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

FY 2023 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs Question and Answer Summary Document

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

IQR: Health Equity and Social Drivers of Health Measures

Question 1: **What quarter in 2023 will attestation be required for the Hospital Commitment to Health Equity measure?**

CMS will require attestation to the Hospital Commitment to Health Equity measure, a structural measure, on an annual basis. The annual submission period for the structural measures is from April 1 through May 15. For the calendar year (CY) 2023 reporting period, hospitals will be able to attest to the measure, in the *Hospital Quality Reporting (HQR) Secure Portal*, from April 1, 2024 through May 15, 2024.

Question 2: **What is the expected timeline for attestation on the health equity structure measure for CY 2023? There are five domains in the Hospital Commitment to Health Equity measure. Are we attesting this occurred for the entire year or just put in place by the end of the year?**

Qualifying activities must be in place by end of CY 2023. If hospitals participate or complete qualifying activities anytime within the reporting year they may answer yes to their attestation; the intent is that hospitals will put activities in place for a duration that allows meaningful impact on their priority population(s). CMS intends to provide an attestation guidance document with further detail on examples of qualifying activities and the timeline for implementation.

Question 3: **Will the Screening for Social Drivers of Health (SDOH) measures be reported quarterly?**

CMS will require attestation to the SDOH measures on an annual basis. The annual submission period for the structural measures is from April 1 through May 15. For the CY 2023 reporting period, hospitals will be able to attest to these measures, in the *HQR Secure Portal*, from April 1, 2024 through May 15, 2024.

Question 4: **How is the Screening for Social Drivers of Health measure submitted? Is this a claims-based or web-based measure?**

The SDOH measures will be submitted through a web-based data form within the *HQR Secure Portal.*

Question 5: **For the Screening for Social Drivers of Health measures, is the mandatory reporting period of CY 2024 due for submission in May 2025?**

For the CY 2024 reporting period, hospitals will be able to attest to these measures, in the *HQR Secure Portal*, from April 1, 2025 through May 15, 2025.

Question 6: **For the Screening for Social Drivers of Health measures, are there any exclusions and is sampling allowed? Is the expectation to use 100% of the inpatient population?**

The measure denominator consists of the total number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission. The measure is not sampled. The numerator consists of the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all the following five health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay. The following patients would be excluded from the denominator: (1) Patients who opt out of screening, and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Question 7: **For the screening of SDOH measures, is there a list of acceptable forms/surveys for the screening? Could hospitals modify the forms?**

For data collection of this measure, providers could use a self-selected screening tool and collect these data in multiple ways. Multiple screening tools exist, and many hospitals already have screening tools integrated into their electronic health records (EHRs). We suggest hospitals refer to the Social Interventions Research and Evaluation Network (SIREN) website, for example, for

comprehensive information about the most widely used HRSN screening tools. SIREN contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions.

Question 8: **When will measure specifications for the Hospital Commitment to Health Equity, Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health measures be available?**

The measure specifications can be found on the QualityNet website under the IQR Resources page. Additional resources will be forthcoming.

Hospital IQR Program – Electronic Clinical Quality Measures (eCQMs)

Question 9: **Are all hospitals required to report the electronic perinatal care (ePC)-02 measure, including children's hospitals?**

Beginning with the CY 2024 reporting period, hospitals participating in the Hospital IQR Program and/or the Medicare Promoting Interoperability Program will be required to report the Cesarean Birth eCQM (ePC-02). Hospitals that do not have an obstetrics department and do not perform deliveries are exceptions. Hospitals with inpatients who are predominately individuals under 18 years of age (e.g., children's hospitals) are not eligible for the Hospital IQR Program; therefore, they are not able to submit eCQM data to the *HQR Secure Portal*.

Question 10: **When the ePC-02 and the Severe Obstetric Complications eCQM (ePC-07) become mandatory for the CY 2024 reporting period, will hospitals that don't provide maternity careservices just have one required eCQM and five self-selected eCQMs? Or will they be required to submit other measures?**

Hospitals that do not have an obstetrics department and do not perform deliveries will not be required to submit eCQM patient level data for the ePC-07 and ePC-02 measures; however , they will be required to submit a zero denominator. Additionally, they must continue to report the mandatory Safe Use of Opioids-Concurrent Prescribing eCQM and three self-selected eCQMs from the CY 2024 eCQM measure set for four quarters of data.

Question 11: **Since ePC-02 and ePC-07 are not required for eCQM reporting in CY 2023, and since these were not finalized until August 2023 (leaving less time to implement and certify these measures before the CY 2023 reporting period), are vendors required to implement these measures for the CY 2023 reporting period? Can these be implemented, certified, and made available to hospitals for the CY 2024 reporting period?**

CMS requires hospitals to continue to use certified electronic health record (EHR) technology, as specified. CMS also requires that EHRs are certified to all available eCQMs in the measure set used in the Hospital IQR Program (84 FR 42505 through 42506). Specific to the CY 2023 reporting period, hospitals are required to use technology certified to the 2015 Edition Cures Update for all available eCQMs. The available eCQMs in the CY 2023 measure set include the following: Emergency Department (ED)-2; PC-05; Stroke (STK)-2; STK-3; STK-5; STK-6; Venous Thromboembolism (VTE)-1; VTE-2; Safe Use of Opioids-Concurrent Prescribing; Hospital Harm-Severe Hypoglycemia Measure (HH-01); Hospital Harm-Severe Hyperglycemia Measure (HH-02); ePC-02; and ePC-07. Refer to slides 97 and 98 for a complete list of eCQMs based on fiscal year. CMS encourages hospitals to work with their vendor(s) to successfully meet the eCQM reporting requirement for the applicable reporting period.

Hospital IQR Program- Hospital-Level, Risk Standardized Patient Reported Outcome (PRO)-Performance Measure (PM) Following Elective Primary Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)

Question 12: **Is the Hospital-Level, Risk Standardized PRO-PM Following Elective Primary THA/TKA determined through claims data?**

The measure uses patient-reported outcome measure (PROM) data and Medicare administrative claims data. The hip disability and osteoarthritis outcome score (HOOS), joint replacement (JR) and knee injury and osteoarthritis outcome score (KOOS), JR PROMs are used to determine the measure outcome. Additional PROMs are used in risk adjustment. Those PROMs include mental health questions of the Patient-Reported Outcome Measurement Information System (PROMIS)-Global; Veterans RAND 12 Item Health Survey (VR-12); health literacy; pain in the non-operative lower extremity joint; and back pain. Claims data are used to identify the measure cohort and some risk variables.

Question 13: **Must we use a specific survey/tool for PRO-PM measure data? Is the Hip Disability and Osteoarthritis Outcome Score (HOOS)/ Knee Injury and Osteoarthritis Outcome Score (KOOS) acceptable? When will specifications publish?**

Data Elements: The measure requires specific data elements, including the short-form HOOS, JR (for THA patients) and KOOS, JR (for TKA patients). The HOOS/KOOS (long form) surveys include additional questions which are not required for this measure and providers do not need to submit them.

In addition to collection of the HOOS, JR or KOOS, JR preoperatively and postoperatively, the measure requires collection of the following data elements preoperatively: Mental Health Subscale items from either PROMIS-Global or VR-12; Health Literacy (SILS2) ("How comfortable are you filling out medical forms by yourself?"); Body Mass Index (BMI) or Height/Weight; Use of Chronic (≥ 90 days) Narcotics; Total Painful Joint Count, Patient-Reported Pain in Non-Operative Lower Extremity Joint ("What amount of pain have you experienced in the last week in your other knee/hip?"); Quantified Spinal Pain, Patient-Reported Back Pain, Oswestry Index Question ("My BACK PAIN at the moment is...")

A complete list of the data elements and timing of data collection for this measure can be found in the "What Data Should I Collect?" fact sheet on Quality Net: (https://qualitynet.cms.gov) > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Resources

Specifications Timing: Measure specifications and resources are now live on QualityNet: (https://qualitynet.cms.gov) > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Methodology or Resources

Question 14: **How should hospitals collect patient-reported data a year postoperatively?**

To clarify, the postoperative PRO data collection timeframe is 10–14 months (300–425 days) after an eligible elective primary THA/TKA procedure. Hospitals can collect PRO data using methods that align with their clinical workflow and patients' preferences.

Potential postoperative PRO collection methods include email, telephone, mail, electronic submission, tablet, paper form during a follow up appointment, or with a care team member.

A summary of these possible methods is in the "How and When Can Patient-Reported Outcome (PRO) Data Be Collected?" fact sheet on the Quality Net website: (https://qualitynet.cms.gov) > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Resources.

Question 15: **Is the THA/TKA PRO-PM measure calculated whether or not the patient has their procedure as an outpatient or an inpatient?**

The THA/TKA PRO-PM under the Hospital IQR Program only considers patients who undergo an inpatient elective primary THA/TKA procedure in the measure calculation. THA/TKA procedures completed as an outpatient are not eligible for the measure.

Question 16: **Does the THA/TKA PRO-PM measure use the same denominator specifications as the THA/TKA measure in the Hospital Readmissions Reduction Program (HRRP)?**

We believe your use of the term "denominator" in your question refers to the measure cohort criteria.

The cohort of the THA/TKA readmission measure in the HRRP aligns closely with the cohort of the THA/TKA PRO-PM. Specifically, the definition of elective primary THA/TKA procedures is aligned across these measures. However, the THA/TKA readmission measure has some slight differences in measure cohort criteria (such as the requirement of Medicare enrollment 30 days following the admission). The THA/TKA PRO-PM has additional measure exclusion criteria: staged procedures and patients who die prior to the postoperative collection timeframe.

Please refer to the measure methodology reports available on QualityNet for complete details on the cohort inclusion/exclusion criteria for each measure:

THA/TKA PRO-PM: (https://qualitynet.cms.gov) > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Methodology.

THA/TKA readmission measure:
(https://qualitynet.cms.gov) > Hospitals – Inpatient >
Measures > Readmission Measures > Methodology

Hospital IQR Program – Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Primary Elective THA and/or TKA

Question 17: **Where can we find the additional comorbidity codes for the THA/TKA exclusion?**

The additional International Classification of Diseases (ICD)-10 codes are below.

ICD-10 Code	Description
M96.65	Fracture of pelvis following insertion of orthopedic implant, joint prosthesis, or bone plate
M96.661	Fracture of femur following insertion of orthopedic implant, joint prosthesis, or bone plate, right leg
M96.662	Fracture of femur following insertion of orthopedic implant, joint prosthesis, or bone plate, left leg
M96.669	Fracture of femur following insertion of orthopedic implant, joint prosthesis, or bone plate, unspecified leg
M96.671	Fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, right leg
M96.672	Fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, left leg
M96.679	Fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, unspecified leg
M97.01XA	Periprosthetic fracture around internal prosthetic right hip joint, initial encounter
M97.01XD	Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter
M97.01XS	Periprosthetic fracture around internal prosthetic right hip joint, sequela

M97.02XA	Periprosthetic fracture around internal prosthetic left hip joint, initial encounter
M97.02XD	Periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter
M97.02XS	Periprosthetic fracture around internal prosthetic left hip joint, sequela
M97.11XA	Periprosthetic fracture around internal prosthetic right knee joint, initial encounter
M97.11XD	Periprosthetic fracture around internal prosthetic right knee joint, subsequent encounter
M97.11XS	Periprosthetic fracture around internal prosthetic right knee joint, sequela
M97.12XA	Periprosthetic fracture around internal prosthetic left knee joint, initial encounter
M97.12XD	Periprosthetic fracture around internal prosthetic left knee joint, subsequent encounter
M97.12XS	Periprosthetic fracture around internal prosthetic left knee joint, sequela
M97.8XXA	Periprosthetic fracture around other internal prosthetic joint, initial encounter
M97.8XXD	Periprosthetic fracture around other internal prosthetic joint, subsequent encounter
M97.8XXS	Periprosthetic fracture around other internal prosthetic joint, sequela
M97.9XXA	Periprosthetic fracture around unspecified internal prosthetic joint, initial encounter
M97.9XXD	Periprosthetic fracture around unspecified internal prosthetic joint, subsequent encounter

M97.9XXS	Periprosthetic fracture around unspecified internal prosthetic joint, sequela
M96.69	Fracture of other bone following insertion of orthopedic implant, joint prosthesis, or bone plate

Question 18: **Can hospitals face penalties in the Hospital IQR and Hospital VBP Programs for this measure?**

The updated version of the THA/TKA Complication measure was finalized for the Hospital IQR Program only. The statutory requirements of the Hospital VBP Program, as set forth in section 1886(o) of the Social Security Act and at 42 CFR 412.164(b), state that measures must be publicly reported for one year prior to the beginning of the performance period in the Hospital VBP Program. Therefore, we proposed to adopt this updated version of the THA/ TKA Complication measure into the Hospital IQR Program with the intention to consider proposing the updated measure for use in the Hospital VBP Program in the future.

Medicare Promoting Interoperability Program

Question 19: **For the Promoting Interoperability Program, is there a penalty for attesting "No" to the use of Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) guides for the 2024 reporting year?**

Currently, the SAFER Guides measure, required by section 106(b)(2)(B) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is required, but will not be scored. Either a "yes" or a "no" fulfills the measure. Any future changes to the scoring of this measure would be considered through rulemaking.

Hospital Value-Based Purchasing (VBP) Program

Question 20: **Slide 63. Regarding COVID-19, when CMS states that normal scoring returns for FY 2024, is that CY 2022 data?**

The table of baseline and performance periods for FY 2024 is below.

Domain	Baseline Period	Performance Period
Clinical Outcomes MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, MORT-30-PN	July 1, 2014–June 30, 2017	July 1, 2019–June 30, 2022
COMP-HIP-KNEE	April 1, 2014–March 31, 2017	April 1, 2019–March 31, 2022
Person and Community Engagement	January 1–December 31, 2019	January 1–December 31, 2022
Safety	January 1–December 31, 2019	January 1–December 31, 2022
Efficiency and Cost Reduction	January 1–December 31, 2019	January 1–December 31, 2022

Hospital-Acquired Condition (HAC) Reduction Program

Question 21: **Slide 76. Is there any plan to look at suppressing CY 2022 data due to the ongoing impact of COVID-19?**

Beginning in the FY 2024 HAC Reduction Program, CMS will risk adjust the CMS Patient Safety Indicator (PSI) 90 measure for COVID-19 diagnosis to account for the ongoing impact of the public health emergency. The CMS PSI 90 measure's performance period for the FY 2024 program year will be January 1, 2021–June 30, 2022.

Under current data collection processes for the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures, CMS is not able to risk-adjust for or otherwise account for COVID-19 diagnoses. Therefore, CMS must suppress the CY 2021 data to account for COVID-19 diagnoses in the CDC NHSN HAI data (87 FR 49131). CMS intends to resume normal scoring for FY 2024 given the widespread availability of vaccines in CY 2022 as well as advances in the treatment of COVID-19. CMS is closely monitoring the dynamic situation of the public health emergency and will communicate further guidance as soon as it is available. Additional guidance would be

announced via the http://cms.gov website and communicated through the QualityNet Listservs.

If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking on Join Now.

Question 22: **Slide 79. When will hospitals without applicable wards need to start submitting the Inpatient Prospective Payment System (IPPS) Measure Exception Form?**

Hospitals must submit an IPPS Measure Exception Form annually to receive an exemption from HAI reporting requirements for the calendar year. Hospitals must submit the form no later than the NHSN submission deadline for quarter (Q)4 of the calendar year for which they are requesting a reporting exemption.

Because hospitals submit data to NHSN throughout the year, hospitals can submit their forms any time, but they must submit, at the latest, by the Q4 submission deadline. Hospitals should verify their eligibility for an exemption from HAI reporting requirements each year before the Q1 NHSN submission deadline. The recommended and final submission deadlines for the form for each calendar year included in the FY 2024 and 2025 HAC Reduction Programs are below.

Calendar Year	FY Program Year	Recommended Deadline (Q1 Submission Deadline)	Final Deadline (Q4 Submission Deadline)
2023	2025	August 15, 2023	May 15, 2024
2022	2024 and 2025	August 15, 2022	May 15, 2023
2021	2023 and 2024	August 16, 2021	May 16, 2022

Question 23: **Will the hospital-acquired infection (HAI) validation component, for the HAC Reduction Program, also be excluded for FY 2024?**

CMS will use data from CY 2021 to validate HAI measure data for the FY 2024 HAC Reduction Program. As stated in the FY 2023 IPPS/LTCH Prospective Payment System (PPS) final rule, although CMS is excluding

CY 2021 HAI measure data from scoring calculations for the FY 2024 HAC Reduction Program, hospitals are still required to submit such data and such data will be used for validation purposes.

If hospitals do not submit measure data for validation during the FY 2024 program year, then those hospitals will automatically receive the maximum Winsorized *z*-score for the measure in the FY 2024 program year (87 FR 49137).

Question 24: **When will the PSI 90 results be available to hospitals?**

CMS will continue to collect, calculate, and confidentially report hospital CMS PSI 90 results via measure specific reports and publicly report those results to provide transparency on important patient safety metrics during the public health emergency. Measure specific reports will be delivered in Fall 2022 and the results will be publicly reported in early 2023. CMS will announce the specific dates of the measure-specific report delivery and public reporting via the QualityNet Listservs. If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking on Join Now.

Hospital Readmissions Reduction Program (HRRP)

Question 25: **How will you "re-baseline" and set benchmark/thresholds for the pneumonia readmission measure for FY 2024 when there is not enough historical data to do so?**

HRRP does not involve benchmarks or a baseline period for any of the readmission measures included in the program. Instead, hospitals are sorted into peer groups based on their proportions of patients who are dually eligible for Medicare and full Medicaid benefits. We then determine the peer group median excess readmission ratio (ERR) of each measure and peer group. The peer group median ERR is the threshold used to assess excess readmissions relative to other hospitals within the same peer group. The peer group median ERR is calculated with data from the same time period as the HRRP performance period. The FY 2024 HRRP performance period is July 1, 2019, to December 1, 2019, and July 1, 2020, to June 30, 2022.

Question 26: **Slide 85. What CY period is FY 2024 referring to?**

The performance period for the FY 2024 program will be July 1, 2019, to December 1, 2019, and July 1, 2020, to June 30, 2022. The FY 2024

payment reductions will be applied to all Medicare fee-for-service base operating diagnosis-related group payments from October 1, 2023, to September 30, 2023.

Typically, HRRP uses a three-year rolling data period. However, due to the nationwide Extraordinary Circumstance Exception (ECE), claims data representing Q1 and Q2 2020 (reflecting services provided January 1, 2020, through June 30, 2020) are excluded from the HRRP calculations (86 FR 45260-45261). The readmission measures used in HRRP identify readmissions within 30 days of each index stay; therefore, the performance period for HRRP will also not use claims data representing the 30 days before January 1, 2020.

Question 27: **COVID-19 was statistically significant on THA/TKA readmissions. The denominator is reduced due to elective surgery changes that continued AFTER June 30, 2020, and the move to outpatient care. This means data MUST be recalculated for the benchmark and threshold. CMS committed to re-evaluating data out of tolerance, but that did not seem to occur for THA/TKA readmissions. What is the plan to correct that? Will CMS exclude the data from penalty for FY 2023?**

We continue to closely monitor changes in care and quality measures to determine the suitability of measures included in HRRP. Our analyses found that the distribution of THA/TKA results for the FY 2023 program year was similar to FY 2022.

Additionally, hospitals that perform fewer elective total hip and knee cases due to the shift to the outpatient setting may no longer meet the 25-case threshold required for the measure to be eligible to contribute to the payment reduction. Therefore, the THA/TKA readmission measure will NOT be suppressed from FY 2023 HRRP payment reduction calculations.

We continue to monitor the volume of index admissions for the conditions and procedures included in HRRP to make sure that the measures remain appropriate. We make changes to the program requirements, such as the set of included readmission measures, through rulemaking. We publish these changes annually with the IPPS/LTCH PPS final rule following a public comment period.

Question 28: **Will the covariate adjustment for patient history of COVID-19 in the 12 months prior to the admission continue in FY 2024 and FY 2025?**

To clarify, the history of COVID-19 covariate includes both a patient history of COVID-19 in claims in the12 months prior to the index admission and the code Z86.16 (personal history of COVID-19) at the

index admission. We finalized the use of the covariate for FY 2024; and this will likely continue in future program years. We will continue to monitor the relationship between the history of COVID-19 and the measure outcome, in addition to evaluating additional COVID-19-related codes. Adding a covariate to adjust for history of a COVID-19 diagnosis in the 12 months prior to an admission will ensure that readmission measures continue to account for readmissions as intended and meet the goals of incentivizing patient safety and better care coordination of the HRRP.