



Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

FY 2027 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

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Candace Jackson: Hello. Welcome to *Fiscal Year 2027 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs*. My name is Candace Jackson, and I am part of the Inpatient and Outpatient Health Care Quality Systems Development and Program Support team. I will be hosting today's event. Before we begin, I would like to share a few announcements. If you registered for today's event, a link to the slide was emailed to you earlier today. If you did not receive that link, the slides are also available on the Quality Reporting Center website at www.QualityReportingCenter.com/. During the event, you may also download the slides by selecting the Handouts link. Please note that this webinar is being recorded. The recording will be available on the Quality Reporting Center website and on the [QualityNet website](#) in the near future.

Today's speakers include Julia Venanzi, CMS Program Lead for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program; John Green, CMS Program Lead for the PPS-exempt Cancer Hospital Quality Reporting Program; Lang Lee, CMS Program Lead for the Hospital Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program; and Jessica Warren, CMS Program Lead for the Medicare Promoting Interoperability Program.

As you are participating in or listening to the webinar, if your question was not addressed during the presentation or your question was not responded to, we encourage you to submit them directly to the [Quality Question and Answer Tool](#). You can use the link on this slide.

This event will provide an overview of the final rule as it relates to the programs listed on this slide.

At the end of today's event, participants will be able to locate the fiscal year 2027 IPPS/LTCH PPS final rule text and identify the program-specific finalized proposals included in the rule.

This slide and the next slide have acronyms and abbreviations that we may use during today's webinar. I'll now turn the presentation over to Julia Venanzi. Julia, the floor is yours.

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Julia Venanzi: Hello, I'm Julia Venanzi. Today, I will be covering cross-program policies, the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. I'll start first with proposals that include multiple programs.

First, we finalize the proposal to add the Advanced Care Planning electronic clinical quality measure in the Hospital Inpatient Quality Reporting Program, the Promoting Interoperability Program and the PPS-exempt Cancer Hospital Reporting Program. This measure is finalized for adoption beginning with the calendar year 2028 reporting period, which is associated with the fiscal year 2030 payment determination for the Hospital Inpatient Quality Reporting Program and the Promoting Interoperability Program. For the PCH Quality Reporting Program, this will be a voluntary measure with the initial calendar year 2028 reporting period, fiscal year [20]30 program year, and then it will become mandatory for the calendar year 2029 reporting period, fiscal year 2031 program year.

The Advanced Care Planning eCQM calculates the proportion of adult patients who have an advanced care planning document or documentation of an advanced care planning discussion that resulted in a documented decision in the patient's EHR. This eCQM is intended to promote timely advanced care planning by encouraging communication between patients and providers to elicit and document the patient's care preferences and surrogate decision-makers, thereby supporting age-friendly and goal-concordant care.

The numerator for this measure is patients 18 or older with an inpatient encounter during the measurement period who, by discharge from at least one encounter, have an advanced care planning document or a documented discussion and decision in the EHR. The numerator can be satisfied with either of the following. The first would be an advance care planning document as evidenced by the following types of documents: A designated health care agent, an advance directive, a portable medical order, or the documentation that an advance care planning discussion with the documented decision occurred during the measurement period.

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Further details on the measure numerator can be found on QualityNet.

The next cross-program policy relates to the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Here, we're finalizing the proposal to modify five of the existing mortality measures in the Hospital VBP Program. That's the 30-day, all-cause, risk standardized mortality for the following five procedures or conditions: AMI, heart failure, pneumonia, COPD, or CABG. We are finalizing the proposal to modify the measures to add Medicare Advantage beneficiaries into the cohort. Since we are adding MA beneficiaries, this increases the cohort significantly, which means we are able to also finalize the policy to reduce the performance period from three years to two years without losing any reliability to the measure. This is a cross-program policy because of the statutory requirement that requires CMS to publicly report any new or substantively modified measure for one year in the Hospital Inpatient Quality Reporting Program before it can be moved into the Hospital Value-based Purchasing Program. Given this, we are finalizing a staged timeline with the modification first moving into the [Hospital] IQR Program with the July 1, 2024, through June 30, 2026, performance period, and then moving it into the Hospital Value-Based Purchasing Program with the July 1, 2028, to June 30, 2030, performance period.

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

As an overview, we are finalizing the adoption to add three new measures, to remove three measures, and then to modify three existing measures. We are also finalizing updates to the four manner and timing requirements.

Looking first at the adoption of new measures, I covered one of these, the Advanced Care Planning eQIM, in the cross-program section.

The second new eQIM that we are finalizing for adoption is the Excess Days in Acute Care After Hospitalization for Diabetes measure.

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This newly finalized measure supports the CMS and HHS priority to address chronic illness while aiming to improve disease-specific outcomes, reduce avoidable acute care utilization, and to improve care transition. The measure assesses the number of days a patient spends in acute care within 30 days of discharge from an inpatient hospitalization for a diagnosis of diabetes with complications. The numerator of the measure is the number of days a patient spends in acute care for any cause within 30 days of a discharge from the index hospitalization for diabetes.

The denominator includes a principal diagnosis of diabetes; the patient is either original Medicare or Medicare Advantage; 65 and older; and not transferred to another acute care facility. This newly finalized measure is similar in structure to our existing EDAC measures for other conditions and uses only claims. The new adoption to include MA beneficiaries begins with the July 1, 2025, through June 30, 2027, reporting period, which is associated with the fiscal year 2029 payment determination.

The final new measure for the Hospital IQR Program is the Hospital Harm - Postoperative VTE eCQM. This measure assesses the proportion of inpatient hospitalizations for patients age 18 or older who have at least one surgical procedure performed inside the operating room during the admission and who suffer the harm of a postoperative VTE during hospitalization or within 30 days after that first surgical procedure. The numerator is the number of inpatient hospitalizations for patients 18 and older who had a surgical procedure performed in the operating room during the hospitalization and experienced a VTE within 30 days of the procedure. The denominator is the number of patients 18 and older who had a surgical procedure performed in the operating room during an inpatient hospitalization. This eCQM is similar to the other previously adopted Hospital Harm eCQMs. We are finalizing to adopt this measure onto the list of eCQMs from which hospitals can choose to report it, beginning with the calendar year 2028 reporting period.

Here we are finalizing the removal of three measures beginning with the calendar year 2028 reporting period.

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The first two, VTE Prophylaxis and the ICU VTE Prophylaxis eCQM, are being removed given that we are finalizing the more outcome-focused Hospital Harm eCQM that I just mentioned. The last measure we're removing is the Discharge on Antithrombotic eCQM. This is being finalized for removal because it is reaching topped-out status in the program.

Next, we are finalizing modifications to three of the existing Excess Days in Acute Care measures: one for AMI, one for heart failure, and one for pneumonia. Here we are finalizing the proposal to add MA beneficiaries and to reduce the performance period. The first year of the addition of MA patients will begin with the July 1, 2024, through June 30, 2026 performance period.

Our next finalized policy is related to previously adopted eQMs. Here, we are making certain eQMs that were previously available for hospitals to self-select to report, mandatory to report. So, first, we are going to require mandatory reporting of the Malnutrition Care Score eCQM. Second, we are establishing a policy that once Hospital Harm eQMs have been available for self-selection for two years in the program, they then automatically become mandatory to report in the third year.

This table shows the eCQM reporting requirements for the next three years. The last two columns show which eQMs are mandatory as selected by CMS and then which are available for self-selection by the hospital.

We are also finalizing an administrative update the Maternal Morbidity Structural Measure. The current measure asks hospitals whether or not they participate in and implement practices from a nationwide or state quality collaborative. Here we are finalizing the addition of a sub-question for hospitals that attest Yes to the measure to ask the name of the specific quality collaborative that they participate in.

I will now cover policies related to the Hospital Value-Based Purchasing Program.

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So, as an overview, we did not propose to add or remove any measures to the program. We are finalizing our proposal to modify five existing measures. We're also providing various required annual updates to the performance standards.

The only measure-related policy is the modification to the five existing mortality measures that I mentioned in the cross-program section, but they also are featured here.

Here and in the next few slides, we display an updated performance standards for the upcoming fiscal years.

We also note that we will display an updated Table 16B in the fall that reflects actual payment adjustments for the fiscal year 2027 payment adjustment.

I will now pass things over to Jessica Warren to cover the Promoting Interoperability Program.

Jessica Warren: Thank you, Julia. This is Jessica Warren, and I'll be presenting on the Medicare Promoting Interoperability Program.

Here is a quick overview of what we'll be covering during this presentation in more detail later: Revision of the definition of Certified Electronic Health Record Technology, or CEHRT; measure modifications; measure removals; attestation removals; eCQM removals; measure adoptions; and eCQM adoptions.

In the ONC HTI-5 proposed rule, ONC outlined their deregulatory plans, which included the proposed removal of four certification criteria in the Medicare Promoting Interoperability Program. In an effort to maintain alignment with ONC, we finalized the removal of these criteria effective January 1, 2027. This resulted in updates to our definition of CEHRT. The criteria finalized for removal are family health history, patient health information capture, automated numerator recording, and automated measure calculation.

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Here is a reminder that the HTI-5 final rule has not gone on display yet, so please keep an eye on that.

We have finalized modifications to the electronic Prior Authorization measure. First, we have modified the measure description beginning with the EHR reporting period in calendar year 2027 to require the use of CEHRT rather than data from CEHRT, and we also clarified that we are focusing on patient encounters rather than the previously finalized patient discharge. For the EHR reporting period in calendar year 2027, the measure is optional for reporting. For those who attest Yes, you would earn 10 bonus points. If you attest No, you would not earn 10 bonus points. Because the measure is optional for attestation, no exclusions are available. For the EHR reporting period in calendar year 2028, the measure is again required and no points are offered. For those who attest Yes, you would meet program requirements. An attestation of No would result in being subject to a downward payment adjustment. Since the measure is required, exclusions would be available. We finalized that the use of one or more than one of the certified health IT modules must be used. Those are G31, 32, and 33, also known as CDR, DTR, and PAS.

Beginning with the EHR reporting period in calendar year 2027, we finalized requiring the Unique Device Identifier, or UDI, for Implantable Medical Devices measure. We are requiring the electronic capture and storage of a complete UDI for implantable medical devices in EHR that are stored as discrete data elements, meaning not embedded within a patient note. As this is the first year of the requirement, we are allowing for both Yes and No attestations. Failure to respond Yes or No would result in a downward payment adjustment.

Beginning with the EHR reporting period in calendar year 2026, we are no longer requiring that eligible hospitals and CAHs attest to the ONC Direct Review, and there will no longer be an optional attestation for the ONC Authorized Certification Body Surveillance Attestation. This means that the attestations reported for the EHR reporting period in calendar year 2025, those reported in HQR, our data submission portal, between January and February [20]26, would be the last time an attestation was required.

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No attestation is required for the EHR reporting period in 2026, again attestations reported to HQR, the data submission portal, in 2027. We do encourage eligible hospitals and CAHs to continue to work with ONC or an ACB should they contact you, but the act of attestation is no longer required.

We propose to remove two measures from the Health Information Exchange Objective. Those are Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information beginning with the EHR reporting period in calendar year 2028. In our final rule, however, we modified the effective date. So the removal of these two measures will begin with the EHR reporting period in calendar year 2029, not the EHR reporting period in calendar year 2028.

The Medicare Promoting Interoperability Program continues to work closely with the Hospital Inpatient Quality Reporting Program, or Hospital IQR, with eCQMs. As such, we are proposing to first adopt the Hospital Harm-Postoperative Venous Thromboembolism and Advanced Care Planning eCQMs and remove the Discharged on Antithrombotic Therapy, Venous Thromboembolism Prophylaxis, and the ICU Venous Thromboembolism Prophylaxis eCQMs. We are going to require the Hospital Harm-Postoperative Respiratory Failure and Malnutrition Care Score eCQMs. Please refer to the Hospital IQR presentation by Julia Venanzi for additional information. This concludes the Medicare Promoting Interoperability Program presentation. Next is John Green, and he will present on the PCHQR Program. John.

John Green:

Thank you. My name is John Green, and I'm here today to summarize the changes in the Prospective Payment System-exempt Cancer Hospital Quality Reporting Program, more commonly known as the PCH Quality Reporting Program, that we finalized in this year's rule.

At a high level for the PCHs, in this year's rule, we finalized the adoption of two new measures, removed one measure, and updated some program language to support using electronic clinical quality measures, better

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known as eQMs. Both of the measures we are adding are eQMs. While eQMs have been around for a while in other quality reporting programs, this is the first time we are including this measure type for the 11 hospitals covered by the PCH Quality Reporting Program.

The first measure adopted is the Advanced Care Planning eQM. Julia already covered the details of this measure at the beginning of the presentation, as this is a cross-program policy, so I won't repeat background information on what this measure is and what it covers. We do want to highlight the third bullet on this slide, though. In the proposed rule, we had laid out the same timeline for measure adoption as in the Hospital IQR Program, but we received multiple comments detailing concerns about accurate and reliable data submission when PCHs have no prior experience using eQM for quality reporting. After consideration, we finalized a change specific to the PCH setting to make the first year of eQM reporting voluntary, so PCHs are not required to submit data for this measure for calendar year 2028. However, participation offers an opportunity to confirm that everything is working properly before we begin publicly reporting data in calendar year 2029 and onwards.

Our second measure finalized for PCHs, which is also an eQM, is the Malnutrition Care Score measure. As I mentioned back in the proposed rule webinar, this measure has previously been in the Hospital IQR Program. Given the unique nutritional challenges that cancer patients can face, this measure will be valuable now that eQMs are available in the PCH setting. We finalized the same modification here that I've just discussed for the Advanced Care Planning measure since eQMs are new for the PCH Quality Reporting Program. Again, we do encourage facilities to make use of voluntary reporting period so that any issues can be resolved before mandatory reporting starts.

Folks interested in the Malnutrition [Care Score] eQM should consult the rule language for the specific details, but, basically, this measure has four steps of malnutrition care screening responses appropriate to the level of risk and severity of a given patient. The denominator comprises adult patients who are admitted for at least 24 hours.

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Our third measure change finalized for the PCH program is the removal of the Healthcare Provider COVID-19 Vaccination measure, effective for the calendar year 2026 reporting period. This change is made due to changing clinical guidance that made collecting and reporting meaningful data on COVID-19 vaccination rates difficult. CMS will not be publicly reporting data for calendar year 2026 that would have been collected under this measure.

Lastly, we finalized the technical details to enable eQMs in the PCH Quality Reporting Program. The intent we had was to align eQM activity with other programs to the extent possible to limit confusion. The summary is not exhaustive, but we implemented Office of the National Coordinator Standards for Relevant Data Systems, the use of measure specifications from the eCQI Resource Center, and the transmission of files to CMS in the QRDA I file format. This brings me to the end of the PCH content. At this point, I would like to hand it over to Lang for the Hospital Readmissions Reduction Program.

Lang Le:

Hi, my name is Lang Le. I'm the Program Lead for the Hospital Readmissions Reduction Program.

CMS has finalized the Sepsis Readmission measure. Full implementation begins with the fiscal year 2030 program year. The Sepsis Remission measure provides key stakeholders such as patients, clinicians, hospitals, and policymakers with visibility into the hospital-level unplanned remission rates following sepsis hospitalization. It also encouraged improved patient safety and care continuum across the care setting. As part of program implementation, CMS responded to stakeholder feedback by adding a phased approach. Hospitals will receive confidential or early look reports. The early look reports contain sepsis admission measure results, along with an estimated payment reduction under the program. The early look report covers both fiscal year 2028 and fiscal year 2029 program years. During this early look window, data will not be publicly reported. Again, data will not be publicly reported, or data will not be used for payment adjustment.

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The rationale for the phased approach provides hospitals with confidential reporting which also enables them to understand the Sepsis Readmissions measure specifications during this two-year period. It allows us to review performance results. Finally, hospitals can assess and implement improvement opportunities in their hospital operations. That concludes the presentation for the Hospital Readmissions Reduction Program.

This section of the presentation focuses on the Hospital-Acquired Condition Reduction Program.

For the fiscal year 2027 IPPS/LTCH PPS final rule, there were no proposals or updates finalized for the HAC Reduction Program. All previously finalized policies on the program will continue to apply. That concludes our presentation for the HAC Reduction Program.

Candace Jackson: Thank you, Lang. Now, next slide, please.

To assist with finding the program's specific finalized changes, the Fiscal Year 2027 Final Rule Page Directory is on this slide. Next slide, please.

We do now have some time for a few questions and answers. As stated earlier, if we did not get to your question during the webinar, you can send your inquiry to the Q&A tool using the link that was provided earlier. So, let's get started with our first question. That question is: Did Julia say that the new EDAC measure for diabetes was going to be an eCQM?

Julia Venanzi: Thanks, Candace. I think I must have misspoken because I saw the question a few times, but, yes, the EDAC measure is a claims-based measure similar to the existing three EDAC measures that are already in the program. So, they're using claims. So, the difference here is that we are now adding in the MA patients, as well.

Candace Jackson: Thank you, Julia. Since I have you on, Julia, do any of the new eCQMs include patients that were discharged directly from observation or only those that convert from observation to inpatient status?

Julia Venanzi: It depends on a measure-by-measure basis.

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So, I'm going to drop into the chat, the eCQI Resource Center, which has the specific specifications for each of the eQMs.

Candace Jackson: Our next question: For the UDI measure, if the data cannot be stored in as a discrete data element, where can the information be entered in the EHR as an entirely separate note? Do we have Jessica? Since we are unable to answer that question, we will go on to the next question.

For the two HIE PI measures being removed, does this mean clients must use one of the other options for HIE to meet this measure? I think that would go to Jess.

Jessica Warren: Sorry. I was unable to get off of mute. So, for the HIE objective, we finalized removal of health information exchange sending and receiving as an option for reporting effective 2029. So, beginning with 2029 EHR reporting period, you would have to respond to the HIE objective by choosing either the bi-directional option Number 2 or TEFCA option Number 3. If you wouldn't mind, could you repeat the prior question? I'm off mute.

Candace Jackson: For the UDI measure, if the data cannot be stored in as a discrete data element, where can the information be entered in the EHR as an entirely separate note?

Jessica Warren: So, what people are currently doing is either storing the UDI in a note or they are peeling the sticker off of the product, keeping it on a paper note that gets archived, uploaded into your medical records. One key thing about the UDI measure is that it is electronically-based, and you want to be able to find that information should you have a need for it later. What we are requiring is that you work with your hospital IT team, your vendors, and a field specific to UDIs is created in your EHR workflow. So, instead of peeling a sticker, putting it on a paper, going to medical records, you would scan or type in the UDI information into a field specific to that. We're trying to capture as many UDIs as we can. I understand that there's going to be a transition period.

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The first year, you can say that you've done it or not, but the end goal is that you can easily find it, easily enter it, and you know exactly where to look for it in a specific field, preferably not in a note.

Candace Jackson: All right. Thank you, Jessica. I think we have one more for you. When will the Hospital Harm-Postop Respiratory Failure measure be mandatory for [the Medicare] Promoting Interoperability [Program]?

Julia Venanzi: I can actually answer this one, Candace. The implementation timeline for the eCQMs is entirely aligned between the Promoting Interoperability Program and the Hospital IQR Program. For the Postop Respiratory Failure eCQM, the first year that it was put into both Promoting Interoperability and [Hospital] IQR was the calendar year 2026. So, that was as a self-selected eCQM. It will become mandatory starting with the calendar year 2028 reporting period.

Candace Jackson: Thank you, Julia. We have time for just a couple more questions. Is there a list of CMS-approved maternal morbidity initiatives, and how will hospitals enter the initiative into the HQR system?

Julia Venanzi: So, there will not be a list of PQCs that CMS approves per se, but we will note all of the state and national collaboratives that we are aware of on QualityNet. That same list will be available for hospitals to select from within the Hospital Quality Reporting system when you're going into attest to the Maternal Morbidity Structural Measure. That will basically be a drop-down list from which you can select a given PQC. We will also allow for a free text field if the PQC that you participate in is not on the list at that time.

Candace Jackson: Thank you, Julia. We have time for one more question here. On slide 9 of the presentation, it says the Advanced Care Planning eCQM will be mandatory beginning calendar year 2029. However, in the IPPS final rule, it shows that the advanced care planning eCQM is listed as self-select reporting through calendar year 2030.

John Green: Candace, I'll take that one. I couldn't pull up that page of the rule because that's the display copy, not the publication copy.

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Looking at the slide, I think there's a confusion. Remember, this is a cross-program policy, so it's voluntary in the PCH program. It is on the self-select list in the Hospital IQR Program.

Candace Jackson: Thank you, John. That is all the time we have for questions today. Next slide, please.

That concludes today's event. Thank you for joining us. Enjoy the rest of your day.