Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2022 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs Question and Answer Summary Document

Speakers

Julia Venanzi, MPH
Program Lead, Hospital IQR Program and Hospital Value-Based Purchasing (VBP) Program,
Quality Measurement and Value-Based Incentives Group (QMVIG),
Center for Clinical Standards and Quality (CCSQ), CMS

Alex Feilmeier, MHA
Lead Solutions Specialist
Value, Incentives, and Quality Reporting Center (VIQRC) Validation Support Contractor

Jessica Warren, RN, BSN, MA, FCCS, CCRC
Program Lead, Medicare Promoting Interoperability Program, QMVIG, CCSQ, CMS

Jennifer Tate, MPH, MLS(ASCP)^{CM}
Program Lead, Hospital-Acquired Condition (HAC) Reduction Program,
Hospital Readmissions Reduction Program (HRRP), QMVIG, CCSQ, CMS

Moderator

Candace Jackson, RN
Project Lead, Hospital IQR Program, Inpatient VIQR Outreach and Education Support Contractor

September 9, 2021
1:00 p.m. Eastern Time (ET)

DISCLAIMER: This presentation question-and-answer summary document was current at the time of publication and/or upload onto the Quality Reporting Center and QualityNet websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated. The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations.

Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Hospital Inpatient Quality Reporting

Question 1: **For the COVID-19 Vaccination Coverage Among Health Care Personnel measure, is data submission mandatory for the shortened reporting period for quarter (Q)4 2021? If so, what is the deadline to meet Hospital IQR Program reporting requirements?**

Data submission for the shortened reporting period, for Q4 2021, is required. This measure should be reported with other Hospital IQR Program Q4 2020 data by May 16, 2022.

Question 2: **Is the COVID-19 Vaccination Coverage Among Health Care Personnel measure submitted monthly or at the end of the quarter?**

Hospitals will be required to submit the measure data by the quarterly submission deadlines; hospitals will not be required by CMS to submit each month; however, CMS and CDC encourage more frequent reporting to have sufficient time to review and make any necessary corrections of the data before each deadline. For example, for the Q4 2021 reporting period, you would be required to submit all three months' worth of data by the May 16, 2022 deadline.

Question 3: **Will the COVID-19 Vaccination Coverage Among Health Care Personnel measure be required for both acute care facilities and critical access hospitals (CAHs)?**

All Hospital IQR-eligible acute care hospitals will be required to submit the COVID-19 Vaccination Coverage Among Health Care Personnel measure. CAHs are not included in the Hospital IQR Program, but we encourage them to voluntarily submit data for the measure.

Question 4: **What is considered "Healthcare Personnel" (HCP)? Is it all clinical staff or any employee working in the clinical areas?**

HCPs include the following categories:

- Employee – Include all persons receiving a direct paycheck from the healthcare facility (i.e., on the facility's payroll), regardless of clinical responsibility or patient contact.
- Non-Employee
  - Licensed independent practitioners – Include physicians (MD, DO); advanced practice nurses; and physician assistants only who are affiliated with the healthcare facility, but not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are included in this category.
  - Adult students/trainees and volunteers – Include medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.
  - Other contract personnel – These are defined as persons providing care, treatment, or services at the facility through a contract who do not meet the definition of any other required denominator category. This includes agency and/or PRN staff who are scheduled to work at the facility at least once per week.

Question 5: **Are the eligible HCPs the same for the Hospital IQR Program COVID-19 vaccine cohort and the Hospital Outpatient Quality Reporting (OQR) Program COVID-19 vaccine proposed metric cohort? Are the submission requirements the same across programs?**

The measure specifications and submission requirements are the same for both the Hospital IQR and OQR Programs.

Question 6: **In the Outpatient Prospective Payment System (OPPS) Proposed Rule the COVID-19 measure reporting period starts January 2022. Why is there a difference between outpatient and inpatient?**

As the OPPS final rule will not be posted until November 1st, it was not feasible to require Q4 2021 reporting. Measure reporting for the OQR Program will begin January 1, 2022, if finalized.

Question 7: **Are you providing specific training on reporting the COVID-19 Vaccination Coverage among HCP measure for those hospitals that have not been reporting this measure voluntarily? If so, when?**

NHSN training material and resource documents can be found on the Weekly HCP COVID-19 Vaccination webpage.

Additionally, the HCP COVID-19 Vaccination Measure and Maternal Morbidity Structural Measure webinar can be found on the Quality Reporting Center webpage.

Question 8: **Are religious reasons an acceptable contraindication for the COVID-19 Vaccination Coverage Among Health Care Personnel measure?**

As of March 2021, the Centers for Disease Control and Prevention (CDC) considers contradictions to the vaccine to be severe allergic reaction after a previous dose or component to the COVID-19 vaccine and to the immediate allergic reaction to a previous dose of the COVID-19 vaccine. Those are the only two contraindications.

Question 9: **Does the CDC COVID-19 Vaccination Coverage Among Health Care Personnel measure denominator exclusion of "immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine" apply to staff who have medical waivers for other vaccine requirements due to allergic reactions, such as myalgias?**

The acceptable contraindications for the COVID-19 vaccination does not include reactions or medical waivers for other vaccinations.

Question 10: **Do hospitals need to have a National Healthcare Safety Network (NHSN) account to report the COVID-19 Vaccination Coverage Among Health Care Personnel measure? Do we manually add a numerator or denominator, or will we be required to file?**

To enter the COVID-19 measure information, you will need to be enrolled in NHSN. Facilities that are currently not participating in NHSN that wish to participate must enroll in NHSN. The initial enrollment process usually takes at least 4–6 weeks. Details regarding the enrollment process are on the NHSN website: http://www.cdc.gov/nhsn/enrollment/index.html

Question 11: **Will we report the COVID-19 vaccine measure data in the NHSN COVID-19 weekly summary under the Vaccination Summary tab?**

To enter the COVID-19 measure data into NHSN, select the Healthcare Safety Component on the landing page. Then, select Vaccination Summary on the left-hand navigation bar. Then, select COVID-19 Weekly Vaccination Summary.

Question 12: **Is the "Vermont Oxford Network" considered a National Perinatal Quality Improvement Collaborative Program?**

The following are examples of a National Perinatal Quality Improvement Collaborative Program:

- California Maternal Quality Collaborative
- CDC's Perinatal Quality Collaborative Networks (includes state-level networks)
- AIM (Alliance for Innovation on Maternal Health)

However, this list is not all inclusive and there are/could be other entities that would also meet CMS's definition. CMS defines 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. Hospitals will need to use their own judgement when determining if any entities that work with them meet this definition.

Question 13: **Will digital quality measures (dQMs) replace electronic clinical quality measures (eCQMs)?**

CMS views eCQMs as a subset of dQMs. In the proposed rule, we sought to refine the definition of dQMs to further operationalize our objective of fully transitioning to dQMs by 2025. We previously noted dQMs use "sources of health information that are captured and can be transmitted electronically and via interoperable systems" (85 FR 84845). In the RFI, we sought input on the definition of a dQM as a software that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources. We also noted that dQMs are intended to improve the patient experience

including quality of care, improve the health of populations, and/or reduce costs.

Question 14: **When is the last time we can report on the Emergency Department (ED)-2 eCQM?**

Beginning with the calendar year (CY) 2024 reporting period, for the FY 2026 payment determination, CMS is removing the ED-2 measure from the list of available eCQMs that hospitals can select to report. The CY 2023 reporting period, for the FY 2025 payment determination, is the last time to electronically report ED-2 data. As a reminder, that data are submitted by February of 2024.

For further information regarding the removal of this measure from the Hospital IQR Program and the Medicare Promoting Interoperability Program, refer to the FY 2022 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (86 FR 45393–45407).

Question 15: **Is CMS only removing the ED-2 and Perinatal Care (PC)-05 eCQMs? Is CMS removing any chart-abstracted measures?**

Beginning with the CY 2024 reporting period, CMS finalized the removal of three eCQMs from the eCQM measure set for the Hospital IQR and Medicare Promoting Interoperability Programs. They are ED-2, PC-05, and Stroke (STK)-06.

Slide 71 provides a list of the electronic health record (EHR)-based clinical process of care measures (eCQMs). For further information regarding the removal of these eCQMs, refer to the FY 2022 IPPS/LTCH PPS final rule (86 FR 45391–45407).

The chart-abstracted measures for the Hospital IQR Program, which include PC-01 and Sepsis, remain the same and continue to be required. Any changes to the chart-abstracted measure requirements would be done in future rulemaking.

Question 16: **When will the PC-05 Exclusive Breastmilk Feeding measure be removed from the Hospital IQR Program? Is The Joint Commission going to discontinue PC-05 as well?**

Beginning with the CY 2024 reporting period, CMS finalized the removal of three eCQMs from the eCQM measure set for the Hospital IQR and Medicare Promoting Interoperability Programs. They are ED-2,

PC-05, and STK-06. Slide 71 provides a list of the EHR-based eCQMs. For further information regarding the removal of these eCQMs, refer to the FY 2022 IPPS/LTCH PPS final rule (86 FR 45391–45407).

The Joint Commission maintains close alignment with CMS measures where possible and continues to advance eCQM development to drive quality improvement. Please access the The Joint Commission eCQM Service Desk for questions on eCQM reporting requirements.

Question 17: **Can you clarify why CMS did not finalize the STK-03 eCQM for removal?**

CMS did not finalize the proposal to remove the Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) eCQM from the eCQM measure set after considering stakeholder feedback and concerns. For a better understanding, refer to the comments and responses in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45397–45398).

Question 18: **Slide 19. Is the hyperglycemia eCQM description accurate? The description on the slide indicates that the denominator is patients who have diabetes AND either received anti-diabetic medication or had an elevated blood glucose. CMS has confirmed it should be patients with one of the three criteria: 1. diabetes diagnosed before or during the encounter; 2. an anti-diabetic medication; or 3. an elevated blood glucose. In other words, the denominator is NOT isolated to patients with diabetes as indicated on the slide.**

The Hospital Harm-Severe Hyperglycemia eCQM (HH-02) assesses the number of inpatient hospital days with a hyperglycemic event (harm) per the total qualifying inpatient hospitals days for patients 18 years of age or older at admission.
You are correct. The initial population includes inpatient hospitalizations where the patient is 18 years or older, at the start of the admission, with a discharge during the measurement period, as well as either:

1. A diagnosis of diabetes that starts before or during the encounter; or
2. Administration of at least one dose of insulin or any hypoglycemic medication during the encounter; or
3. Presence of at least one blood glucose value >=200 milligrams (mg)/deciliter (dL) at any time during the encounter.

For information on eCQM specifications and data elements, refer to the eCQI Resource Center at https://ecqi.healthit.gov/. For a direct link to the

HH-02 eCQM specifications, visit https://ecqi.healthit.gov/ecqm/eh/pre-rulemaking/1/cms871v1).

Question 19: **In the FY 2022 IPPS/LTCH PPS final rule, the hybrid measures comply with the same certification requirements and timeline as eCQMs. This provision is in alignment with the updates, as previously discussed, for eCQMs requiring the use of certified technology updated consistent with the 2015 Edition Cures Update beginning with the CY 2023 reporting period/CY 2025 payment determination. Does the statement "comply with same certification requirements" include a moderator certification similar to new eCQMs. For example, does it include a moderator certification scheduled with and conducted by the Office of the**
National Coordinator-Authorized Certification Bodies (ONC-ACB)?

The finalized CMS hybrid measures comply with the same certification requirements as eCQMs; however, the timelines do not align, and the reporting period timeframes differ.

Hospital EHRs are required to be certified and, beginning with the CY 2023 reporting period, they are required to use the 2015 Edition Cures Update for Certified EHR Technology. Furthermore, all available eCQMs used for the CY 2023 reporting period and subsequent years would need to be certified to the 2015 Edition Cures Update.

The ONC for Health Information Technology is responsible for the certification of Health Information Technology (IT). ONC-ACBs assess Health IT and make certification decisions based on the Health IT's conformity to program requirements. They are required to ensure continued conformity of the certified Health IT on the Certified Health IT Product List (CHPL).

For detailed information on modifications to the ONC Health IT Certification Program, we refer readers to the 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program Final Rule. (85 FR 25709–25713). Questions about the ONC Health IT Certification Program can be submitted to onc.certification@hhs.gov.

Question 20: **Slide 17. When does reporting for the hybrid readmission (HWR) measure become mandatory?**

Implementation of the new Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure is similar to the implementation

of the Hybrid Hospital-Wide Readmission (HWR) measure. Reporting data for both measures will use a stepwise fashion.

If you are referring to the Hybrid HWR measure, finalized in the FY 2020 IPPS/LTCH PPS final rule, mandatory reporting starts with the 2025 reporting period which include hospitalizations from July 1, 2023–June 30, 2024. The data submission timeframe is in the fall 2024. CMS recommends that hospitals participate in the 2023 and 2024 voluntary reporting periods. A webinar on Hybrid HWR measure reporting was presented on May 18, 2021. The webinar materials, including slides, transcript, and questions and answers are on the Quality Reporting Center.

As reviewed during today's webinar, CMS has finalized the addition of the Hybrid HWM measure to the Hospital IQR Program. This measure is voluntary for the 2024 reporting period (July 1, 2022–June 30, 2023). It is mandatory beginning with the 2025 reporting period (July 1, 2023–June 30, 2024) and will be publicly reported as part of the Hospital IQR Program.

Question 21: **Does the COVID-19 exclusion apply to the Hospital-Wide Readmission (HWR) measure?**

In terms of FY 2023 and beyond, CMS continues to evaluate the impact of COVID-19 cases on measure specifications and programs. Any proposed or finalized changes to the hospital-wide readmission (HWR) measure will be announced in future HWR measure updates and specifications reports on QualityNet and/or through the federal notice and comment rulemaking process, as appropriate.

Final, updated HWR measure specifications for 2022 public reporting will be published in the 2022 HWR measure updates and specifications report and posted on QualityNet:
www.qualitynet.org > Hospitals – Inpatient > Measures > Readmission Measures > Methodology. At this time, we expect this posting to follow the usual timeline. A summary of the updates to the measure methodology/specifications will be in Section 3 of the report.

Question 22: **Where can I find a link to the mortality risk scoring for stroke patients and information on how to improve documentation to reflect an accurate mortality risk score? Additionally, will the National Institutes of Health (NIH) neurological assessment be used as part of the mortality risk score and will any billing be associated with the NIH neurological assessment?**

The Stroke Mortality measure, with the NIH Stroke Scale, will be used for payment determination in the Hospital IQR Program in FY 2023. This measure aligns with the 30-Day Risk-Standardized Publicly Reported Stroke Mortality measure in outcome, cohort, and measure calculation. However, the Stroke Mortality measure uses the NIH Stroke Scale to adjust for stroke severity to better reflect a hospital's ability to influence survival and estimate more reasonable stroke mortality scores. The NIH Stroke Scale has been available as secondary diagnosis ICD-10-CM codes within administrative claims since October 2016. Specifically, 43 codes (R29.700–R29.742) were incorporated to correspond with the range of NIH Stroke Scale scores. Hospitals should include their stroke patients' NIH Stroke Scale score on their claim for risk adjustment of this measure.

For guidance on if/how you may resubmit your claims to include your NIH Stroke Scale values, contact your Medicare Administrative Contractor (MAC). Corrected claims may be incorporated in future hospital reports if they are finalized in time for the extraction of data for future reporting. Visit https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html to locate your MAC.

The Stroke Mortality measure with NIH Stroke Scale resources, such as the measure methodology report, FAQs, and the NIH Stroke Scale Fact Sheet, can be found on QualityNet on these webpages:

- https://qualitynet.cms.gov/inpatient/measures/stroke-mort-nih/methodology
- https://qualitynet.cms.gov/inpatient/measures/stroke-mort-nih/resources

Question 23: **Will patients who are positive for COVID-19 be excluded from the 30-day stroke mortality measure?**

In terms of FY 2023 and beyond, CMS continues to evaluate the impact of COVID-19 cases on measure specifications and programs. Any proposed or finalized changes to the stroke mortality measure will be announced in future condition-specific mortality measure updates and specifications reports on QualityNet and/or through the federal notice and comment rulemaking process, as appropriate.

Final, updated stroke mortality measure specifications for 2022 public reporting will be published in the 2022 condition-specific mortality measures updates and specifications report and posted on QualityNet: www.qualitynet.org > Hospitals – Inpatient > Measures > Mortality Measures > Methodology. At this time, CMS expects this to post in spring

2022 as part of the preview period. A summary of the updates to the measure methodology/specifications will be in Section 3 of the report.

Question 24: **The CMS Patient Safety Indicator (PSI)-04 measure contains codes that capture bedside procedures during emergencies. Why can't the Agency for Healthcare Research and Quality (AHRQ) refine the measure to avoid potentially penalizing organizations trying to save a patient during an emergency?**

Thank you for your question. CMS will take it under consideration. CMS v11.0 PSI software is based upon AHRQ's v2020 PSI software for SAS®, to the extent that PSI 04, PSI 90, and the ten PSI 90 component measures are included in both versions of the PSI software. Both versions draw from the same format library, so the ICD-10-CM/PCS codes used to specify the AHRQ and CMS PSIs are identical.

Question 25: **Is the CMS PSI 04 measure exclusively for Medicare Fee for Service (FFS) beneficiaries? What is considered Medicare FFS? Does it include Medicare Indirect Medicare Education (IME)?**

The CMS v11.0 PSI software is used for the CMS PSI 04 measure to calculate CMS PSI rates based on Medicare FFS discharge data. CMS does not use non-acute inpatient (Part A), outpatient (Part B), or prescription drug (Part D) claims for estimating the CMS PSIs.

Medicare Promoting Interoperability

Question 26: **To meet the Safety Assurance Factors for Electronic Health Records (EHR) Resilience (SAFER) requirement, does the EH or CAH only need to complete the attestation or does the EH or CAH also need to complete the self-assessment?**

The nine SAFER guides can be located on the Office of the National Coordination from Health Information Technology (ONC) website. Each of the nine SAFER Guides has a series of practice worksheets attached; the completion of these worksheets is considered the self-assessment. You can answer the checklist questions based on current practice, or by working alongside your EHR vendor. How the self-assessment is completed is completely site-specific.

Our measure requirement asks an EH or CAH to attest 'yes' (you completed the self-assessment), or 'no' (you did not complete the self-

assessment). The attestation does not reflect the degree to which you completed the self-assessment, or how well the assessment was performed.

Question 27: **If you answer "No" that you have not completed the assessment, will that impact your score or cause you to fail as a meaningful user?**

We only require EHs and CAHs to attest to whether they completed the annual self-assessment or not on all nine SAFER Guides. A self-assessment includes answering the questions on the checklists provided under each of the nine SAFER Guides. The degree to which you 'complete' or 'pass/fail' the self-assessment does not affect scoring. The "yes/no" attestation is simply asking if an EH or CAH completed the self-assessment. Yes and no are both acceptable answers, and neither will affect total Program points or Meaningful User status for CY 2022.

Question 28: **Are the SAFER guides replacing the security risk analysis?**

The security risk analysis and the SAFER Guides requirement are both measures that are housed under the Protect Patient Health Information objective. They are both independent measures, and both are required.

Question 29: **Is the EHR reporting period a minimum of any continuous 90-day period in CY 2023 for new and returning EHs and CAHs? According to the CMS website, beginning with the 2021 reporting period, we are to submit for a minimum of two self-selected quarters (180 days). This seems to be contradictory.**

For CY 2023, the EHR reporting period for the measures and objectives other than eCQMs is a minimum of any continuous 90-day period for new and returning EH and CAHs. Please note that beginning with the 2021 reporting period, the reporting requirements for eCQMs increase as follows, in alignment with the reporting requirements for the Hospital IQR Program:

- 2021 = 2 quarters of data
- 2022 = 3 quarters of data
- 2023 and subsequent years = 4 quarters of data

For CY 2024, the EHR reporting period for the measures and objectives other than eCQMs is a minimum of any continuous 180-day period for new and returning EH and CAHs.

Question 30: **If a hospital was not able to successfully attest to the Medicare Promoting Interoperability Program in CY 2020 will they receive a penalty or are they being waived too?**

If an EH or CAH was unable to attest to the Medicare Promoting Interoperability Program for CY 2020 (reported in 2021), we are not offering any waivers due to existing statutory limitations. Instead, EHs and CAHs are encouraged to consider applying for hardships. More information is available on the Promoting Interoperability website's Scoring, Payment Adjustment, and Hardship Information page at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.

Hospital Value-Based Purchasing (VBP) Program

Question 31: **Is there a 1.0 adjustment factor for the FY 2022 Hospital VBP Program neutral payment adjustment? Will it remain the same as FY 2021?**

The adjustment factor would be 1.00000, which has the effect of every hospital receiving back the amount that we are required to reduce by statute (2% reduction in to the base operating DRG amount). All hospitals will receive a neutral payment adjustment, meaning a hospital's base payment would remain unchanged for FY 2022. No hospital will be penalized, and no hospital will receive a positive incentive payment. It is different from your FY 2021 score.

Question 32: **Slide 34. What is the month and year of the data being suppressed?**

- FY 2022 (January 1, 2020–December 31, 2020)
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
  - Medicare Spending Per Beneficiary (MSPB)
  - Healthcare-Associated Infection (HAI) measures
- FY 2023 (July 1, 2018–June 30, 2021)
  - Pneumonia (PN) 30-Day Mortality Measure (MORT-30-PN)

Question 33: **Will COVID-19 be removed from all Hospital VBP Program mortality measures and will CMS completely suppress the pneumonia mortality measure?**

CMS finalized several updates to the Hospital VBP Program in the FY 2022 IPPS/LTCH PPS proposed rule, including:

- Establish a measure suppression policy (as described in the final rule), for the duration of the COVID-19 public health emergency (PHE).
- Suppress the pneumonia mortality measure for the FY 2023 Hospital VBP Program year. Additionally, CMS finalized that they we will modify the acute myocardial infarction (AMI), heart failure (HF), chronic obstructive pulmonary disease (COPD), and coronary artery bypass graft (CABG) surgery mortality measures and the total hip/knee arthroplasty (THA/TKA) complication measure beginning with the FY 2023 program year as follows:
  - Exclude patients with either a principal or secondary diagnosis of COVID-19 from the measure denominators.
  - For the hip/knee complication measure, exclude readmissions with a principal or secondary diagnosis present on admission of COVID-19 (ICD-10-CM U07.1) from the numerator for the four medical complications in the complication outcome (AMI, pneumonia or other acute respiratory complication, sepsis/septicemia/shock, and pulmonary embolism).

For more information on the Hospital VBP Program updates, please refer to pages 45266–45300 of the Final Rule on the *Federal Register* website: https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-

For the FY 2023 Program Year, we will suppress only the MORT-30-PN measure as we have determined that circumstances caused by the COVID-19 PHE have affected this measure significantly. However, we are not adopting a special scoring and payment rule for that program year.

Question 34: **When will the updated mortality measure specifications, excluding the COVID-19 patients, be posted?**

Final, updated mortality measure specifications for 2022 public reporting will be published in the 2022 condition-specific and procedure-specific mortality measures updates and specifications reports and posted on QualityNet: www.qualitynet.org > Hospitals – Inpatient > Measures > Mortality Measures > Methodology.

At this time, CMS expects this to post in spring 2022 as part of the preview period. A summary of the updates to the measure methodology/specifications will be in Section 3 of the reports.

CMS finalized the following for the mortality measures included in the Hospital VBP program (AMI, HF, COPD, pneumonia, and CABG surgery) in the FY 2022 IPPS Final Rule for FY 2023:

- Suppression of the pneumonia mortality measure
- Exclusion of patients with either a principal or secondary diagnosis of COVID-19 from the measure denominators (AMI, HF, COPD, and CABG surgery)

Question 35: **When will CMS send out the reports for the FY 2022 Hospital VBP Program, or will CMS not send a report since all hospitals are not receiving a score?**

CMS still will send out the Percentage Payment Summary Report. These will include measure rates for all measures, but they will not include the domain, improvement, or achievement scores for the measures that have been suppressed in the Hospital VBP Program. We anticipate sending these reports via the Hospital Quality Reporting (HQR) System in mid to late October.

Hospital-Acquired Condition (HAC) Reduction Program

Question 36: **Are healthcare-associated infection (HAI) measures suppressed for any data required in CY 2023? The wording states that the suppression policy will be in effect until the end of the COVID-19 PHE.**

At this time, CMS is only suppressing the use of both the claims data and HAI data representing CY 2020 from all future program scoring calculations. CMS is closely monitoring the dynamic situation of the PHE and will communicate further guidance as soon as it is available. Additional guidance would be announced via the CMS.gov website and communicated through the QualityNet Listserves. If you're not signed up, you can sign up for e-mail updates by visiting the QualityNet website.

Question 37: **Are bundled payment programs, such as Bundled Payments for Care Improvement (BPCI) that use the PSI 90 composite score, affected by the suppression of PSI 90 in the HAC Reduction Program?**

The suppression of CY 2020 data from scoring calculations for the HAC Reduction Program may not necessarily impact other programs. For information on policy changes in response to the COVID-19 PHE for the BPCI model, we encourage you to contact the BPCI Advanced team by emailing BPCIAdvanced@cms.hhs.gov.

Question 38: **What is the performance period for FY 2024 in the HAC Reduction Program?**

At this time, the FY 2024 performance periods for the measures included in the HAC Reduction Program will be January 1, 2021–December 31, 2022, for the HAI measures and January 1, 2021–June 30, 2022, for the CMS PSI 90 measure. These performance periods are finalized. Any extensions to the COVID-19 suppression policy will be announced through future IPPS rules.

Validation

Question 39: **What impact will the suppression of Q3 and Q4 2020 HAI measure data have on the HAC Reduction Program validation process for those time periods? Additionally, are the charts for sepsis, validated for Q3 and Q4 of 2020, also part of the measure suppression? Will they still count towards payment?**

In light of the finalization of proposals in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45302–45305) regarding the HAC Reduction Program scoring rubric for FY 2023, CMS intends to follow a process for the HAC Reduction Program measure suppression policy analogous to the current Extraordinary Circumstances Exception (ECE) validation scoring protocol, which is outlined below.

Hospitals will not be required to submit a request for ECE and will not be required to submit validation-related data to CMS for the applicable validation requirements; however, CMS understands that some hospitals may choose to submit data for Q3 2020 and Q4 2020.
To ensure these hospitals receive feedback based on data they submitted, CMS will evaluate all submitted data per the normal validation process.

- For those hospitals that choose *not* to submit requested data, for the purposes of final HAC Reduction Program payment adjustment, CMS will evaluate the final confidence interval (CI) *without* penalizing hospitals for choosing not to submit data.

- For those hospitals that choose to submit requested data despite the exception, for the purposes of final HAC Reduction Program payment adjustment, CMS will evaluate the final CI both *with* and *without* the submitted data, ultimately applying whichever method is in the hospital's favor.

- CMS is aware that submission deadlines for some hospitals may have already passed prior to the finalization of this policy, so their data will move through the normal validation process. Quarterly feedback will be provided on Case Detail Reports; however, since only Q3 and Q4 2020 HAIs are validated under the HAC Reduction Program for the FY 2023 program year, all selected hospitals will receive a FY 2023 confidence interval validation score of 100 percent for HAI measures.

In summary, selected hospitals may choose to comply with requests for HAI Validation Templates and medical records and subsequently receive detailed individual case feedback per the normal validation process, or hospitals may choose to ignore these requests entirely. Neither option will negatively affect their end-of-year confidence interval score for the HAC Reduction Program.

Please note: Hospitals may still receive additional requests and email reminders up until the deadlines.

Although HAI measures validated under the HAC Reduction Program are not being scored to affect payment adjustment for the FY 2023 program year, hospitals are still required to submit for scoring on clinical process of care cases selected for data validation under the Hospital IQR Program for FY 2023 payment determination.

Hospital Readmissions Reduction Program (HRRP)

Question 40: **Will CMS also suppress the pneumonia readmissions?**

CMS will suppress the 30-day Pneumonia Readmission Measure from the Hospital Readmissions Reduction Program (HRRP) FY 2023 program year. To suppress the measure, CMS will weigh the pneumonia readmission measure at 0 percent in the FY 2023 HRRP payment methodology so that this measure will not be used to assess that hospital's performance.

CMS will still publicly report pneumonia readmission measure data for FY 2023 with appropriate caveats noting the limitations of the data due to the COVID-19 PHE.

Question 41: **Slide 57. Does the second bullet mean that the Medicare Provider and Analysis Review (MedPAR) data are used for payment determination, but not used for evaluating the outcomes in HRRP? Are you still using only Medicare FFS patient data?**

CMS uses claims data from the MedPAR files to identify stays and payment information, including the ratio of base operating diagnosis-related group (DRG) payments per measure to total payments and the neutrality modifier, for its HRRP calculations. The excess readmission ratios (ERR) calculated for each readmission measure in HRRP are based on Medicare administrative claims and enrollment information. The FY 2022 IPPS/LTCH PPS final rule did not change the data source used for ERR calculations. In the FY 2022 IPPS/LTCH PPS final rule, CMS finalized a policy to identify aggregate payments for each condition/procedure and all discharges for the FY 2022 applicable period using data from the applicable MedPAR files. In addition, CMS finalized a policy to automatically adopt the use of MedPAR data corresponding to the applicable period for HRRP calculations for FY 2023 and all subsequent program years.

The stays included in HRRP calculations will not change with the automatic adoption of the MedPAR files. While the dual proportion includes all Medicare FFS and managed care stays, the other components of the calculations only include Medicare FFS stays.

Cross Program Questions

Question 42: **With the COVID-19 measure suppression policies adopted for Hospital VBP Program, HAC Reduction Program, and HRRP, could more measures be suppressed based on the continuing impact of COVID-19?**

CMS continues to evaluate the impact of COVID-19 cases on measure specifications and programs. Any proposed or finalized changes to the suppression policy will be announced in future federal notice and comment rulemaking process, as appropriate.

Question 43: **Since COVID-19 appeared later in hospitals in the southern states at the end of Q2 and Q3 2020, has CMS considered that hospitals impacted after Q2 2020 would need measures suppressed?**

CMS continues to evaluate the impact of COVID-19 cases on measure specifications and programs. Any proposed or finalized changes to the suppression policy will be announced in future federal notice and comment rulemaking process, as appropriate.

Question 44: **Will CMS consider the impact of severe national nursing and healthcare worker staff shortages on reporting and data submissions?**

CMS continues to evaluate the impact of COVID-19 cases on measure specifications and programs. Any proposed or finalized changes to the suppression policy will be announced in future federal notice and comment rulemaking process, as appropriate.

Question 45: **Is CMS developing a summary document of programs and changes based on program year? Is there a summary document available that shows all the data suppression dates like the one showed on slide 53 for the HAC Reduction Program?**

Currently, there are no resource documents that summarize program changes or data suppression dates. We will take the request under consideration.

Question 46: **Can you remind me what the fiscal year (FY) is?**

CMS uses quality data reported by hospitals from a previous calendar year (CY) to make payment decisions for a future year. This future year is known as the federal fiscal year (FY) which runs from October 1 through September 30. Every calendar year is connected to a specific fiscal year. For example, CY 2021 reporting is connected to FY 2023 payment. For additional guidance refer to the Understanding CYs and FYs resource document.

Public Reporting/Care Compare

Question 47: **How does the data suppression affect the 5-Star measures? Are data also suppressed for 5-Star measures?**

Star rating data are based on publicly reported data. CMS' decision to except Q1 2020 and Q2 2020 data from data calculations would also exclude the data from measures included in the star ratings calculation.

Please note that CMS will still publicly report excepted measure data that is received for Q3 2020 and beyond with appropriate caveats noting the limitations of the data due to the COVID-19 PHE.

Question 48: **Will suppressed measure data still be provided on the reports posted to the Provider Data Catalogue so it is available for reference even though it is not being posted publicly on Care Compare?**

No, excepted data for Q1 and Q2 2020 will not be provided on reports posted to the Provider Data Catalogue website. The CMS decision to except Q1 2020 and Q2 2020 data from data calculations includes the public display of data on the Provider Data Catalogue and the Care Compare site.

Please note that CMS will still publicly report excepted measure data that is received for Q3 2020 and beyond with appropriate caveats noting the limitations of the data due to the COVID-19 PHE.