Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2023 IPPS/LTCH PPS Final 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 Final 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, 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 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. We will not be having a live question-and-answer session at the conclusion of today's event; however, you are still able to submit your questions into the Ask a Question section, and those questions will be responded to and posted at a later date.

Our speakers for today's event are Julia Venanzi, program lead for the Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs; Jessica Warren, program lead for the Medicare Promoting Interoperability Program; and Sophia Chan, program lead for the Hospital Readmissions Reduction Program and interim lead for the Hospital-Acquired Condition Reduction Program. All are with the Centers for Medicare & Medicaid Services. Additionally, 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 Final 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 the finalized proposed program changes.

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 Request For Information and to provide the overview of the IQR finalized changes. Julia, the floor is yours.

Julia Venanzi: Thank you, Candace. I'm going to start today by mentioning the Requests For Information that were included in the Fiscal Year 2023 IPPS Proposed Rule.

We sought comment on three different topics. First, 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, CMS, can support them in doing so.

Second, we sought comment on the potential future use of measure reports that are stratified by certain social risk factors as a way to provide hospitals with actionable and comprehensive data

Third, we sought comment on our refined definition of digital quality measures. We sought feedback on specific implementation guides that we are considering, as well as data flow options to support the FHIR-based eCQM reporting.

We received stakeholder comments on these three cross-program RFIs. We have summarized comments that we received in the final rule, and we will take these comments into consideration for future potential rulemaking.

I will move now to the newly finalized Hospital Inpatient Quality Reporting Program policies.

To start, first a quick summary of our hospital IQR finalized policies related to measures, we finalized the adoption of 10 new measures and the refinement of two existing measures. We also established a publicly reported hospital designation that reflects quality and safety of maternity care. We also finalized a number of submission requirements that are associated with the new measures that we are adopting.

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

Starting first with Measure 1, the Hospital Commitment to Health Equity structural measure, we finalized the adoption of 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 Request For Information, 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 finalized this measure which assesses hospital leadership commitment to collecting and monitoring health equity performance data. This is an adaptation measure that will ask hospitals a set of yes or no questions regarding their commitment to health equity, specifically if they have a strategic plan, if they collect and analyze data, if they participate in a quality improvement activity, and if hospital leadership is engaged in these activities. Hospitals will respond yes or no to these questions, again beginning in calendar year 2023.

The second and third measures are two related measures that focus on identifying health-related social needs. The first measure, the Screening for Social Drivers of Health measure, CMS previously defined health-related social needs as individual-level adverse social conditions that negatively impact a person's health or healthcare and that are significant risk factors associated with worse health outcomes, as well as increased healthcare utilization. We believe that consistently pursuing the 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 address disparities, improve health equity through addressing the social needs with community partners, and implement associated equity measures that track progress.

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 finalized 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 five health-related social needs, including food insecurity, housing and stability, transportation needs, utility difficulties, and interpersonal safety. We are adopting this measure, beginning with a voluntary reporting period that begins in calendar year 2023, followed by a mandatory reporting period in calendar year 2024, which impacts the fiscal year 2026 payment.

Next is 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, 18 years or older on the date of admission who are screened for a health-related social need and who screen positive for one 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 have been screened for all five health-related social needs.

Again, this measure is finalized for adoption with a voluntary period in calendar year 2023, followed by a mandatory reporting period in calendar year 2024.

Moving now onto Measures 4 and 5, 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-sections 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 finalized the inclusion of this measure in 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 on this eCQM as one of their eCQMs to meet the eCQM reporting requirement.

Next, we have the Severe Obstetric Complications eCQM. As stated in HHS's 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 finalized the Severe Obstetric Complications eCQM. This eCQM assesses the proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization that were not present on admission. The full list of obstetric complications is included in the rule text, as well as in the measure specifications that are posted on the eCQI Resource Center. Generally speaking, 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.

This measure will be added to the list 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 requirement.

Moving now to our sixth newly finalized measure, another eCQM, 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 who have been administered opioids during hospitalization and to avoid harm, such as respiratory depression which can 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 ED.

The eCQM assesses the proportion of inpatient hospital encounters where patients aged 18 or older have been administered an opioid medication who then subsequently suffer the harm of an opioid-related adverse event and then are administered an opioid antagonist, such as Naloxone within 12 hours. We are adding this measure to the list from which hospitals can self-select as one of their eCQMs, 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 and older who are admitted to an inpatient hospital service who receive care appropriate to their level of malnutrition risk and malnutrition diagnosis, if properly identified. This eCQM 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, then appropriate documentation of a malnutrition diagnosis in the patient's medical record if indicated by the assessment findings, and lastly the development of a nutrition care plan for malnourished patients including the recommended treatment plan.

We are adding this measure to the list of measures from which hospitals can self-select, beginning in calendar year 2024.

Our eighth measure is the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty or Total Knee Arthroplasty, and we are abbreviating this measure to be called the THA/TKA PRO-PM. Elective Total Hip Arthroplasty, or THA, and Total Knee Arthroplasty, TKA, are most commonly performed for degenerative joint disease or osteoarthritis which affects more than 30 million Americans. THA and TKA offer significant improvements 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 know that their pre-operative expectations for functional improvement have not been met. In addition, clinical practice variation has been well documented in the U. S., including varied readmission and complication rates. This measure uses four different sources of data, the first of which is Patient-Reported Outcome data, which are collected both before and after surgery, claims data, Medicare enrollment and beneficiary data, as well as U. S census data.

The denominator of this measure is Medicare Fee for Service beneficiaries who are age 65 and older who undergo elective primary THA or TKA procedures as inpatients in an acute care hospital. Claims data are then used to identify eligible elective primary THA/TKA procedures for the measure cohort to which Patient-Reported Outcome data can then be matched. The numerator is the risk-standardized proportion of patients 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.

We adopted this measure with 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. During the two voluntary periods, we will share confidential reporting. Then, beginning with the mandatory period, we will also publicly report this data.

I will move now to our last two newly finalized measures. These two finalized measures are slightly different from the previous eight that I just went over. Versions of these two measures are currently in use in the Hospital Value-Based Purchasing Program and were previously adopted and then removed from the Hospital Inpatient Quality Reporting Program. We had to propose to adopt updated versions of these two measures back into the Hospital IQR Program because by statute we are required to adopt and publicly report measures for at least one year in the Hospital IQR Program before being able to then propose to adopt them in the Hospital Value-Based Purchasing Program. So, our intent here is to eventually propose that these updated versions are adopted into the Hospital Value-Based Purchasing Program to replace the existing versions of these two measures. 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, starting first with the Medicare Spending per Beneficiary Measure, this updated measure includes three changes to the previous version. The first of which is allowing readmissions to trigger new episodes. The second is adding a new indicator variable into the risk-adjustment model. Lastly is updating the Medicare spending beneficiary amount calculation methodology.

For the second updated measure, the Risk-Standardized Complication Rate Following Elective Total Hip Arthroplasty or Total Knee Arthroplasty, this updated measure includes one change to the previously finalized measure which is to expand the measure outcome to include 26 additional mechanical complication ICD-10 codes.

That covers the newly adopted measures for the Hospital IQR Program. I will move next to two refinements made to measures that are currently in use in the Hospital IQR Program, the first of which is the Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective THA or TKA.

The refinement that we made to this measure is the same refinement that we made to the Risk-Standardized Complication Rate for THA, which I just mentioned, which is to add those additional 26 ICD-10 mechanical complications codes. The second refinement is a change to the Excess Days in Acute Care, or EDAC, after Hospitalization for Acute Myocardial Infarction measure, also known as the EDAC AMI measure. The refinement here is to increase the minimum case count from 25 cases to 50 cases. This refinement comes as a result of a recommendation from the National Quality Forum scientific methods panel.

That concludes all the measure-related requirement changes that we made in the rule this year. I'll move now to our finalized proposal that establishes a hospital designation related to maternal health that would be posted on a public-facing CMS website to assist consumers in choosing hospitals that have demonstrated a commitment to maternal health.

Initially, the designation will be awarded to hospitals based on their attestation to the Hospital Inpatient Quality Reporting Program's Maternal Morbidity Structural Measure, which was finalized in the Fiscal Year 2022 IPPS Final Rule last year. Data collection on that measure began in October 2021 and was [inaudible] for the first time in May 2022.

We did seek comment on additional requirements that we could potentially include in the designation in the future and included summaries of comments that we received in the final rule.

The next finalized change we made is to the eCQM reporting requirement. As previously finalized, the requirement for calendar year 2024 was to report on four quarters of data for three self-selected eCQMs and the Safe Use of Opioids eCQM. This year, we finalized the change that expanded that requirement to require reporting on four quarters of data on six total eCQMs with three of them being self-selected from the list of available eCQMs and then three required eCQMs: the Safe Use of Opioids eCQM, the new c-section eCQM, and the new severe obstetric complications eCQM.

This slide is just a summary of the eCQMs that are available to self-select. Then, it also includes mandatory eCQMs for a given calendar year.

We also modified the hybrid measure reporting requirement. Previously, we finalized a policy that required hospitals that have 0 eligible cases for a given eCQM to report a 0 denominator exclusion. We initially included hybrid measures in this policy in order to stay aligned with eCQMs, but we have since determined that CMS will be able to identify which hospitals have 0 cases using claims data for hybrid measures. So, there is no need for hospitals to additionally submit the 0 denominator exclusion.

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 quality measures which could potentially be proposed to replace some of the existing hospital-acquired condition measures that are currently used in the Hospital VBP and Hospital-Acquired Conditions Reduction programs. I will now pass things off to Alex Feilmeier to talk about our hospital IQR-related validation proposals.

Alex Feilmeier: Thanks, Julia. I'm Alex Feilmeier, program manager of the Value, Incentives, and Quality Reporting Center validation support contractor. I only have one topic to present, and that is the finalization of the proposal to modify eCQM validation medical record submission requirements.

Back 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 has finalized a change to that data submission threshold by increasing the requirement 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. Under CMS current policy, the accuracy of eCQM data submitted for validation does not affect the hospital's validation score and would not be impacted by this finalized update to the submission threshold.

This slide shows a more visual representation of the previously finalized eCQM validation record submission requirement versus the new finalized change to the eCQM validation requirement. As you can see at the top of the table, you'll notice the hospitals selected for inpatient data validation efforts at this time are required to achieve at least a 75 validation score weighted at 100 percent for the chart-abstracted measures and successfully submit at least 75 percent of requested eCQM medical records. Under this new CMS finalized policy, the chart-abstracted portion of the validation requirement remains the same, but for eCQM validation requirement, it is finalized 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 finalizations this year. Thank you.

Jessica Warren: Thank you, Alex. My name is Jessica Warren, and I'm with the Medicare Promoting Interoperability Program for eligible hospitals and CAHs. I'll be presenting an overview of our finalized policies from the Fiscal Year 2023 IPPS Final Rule.

Beginning with the calendar year 2023 EHR reporting period, we finalized requiring the Query of Prescription Drug Monitoring Program measure. This measure will be worth 10 points, and we did modify our original proposal by adopting three exclusions versus the two exclusions that we proposed. We also expanded the measure to include not only Schedule 2 opioids but Schedule 3 and 4 drugs, as well. In the final rule, you will see that we included a table of drugs that could be included in each of these categories for your reference.

Under the Health Information Exchange objective, we finalized the addition of a third measure called the Enabling Exchange under the Trusted Exchange Framework and Common Agreement, TEFCA, measure. Eligible hospitals and CAHs may now choose between the sending and receiving measure, the bi-directional exchange measure, and now the Enabling Exchange under TEFCA measure to fulfill the objective. For the Public Health and Clinical Data Exchange Objective, we consolidated the existing three levels of active engagement into two.

The former Options 1 and 2 have been combined and renamed to the current Finalized Option 1: Pre-production and Validation. The former Option 3 is now called Finalized Option 2: Testing and Validation.

Under the Public Health and Clinical Data Exchange Objective, we have included a new measure, and that is called the Antimicrobial Use and Antimicrobial Resistance Surveillance measure. This was modified from our proposed rule to now begin with the 2024 EHR reporting period.

We have finalized modifications to our scoring methodology. We have a reduction in the points associated with the Health Information Exchange Objective measures, and that would go from 40 points to 30 points. We finalized an increase in the points allocated to the Public Health and Clinical Data Exchange Objective. That would go from 10 points to 25 points. We finalized a reduction in the points associated with the Provide Patients Electronic Access to Their Health Information measure, and that would go from 40 points to 25 points

Here, we have our PI objectives and measures table, which you will also find in our final rule. This highlights changes to both the point distribution that we just discussed, along with a full list of our finalized objectives and measures that you can see right here in one place.

Now, as Julia discussed earlier in the presentation, the Medicare Promoting Interoperability Program is aligning with the Hospital IQR Program with the adoption of two new eCQMs. These are the Cesarean Birth and Severe Obstetric Complications eCQM and the Hospital-Harm–Opioid-Related Adverse Events and GMCs eCQMs.

Finally, here are references to highlight. First is a link to the Promoting Interoperability Program page for all program requirements, and it also has links to the final rule. Second is a link to ONC’s 21st Century Cures Act final rule. This is the end of the presentation for the Promoting Interoperability Program. I will now turn it over to Julia Venanzi. She will speak to the Hospital VBP Program. Thank you. Julia?

Julia Venanzi: Thank you, Jessica. I will now talk through the newly finalized policies for the Hospital Value-Based Purchasing Program for this year.

To first summarize the newly finalized policies at a high level, there were no new measures added or removed from the program this year. We did finalize a policy to suppress the HCAHPS and hospital-acquired infection measures from fiscal year 2023 scoring calculations as a result of the impact of COVID-19. As a result of suppressing these measures, we are also finalizing a revision to the scoring methodology for fiscal year 2023 to not calculate Total Performance Scores and, as a result of that, awarding all hospitals with a net neutral payment adjustment. We also included some technical updates for measures that we are not suppressing to add COVID-19 related risk adjustments. Lastly, we are proposing fiscal year 2025 baseline updates on certain measures as required by statutes.

So, starting first with the COVID-19related measure suppression policies, I will first quickly summarize some of the flexibilities that we finalized last year in the Fiscal Year 2022 IPPS Final Rule related to COVID-19. The COVID-19 Public Health Emergency had and continues to have a significant impact on healthcare systems and hospitals that affect care decisions, including the clinical topics covered by the Hospital VBP Program. Additionally, COVID-19 has had different impacts on different regions at different points of time over the past two years.

As a result of this, CMS proposed and finalized a measure suppression policy in the fiscal year 2022 final rule that allows us to suppress Hospital Value-Based Purchasing Program measures from the scoring calculation in order to not financially penalize hospitals for impact of changing conditions that are beyond participating hospitals' 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 to continue to publicly report this data during this time. As a result of this, for fiscal year 2022, we finalized that we would suppress a number of measures from scoring, and as a result, not award Total Performance Scores.

Since we did not award Total Performance Scores, we also finalized that we would award each hospital with a net neutral payment adjustment, meaning that every single hospital would receive back an adjustment that is equal to the 2-percent operating base DRG reduction that each hospital is subject to under the Hospital VBP Program.

So, for fiscal year 2023, we carefully analyze each measure to first see if it would be possible for us to risk adjust or otherwise update the measure so that they would be able to be used for fiscal year 2023 scoring calculations or if suppression would be needed again in fiscal year 2023. As a result of those analyses, we are finalizing the suppression of six measures from the Total Performance Score calculation: the HCAHPS measure as well as the five hospital-acquired infection measures: CAUTI, CLABSI, MRSA, SSI, and CDI. We will still calculate measure rates for all 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. As a result of this, we will not calculate a Total Performance Score for fiscal year 2023. Again, as a result of not awarding Total Performance Scores, we will also not be awarding incentive payments or assigning penalty payments. All hospitals will again receive a net neutral payment adjustment.

We would still continue to provide confidential feedback reports to hospitals like we normally do. These reports will be delivered prior to the end of 2022. In addition to confidential reporting similar to last year, we would again continue to publicly report on all measures for fiscal year 2023. I did 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, that we do intend to return to normal scoring in fiscal year 2024.

That covers our measure suppression-related finalized policies. For remaining measures in the fiscal year 2023 and fiscal year 2024 program, we made some technical updates associated with COVID-19. For all measures in the Clinical domain for fiscal year 2023, with the exception of the pneumonia mortality measures, we are including a covariate in our

existing risk adjustment model to account for patient history of COVID-19in the past 12 months. The reason the pneumonia mortality measure is not included is because we finalize suppression of that measure for the fiscal year 2023 program year in the last year's rule, in the fiscal year 2022 IPPS rule. We also are including that same covariate to be added to the pneumonia mortality measure in fiscal year 2024, when it is no longer suppressed.

Our last COVID-29 related change was to make changes to the baseline periods for the hospital-acquired infection measures and the HCAHPS measures since we are suppressing those measures for the fiscal year 2023 program year.

This slide summarizes the measures by domain for fiscal year 2023 and subsequent years. As mentioned earlier, we did not finalize adding any new measures or removing any existing measures at this time.

I won't spend a ton of time on the next few slides, but we've included the baseline and performance periods for fiscal year 2024 through fiscal year 2028 for future reference. I will now pass things off to Sophia Chan to talk about the Hospital-Acquired Condition Reduction Program.

Sophia Chan: So, this section of the presentation focuses on the final policies for the Hospital-Acquired Condition Readmission [Reduction] Program in the Fiscal Year 2023 IPPS/LTCH PPS Final Rule.

In the final rule, CMS finalized the following updates to the measure suppression policy. CMS will pause the use of all measures in the program for fiscal year 2023 program year due to the continued impact of the COVID-19 Public Health Emergency on quality measurement, and CMS will suppress calendar year 2021 HAI data for fiscal year 2024. CMS also updated the new hospital definition for HAI measures and clarified the removal of the No Mapped Locations policy. CMS also made two technical measure 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.

In response to the COVID-19 Public Health Emergency's continued impact on hospital performance and concerns about the national comparability of these data, CMS finalized the proposal to update the measure suppression policy that was previously finalized in the Fiscal Year 2022 IPPS/LTCH PPS Final Rule to pause the use of all program measures for fiscal year 2023 from scoring and payment calculations. Through this finalized proposal, CMS would not calculate measure scores or a Total HAC Score for any hospital. No hospital will be in the worst performing quartile or subject to the 1-percent payment penalty.

In response to public comments, CMS did not finalize the proposal to not calculate the CMS PSI 90 measure for fiscal year 2023. CMS is not including CMS PSI 90 in fiscal year 2023 HAC Reduction Program HSRs. However, CMS would still be collecting calculating and confidentially reporting hospital CMS PSI 90 results via Hospital-Specific Reports and publicly reporting those measures in a Care Compare website.

CMS finalized the proposal to update the fiscal year 2023 measure suppression policy to suppress calendar year 2021 HAI data from fiscal year 2024 program calculations. As mentioned on a previous slide, this proposal is based on CMS concern over COVID-19's continued impact on measure 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 or otherwise account for COVID-19 diagnosis. Therefore, CMS will suppress the calendar year 2021 data from program calculations. Under this finalized proposal, the fiscal year 2024 HAI performance period will effectively be shortened to one year, specifically from January 1, 2022, through December 31, 2022.

So, as finalized in the Fiscal Year 2022 IPPS/LTCH PPS Final Rule, CMS is excluding all HAI and claims data for stays that occurred in calendar year 2020 from all program calculations.

In addition, the finalized proposal outlined on the previous slide had 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 results will not be included in HAC Reduction Program Hospital-Specific Reports. Calendar year 2021 data for HAI measures will also be excluded from scoring calculations in future program years. These data exclusion results in the revised performance periods display in the graphic on the slide. The fiscal year 2023 program year will rely on a performance period of January 1, 2021, through December 31, 2021, for the HAI measures. As mentioned previously, for fiscal year 2023 CMS will provide HAI measure results to hospitals for monitoring purposes only. CMS is not including the CMS PSI 90 composite measure in the HAC Reduction Program Hospital-Specific Report; however, CMS will still be collecting calculating and confidentially reporting CMS PSI 90 results via measure-specific Hospital-Specific Reports and publicly reporting those results on the Care Compare website. CMS will not calculate a total HAC score for any hospital and no hospitals will be subject to the 1-percent payment reduction. For the fiscal year 2024, the CMS PSI 90 performance period will be from January 1, 2021, through June 30, 2022. The HAI measures performance period will be from January 1, 2022, through December 31, 2022. To account for the impact of the COVID-19 Public Health Emergency on the CMS PSI 90 measure, we are updating the measure specifications to risk adjust for COVID-19 diagnoses beginning with the fiscal year 2024 program year, and we will resume the use of the PSI 90 measure at that time.

CMS finalized the proposal to update the definition of “newly-opened hospitals” for the HAI measures. Under this finalized proposal, the new hospital definition will be revised to “a hospital with a Medicare accept date within the last 12 months of the HAI measures performance period.” Hospitals categorized as new do not receive HAI measure scores. The “newly opened hospital” definition for HAI measures was initially based on the date that a hospital filed a Notice of Participation, or NOP, with the Hospital IQR Program.

Given the HAI measures transition from the Hospital IQR Program to the HAC Reduction Program starting in calendar year 2020, CMS finalized policy to change the HAI "newly-opened hospital" definition to align the definition with that of the CMS PSI 90 measure.

CMS also clarified the removal of the No Mapped Locations policy. Previously, if hospitals did not map applicable wards for the CLABSI and CAUTI measures, that is intensive care units, surgical, medical, and medical surgical wards, CMS would apply a No Mapped Locations definition. However, the CDC indicated that not mapping wards is not an appropriate data submission practice. So, going forward, hospitals that do not have the applicable wards will be expected to submit an IPPS Measure Exception Form to receive an exemption from CMS reporting requirements.

CMS finalized two technical updates to the CMS PSI 90 measure. The first technical update is to increase the minimum volume threshold for hospitals to receive a CMS PSI 90 composite score. Starting in fiscal year 2023, in order to be scored on the CMS PSI 90 measure, hospitals will need to have 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 each. This change in the minimum volume threshold will improve the overall measure reliability of the CMS PSI 90 measure. The second technical update, as mentioned in previous slides, is to include a COVID-19 diagnosis as a risk adjustment parameter in the CMS PSI 90 software. Starting in 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.

More information about the HAC Reduction Program can be found on the CMS.gov and QualityNet website. You can submit questions about the HAC Reduction Program via the QualityNet Question and Answer Tool which can be found via the QualityNet website.

This section of the presentation focuses on the final policies for the Hospital Readmissions Reduction Program, or HRRP, in the Fiscal Year 2023 IPPS/LTCH PPS Final Rule.

In the final rule, CMS made two technical measure specification updates to readmission measures. The first is an update to the specifications for all six readmission measures to include a history of COVID-19 covariate adjustment, beginning with the fiscal year 2023 program year. The second is an update to the specifications for the pneumonia readmission measure to exclude patients with the COVID-19 diagnosis, beginning with the fiscal year 2023 program year. So, CMS also finalized the policy to resume the use of a pneumonia readmission measure, beginning with the fiscal year 2024 program year. Finally, CMS responded to comments from a request for public comment on the possible future inclusion of health equity performance in the HRRP.

So, as we continue to evaluate the effects of the COVID-19 Public Health Emergency on our program and the effect 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 others potentially related to organ damage, post viral syndrome, post critical care syndrome, or other reasons. These clinical conditions may be associated with the patient's risk for being readmitted following an index admission for any of the six condition procedures in the HRRP. Therefore, we modified the technical measure specifications of each of our six condition measure-specific, risk-standardized readmission measures to risk adjust for patient history of COVID-19 in the 12 months prior to the admission, beginning with the fiscal year 2023 program year. In addition, we modified the technical measure specifications of the pneumonia readmission measure to exclude patients with COVID-19 diagnosis present on admission from the measure numerator and denominator. These updates are included in the results provided to hospitals in the Hospital-Specific Reports and public reporting for the fiscal year 2023 program year. This is consistent with the change for the exclusion of patients with the COVID-19 diagnosis present on admission that was made for out of the other five conditions or procedure-specific readmission measures in the Fiscal Year 2022 IPPS/LTCH PPS Final Rule.

Although the pneumonia remission measure is suppressed in HRRP program calculations for fiscal year 2003, these updates will be reflected in the confidential and public reporting of the pneumonia readmission measure for fiscal year 2023.

In the final rule, we finalized the proposal to resume the use of the pneumonia readmission measure in the HRRP, beginning with the fiscal year 2024 HRRP program year. We believe the resumption of the pneumonia remission 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, this is pneumonia due to coronavirus in 2019. In January 2021, the proportion of the pneumonia cohort with the COVID-19 diagnosis present admission, or POA, declined substantially. 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, our analysis for the Fiscal Year 2022 IPPS/ LTCH PPS Final Rule found that patients with a diagnosis of COVID-19 POA had lower observed readmission rates than patients without a diagnosis of COVID-19. That is 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 measures specifications in order to further account for how patients with the COVID-19 diagnosis might impact the quality of care assessed by this measure. Based on this analysis, we believe that the measure's focus, that is pneumonia readmission, is no longer clinically close to the health impacts of the COVID-19 Public Health Emergency. So, as a result, the second measure suppression factor, that is the 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 the results of the measure without these changes.

CMS is committed to promoting equity in healthcare outcomes for our beneficiaries by supporting providers quality improvement activities that aim to reduce health inequities by enabling patients from underserved and under-resourced communities to make informed decisions and by strengthening provider accountability for healthcare disparities. We are 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. So, we sought comments on the following: firstly, the benefit and potential risk, unintended consequences, and costs of incorporating hospital performance for beneficiaries with social risk factors in HRRP; secondly, the approach of linking performance in caring for socially at-risk populations and payment reductions by calculating the reduction based on readmission outcome for socially at-risk beneficiaries compared to other hospitals or compared to performance for other beneficiaries within the hospital; thirdly, variables associated with measures of social risk and beneficiary demographics that are already collected at a claims- or patient-level that can be added to the program along with geo-eligibility as factors for stratifying measure results. We thank everyone who submitted comments in response to this request for public comment. We appreciate all the comments and interest in this topic. The input we have received is very valuable in the continued development of CMS health equity efforts. We provided responses to comments in the final rule, and we will continue to take all concerns, comments, and suggestions into account for future development and expansion of our health equity efforts.

More information on HRRP can be found on CMS.gov and the QualityNet website. You can submit questions about the HRRP via the QualityNet

Question and Answer Tool, which can be found via the QualityNet website. I'm now handing it back to Candace.

Candace Jackson: Thank you, Sophia. We will now proceed by going over how to locate the programs within the final rule.

This slide lists the pages for each of the different programs and the link to the *Federal Register*.

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 mortality measures.

This slide goes over the safety measures.

The payment and efficiency measures are included on this slide.

Clinical process of care or the chart-abstracted measures are on this slide.

A portion of the electronical clinical quality measures is on this slide.

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 [Program] structural measures.

This slide lists the finalized Patient-Reported Outcome, or PRO, performance measure.

This slide lists the two finalized 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 Program.

Finally, this slide includes the patient experience of care survey measure.

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

For continuing education credit, please access the link on this slide. Thank you, and we hope you have a great day.