Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2023 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

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Candace Jackson: Good afternoon. Welcome to the *Fiscal Year 2023 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Proposed Rule Overview for Hospital Quality Reporting 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 a question-and-answer summary, will be posted to the inpatient website, https://www.QualityReportingCenter.com in the upcoming weeks. If you are registered for this event, a 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 education. The survey will no longer be available if you leave the event early. So, 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.

Our speakers for today's event are Julia Venanzi, program lead for the Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs; Elizabeth Holland, program lead for the Medicare Promoting Interoperability Program; Jennifer Tate, program lead for the Hospital-Acquired Condition Reduction Program; and Sophia Chan, program lead for the Hospital Readmissions Reduction Program. All are with the Centers for Medicare & Medicaid Services. Alex Feilmeier is the lead solutions specialist for the Value, Incentives, and Quality Reporting Center Validation Support Contractor.

This presentation will provide an overview of the Fiscal Year 2023 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System 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 2023 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 live 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.

This slide also lists acronyms and abbreviations used in the presentation.

I would now like to turn the presentation over to Julia to go over the cross-program requests for information and provide the overview of the IQR proposed changes. Julia, the floor is yours.

Julia Venanzi: Thank you, Candace. I'm going to start out today by talking about our cross-program Requests for Information, or RFIs. As the name implies, these are requests for comments on topics that could impact multiple hospital programs in the future. We encourage all stakeholders to review and submit comments on these topics as we consider them for potential future rulemaking.

First, we are seeking comment on how providers in a variety of care settings including hospitals can better prepare for the harmful impacts of climate change on their patients and how we can support them in doing so.

Specifically, we are seeking information on what information hospitals are currently using to better understand climate change threats to their patients, community, and staff; if hospitals are conducting risk assessments to better understand climate risks; and what tools or systems hospitals may be using to track these impacts.

Our second RFI topic is around health equity. CMS recently announced its comprehensive health equity strategy. In it, we articulate our commitment to advancing health equity as a key pillar of CMS's strategic vision and a core agency function. We define health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and any other factors that affect access to care and health outcomes.

In this RFI, we are specifically interested in stakeholder comments on potential use of stratified reporting on our quality measures as a way to provide hospitals with actionable and comprehensive data. Specifically, we are seeking comment on our approach to stratifying measures, including which social risk factors to use to stratify data, as well as seeking comment on how we are prioritizing which measures to stratify, and on how we plan to share those stratified results with hospitals.

Lastly, in our third cross program RFI, we are seeking comment on our next step towards modernizing our quality approach by transitioning all measures to digital quality measurements. Last year, you may remember in the fiscal year 2022 IPPS proposed rule, we included an initial RFI that outlined our approach to transition measurement towards the use of Fast Healthcare Interoperability Resources, or FHIR. This year, we are specifically seeking comment on our refined definition of digital quality measures. We're also seeking feedback on our specific implementation guides that we are considering, as well as data flow options that would support FHIR-based eCQM reporting.

So, those are our three-cross program RFIs. Again , we encourage all stakeholders to share comments and information on these topics as we consider them for future rulemaking.

I will move now to the Hospital IQR Program-specific proposal. These are different from the RFIs that I just described, which are areas where we are seeking feedback on potential future changes to the program. What I will cover next are proposals which, if finalized, would go into effect with the publication of the final rule later this year.

To start, first with a quick summary of our Hospital IQR Program proposals for this year, related to measures, we're proposing to adopt 10 new measures, as well as proposing to refine two current measures. We are also proposing to establish a publicly reported hospital designation that reflects quality and safety of maternity care. We also propose a number of submission requirements associated with new measures that we are proposing.

I will go into each of the new measure proposals in more depth as we go through this presentation, but I wanted to note that this table pulls all 10 newly proposed measures into one place for future reference.

So, starting first with our first measure proposal, the Hospital Commitment to Health Equity Structural Measure, we are proposing to adopt this measure beginning with the calendar year 2023 reporting period, which impacts the fiscal year 2025 payment determination. As I mentioned before when discussing the health equity RFI, health equity is a top priority in CMS's strategic plan. We believe that strong and committed leadership from hospital executives is essential and can play a role in shifting organizational culture and advancing equity goals. Therefore, we are proposing this measure, which assesses hospital leadership commitment to collecting and monitoring health equity performance data. This measure includes attestations across five domains, including equity as a strategic priority, data collection, data analysis, quality improvement, and leadership engagement.

This is a structural attestation measure that would be reported via the Hospital Quality Reporting System, also known as the HQR System. Reporting on this measure is similar to how hospitals reported on the previously finalized Maternal Morbidity Structural Measure.

So, our second and third measure proposals are two related measures that focus on identifying health-related social needs. The first of those two is the Screening for Social Drivers of Health measure. CMS has previously defined a health-related social need as an individual-level adverse social condition that negatively impacts a person's health or healthcare and that have significant risk factors associated with worse health outcomes, as well as increased healthcare utilization. We believe that consistently pursuing identification of health-related social needs will have two significant benefits. First, because social risk factors disproportionately impact underserved communities, promoting screening for these factors could serve as evidence-based building blocks for supporting hospitals and health systems in actualizing commitment to addressing disparities. Second, these measures could support ongoing hospital quality improvement initiatives by providing data with which to stratify patient risk and organizational performance. With that in mind, we are proposing these two social drivers of health measures. The first measure looks at the rate of inpatient admissions for patients who are 18 and over who have been screened for each of the five health-related social needs, including food insecurity, housing and stability, transportation needs, utility difficulties, and interpersonal safety.

We are proposing that this measure began with a voluntary reporting period in calendar year 2023, followed by a proposed mandatory reporting period in calendar year 2024, which would impact the fiscal year 2026 payment determination. This measure would be reported through the HQR System, similar to how other structural measures have been collected.

Next is the third measure, the Screen Positive Rate for Social Drivers of Health measure. This measure will be calculated as five separate rates.

Each rate is derived from the number of patients admitted for an inpatient hospital stay who are 18 years or older on the day of admission who are screened for health related social needs and who screen positive for each of the five health-related social needs. That number is then divided by the total number of patients 18 years or older on the date of admission who were screened for all five of the health-related social needs.

As I mentioned for the Screening for Social Drivers of Health measure, this measure is being proposed with a voluntary [reporting] period in calendar year 2023, followed by a mandatory reporting period beginning with calendar year 2024.

So, moving on to measures four and five, these two measures are related to another high priority topic area identified by the Biden-Harris administration, pregnancy-related mortality and morbidity. The first measure is the Cesarean Birth electronic clinical quality measure, or eCQM. This eCQM is intended to facilitate safer patient care by assessing the rate of c-section to ultimately reduce the occurrence of non-medically indicated c-sections to promote adherence to recommended clinical guidelines and to encourage hospitals to track and improve their practices of appropriate monitoring and care delivery for pregnant and postpartum patients. We are proposing to include this measure from the list of measures from which hospitals are able to self-select, beginning in calendar year 2023. Then, beginning in calendar year 2024, we are requiring that all hospitals report this eCQM as one of their eCQMs to meet the eCQM reporting requirement.

Next, we have the Severe Obstetric Complications eCQM. As stated in the HHS action plan to improve maternal health in America, we are pursuing a vision for improving maternal health by focusing on reducing maternal mortality and severe maternal morbidity in the next five years with a specific focus on reducing disparities in outcomes by race and ethnicity, as well as increasing hospital participation in HHS-sponsored maternal health quality improvement initiatives. With that in mind, we propose the Severe Obstetric Complications eCQM.

This eCQM assesses the proportion of patients with severe obstetric complications which occurred during the inpatient delivery hospitalization that were not present on admission. The full list of complications is included in the rule text as well as in the measure specifications that are posted on the eCQI Resource Center but, speaking generally, the obstetric complications include severe maternal morbidity diagnoses, such as acute heart or renal failure, sepsis or cardiac arrest, as well as severe maternal morbidity related procedures, such as blood transfusions or ventilation.

We are proposing to include this measure from the list of measures from which hospitals are able to self-select beginning in calendar year 2023. Then, beginning in calendar year 2024, we are requiring that all hospitals report this eCQM as one of their eCQMs to meet the reporting requirements.

Moving now to our sixth proposed measure, another eCQM is the Hospital Harm–Opioid-Related Adverse Events eCQM. The intent of this measure is for hospitals to track and improve their monitoring and response to patients administered opioids during hospitalization and to avoid harm, such as respiratory depression, which could lead to brain damage and death. This measure focuses specifically on in-hospital opioid-related adverse events rather than opioid overdose events that happen in the community and may bring a patient into the emergency department.

This eCQM assesses the proportion of inpatient hospital encounters where patients 18 years of age and older have been administered an opioid medication who then subsequently suffer the harm of an opioid-related adverse event and are administered in opioid antagonist, such as naloxone, within 12 hours. We are proposing to add this measure to the list of measures from which hospitals can self-select it, beginning in calendar year 2024.

Moving next to our seventh measure proposal, the Global Malnutrition Composite Score eCQM. This eCQM assesses adults 65 years of age or older who are admitted to inpatient hospital service who receive care appropriate to their level of malnutrition risk and malnutrition diagnosis, if properly identified.

So, this measure includes four component measures which are first scored separately and then rolled up into an overall composite score. The four components include screening for malnutrition risk at admission, completing a nutrition assessment for patients who screen for a risk of malnutrition, appropriate documentation of malnutrition diagnosis in the patient's medical record if indicated by the assessment findings, and then lastly the development of a nutrition care plan for malnourished patients, including a recommended treatment plan.

We are proposing to add this measure to the list of eCQMs from which hospitals can self-collect it beginning in calendar year 2024.

Our eighth proposed measure is the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty, or THA, or Total Knee Arthroplasty, or TKA. Elective total THA and TKA are most commonly performed for degenerative joint disease or osteoarthritis, which affects more than 30 million Americans. THA and TKA offer significant improvement in quality of life by decreasing pain and improving function in a majority of patients without resulting in a high risk of complications or deaths. However, not all patients experience benefit from these procedures. Many patients note that their preoperative expectations for functional improvement have not been met. In addition, clinical practice variation has been well documented in the United States and includes variance in readmission and complication rates. So, with that in mind, we proposed this measure. This measure uses four sources of data, including patient reported outcome data collected both before and after the procedure, claims data, Medicare enrollment and beneficiary data, as well as U. S. Census Bureau survey data.

The denominator of this measure is Medicare fee for service beneficiaries age 65 or older who are undergoing elective primary THA or TKA procedures as inpatients. Claims data is used to identify eligible elective primary THA/TKA procedures for the measure cohort to which submitted patient reported outcome data can then be matched.

The numerator is the risk-standardized proportion of patients who are undergoing elective primary THA or TKA who meet or exceed a substantial clinical improvement threshold between the pre-operative and post-operative assessments on two joint-specific, patient-reported outcome instruments.

The proposed adoption for this measure includes two voluntary periods followed by a mandatory period that uses pre-operative data from calendar year 2024 and post-operative data from calendar year 2026 which would impact the fiscal year 2028 payment determination. We would share confidential reporting during the two voluntary periods but then begin publicly reporting data associated with the first mandatory reporting period.

I will now move to our last two measures. These proposals are different from the previous eight. The next two measure proposals are proposing to add two measures, the Medicare Spending per Beneficiary measure and then the Risk-Standardized Complication Rate Following Elective Primary THA/TKA. These two measures are currently in use in the Hospital Value-Based Purchasing Program and were previously adopted and then finalized for removal in the Hospital IQR Program. We are proposing to adopt updated versions of these two measures back into the Hospital IQR Program. By statute, we are required to adopt and publicly report measures for at least a year in the Hospital IQR Program before being able to propose to adopt them in the Hospital Value-Based Purchasing Program. So, our intent here is to eventually propose these updated versions into the Hospital Value-Based Purchasing Program to replace the older versions. If these updated versions are finalized in the Hospital IQR Program, there will be a period of time where there will be two versions of these measures in use, the updated versions in the Hospital IQR Program and the original versions in the Hospital Value-Based Purchasing Program. With that said, I do want to note that, since both of these measures are claims-based measures, there is no additional burden on hospitals to submit additional data for the updated measure. So, to start first with the Medicare Spending per Beneficiary measure, the updated measure we are proposing includes three changes to the previous version.

Those changes are allowing readmissions to trigger new episodes, adding a new indicator variable into the risk adjustment model, and updating the MSPB amount calculation.

For the second updated measure, we are proposing the Risk-Standardized Complication Rate Following Elective THA/TKA. The updated measure includes one change to the previously finalized measure, which is expanding the measure outcome to include 26 additional mechanical complication ICD-10 codes. That covers new measure proposals for the Hospital IQR Program.

I'll move next to two proposals to refine measures that are currently in use in the Hospital IQR Program.

The first measure the Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Electives THA/TKA. The refinement we are proposing to this measure is the same that we are proposing for the Risk-Standardized Complication Rate for THA/TKA, which is to add those additional 26 ICD-10 mechanical complication codes.

The second proposed refinement is a change to the Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction measure, also known as known as the AMI EDAC measure. The proposed refinement is to increase the minimum case count of 25 cases up to 50 cases. This refinement comes as a result of recommendation from the National Quality Forum's Scientific Methods Panel. That concludes all of the measure-related proposals for adoption and refinement for this year.

So, our next proposal is to establish a hospital designation related to maternal health that would be posted on a public-facing CMS website in order to assist consumers in choosing hospitals that have demonstrated a commitment to maternal health. Initially, we're proposing that this designation would be awarded to hospitals based on their attestation to the previously finalized Maternal Morbidity Structural Measure, which many of you may remember was finalized in last year's IPPS rule.

Data collection on that measure began in October 2021 and will be submitted for the first time this May. If finalized, the hospital designation would begin to be displayed in fall 2023.

In relation to this proposal, we are also seeking comment on additional ways that we can support the improvement of maternal healthcare quality and expand this designation in the future. We are specifically seeking comment on potential additional measures to include in the designation with a high priority placed on possible patient experience measures. We are also looking at potential changes to the conditions of participation.

So, next is a proposal to change the eCQM reporting requirement beginning in calendar year 2024. As previously finalized, the requirement for that year was to report on four quarters of data for three self-selected eCQMs and then the Safe Use of Opioid eCQM. Our proposal is to expand that requirement to require reporting on four quarters of data on a total of six eCQMs with three of them being self-selected from the list of available eCQMs and then three required eCQMs, which would include the Safe Use of Opioids eCQM, the c-section eCQM, and then the severe obstetric complications eCQM.

This next slide is a summary of the eCQMs that are available to self-select and then the mandatory eCQMs for a given calendar year.

Our next proposal is to modify the hybrid measure reporting requirement. Hospitals that have zero eligible cases for a given eCQM are required to report a zero denominator exclusion. We had initially finalized that hybrid measures would be included in this policy in order to stay aligned between hybrid measures and eCQMs, but we have actually since determined that CMS will be able to identify which hospitals have zero cases using claims data for hybrid measures. So, there is no need for hospitals to additionally submit the zero denominator exclusion for those hybrid measures.

The last item I will touch on is the request for comment on two future potential measures, a C. diff outcome measure and a Hospital-Onset Bacteremia and Fungemia measure.

These are digital measures which could potentially be proposed to replace some of the existing hospital-acquired condition measures that are currently in use in the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program.

I will now pass things off to Alex Feilmeier to talk about our Hospital IQR Program-related validation proposals.

Alex Feilmeier Thanks, Julia. My name is Alex Feilmeier, program manager at the Value, Incentives, and Quality Reporting Center Validation Support Contractor.

I only have one proposal to present for you this year and that is the proposal to modify the eCQM validation medical record submission requirement. In the fiscal year 2017 final rule, CMS finalized several policies for submission requirements for eCQM data validation in the Hospital IQR Program, including a policy to require submission of at least 75 percent of sampled eCQM medical records. Now, CMS is proposing a change to that data submission threshold by increasing the requirement from 75 percent to 100 of requested medical records beginning with calendar year 2022 data, affecting fiscal year 2025 payment determination and subsequent years. Under CMS's current policy, the accuracy of eCQM data submitted for validation does not affect a hospital score, and there would not be any impact to this proposed update for the submission threshold.

This slide shows a more visual representation of the previously finalized eCQM validation record submission requirement versus the proposed change to the eCQM validation requirements. As you can see at the top of the table, you'll notice that hospitals selected for inpatient data validation efforts are required to achieve at least a 75 percent validation score, weighted at 100 percent, for the chart-abstracted measures, and they must successfully submit at least 75 percent of requested eCQM medical records.

In CMS's new proposal, the chart-abstracted portion of the validation requirement remains the same, but, for the eCQM validation requirement, it is proposed to increase from 75 percent to 100 percent of requested

medical records beginning with calendar year 2022 data, affecting fiscal year 2025 payment determination and subsequent years. That's all I have for data validation proposals for this year. So, I'll pass the presentation off to Elizabeth Holland.

Elizabeth Holland: Hello, I'm Elizabeth Holland. I'm the lead for the Promoting Interoperability Program and Performance Category. Today, I'm going to talk about the Medicare Promoting Interoperability program for eligible hospitals and critical access hospitals, specifically the proposals that we made in the IPPS proposed rule. Just as a reminder, this is not a proposal, but, starting in 2023, all hospitals are required to use the 21st Century Cures edition of Certified EHR technology.

Our first change is to our Electronic Prescribing objective for the Query of Prescription Drug Monitoring Program, or PDMP, measure. This has been an optional measure for several years, and this year we are proposing to require this measure. The measure is proposed to be worth 10 points. In addition, we are proposing to expand the measure description to not only include Schedule II opioids like it does now but also include Schedule III and IV drugs, beginning with a calendar year 2023 EHR reporting period. In addition, because the measure is proposed to be required, we are adopting measure exclusions that can be claimed if they are applicable.

Next, we have some changes to our Health Information Exchange objective. We are adding another option, and this new option is called Enabling Exchange Under the Trusted Exchange Framework and Common Agreement, also called the TEFCA measure. So, if this proposal is finalized for the Health Information Exchange objective, hospitals have three choices, taking either report on the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, or they can report on the Health Information Exchange Bi-Directional Exchange measure, or they can report on this new measure, Enabling Exchange Under the TEFCA.

So, we also have some changes that are proposed for our Public Health and Clinical Data Exchange objectives. First, we currently have three levels of engagement, and we are proposing to collapse these levels, so that we would only have two levels of engagement. So, the options would be Pre-Production and Validation or Testing and Validation, and the other option is Validated Data Production. We're also proposing that you would only be able to be an option one for one year unless you're actually switching registry.

We are also adding an additional measure to the Public Health and Clinical Data Exchange objective. You may remember that last year we changed our policies so that the Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Lab Result Reporting are all required. This year, we're adding another required measure, called the Antimicrobial Use and Resistance Surveillance measure.

To reflect these changes, in addition to all the changes we made last year, we are proposing some changes to our scoring methodology that I'll talk about in a moment. We are also proposing to start public reporting of Medicare Promoting Interoperability Program data. We're going to start with just a couple of data points, but this would begin to be posted on our Care Compare website.

As I mentioned, we're changing the scoring. This looks a little complicated, but it's really not. The maximum points that you can earn is 100 points. So, you can see that the Query of PDMP used to be a bonus measure, but now it's going to be required. So, that has 10 points associated with it. The two measures used to be worth 20 points, but now they're worth 10. The Health Information Bi-Directional Exchange and the TEFCA measure are both proposed to now be worth 30. Bi-Directional Exchange had been 40. The Provide Patient's Access used to be 40, but we're lowering it to 25. For the Public Health and Clinical Data Exchange measure, there were 10 points that used to be associated with it, but now, because there's so many requirements, this is really important during public health emergencies, we're increasing the points to 25.

In addition, if you report one of the remaining public health measures, the public health registry reporting or the clinical data registry reporting, you could earn an additional five bonus points. As a reminder, the threshold for hospitals to meet will remain at 60 points. So, you must score a minimum of 60 points to avoid a negative payment adjustment.

In addition, one of the requirements for the Medicare Promoting Interoperability Program is the submission of electronic clinical quality measures. We are proposing to stay in alignment with the requirements for the Hospital IQR Program. So, we would be adopting the Cesarean Birth and Severe Obstetric Complications eCQM, and we would adopt the Hospital Harm–Opioid-Related Adverse Events and Global Malnutrition Composite score eCQMs. Next.

To finish up, we have some resources. I highly recommend that you check out our website. We have many fact sheets and specifications sheets on each particular measure. You can find that at that link. As I mentioned, in the beginning for 2022, you still have the option to use the 2015 edition CEHRT, or the 21st Century Cures CEHRT, or a combination, but, as our policy has already been finalized for 2023, you must be using the 2015 edition Cures update. So, here's a link for more information on the Cures update. Now, I'm turning it over to Julia Venanzi.

Julia Venanzi: Thank you, Elizabeth. I will now talk through the Hospital Value-Based Purchasing Program-related proposals for this year.

To first summarize the proposals at a high level, there are no proposals to add new measures or to remove existing measures from the program this year. We are proposing to suppress the HCAHPS and healthcare-acquired infection-related measures from the fiscal year 2023 program as a result of the impact of COVID-19. Then, as a result of suppressing those measures, we are also proposing to revise the scoring methodology for fiscal year 2023, do not calculate Total Performance Scores, and, as a result of that, awarding all hospitals a net neutral payment adjustment. We also included some technical updates for measures for fiscal year 2023 for those measures that we are not suppressing.

Lastly, we are proposing fiscal year 2025 baseline updates on certain measures as required by statutes.

So, starting first with the COVID-19 related measure suppression proposals, I will first quickly summarize some of the flexibilities that we finalized related to COVID-19 in last year's rule, as we are proposing similar updates in this year's rule. So, last year the COVID-19 Public Health Emergency had and continues to have a significant impact on healthcare systems and hospitals that affect care decisions including clinical topics covered by the Hospital VBP Program. Additionally, COVID-19 has had different impacts on different regions at different points in the last two years.

As a result, in the fiscal year 2022 IPPS rule, CMS proposed and finalized a measure suppression policy that allowed us to suppress certain hospital value-based purchasing measures from the scoring calculation in order to not financially penalize hospitals for the impact of changing conditions that were beyond their control. While we did make these changes to not penalize hospitals during this time, we also believe that it is still of the utmost importance to be transparent and, therefore, we continue to publicly report data during that time.

As a result of this, for fiscal year 2022, we also finalized that we would suppress a number of measures and, as a result, not award Total Performance Scores. By not awarding Total Performance Scores, we also finalized that we would award each hospital with a net neutral payment adjustment, meaning every hospital would receive back an adjustment equal to the two-percent operating base Diagnosis-Related Group reduction that each hospital is subject to under the Hospital VBP Program.

So, for fiscal year 2023, we then carefully analyzed each measure to first see if we would be able to either risk adjust or otherwise update the measures so that they would be able to be used in the fiscal year 2023 program or if suppression would be needed again.

As a result of that analysis, we are proposing to suppress six measures from the Total Performance Scores calculation, the HCAHPS measure and the five hospital-acquired infection measures: CAUTI, or catheter-associated urinary tract infection; CLABSI, the central-line acquired bloodstream infection measure; the MRSA measure, the Surgical Site Infection measure, and then the C. diff measure. We would still calculate measure rates for all these measures, including those that we are suppressing, but we would only score the remaining measures in the Clinical domain and the Efficiency and Cost Reduction domain. We would then also not calculate a Total Performance Score, and, as a result of that, we will also not award incentive payments or penalty payments. All hospitals will receive a net neutral payment adjustment.

We would still provide confidential feedback reports to hospitals like we normally do. They'll want to note that, if this proposal is finalized, in order to leave enough time after the final rule to make this scoring change and to leave time for the required review and corrections period, these reports will be delayed from the normal August 1st timeline, but they would be delivered prior to the end of 2022. In addition to confidential reporting, similar to last year, we would continue to publicly report on all measures for fiscal year 2023. I also want to highlight that we note in the rule that, as a result of more widespread vaccine availability as well as advances in the treatment of COVID-19, we intend to return to normal scoring beginning in fiscal year 2024.

So, that covers measure suppression-related proposals. For the remaining measures in the fiscal year 2023 and fiscal year 2024 program, we are making some technical updates. For all measures in the Clinical domain for fiscal year 2023, except the pneumonia mortality measure, we are including a covariant in our existing risk adjustment model to account for patient history of COVID-19 in the past year. The reason the pneumonia mortality measure is not included is because we finalized the suppression of that measure in the fiscal year 2022 IPPS rule for the fiscal year 2023 program year.

We are including that technical update to include that covariant in the pneumonia mortality measure in fiscal year 2024 when it is no longer suppressed. Our last COVID-19 related change is to make updates to the baseline periods for the hospital-acquired infection measures and the HCAHPS measure since we are proposing to suppress those measures.

Related to some of these COVID-19 proposals, we also want to notify stakeholders to some changes related to the posting of the various versions of Table 16 that are usually published with the proposed and final rules. If our suppression and scoring change proposals are finalized, we will not update Table 16a or Table 16b since no hospital will receive incentive payments or penalties.

This slide summarizes the measures by domain for fiscal year 2023 and subsequent years. As mentioned earlier, there are no proposals to add new measures or to remove existing measures at this time.

So, here I won't spend a lot of time on the next few slides, but we have included the baseline and performance periods for fiscal year 2024 through 2028 for your future reference.

Then, I will now pass things off to Jennifer Tate to talk about the Hospital-Acquired Conditions Reduction Program.

Jennifer Tate: All right. Thank you, Julia. Good day, everyone. My name is Jennifer Tate, and I am the program lead for the Hospital-Acquired Condition Reduction Program. This section of the presentation focuses on the proposed policies for the HAC Reduction Program in the Fiscal Year 2023 IPPS/LTCH PPS Proposed Rule.

In the proposed rule, CMS is proposing updates to the measure suppression policy. The first proposal is to suppress all measures in the program for the fiscal year 2023 program year due to the continued impacts of the COVID-19 Public Health Emergency on quality measurement. The second proposal is to suppress calendar year 2021 HAI data for the fiscal year 2024. CMS also updated the new hospital definition for HAI measures.

CMS also made two technical updates to the CMS PSI 90 measure. First, starting in fiscal year 2024, the CMS PSI 90 measure will risk adjust for COVID-19. Second, CMS updated the minimum volume threshold for hospitals to receive a CMS PSI 90 composite score.

CMS is proposing to update the measure suppression policy that was previously finalized in the Fiscal Year 2022 IPPS/LTCH PPS Final Rule to now suppress all program measures for fiscal year 2023. Through this proposal, CMS will provide HAI measure results, that is the standardized infection ratios to hospitals, but CMS would not calculate the following for any hospital: a CMS PSI 90 measure result or measure score, HAI measure scores, or a total HAC score. If the proposal is adopted, no hospital would be in the worst performing quartile or subject to the one-percent payment penalty. This proposal is based on the COVID-19 PHE's continued impact on hospitals performance and concerns about the national comparability of these data.

CMS is also proposing to update the fiscal year 2022 measure suppression policy to suppress calendar year 2021 HAI data from fiscal year 2024 program calculations. As mentioned on the previous slide, this proposal is based on CMS's concern over measured performance and the national comparability of such performance during calendar year 2021. Under the current data collection process for the CDC NHSN HAI measures, we are unable to risk adjust for or otherwise account for COVID-19 diagnoses. Therefore, we are proposing to suppress the calendar year 2021 data in order to account for a COVID-19 diagnosis in the CDC NHSN HAI data. If the proposal is adopted, the fiscal year 2024 HAI performance period would effectively be shortened to one year, specifically January 1, 2022, through December 31, 2022.

As finalized in the Fiscal Year 2022 IPPS/LTCH IPPS Final Rule, CMS is excluding all HAI and claims data for stays that occur in calendar year 2020 from all program calculations. In addition, the proposals outlined in the previous slides have the following effect on the performance periods for the fiscal year 2023 and fiscal year 2024 program years.

For fiscal year 2023, the CMS PSI 90 measure result would not be calculated. Also, for calendar year 2021, data from HAI measures will also be excluded from scoring calculations in future program years. These data exclusions in the revised performance period are displayed in the graphic on the next slide.

This figure depicts the impact from the updates on the previous slide on the measure performance periods for the fiscal year 2023 and fiscal year 2024 program years. Calendar year 2020 and calendar year 2021 data exclusions applied to the original performance periods are shown in red, and the remaining effective performance periods are shown in blue and gray for the CMS PSI 90 and HAI measures, respectively. If the measure suppression policy proposal is adopted, the fiscal year 2023 program year will rely on a performance period of January 1, 2021, through December 31, 2021, for the HAI measures, and the CMS PSI 90 measure will be suppressed entirely. As previously mentioned, for fiscal year 2023, CMS would provide HAI measure results to hospitals for monitoring purposes only. CMS would not calculate a Total HAC Score for any hospital and no hospital would be subject to the one-percent payment reduction. For fiscal year 2024, the CMS PSI 90 performance period would be January 1, 2021, through June 30, 2022. The HAI measures performance period would be January 1, 2022, through December 31, 2022.

CMS is proposing to update the definition of “newly-opened hospitals” for the HAI measures. Under this policy, the new hospital definition will be revised to “hospitals with a Medicare accept date within the last 12 months of the HAI measure performance period.” Hospitals categorized as “new” do not receive measure scores. The new hospital definition for HAI measures was initially based on the date that a hospital filed a Notice of Participation with the Hospital IQR Program. Given the HAI transition from the Hospital IQR Program to the HAC Reduction Program starting calendar 2020, CMS proposed this change to the new HAI hospital definition to align the definition with that of the CMS PSI 90 measure.

CMS is proposing two technical updates to the CMS PSI 90 measure.

The first technical update is to include the COVID-19 diagnosis as a risk-adjustment parameter in the CMS PSI 90 software starting fiscal year 2024. By including this diagnosis in the risk adjustment, CMS will be able to adjust for the impact of COVID-19 on measure performance. The second update is to increase the minimum volume threshold for hospitals to receive a CMS PSI 90 composite score. If the threshold change is adopted, in order to be scored on the CMS PSI 90 measure, hospitals will need to have both, at least one component PSI measure with at least 25 eligible discharges and at least seven component PSI measures with at least three eligible discharges. This change in the minimum volume threshold will improve the overall measure reliability of the CMS PSI 90 measure.

For more information on the HAC Reduction Program, it can be found on the CMS.gov and QualityNet.org websites. You can submit questions about the HAC Reduction Program via the QualityNet Quality Question and Answer Tool which can be found via the QualityNet website. Thank you, and I will pass the presentation to Sophia.

Sophia Chan: So, this section of the presentation focuses on the proposed policies for the Hospital Readmissions Reduction Program, or HRRP, in the Fiscal Year 2023 IPPS/LTCH PPS Proposed Rule.

In this proposed rule, CMS is proposing a couple of policies and requests. The first one is an update to the specifications of all six readmission measures to include a history of COVID-19 covariate adjustment beginning with the fiscal year 2023 program year. The second one is a request for public comment on the possible future inclusion of health equity performance in HRRP. CMS welcomes public comments on these proposed policies.

In this proposed rule, we are resuming the use of the pneumonia readmission measure in HRRP, beginning with the fiscal year 2024 HRRP program year. We believe the resumption of the pneumonia admission measure for fiscal year 2024 is appropriate based on the following differences between the fiscal year 2023 and fiscal year 2024 performance periods.

The availability of COVID-19 related ICD-10-CM and ICD-10 PCS codes have improved hospitals coding practices. This, in turn, enabled us to differentiate patients with COVID-19 from pneumonia patients without COVID-19 within certain data periods. In our analysis, we found that, after the introduction of the J12.82 ICD-10 code, pneumonia due to corona virus disease, in January 2021, the proportion of the pneumonia cohort with the COVID-19 diagnosis present on admission, or POA, declined substantially. Now, note that J12.82, which is a secondary code used with the U07.1 COVID-19 code as a principal diagnosis, is not included within the cohort of the pneumonia readmission measure. In addition, while our analysis for the Fiscal Year 2022 IPPS/LTCH PPS Final Rule found that the patients with the diagnosis of COVID-19 POA had lower observed readmission rates than patients without a diagnosis of COVID-19 (a difference between 12.4 percent versus 15.8 percent), our analysis of more recent data available after the publication of that rule found that the observed readmission rates are more similar. That is 17.3 versus 17.2 percent. We now have sufficient available data to make technical updates to the measure specifications in order to further account for how patients with the COVID-19 diagnosis in the calculation of this measure. So, based on this analysis, we believe that the measure's focus, pneumonia readmission, is no longer clinically close to the health impacts of the COVID-19 Public Health Emergency, and, as a result, the second measure suppression factor, Clinical Proximity of the Measure's Focus to the Relevant Disease, Pathogen, or Health Impacts of the COVID-19 Public Health Emergency, is no longer applicable. Additionally, in our analysis, after excluding patients with COVID-19 from the denominator and numerator and adjusting for history of COVID-19 diagnosis in the 12 months prior to admission, results of the updated measure were closer to the pre COVID-19 period than results of the measure without changes.

As we continue to evaluate the effects of the COVID-19 Public Health Emergency on our programs and the effects of COVID-19 on our measures, we have observed that, for some patients, COVID-19 continues to have lasting effects, including fatigue, cough, palpitations, and other potentially related to organ damage, post viral syndrome, post-critical care

syndrome, or other reasons. These clinical conditions may be associated with a patient's risk for being readmitted following an index admission for any of the six conditions or procedures in the HRRP. Therefore, we are modifying the technical measure specifications of each of our six condition or procedure-specific, risk-standardized readmission measures to risk adjust for patient history of COVID-19 in the 12 months prior to admission, beginning with the fiscal year 2023 program. Although the pneumonia measure is suppressed in the HRRP program calculation for fiscal year 2023, this update will be reflected in the confidential and public reporting of the pneumonia readmission measure for fiscal year 2023.

CMS is committed to promoting equity in healthcare outcomes for our beneficiaries by supporting provider quality improvement activities that aim to reduce health inequities by enabling patients from undeserved and under-resourced communities to make informed decisions and by strengthening provider accountability for healthcare disparities. We're interested in encouraging providers to improve health equity and reduce healthcare disparities through the HRRP without disincentivizing hospitals to treat socially at-risk beneficiaries or disproportionately penalizing hospitals that treat a large proportion of socially at-risk beneficiaries. We are seeking comments on the following: 1) the benefit and potential risk of unintended consequences and cost of incorporating hospital performance for beneficiaries with social risk factors in the HRRP; 2) the approach of linking performance in caring for socially at-risk populations and payment reductions by calculating the reductions based on readmission outcomes for socially at-risk beneficiaries compared to other hospitals or compared to performance for other beneficiaries within the hospital; 3) variables associated with or measures of social risk and beneficiary demographics already collected at the claims- or patient-level that can be added to the program with dual eligibility as factors for stratifying measure results.

This slide contains more detailed resources on the HRRP. You can submit questions about the HRRP via the QualityNet Question and Answer Tool, which can be found via the QualityNet website. I am now turning it over to Candace.

Candace Jackson: Thank you, Sophia. We'll now proceed by going over how to locate the programs within the proposed rule and how to submit comments.

This slide lists the pages for each of the different programs.

CMS is accepting comments until 5 p.m. Eastern Daylight Time on June 17, 2022. 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 on each submission method and submit by only one method. CMS will respond to comments in the final rule, scheduled to be issued by August 1, 2022.

The next few slides display each of the measures by program and the fiscal years they are required.

This slide goes over the Excess Days in Acute Care measures.

This slide displays the readmission measures.

This slide includes the mortality measures.

This slide goes over the safety measures.

The payment and efficiency measures are included on this slide.

The clinical process of care, chart-abstracted, measures is on this slide.

A portion of the electronic clinical quality measures is on this side.

The eCQM measures are continued on this slide.

This slide includes the two hybrid claims and electronic data measures. Just to reiterate, these two measures are not the same as the eCQMs.

This slide contains the National Healthcare Safety Network Healthcare Personnel vaccination measures.

This slide includes the hospital IQR structural measures.

This slide lists the proposed Patient-Reported Outcome (PRO) performance measure.

This slide lists the two proposed process measures for the Hospital IQR Program.

This slide lists the HAI measures that are included in the HAC Reduction and Hospital Value-Based Purchasing Programs.

Finally, this slide includes the Patient Experience of Care survey measure.

We would like to thank our speakers for today's presentation and would like to thank all of you for joining us today.

For continuing education credit, please access the link on this slide.

Thank you. We hope you have a great day.