Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

FY 2026 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

Speakers

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Hospital Value-Based Purchasing (VBP) Program

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Donna Bullock: Hello. Welcome to today's event: *FY 2026 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs*.

My name is Donna Bullock, and I am with the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support team. I will be hosting today's event. Our speakers are Kim Rawlings for the CMS Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program; Jessica Warren for the CMS Medicare Promoting Interoperability Program; and Lang D. Le for the CMS Hospital-Acquired Condition Reduction Program and CMS Hospital Readmissions Reduction Program

This presentation will provide an overview of the fiscal year 2026 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System proposed rule for the Hospital IQR Program, Hospital VBP Program, HAC Reduction Program, Hospital Readmissions Reduction Program. and the Medicare Promoting Interoperability Program.

At the conclusion of the event, participants will be able to locate the proposed rule text, identify program specific proposals within the proposed rule, and understand the timeline and methods for submitting public comments to CMS regarding the proposed rule.

In compliance with the Administrative Procedures Act, we are not able to provide additional information, clarification, or guidance related to fiscal year 2026 IPPS/LTCH PPS proposed rule. We encourage stakeholders to submit comments or questions through the formal comment submission process as described later in this webinar,

This slide just includes acronyms and abbreviations that we may use in today's webinar.

So does this slide.

Now, I will turn the presentation over to Kim Rawlings. Kim, the floor is yours.

Kimberly Rawlings: Thank you for taking the time to listen to this webinar. My name is Kimberly Rawlings, and I'm the CMS lead for the Hospital IQR and Hospital VBP Programs. Today I'll be providing an overview of the proposals for both of these programs, along with a cross-cutting proposal and Request for Information, just to kind of help aid you in your understanding of the proposed rule and, you know, really just support your ability to provide us at CMS with some thoughtful comments for consideration as we write the final rule. So, let us get started with a few of the proposals that's span across the quality programs.

So, under our current Extraordinary Circumstances Exception, or ECE, policies, we have granted exceptions to exclude data from payment reduction calculations, and an exception could be granted for any extraordinary circumstance, including, but not limited to, natural disasters or systemic problems with the CMS data collection systems. You know, something directly affects the ability of the facility to submit data. So, this year, CMS proposes to update and really codify that ECE policy to clarify that we at CMS have the discretion to grant an extension rather than only a full exception in response to ECE requests. So, a hospital may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred instead of 90 days. So, this update and clarification is proposed for Hospital IQR, Hospital Readmissions Reduction, PCHQR, HAC Reduction, and Hospital VBP Programs.

Additionally, we have a Request for Information, or an RFI, that crosses several programs as well. CMS has previously issued RFIs on CMS's modernization of our digital quality measurement enterprise as part of our intention to transition to a fully digital landscape. In this proposal, we provide an update on our progress, as well as a request to gather further comment on continuing advancements in digital quality measurement and our use of Health Level 7, or HL 7, Fast Healthcare Interoperability [Resources],or FHIR standards. So, in the RFI, we outline a dozen or so specific questions on the approach to eCQM reporting using FHIR across multiple CMS quality programs.

These questions get into specifics around eCQM FHIR conversation activities, data standardization for quality measurement and reporting, timeline under consideration for FHIR-based eCQM reporting, as well as measure development and reporting tools. This is along with a specific request to comment on the approach to FHIR patient assessment reporting in the IPFQR Program. So, we're really looking forward to your comments on the cross-cutting ECE proposal, policy proposal, as well as the Request for Information around CMS's continued transition toward digital quality measurement.

Now, transitioning to review some of the program-specific proposals, I would like to start with the Hospital Inpatient Quality Reporting, or Hospital IQR Program. As a reminder, the Hospital IQR Program is a pay-for-reporting quality program that reduces payments to hospitals that do not meet program requirements. This means performance is not a factor, only that the hospital has reported the data. So, hospitals that do not submit quality data or do not meet all of the Hospital IQR Program requirements are subject to a 1/4 reduction in their annual payment update.

So, for Hospital IQR [Program] in this proposed rule, CMS requests comments and feedback on new measure concepts related to well-being and nutrition, along with comments on the following proposed changes: refinement to four current measures, removal of four measures, some technical updates related to the removal of COVID-19 as an exclusion criteria, and then updates and a proposal to the ECE policy I just covered.

So, we are seeking input on well-being and nutrition measures for future years in the Hospital IQR Program, and we intend to use this input to inform our future measure development efforts. Just to take a quick step back, well-being is a comprehensive approach to disease prevention and health promotion as it really integrates mental and physical health while also emphasizing preventive care to proactively address some potential health issues. So, this comprehensive approach really emphasizes person-centered care by promoting the well-being of patients and family members.

We're seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life. That could include aspects of emotional well-being, social connections, purpose fulfillment, etc. So, we'd like to receive input and comments on the applicability of these tools and different constructs that assess for integration of complementary and integrative health, skill building, and self-care that would be appropriate for the Hospital IQR Program. In addition, we're also seeking similar feedback on tools and measures assessing optimal nutrition. Previously we've adopted the malnutrition care score to the Hospital IQR Program. That assesses adults 65 and older, admitted to inpatient hospital services who received care appropriate to their level of malnutrition risk and malnutrition diagnosis. That was finalized in the FY [20]23 IPPS/LTCH PPS final rule. Then we expanded that population to be 18 years and older in a subsequent year. We're continuing to seek comments and feedback on additional tools and measures that assess optimal nutrition as well as the preventive care in the Hospital IQR Program.

Next up we have proposed refinements to four measures currently in our program. These refinements, some of them would begin in FY [20]27 which would be for the Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization, as well as the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty. Then the proposed refinements for the Hybrid Hospital-Wide Readmission and Hybrid Hospital-Wide Mortality measures would begin for fiscal year 2028 payment determination.

So, to dig into these proposals a little bit further, the proposal to modify the Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization would add Medicare Advantage patients to the current cohort of patients, shorten the performance period from three years to two years, as well as make changes to the risk adjustment methodology. So with these proposed changes, the period of performance will be changing.

The reporting period would change from July 1, 2022, through June 30, 2025, to be updated to July 1, 2023, through June 30, 2025. So, again, these proposed refinements would begin with fiscal year [20]27 payment determination.

The proposal to modify the Hospital-level RSCR following elective primary THA and/or TKA would align with the modifications I just mentioned by adding Medicare Advantage patients, shortening the performance period, and making changes to the risk adjustment methodology. Similarly, with the proposed change in performance period, the reporting period would shift and change from July 1,2022, through June 30, 2025, to July 1, 2023, through June 30, 2025. Again, these proposed refinements would begin with fiscal year [20]27 payment determinations, and the measure would be removed from the Hospital IQR Program beginning with fiscal year 2030 as the modifications transition to the Hospital VBP Program, which we will cover later.

Last set of modifications, we have a proposal to modify both the Hybrid HWR and Hybrid HWM measures to lower the submission thresholds to allow for up to two missing laboratory results and up to two missing vital signs. The second modification would be to reduce the core clinical data elements submission requirement to 70% or more discharges and then lastly to reduce the submission requirement of linking variables to 70% or more of discharges. These proposed refinements would begin with fiscal year 2028 payment determination.

So, here in the proposed rule, CMS has also proposed the removal of four measures from the Hospital IQR Program beginning in the calendar year 2024 reporting period, thus impacting the fiscal year 2026 payment determination. We proposed to remove the HCHE, or the hospital Commitment to Health Equity measure beginning with the fiscal year 2026 payment determination due to costs associated with achieving a high score on the measure outweigh the benefit of its continued use in the program. Second, we propose to remove the COVID-19 Vaccination Coverage Among Healthcare Personnel.

That measure would again be proposed for removal beginning with fiscal year 2026 payment determination under Removal Factor 8: Costs associated with the measure outweigh the benefit of its continued use in the program. Lastly, we propose to remove both SDOH measures beginning with the fiscal year 2026 payment determination, again under Removal Factor 8: Costs associated with the measure outweigh the benefit of its continued use in the program. It's important to note that if removal is not finalized for any or all of these four proposals, hospitals that do not report their calendar year 2024 reporting data to CMS would be considered non-compliant with the measures for their fiscal year 2026 payment determination and would receive a letter of noncompliance after August 1, 2025, at which time the required 30-day reconsideration period would begin.

Lastly, for Hospital IQR, we have technical updates to the specifications for several measures beginning with the fiscal year 2027 program year to remove the COVID-19 exclusion from all of the following measures that you see listed here. We are providing notice in this proposed rule of our intention to do so. The technical update would modify these measures to remove the exclusion of COVID-19 diagnosed patients from the index admissions and readmissions, including the removal of the exclusion of certain ICD-10 codes that represented patients with a secondary diagnosis of COVID-19 and the history of COVID-19 risk variable.

So, now moving on to the Hospital Value-Based Purchasing, or VBP, Program, again, for a tiny bit of context, the Hospital VBP Program is a budget neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2% and redistributing the entire amount back to hospitals as value-based incentive payments.

This slide just provides a high-level overview of the proposed changes that we'll be discussing in detail. I'll be presenting on the modifications and technical updates for specific measures, then we'll discuss and recap quickly the proposal for the ECE policy and removal of the Health Equity Adjustment.

Finally, we'll note some updates to the performance standards for fiscal year 2027 through fiscal year 2031 program years, which will be included in the appendix.

So, CMS has proposed updates to the THA/TKA complication measures begin in fiscal year 2033. Key changes include what we've mentioned earlier. Under Hospital IQR, this includes adding Medicare Advantage patients, which nearly doubles the cohort size and shortens the performance period from three years to two years for more timely data. So, please note that when it comes to Hospital VBP, the adoption of these changes in the Hospital VBP Program is contingent on their adoption in the Hospital IQR Program.

So, this table shows the comp hip/knee measure and how it will evolve in the Hospital IQR and Hospital VBP Programs from fiscal year 2026 onward. So, for the [Hospital] IQR Program, if finalized as proposed, the [Hospital] IQR Program will adopt modifications earlier starting in fiscal year 2026, while Hospital VBP will lag slightly, adopting Modification 1 in fiscal year 2030 and then Modification 2 in fiscal year 2033. Modification 1 refers to the expansion of the measure cohort from the addition of 26 ICD-10 codes, capturing additional diagnosis as finalized in the fiscal year 2024 final rule. Whereas Modification 2 refers to the changes proposed in this fiscal year 2026 proposed rule, which includes adding MA patients and shortening the performance period from three years to two years. Finally, I just want to note that implementing the modification in this phase approach will allow time for testing as well as alignment between programs.

So, as far as technical updates go, beginning in the fiscal year 2027 program year, COVID-19 exclusions are being removed from the mortality and complications measures. Patients with a COVID-19 diagnosis will again be included in measure cohorts and calculations. Additionally, prior COVID-19 history will no longer be a covariant in risk models across all six clinical outcomes domains measures. Just to give a tiny bit of history and expand on this, the exclusions began as a response to the COVID-19 public health emergency.

As we all know, that expired May 11 in 2023. So, we at CMS believe that hospitals have had adequate time to adjust to the presence of COVID-19 as an ongoing virus, and that the inclusion of COVID-19 patients supports a more complete measure of the hospital's quality of care post pandemic. So, this update reflects CMS's analysis that data have normalized post pandemic and that the updates align with the sub regulatory technical updates policy, which was finalized in fiscal year 2015.

Another technical update that will be beginning in fiscal year 2029 is around the CDC. So, the CDC will update the standard population used for calculating the standardized infection ratios, or the SIRS, for the hospital associated infection measures to use calendar year 2022 data rather than calendar year 2015 data. Standard population data are used to establish hospitals predicted infection rates, which is the denominator of their SIRS. This update will promote more accurate risk adjustment as well as fair comparisons across hospitals by using more recent data. To allow for comparisons between the baseline and the performance periods, the current calendar year 2015 baselines will be used throughout fiscal year 2028, and the calendar year 2022 baseline will begin in fiscal year 2029.

So, our last proposal under Hospital VBP is to remove the Health Equity Adjustment points from the Hospital VBP Program starting with fiscal year 2026 payment determinations. The Health Equity Adjustment points were adopted in the fiscal year 2024 final rule for implementation in fiscal year 2026. The goal of removing the Health Equity Adjustment bonus points is to simplify scoring, enhance program clarity, and reduce burden for hospitals by streamlining regulatory requirements. So, with that, my portion of the presentation is done, and I would like to kick it off to my colleague, Jessica Warren.

Jessica Warren: Thank you, Kim. This is Jessica Warren, the program lead for the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

Today we will describe four proposals included in the fiscal year 2026 IPPS proposed rule for the Medicare Promoting Interoperability Program.

Some of the changes include defining the EHR reporting period, modifications to measures or objectives, an additional optional bonus measure, and Requests for Information.

First, we are proposing to continue with the 180-day EHR reporting period as we have with previous years. This proposal is for the calendar year 2026 EHR reporting period and subsequent years. Just a reminder that the EHR reporting period is any self-selected minimum continuous 180 days.

For the next few slides, I'll talk about measure-specific proposed modifications.

Currently, we require that eligible hospitals and CAHs attest Yes or No for having conducted a security risk analysis. Essentially, we're asking: Did you do it? Under this proposal, we are asking that eligible hospitals and CAHs not only attest to having conducted a security risk analysis, but also, did they do a risk management plan, as referenced in the HIPAA security rule? This proposal would be effective with the EHR reporting period in calendar year 2026 and subsequent years.

We are also proposing a modification to the SAFER Guides measure. In response to feedback we've received from the public, ASTP ONC updated the 2016 version of the SAFER Guides and released the 2025 version of the SAFER Guides in January 2025 for public review. We are proposing that, effective beginning with calendar year 2026, eligible hospitals and CAHs would do a self-assessment using the 2025 SAFER Guides. Please note that unless or until this proposal is finalized or modified, the requirement is still that you use the 2016 version of the SAFER Guides for your self-assessment.

We are proposing to include a third optional bonus measure under the Public Health and Clinical Data Exchange objectives. For this bonus measure, an eligible hospital or CAH would attest Yes if they are actively transmitting health information under this objective using TEFCA.

Reminder: For the bonus measures under this objective, no more or less than five points would be allocated for participating in one, two, or all three of the bonus measures.

For our first RFI, or Request for Information, we are asking for public feedback on potential future modifications to our PDMP measure, the Prescription Drug Monitoring Program measure. We are requesting feedback from the public on our goals of moving towards performance-based scoring. For PDMP, this would look like moving away from an attestation-based Yes or No, having done this at least one type of measure, to numerator and denominator reporting, which would look like reporting how many times the action has occurred. We are also asking for feedback on including all Schedule II drugs, as opposed to our current Schedule II opioids, Schedule III drugs, and Schedule IV drugs.

Expanding on the overall idea of shifting away from Yes/No attestation-based measures (Did you do it?) and towards a performance-based approach (How many times have you done it?), we have a second Request for Information asking for feedback on moving towards numerator-denominator (How many times have you done it?) reporting for measures under the Public Health and Clinical Data Exchange objective.

Again, this looks like: How much data have you sent and how many times have you sent it? This is not: Have you done it. yes or no?

For our last Request for Information, we are soliciting feedback on the concept of improving the quality of data being submitted. As we move towards a numerator-denominator performance-based approach, it is important that we also focus on the quality of data being shared. For this and the prior two Requests for Information just discussed, we appreciate, welcome, and read all of the feedback and suggestions that are shared. So, we encourage you to do so. This is all for the Medicare Promoting Interoperability Program. All of the proposals we have included in the fiscal year 2026 IPPS proposed rule.

Next up, we have Lang. Thank you.

Lang Le: Thank you, Jess. My name is Lang Lee For today's webinar, I'll be reviewing the HAC Reduction Program. This section of the presentation focuses on the proposed policies for the Hospital-Acquired Conditions Reduction Program in the fiscal year 2026 IPPS/Long-Term Care PPS proposed rule.

In the proposed rule, similar to the technical update discussed for the Hospital Value-Based Purchasing Program, CMS is announcing a technical update to the CDC's National Health Safety Network healthcare-associated infection measures to use standard population data from calendar year 2022 for the HAC Reduction Program. As aforementioned, CMS is proposing cross-program updates to the ECE policy.

CMS anticipates that the new 2022 standard population data will affect the HAC Reduction Program beginning with the fiscal year 2028 program year. The rationale for the updates includes providing timely, comparable, and clinically relevant evaluation of AI; promoting accurate risk-adjustment and valid comparisons across hospitals since standard population data are used to calculate the expected infection rates, and lastly, aligning with routine CDC measure maintenance. That concludes the HAC Reduction Program slide overview.

Continuing with the webinar, I'll be discussing the Hospital Readmissions Reduction Program slides.

In the proposed rule, CMS proposed a modification to the readmission measures to include Medicare Advantage data. CMS also proposed shortening the applicable period from three to two years. Additionally, CMS announced a technical update to remove COVID-19 exclusions and risk adjustment covariates from the six readmission measures. CMS also proposed modifications to the calculation of aggregate payments for excess readmissions to include MA data.

Lastly, as aforementioned, CMS is proposing cross-program updates to the ECE policy.

First, CMS proposed to expand the readmission measures, including the criteria to include MA beneficiaries beginning with the fiscal year 2027 program year. The addition of MA data to the measure doubles the cohort size and more accurately reflects the quality of care for both Medicare Fee for Service and Medicare Advantage beneficiaries. CMS also provides a non-substantive update to re-specify the risk model for each measure to primarily use individual ICD-10 codes in place of the previously used ACCs.

CMS also proposed shortening the applicable period from three to two years, beginning with the fiscal year 2027 program year. The applicable period is a data period used to calculate excess admission ratios, or ERRs, aggregate payments for accessory emissions, and dual proportions for the fiscal year. The applicable period will be a two-year period beginning one year in advance from the previous program fiscal year start of the applicable period. For example, if finalized, the fiscal year 2027 period will be July 1, 2023, through June 30, 2025. The proposed update will allow for more recent data to be used when assessing performance. Additionally, with the proposed inclusion of MA patients in the cohort, all measures show better between hospital variants using the two-year Fee for Service and MA combined cohort compared to the current measure specifications of the three-year clinical period in the Fee for Service-only cohort.

Next, we will review a technical update to the readmission measures. As of the fiscal year 2027 program year, patients with COVID-19 diagnoses will no longer be excluded from the measure numerators and denominators for the readmission measures. Additionally, a prior 12-month history of COVID-19 will no longer be adjusted for the measure readjustment models. The exclusion began as a response to the COVID-19 public health emergency, which expired May 11, 2023.

CMS believes that hospitals have had adequate time to adjust to the presence of COVID-19 as an ongoing virus.

Including COVID-19 patients will provide a more complete measure of hospitals' quality of care. Furthermore, this update reflects CMS's analysis that the data have normalized post-pandemic. CMS has found that there has been a decline over time of the number of patients excluded from the cohort due to COVID-19.

In the last slide, CMS also proposed to include payment data for both Medicare Fee for Service and Medicare Advantage beneficiaries in the calculations of aggregate payments for excess readmissions beginning with the fiscal year 2027 program year. This proposal aligns with the proposal to include MA beneficiaries in the readmission measures. This concludes my slide overview for the Hospital Readmissions Reduction Program. Thank you.

Donna Bullock: Thank you, Lang.

This slide contains the link to the proposed rule and the page directory for all programs.

CMS is accepting comments on the physical year 2026 IPPS/LTCH PPS proposed rule until 5:00 p.m. Eastern Time on June 10, 2025. Comments may be submitted via one of these three methods: electronically, by regular mail, or by express or overnight mail. Detailed information about how to submit comments is available in the rule. To access the rule, just use the link on the previous slide.

Thank you for taking the time to attend this presentation today.

A link to the webinar survey is available on this page. That concludes today's event. Thank you again for attending. Have a great day.