heard and are very well aware, it was released on April 27 and formally published to the *Federal Register* on May 10. On this slide, you'll be able to access links to the proposed rule itself as well as the accompanying press release and fact sheet from CMS which includes some of the information that has been shared today. Concluding today's portion on the Medicare Promoting Interoperability Program, I wanted to thank you for listening and encourage you to take advantage of the ongoing comment period which will conclude on June 28. This opportunity is one of the ways in which we can hear back from stakeholders and the stakeholder community to ensure that CMS continues having the most robust, beneficial, and streamlined program policies, specifically as it pertains to promoting interoperability in the Medicare program. I will now turn it over to Julia for the next piece of this presentation. Thank you very much.

Julia Venanzi: Thanks very much, Dylan. I will now go through the proposals that we made for the Hospital Value-Based Purchasing Program, or the Hospital VBP Program for this year.

To start first at a high level summary, we have a number of proposals related to the COVID-19 Public Health Emergency, the first of which is a proposal to establish a measure suppression policy for the duration of the Public Health Emergency for COVID-19. The next is a proposal to then use that suppression policy to suppress a number of measures in the program. Then, we are also proposing to revise the scoring and payment methodology for the fiscal year 2022 program year, such that hospital Total Performance Scores will not include calculations based on the suppressed measures. We believe that awarding a TPS score to any hospital based off of the remaining measures that are not suppressed would not result in a fair, national comparison and, as a result, we are proposing not to award a TPS to any hospital for the fiscal year 2022 program year. Instead, we are proposing to award each hospital a payment incentive multiplier that results in a value-based incentive payment that is equal to the amount withheld for the fiscal year, which is two percent.

We are also proposing to update the baseline periods for certain measures affected by the ECE granted in response to the COVID-19 Public Health Emergency. Lastly, we have one measure-related proposal which is to remove the CMS PSI 90 measure from the Hospital Value-Based Purchasing Program.

Here, I'll go more in depth on the COVID-19 related proposals. As you all know, the COVID-19 pandemic and associated Public Health Emergency have impeded effective quality measurement in many ways. Changes to clinical practices to accommodate safety protocols as well as unpredicted changes in the number of stays- and facility-level case mixes have affected the data used in quality measurement and the resulting quality scores. Measures used in the Hospital Value-Based Purchasing Program need to be evaluated to determine whether their specifications need to be updated in order to account for new clinical guidelines, diagnosis or procedure codes or medication changes that we have observed during the Public Health Emergency. Additionally, because COVID-19 prevalence is not consistent across the country, hospitals located in different areas have been affected differently at different times during the pandemic. It is not our intention to penalize hospitals based on measure scores that we believe may be distorted by the COVID-19 Public Health Emergency.

As a result of this, we are proposing a number of changes related to the fiscal year 2022 program year which uses, in most cases, calendar year 2020 data. First in alignment with a number of other value-based purchasing programs, we are proposing a measure suppression policy that would enable us to suppress the use of measure data that we determined to be significantly impacted by the COVID-19 Public Health Emergency. We are then proposing to use that policy to suppress the following measures in the fiscal year 2022 program year. Those measures are the HCAHPS measure, the Medicare Spending per Beneficiary (MSBP) measure, and then five healthcare-associated infection measures, including the CAUTI CLABSI, C. diff, MRSA, and Surgical Site Infection (SSI) measures.

Additionally, we are also proposing a change to the scoring methodology for the program for fiscal year 2022. We're proposing to calculate measure rates for all measures, including those that we are proposing to suppress, but we would only calculate achievement and improvement scores for the measures in the Clinical Outcomes Domain, which contains measures that we are not proposing to suppress. We would also calculate domain scores for the Clinical Outcomes Domain, but because that domain is only weighted at 25 percent of the Total Performance Score and because we would have no other domain scores left, we are proposing to not calculate Total Performance Scores for hospitals. Finally, we are proposing to reduce each hospital's base operating Diagnosis Related Group payments by 2 percent, which is required by statute. Because no hospital would receive a Total Performance Score for fiscal year 2022, we are proposing to assign to each hospital a value-based incentive payment percentage that results in a value-based incentive payment amount that matches the 2 percent reduction to the base operating DRG payment amount. The net result of these payment adjustments would be neutral for all hospitals. That is, a hospital's base operating DRG payment amount would remain unchanged for fiscal year 2022.

We still feel it's important to provide confidential feedback reports to hospitals on their fiscal year 2022 measure rates on all measures to ensure that hospitals are able to review their own data from calendar year 2020. We would also still plan to publicly report calendar year 2020 Quarter 3 and Quarter 4 data, where feasible, with appropriate caveats, noting the limitations of the data due to the Public Health Emergency for COVID-19.

We are also proposing to suppress the pneumonia mortality measure (MORT-30-PN)but only for the fiscal year 2023 program year since that measure has a different performance period from the measures that I previously mentioned for fiscal year 2022. Calendar year 2020 data for the pneumonia measure is not used until the fiscal year 2023 program year. Since this is the only measure being proposed to be suppressed in fiscal year 2023, we are not proposing to make any changes to the score methodology for that payment year at this time.

For fiscal year 24 and 25 program years, which also use calendar year 2020 data, we are not, at this time, proposing to suppress the pneumonia mortality measure. We will continue to analyze this data and will address the suppression of the pneumonia mortality measure for additional program years in future rule making.

I wanted to make a few notes on the payment adjustment tables that we typically publish associated with the proposed and final rule. Table 16 was posted with the proposed rule earlier this year. Table 16a and Table 16b are typically updated later in the year, but this year I wanted to note that, if our measure suppression proposals are finalized as proposed, we will not post updates for these two tables since all hospitals will receive net neutral payments. If these policies are not finalized, we will update these tables like we normally would.

We are also noting an update to the specifications of the other remaining condition- and procedure-specific mortality measures to exclude patients with either a principal or secondary diagnosis of COVID-19 from the measure denominators beginning with the fiscal year 2023 program year. We believe that excluding these COVID-19 patients from the measure denominator beginning with the fiscal year 2023 program year and subsequent years will ensure that these four condition-specific mortality measures and the one procedure-specific complication measure will continue to account for mortality and complication rates as intended. We do not need to update these measures for the fiscal year 2022 program year because the only data that would be affected by the Public Health Emergency for COVID-19 are from the first and second quarters of calendar year 2020, which are excluded under the ECE, the Extraordinary Circumstances Exception, that we granted last March in relation to the PHE. Because of the close clinical relationship between pneumonia and COVID-19, we are not proposing to update the specifications of the pneumonia mortality measure at this time. Instead, we are proposing to suppress that measure as I previously mentioned. We'll continue to analyze all of these measures for impact of COVID-19 as we move forward through future rule making.

Next, I will move to our one measure proposal in this year's proposed rule. We are proposing to remove the PSI 90 measure beginning with the fiscal year 2023 payment determination under removal Factor 4 [8], which is, "The cost associated with the measure outweighs the benefit of its use in the program." We continue to consider patient safety as a very high priority, but because the CMS PSI 90 measure is also used in the Hospital Acquired Conditions Reduction Program, or the HACRP program [HAC Reduction Program], we believe removing this measure from the Hospital Value-Based Purchasing program will reduce the provider and clinician costs associated with tracking duplicative measures across programs. For example, the scoring methodology for this CMS PSI 90 measure for the Hospital Value-Based Purchasing Program includes comparing an individual hospital's performance during the performance period to all hospital performance during an established baseline period. Hospitals can then be awarded improvement points by comparing an individual hospital's performance during the performance period to that same individual hospital's performance during the baseline period. The HAC Reduction Program assesses performance using an equally weighted average of scores across measures included in the program and does not require a baseline period for scoring purposes. Hospitals may incur additional costs to monitor these differences in scoring methodology even though they're applied to the same measure.

These next few slides don't contain any new proposals. They just summarize previously finalized requirements, but we wanted to make sure that we had this information all in one place so you're able to reference these slides in the future. This first slide shows the four finalized domains and their associated measures for the fiscal year 2023 payment year.

Then, this slide shows the measurement periods, both the baseline and performance period, for each of the measures that will be used for the fiscal year 2023 program year. Just as a reminder, we use hospital performance during the baseline period to establish the performance standards, the benchmark, and the achievement thresholds that we use for scoring in the Hospital VBP Program.

This slide shows the domains and measures for the fiscal year 2024 through the fiscal year 2027 program years, and the next few slides show the same baseline and performance periods for each of those years. I will note here that we are proposing to update the baseline periods for the Patient Safety, Patient and Community Engagement, and Cost domains to no longer use calendar year 2020 data as a comparison.

So, I won't spend too much time on the next few slides, but this contains that same measurement period information for fiscal year 24 through 27.

That wraps up the hospital value-based purchasing proposals for this year. I want to thank you again for your participation today. We really look forward to receiving your feedback through comments. I will now pass it over to Jennifer Tate to talk through the HAC Reduction Program proposals for this year.

Jennifer Tate: Good day, everyone. My name is Jennifer Tate, and I am the Program Lead for the HAC Reduction Program. On the next few slides, I will provide summaries of the proposed policies in the fiscal year 2022 proposed rule for both the HAC Reduction Program and the Hospital Readmissions [Reduction] Program.

We are proposing two policies for the HAC Reduction Program in the fiscal year 2022 proposed rules. The first proposal is to adopt a measure suppression policy for the program due to the impact of the COVID-19 Public Health Emergency on quality measurements. This policy will allow CMS flexibility to suppress data from use in the program calculations, if warranted. The second proposal is to use the proposed measure suppression policy to suppress Q3 and Q4 2020 HAI and claims data from future HAC Reduction Program scoring calculations.

The measure suppression policy is a proposal to be adopted for the duration of the COVID-19 PHE. This policy will enable CMS to suppress use of measure data from the program calculations, if appropriate.

CMS recognizes that the COVID-19 PHE has significant and enduring effects that may directly affect hospital measure performance including, but not limited to, changes to clinical practices to accommodate safety protocols for medical personnel and patients or unpredicted changes in the number of stay- and facility-level case mixes. CMS views this proposal as necessary to ensure the program does not penalize facilities when their quality performance is negatively impacted not due to the care provided but due to external factors.

The Q3 and Q4 2020 data suppression policy suppresses HAI and claims data from the HAC Reduction Program scoring calculations due to the COVID-19 PHE. Combined with exclusions of Q1 and Q2 2020 HAI and claims data announced in the interim final rule published September 2, 2020, this proposed policy will remove all of calendar year 2020 data from future program calculations and effectively shorten the performance period. This figure depicts the impact on the measure performance period for fiscal year 2022 and fiscal year 2023 program years. Calendar year 2020 data exclusions that apply to the original performance periods are shown in red, and the remaining effective performance periods are shown in blue and light gray for the CMS PSI 90 and HAI measures, respectively. The optional data submissions for Q4 2019, granted by the national ECE announced in March, are shown in yellow. If your hospital submitted the data for this quarter, they will still be used in program calculations.

If this policy is adopted, the FY 2022 program year will rely on a performance period of July 1, 2018, through December 31, 2019, for the CMS PSI 90 measure and a period of January 1, 2019, through December 31, 2019, for the HAI measures. For fiscal year 2023, the CMS PSI 90 performance period will be July 1, 2019, through December 31, 2019, and January 1, 2021, through June 30, 2021. The HAI measures performance period will be January 1, 2021, through December 31, 2021.

More information on the HAC Reduction Program can be found on the CMS.gov and QualityNet.org websites. You can submit questions about the HAC Reduction Program via the QualityNet question-and-answer tool, which can be found via the QualityNet website.

Next, I will present this fiscal year 2022 summary of proposals for the Hospital Readmissions Reduction Program.

This section of the presentation will focus on proposed policies for the Hospital Readmissions Reduction Program in the Fiscal Year 2022 IPPS LTCH PPS proposed rule. In this proposed rule, CMS is proposing the following policies, clarifications, and requests. The first is a proposal to adopt a measure suppression policy due to the impact of the COVID-19 Public Health Emergency on quality measurements in HRRP. The second is a proposal to temporarily suppress the pneumonia readmission measure from the FY 2023 HRRP program year. The third is a clarification of how the current Extraordinary Circumstance Exception, or ECE, policy applies to HRRP. The fourth is a proposal to use the MedPAR data that aligns with the applicable period for FY 2022. This proposal is consistent with previous proposed rules where we propose updating the data period to identify aggregate payments for excess readmissions and to continue to use the MedPAR file as the data source. The fifth proposal is a proposal to automatically adopt the use of MedPAR data corresponding to the applicable period unless otherwise specified by the Secretary beginning with the FY 2023 program. This policy is being proposed to provide greater certainty around data sources for identifying aggregate payments for excess readmissions for future program years. We continue to believe that the use of MedPAR claims data is the appropriate source for identifying aggregate payments. The sixth is a request for public comments on the possible future expansion of stratified disparity methods used to confidentially report readmission measures to include stratified results by both dual eligibility, race, and ethnicity, and the possible future expansion of standardized data collection to include additional social factors. CMS welcomes public comments on these proposed policies.

FY 2023 Pneumonia Suppression: In this proposed rule, we are proposing to temporarily suppress the pneumonia readmission measure from the FY 2023 HRRP program year under proposed measure suppression Factor 2: Clinical proximity of the measure's focus to the relevant disease or pathogen, specifically COVID-19.

Pneumonia has been identified as a typical characteristic of individuals infected with COVID-19, and our analyses of 2020 data show that a substantial portion of the 30-day pneumonia readmission measure cohort includes admissions with a COVID-19 diagnosis. Additionally, our analysis performed with available data demonstrated that COVID-19 patients captured in the pneumonia readmission measure cohort likely represent a distinct severely ill group of patients for whom it may be difficult to adequately ascertain appropriate risk adjustments. We are concerned that excluding a significant proportion of all eligible patients may not accurately reflect the care provided. Suppressing this measure for the FY 2023 program year would address this concern. As part of our analysis, we also evaluated the impact of suppressing the pneumonia readmission measure from the fiscal year 2023 program year. Our analysis shows that suppressing the pneumonia readmission measure would have minimal negative impact on eligibility for HRRP payment reductions and on the number of hospitals receiving payment reductions. In this proposed policy, we will weigh the pneumonia readmission measure at 0 percent in the HRRP methodology so that claims data for this measure would not be used to assess that hospital's performance. This proposal is not being made for the FY 2022 HRRP program year since the applicable period does not use data impacted by the COVID-19 Public Health Emergency. In the September 2020 IFC, we noted that we would not use any first or second quarter 2020 claims data to assess performance which shortened the FY 2022 applicable period to July 1, 2017, through December 1, 2019. The technical specifications of the five remaining readmission measures in HRRP will be updated to remove COVID-19 patients from the measure denominators for fiscal year 2023. Our analyses indicate that the impact of COVID-19 on these readmission measures is less severe overall and can be mitigated by excluding these patients with a diagnosis of COVID-19 from the measure denominators. The update to the technical specifications will be made via the sub regulatory process finalized in the FY 2015 IPPS/LTCH [PPS] Final Rule and reiterated in the FY 2020 IPPS/LTCH PPS Final Rule.

In this slide, we would like to provide some clarification to the ECE policy. In the Fiscal Year 2016 IPPS/LTCH PPS Final Rule, we adopted an ECE policy for HRRP. In the fiscal year 2018 IPPS/LTCH PPS Final Rule, we modified the requirement for the HRRP ECE policy to further align the process used by other quality reporting and VBP programs. In this proposal, we are clarifying how the ECE policy applies to HRRP. An approved ECE for HRRP would exclude accepted data from calculations of measure performance. It would not waive the claims data submission requirements for the hospital. An approved ECE for HRRP would exclude the accepted data from HRRP payment reduction calculations, but it would not exempt the hospitals from payment reductions under HRRP.

CMS is committed to achieving equity in health care outcomes for our beneficiaries by supporting providers and quality improvement activities to reduce health inequities and enabling them to make more informed decisions in promoting provider accountability for health care disparities. We have created the CMS Disparity Methods, two complimentary methods to calculate disparities in conditions or procedure-specific readmission measures to better account for social risk factors in the Medicare program. These methods have focused on dual eligibility as the main stratification variable for reporting disparity results. CMS provides hospitals with the disparity results and confidential specific reports and the data are not publicly reported at this time. We are exploring potentially expanding our methods for stratification reporting for the disparity method to better eliminate social disparities in populations served by the Medicare participating hospitals. In particular, we are exploring the significance of racial and ethnic inequities as well as other social factors, such as language preference and disability status in outcomes in HRRP. We welcome public comments on this effort. We are also seeking comment on the possibility of publicly reporting stratified results using both indirectly estimated race and ethnicity and dual eligibility on Care Compare after at least one year of confidential reporting and further rulemaking for the sixth condition and procedure specific measures. Finally, we invite public comment on possible mechanisms of incorporating other demographic characteristics into analyses that address and advance health equity.

This slide contains more detailed resources for HRRP and resources on reducing hospital readmissions. You can submit questions about HRRP via the QualityNet question-and-answer tool which can be found via the QualityNet website. Now, I will turn the presentation over to Candace Jackson. Thank you.

Candace Jackson: I'd like to thank all of the speakers for providing the proposed changes for each of their programs.

The proposed rule can be downloaded at the link provided on this slide. Additionally, the slide provides the pages that the proposed changes for each of the programs can be found on.

Comments can be submitted electronically, by regular email, or by express or overnight mail no later than 5 p.m. Eastern Daylight Time by June 28, 2021. CMS will respond to comments in the final rule scheduled to be issued by august 1, 2021.

These next few slides will go over the measures that will be included in each of the programs for fiscal year 2022 through fiscal year 2026.

This slide goes over the claims-based, coordination of care (Excess Days in Acute Care) measures.

This slide goes over the readmission claims-based, coordination of care measures.

On this slide, it lists the claims-based, mortality outcome measures.

On this slide, are the claims-based, patient safety measures.

On this slide, it lists the claims-based, efficiency and payment measures.

Listed on this slide are the chart-abstracted, clinical process of care measures.

This slide lists the EHR-based, clinical process of care (eCQM) measures.

This slide lists the claims and electronic data measures.

The NHSN vaccination measures are listed on this slide.

This slide lists the proposed structural measure for the IQR program.

This slide lists the HAI measures.

This slide lists the HCAHPS Patient Experience of Care Survey measure.

Again, we thank you for joining our webinar today. Unfortunately, our time overran our hour and we are not able to have a live Q&A session today. However, as stated at the beginning of the webinar, all of the questions that were submitted during today's presentation will be responded to and posted at a later date. Next slide.

Again, the presentation was approved for one continuing education [credit]. You can do that by selecting the link on this slide. Next slide.

Again, we'd like to thank you for joining, and I'd like to thank our speakers for providing the information. We hope that the rest of your day is great. Thank you.