Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2024 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs Presentation Transcript

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Donna Bullock: Welcome to today's presentation, *FY 2024 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs*.

My name is Donna Bullock. I am the [Hospital] Inpatient Quality Reporting [Program] lead for the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I would like to make a few announcements. This webinar is being recorded. The recording, a transcript of the event, and a question-and-answer summary will be available on the Quality Reporting Center website in the near future. This event has been approved for one continuing education credit. More information will be provided at the end of the webinar. Our speakers today are Julia Venanzi, Program Lead, Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program, CMS; William Lehrman, Government Task Leader, Hospital Consumer Assessment of Healthcare Providers and Systems Survey, CMS; Alex Feilmeier, Program Manager, Value, Incentives, and Quality Reporting Center Validation Support Contractor; Jessica Warren, Program Lead, Medicare Promoting Interoperability Program, CMS; Ora Dawedeit, Program Lead, PPS-exempt Cancer Hospital Quality Reporting Program, CMS; and Lang Le, Program Lead, Hospital Readmissions Reduction Program, CMS.

This presentation will provide an overview of the fiscal year 2024 IPPS/LTCH PPS final rule as it relates to the following programs: Hospital Inpatient Quality Reporting Program; Hospital Value-Based Purchasing Program; Hospital-Acquired Condition Reduction Program; Hospital Readmissions Reduction Program; and the Medicare Promoting Interoperability Program.

At the conclusion of today's event, participants will be able to locate the fiscal year 2024 IPPS/LTCH PPS final rule text and identify the finalized program changes within the fiscal year 2024 final rule.

This slide contains the acronyms and abbreviations that we may use during today's presentation.

I would now like to turn the presentation over to Julia Venanzi.

Julia Venanzi: Thank you, Donna, and thank you, everyone, for joining today. I'm Julia Venanzi, the Program Lead of the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Today, I will first start with reviewing the newly finalized policies in the Hospital IQR Program.

As an overview, we finalized the adoption of three new measures, the removal of three measures, and the modification of three existing Hospital IQR [Program] measures. We also finalized a number of administrative proposals, including making some changes to the HCAHPS survey collection and the validation targeting criteria.

Starting first with the new measure adoptions, I wanted to first pull up the previously finalized electronic clinical quality measure, or eCQM, requirements. In last year's final rule, we finalized a requirement for hospitals to submit six total eCQMs beginning with the calendar year 2024 reporting period and for subsequent years. Of those six, three eCQMs are decided by CMS. Those are the Safe Use of Opioids eCQM, the Cesarean Birth eCQM, and the Severe Obstetric Complications eCQM. For the remaining three eCQMs, hospitals have a choice to self-select three from a list of existing eCQMs The three newly finalized eCQMs will all be added to the list from which hospitals can self-select to report them. As a reminder, eCQMs use data collected in hospital EHRs. These measures are designed to be calculated using hospital Certified Electronic Health Record Technology, using patient-level data. eCQMs are submitted to CMS on an annual basis in the beginning of the year following the reporting period. So, for example, calendar year 2024 data will be submitted at the end of February 2025.

This slide has an overview of the three new eCQMs. All three of the new newly finalized eCQMs focused on patient safety.

The first newly finalized eCQM is the Hospital Harm-Pressure Injury measure. Hospital-acquired pressure injuries are serious events.

They are one of the most common hospital patient harms. Pressure injuries commonly lead to further patient harm, including local infection, osteomyelitis, anemia, or sepsis, in addition to causing pain and discomfort to patients. Development of a pressure injury can also increase a patient's length of stay and can increase the risk of readmission. Given these risks and harms, and in light of CMS's goal to achieve zero preventable harms, we finalize the adoption of the Pressure Injury eCQM. This eCQM assesses the proportion of hospital inpatients age 18 or older who develop new pressure injuries during their hospitalization. This eCQM requires hospitals to systematically assess patients to identify new pressure injuries, which is an important step towards early identification of possible causes, initiation of treatment, and the potential development of preventative strategies. Full measure specifications for this eCQM, as well as the two others newly finalized eCQMs, can be found on the eCQI Resource Center.

The second newly finalized eCQM is the Hospital Harm-Acute Kidney Injury eCQM. Acute Kidney Injury Stage 2 or greater is defined as a substantial increase in serum creatinine value or by the initiation of kidney dialysis. Up to two-thirds of intensive care patients will develop acute kidney injury, which may result in the need for dialysis and is associated with an increased risk of mortality. This eCQM is critical since early identification and management of at-risk patients is critical. Not all acute kidney injury is avoidable, but a substantial portion of acute kidney injury cases are preventable and/or treatable at an early stage to improve outcomes. This eCQM assesses the proportion of inpatient hospitalizations for patients aged 18 and older who have an Acute Kidney Injury Stage 2 or greater during their hospital stay.

Moving to the last of the newly finalized eCQMs, the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM. Diagnostic imaging using CT occurs in more than a third of acute care hospitalizations in the U.S., and over 90 million CT scans are performed annually.

There is observed variation in the radiation doses used to perform these exams, which represents the risks to patients as high radiation doses are a risk factor for cancer. This eCQM provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses while still preserving image quality. This eCQM assesses the percentage of eligible CT exams that are out of range based on either having excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam.

Moving now to the three finalized modifications to existing Hospital IQR Program measures. The first two refinements are to add the Medicare Advantage patients to both the Hybrid Hospital-Wide Mortality measure and the Hybrid Hospital Wide Readmission measure. We're expanding the measure cohort in both of these measures to include MA patients since MA beneficiary enrollment has been rapidly increasing as a share of overall beneficiaries. In 2022, nearly half of Medicare beneficiaries, or over 28 million people, were enrolled in MA plans, and it is projected that enrollment will continue to grow.

We believe the addition of MA beneficiaries to Fee for Service beneficiaries, which are currently in the measure, will significantly increase the size of the measure's cohort, enhance the reliability of the measure scores, lead to more hospitals receiving results, and increase the chance of identifying meaningful difference in quality for some of the lower volume hospitals. Including MA beneficiaries in these two measures helps us ensure that hospital quality is measured across all Medicare beneficiaries. This modification would be included in the measure calculation beginning in the fiscal year 2027 payment determination, which uses discharge data from July 1, 2024, through June 30, 2025. We are also finalizing a third modification, which is a modification to the COVID-19 Vaccination Coverage Among Healthcare Personnel measure in order to replace the term “complete vaccination course” with the term “up to date” in order to accommodate the incorporation of booster doses into the measure.

This change in definition includes the bivalent booster, which became available after we had finalized the previous version of this measure, as well as allowing for flexibility for any additional changes to the CDC's definition of "up to date."

Moving now to the three measure removals, the first two measure removals, the removal of the Risk-standardized Complication Rate Following Total Hip or Knee Arthroplasty and the Medicare Spending per Beneficiary measures, these two removals are related to replacing older versions of these measures in the Hospital Value-Based Purchasing Program. The Hospital Value-Based Purchasing Program has a statutory requirement to publicly report measures for a full year in the Hospital IQR Program before those measures are able to be moved into Hospital VBP. So, whenever we want to modify a Hospital VBP measure, we have to put the updated version the Hospital IQR Program first, publicly report that measure data for a year, and then move it into the Hospital VBP Program. The updated versions of these measures have now been in IQR for that required length of time. So, we're finalizing moving the updated versions into the Hospital VBP Program and removing them from IQR. The third removal is the removal of the PC-01 measure, the Elective Delivery Prior to 39 Completed Weeks of Gestation. We're finalizing the removal of this measure since it has been topped out. The measure has been topped out for a number of years, but we previously had not proposed to remove it given that we have a limited number of maternal health measures in the Hospital IQR measure set. As you may remember, last year, we finalized the addition of the Caesarean Birth eCQM and the Severe Obstetric Complications eCQM, as well as establishing the Birthing Friendly designation. So, we now feel it's appropriate to remove PC-01 from the Hospital IQR Program in light of those additions.

Lastly, we finalized the codification of our measure retention and measure removal policies in the Code of Federal Regulations. We did not propose any changes to the actual policies in those, in the measure retention and measure removal policies, but instead we had just proposed to codify these requirements in the Code of Federal Regulations.

This makes it easier for interested parties to find these policies, and it further aligns with our regulations. We have codified with those that are codified in other quality reporting programs. I will now pass things off to Bill Lehrman to talk about the Hospital IQR HCAHPS-related policies.

William Lehrman: Thank you, Julia. In this section of the presentation, I'd like to explain briefly some of the changes to the HCAHPS survey that were finalized in this year's IPPS rule.

We finalized several changes to the administration of the HCAHPS survey. Very important, these changes will take effect with patients discharged beginning in January of 2025 and forward. So, the current rules for HCAHPS will apply to all patients who are discharged up until December 31, 2024. These new changes will take effect with patients discharged January 1, 2025, and forward.

The first change that we re-introduced through the rule is the addition of three new modes to survey administration. Each of these new modes begins with a web-based survey, and that is followed by another mode. So, the three new modes of survey administration for the HCAHPS survey are e-mail survey, followed by a mail survey to non-respondents, which we refer to as Web-Mail mode, e-mail survey, followed by a telephone survey to non-respondents, which we call the Web-Phone mode, an e-mail survey, followed by a mail survey, and then followed by a telephone survey to non-respondents, which we call the Web-Mail-Phone mode. So, each of these new modes begins with an e-mail survey, and that is followed by a secondary, or in the case of Web-Mail-Phone, secondary and tertiary modes. It's important to note that, while these new modes of survey administration will become available in January 2025, we will still offer the three current modes of survey administration that are most popular. Those are the Mail Only mode, the Telephone Only mode, and the mail-followed-by-phone mode.

Another important change to the administration of the HCAHPS survey, beginning in January 2025, is the removal of the requirement that only the patient may respond to the HCAHPS survey.

Up until now, we required that only the patient, himself or herself, answer the survey items, but based upon our experiments and analysis of data, we have decided to drop that prohibition against a patient's proxy answering the survey. So, beginning with patients discharged in January 2025, a proxy may answer the survey for the patient, himself or herself. However, we will still encourage the patient to respond to the survey.

Another important change to the administration of the HCAHPS survey, beginning in January 2025, is we are switching from a 42-day to 49-day data collection period in all survey modes. So, the way this will work is, after the patient has been contacted with the survey, whether by e-mail, mail, telephone, any other modes, the patient will have 49 days to complete the survey. This is seven days longer than has been the case up until now for HCAHPS. So, we're going from 42 days to 49 days to complete the survey. The reason we are extending the data collection period by seven days is to allow time for patients to respond to an e-mail survey before the secondary mode is initiated. So, in other words, we're preserving at least 42 days for the traditional modes but adding seven days for the e-mail mode. However, it's important to note that patients still must be contacted between 48 hours and 42 days after discharge with the survey. The patient is still contacted between 48 hours and 42 days with the survey, but once the patient has been contacted, the patient will have 49 days to complete that survey.

Another important change to the HCAHPS survey is placing a limit on the number of supplemental items that may be added to the survey. Up until now, there was no limit on how many survey supplemental items a vendor or hospital could add to the HCAHPS survey after the official HCAHPS items. Our research, both experimental and from the field data, indicates that the longer the survey is, the less the lower the response rate will be. We have this evidence from HCAHPS and also from other CAHPS surveys administered by CMS. So, we decided to place a limit of 12 supplemental items that may be added to the HCAHPS survey, and these must be added after all the official HCAHPS survey items are asked.

This will bring the HCAHPS survey into alignment with other CAHPS surveys administered by CMS and we believe will also help improve response rates.

Another important change, beginning in January 2025, is kind of a two-part change. First, we will ask hospitals select the patients preferred language while the patient is in the hospital and then administer the HCAHPS Spanish translation whenever indicated. So, we finalized the requirement that hospitals provide to the survey vendor the language the patient refers to speak while in the hospital. We're limiting this to just three choices. The three choices are English, Spanish, or some other language. We will finalize the requirement that if the patient refers to speak Spanish while in the hospital, that the official Spanish translation of the HCAHPS survey be administered to that patient. So, we are essentially requiring that patients who prefer Spanish should be administered the survey in Spanish. We have eight official translations of the HCAHPS survey available for hospitals to use. However, no hospital is required to use any of the translations, only English, but, beginning in January 2025, patients who prefer to speak Spanish must be administered the HCAHPS survey in Spanish.

We also reduced a couple of the options that are available, that have been available, for the HCAHPS survey. In particular, we finalized the removal of the removal of the Active IVR, Interactive Voice Response, survey mode from HCAHPS. We did this because this mode has never been very popular and has not been used by any hospitals in the last several years. So, in order to streamline each HCAHPS administration, training, and oversight, we are removing the Active IVR survey mode beginning with January 2025 discharges. In addition, we also finalized the removal of the Hospitals Administering HCAHPS for Multiple Sites option. So, in this option, hospitals, the hospital, could essentially act as a survey vendor for other hospitals. Both IVR and Hospitals Administering HCAHPS for Multiple Sites have been available for hospitals since the beginning of HCAHPS in 2006. However, neither of these options have been used much at all, ever for that matter, and not at all in the last several years.

So, in order to streamline HCAPHS administration, we are removing these two options beginning in January 2025.

So, in addition to those changes that have been finalized for the HCAHPS survey, beginning in January 2025 we also included in the rule the Request for Information about the potential addition of patients with a primary psychiatric diagnosis to the HCAHPS survey. So, we solicited comments about including patients with primary psychiatric diagnosis in HCAHPS. As you may know, patients with a secondary psychiatric diagnosis have always been eligible for the HCAHPS survey. So, if the patient's primary diagnosis was for medical, surgical and maternity care, but the patient had a secondary psychiatric diagnosis, that patient was included in the HCAHPS sample. Responding to requests from interested parties, we sought information from the public in this rule about including patients with a primary psychiatric diagnosis, admitted to short-term acute care hospitals, that is the hospitals that are eligible for the HCAHPS survey. Specifically, we sought public comment on whether all patients in the psychiatric service line in these MS DRG categories or particular subgroups should be included in HCAHPS, whether the current content for the HCAHPS surveys is appropriate for primary psychiatric diagnosis patients, and whether the current HCAHPS implementation procedures might face legal barriers or pose legal risks when applied to patients with a primary psychiatric diagnosis. We received a lot of comments about these questions. The comments were both for including primary psychiatric diagnosis patients and against. There are cogent, compelling arguments on both sides. CMS, after evaluating the comments, is going to further study the option of including patients with a primary psychiatric diagnosis. The Agency for Healthcare, Research and Quality, or AHRQ, is exploring this issue of which kind of survey would be best suited for patients with a primary psychiatric diagnosis, and they're evaluating the content of the HCAHPS survey and its appropriateness for such patients. CMS will monitor AHRQ’s analysis, research, and studies on this area.

CMS will take that information to heart in consideration, possibly in the future, of including primary psychiatric patients in HCAHPS, or perhaps using a different survey developed specifically for patients in those MS DRG categories.

OK. As I mentioned, we received comments supporting and opposing. AHRQ is funding development to study this area. CMS will monitor AHQR's work to determine which next steps to take in this area.

We, also, in the rule, included advice to hospitals about the survey mode they use to conduct the HCAHPS survey. As you may know, the hospitals have always had several options for administering the HCAHPS survey. The most popular options are Mail Only or Telephone Only, representing about 70 percent and 30 percent of hospitals. We encourage participating hospitals to carefully consider the impact of survey mode administration on response rates and the representativeness of survey respondents. High response rates of the HCAHPS survey for all patient groups promote CMS's health equity goals. CMS has done a lot of research on who responds to which survey mode. We've done this both experimentally and also by using field data from the HCAHPS survey, and we have discovered that survey mode does affect responses to the survey. In particular, Black, Hispanic, and Spanish-language preferring, younger, and maternity patients are more likely to respond to the HCAHPS survey if it's presented in the telephone mode. On the other hand, older patients are more likely to respond to a mail survey. We asked hospitals to carefully consider the mode of survey they choose to use and how that might affect who responses to the survey. Choosing a mode that is easily accessible to the diversity of a hospital patient population provides a more complete representation of all patient care experiences. So, in other words, we're encouraging hospitals to consider the survey they use and how appropriate it is for their patient population and whether another survey mode may garner more representative responses from the hospital's patient population. We have created a podcast which is posted on our official HCAHPS online website. The podcast is called Improving Representativeness of the HCAHPS Survey.

It is available at this link, and we encourage hospitals and other interested parties to view of this podcast, which explains some of the research we've done on the HCAHPS survey in terms of who responds to which survey mode. More details of what I just presented in this brief outline can be found in the final rule in which we responded to comments, in which we clearly laid out all of the HCAHPS proposals, and respond to the comments we received about the modals. I would ask you to please monitor the HCAHPS Online website for more announcements about HCAHPS survey in the future.

With that, I will turn it over to Alex. Thank you.

Alex Feilmeier: Hi, I'm Alex Feilmeier, and I'll be going over the Hospital IQR Program and HAC Reduction Program validation topics today.

For both the Hospital IQR Program and the HAC Reduction Program, beginning with the validation of calendar year 2024 reporting period data for the fiscal year 2027 payment year, CMS finalized to add a new criterion to the previously established targeting criteria better used to select up to 200 additional hospitals for validation. CMS finalized to modify the validation targeting criteria to include any hospital with a two-tailed confidence interval that is less than 75 percent and which submitted less than four quarters of data due to receiving an Extraordinary Circumstances Exemption for one or more quarters.

These hospitals will not fail the validation related requirements for the annual payment update determination in the Hospital IQR Program or the validation or related requirements for the payment adjustment in the HAC Reduction Program for the payment year for which the ECE provides hospitals with an exception from data reporting or validation requirements. These hospitals could be selected for validation in the following year though. We finalized this additional criterion because such a hospital would have less than four quarters of data available for validation, and its validation results could be considered inconclusive for payment purposes.

Our finalizations will also allow us to appropriately address instances in which hospitals that submit fewer than four quarters of data due to receiving an ECE for one or more quarters might face payment and implications under the current validation policies. The finalization of these proposals will align the targeting criteria across all the Hospital IQR and HAC Reduction and the Hospital OQR Programs.

CMS has finalized that, beginning with fiscal year 2025 program year, and that is calendar year 2022 discharges, the hospitals that fail validation will be allowed to request reconsideration of their validation results before its use in the HAC Reduction Program scoring calculations. The validation reconsiderations process will be conducted just once per program fiscal year after the validation of HAIs for all four quarters of the relevant fiscal years data period and after the confidence interval has been calculated.

CMS has finalized to limit the scope of the HAC Reduction Program data validation reconsideration reviews to information that was already submitted by the hospital during the initial validation process. Medical records that were not submitted during the initial validation process will not be abstracted. The review scope will be expanded only if it was found during the review that the hospital correctly and timely submitted the requested medical records. In which case, data elements would be abstracted from the medical record submitted by the hospital as part of the review of its reconsideration request. After the reconsideration process is completed, the hospital's confidence interval will be recalculated based on the results of the reconsideration of the hospital cases and determination made on whether the hospital passed or failed the validation requirements for the HAC Reduction Program. These finalizations will more closely align the validation reconsideration process across the Hospital IQR and HAC Reduction Programs. Additional information on the process specifics will be posted on the CMS QualityNet website. That's all I have for validation topics, so I'll hand it off to Jessica Warren. Thanks.

Jessica Warren: Thank you, Alex. My name is Jessica, and I will be speaking about the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

For the calendar year 2024 EHR reporting period, we previously finalized the policy to increase the 90-day EHR reporting period to any continuous 180 days. We finalized policies this year to continue with this 180-day EHR reporting period to continue in calendar year 2025.

We finalized policy on reporting data to state that all eligible hospitals and CAHs must report their data in HQR from January 1 through February 28 or 29. In 2024, it will be February 29, regardless if they are a new or returning eligible hospital or CAH. Essentially what that is saying is that we removed policies stating that new eligible hospitals or CAHs may report their data as early as October because the HQR system is only open for submission from January 1 through the end of February.

For the SAFER Guides measures, we finalized the policy stating that in order to be considered a meaningful EHR user and passing Promoting Interoperability requirements, eligible hospitals and CAHs must attest "Yes" that they have completed an annual assessment of all nine SAFER Guides beginning with the 2024 EHR reporting period. For the two years prior, we allowed the eligible hospitals and CAHs to attest "Yes" that they did do the annual self-assessment or "No" that they did not do the annual self-assessment, both without penalty. As a reminder, we do not require eligible hospitals or CAHs to attest that they exceed in all areas, nor that they have implemented all recommended practices. We ask that eligible hospitals and CAHs complete this self-assessment alone and utilize the worksheets as appropriate to their facility. For those who attest "Yes," this means that they have fulfilled the minimum requirements and have passed the measure. For those who attest "No," they have failed the measure and are thereby subject to overall PI Program failure and may be subject to a downward payment adjustment.

As was discussed previously, we are aligning with the Hospital IQR Program in the adoption of three new eCQMs available for self-selection.

These include Hospital Harm-Pressure Injury, Hospital-Harm Acute Kidney Injury, and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT. Another reminder, we do require reporting eCQM data for a full calendar year. This is everything for the Medicare Promoting Interoperability Program.

Next up, we have Julia Venanzi. She will present on the Hospital VBP Program. Thanks so much. Julia?

Julia Venanzi: I will now go through the newly finalized policies in the Hospital Value-Based Purchasing Program. To start off with a high-level summary, first, we finalized one new measure in the Hospitals VBP Program and made modifications to two existing measures. We also finalized a change to the scoring methodology in order to include health equity adjustment points into the scoring methodology. We are also finalizing HCAHPS changes that Bill mentioned under the Hospital IQR Program since the HCAHPS measure is in both programs. Lastly, we established annual performance standards for the fiscal years 2026 through 2029.

Starting first with our finalized policy to adopt the Severe Sepsis and Septic Shock Management Bundle measure into the Hospital VBP Program. This measure is the chart-abstracted measure that is also currently collected under the Hospital IQR Program, which is sometimes referred to as the SEP-1 measure. We finalized the addition of this measure into the Safety domain in the Hospital VBP Program. We are adding this measure into the Hospital VBP Program in addition to Hospital IQR in order to further incentivize improvements on the measure. We began publicly reporting the sepsis measure performance on Care Compare in July of 2018. At that time, the average performance was about 49 percentage of patients that met the inclusion criteria for the measure, who received all of the components of the early management of severe sepsis and septic shock. The most recent refresh of data showed that the average performance rate reached 57 percent of all patients. By moving this measure to the Hospital VPB Program, we hope to continue to see further improvement in performance rates on the measure.

I will note that data collection for this measure will be the same under both programs. So, there is no additional data collection burden associated with moving this into the Hospital VBP Program. Hospitals will only have to report on this measure once.

This slide shows the finalized measures for the calendar year 2024, fiscal year 2026, payment determination, including the new edition of the sepsis measure. You can see that measure has been added to the Safety domain.

So, moving now to the two finalized refinements, as I mentioned earlier, these two modified measures are being moved over from the Hospital IQR Program to replace older versions of these measures in the Hospital VBP Program. The first refined measure is the modified Medicare Spending per Beneficiary measure. Modifications to this measure include updating the measure to allow readmissions to trigger new episode, to account for episodes and costs that are currently not included in the measure but that could be within the hospital's reasonable influence. The next modification to the measure was the addition of a new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to the episode start. The last refinement to this measure was an updated MSPB amount calculation methodology to change one step in the measure calculation from the sum of observed cost divided by the sum of expected cost. So, the ratio of sums to the mean of observed costs divided by expected costs, which is the mean of ratios.

The second measure modification is adding 26 to the risk standardized complication rate following hip or knee arthroplasty.

The modification to this measure is just adding 26 additional mechanical complication ICD codes to the Risk-standardized Complication Rate Following Total Hip or Knee Arthroplasty measure.

So, moving now to our scoring policy change, achieving health equity, addressing health disparities, and closing the performance gap and the quality of care provided to populations that have been disadvantaged, marginalized, or underserved by the health care system continues to be a

priority for CMS as outlined in the CMS National Quality Strategy. In order to help progress on these goals, we finalized a scoring change under the Hospital VBP Program that allows the opportunity for hospitals to gain up to 10 Health Equity Adjustment bonus points towards the Total Performance Score in a given year. The bonus points are calculated based on performance on the existing Hospital VBP measures, as well as the proportion of patients at the hospital that are duly eligible within a given performance period. These points are available to all hospitals, but the amount of points scales up as hospitals perform better or have higher proportions of patients that are dually eligible. The scoring change will begin with the fiscal year 2026 payment determination. I'll note that a similar policy was finalized in the calendar year 23 physician fee schedule rule for the Medicare Shared Savings Program, and that the Skilled Nursing Facility Value-Based Purchasing Program also finalized this similar policy this year.

This slide is a high-level overview of the previously finalized scoring methodology. So, first hospitals are scored on individual measures within each of the four domains. Both improvement and achievement points are calculated for each measure. If they meet measure minimums, next, the higher score of the achievement or improvement scores is selected for each measure. Then, those scores are totaled to calculate the unweighted domain weight. The domains are then weighted equally at 25 percent. The domain scores are then summed to create the Total Performance Score. At that point, a linear exchange function is applied to the Total Performance Scores in order to produce payment adjustment percentages, also known as basically the amount of bonus or penalty payment that a hospital would get in a given year.

Under this newly finalized policy, all of those same steps will stay the same on this slide. They are now grayed out. So, our new steps will be added to the process. Those are shown here in bold in Steps 5 through 8. So, the new scoring steps come in after the weighted domain scores are calculated. So, from there, we will now calculate a measure performance scaler.

That is the sum of the points awarded to a hospital for each domain, based on the hospital's performance on the measures in those domains. To do that, we will look at the weighted domain scores and award a value of 0, 2, or 4 based on whether the hospital's performance is in the top third, middle third, or bottom third performance. Hospitals could receive a maximum of 16 measure performance scaler points for being a top performer across all four domains. Then, in Step 6, we calculate the underserved multiplier, which is the mathematical result of applying a logistic exchange function to the number of hospital inpatient stays for duly eligible patients out of a hospital's total Medicare inpatient population. In Step 7, we basically multiply those two values together to get the total number of health equity bonus points. In Step 8, we then add the Health Equity Adjustment bonus points to the sum of the domain scores to give us the Total Performance Score. From there, we continue on to the calculation of the payment adjustment percentage, just like we did previously. I will note that there is a more detailed walkthrough of these steps, as well as sample calculations, within the rule text, and I note that we will provide more detailed education and outreach on the scoring methodologies through QualityNet in the coming months. I also wanted to note that, at this time, we finalized using the proportion of patients who are dually eligible. Note that we did include a Request for Information section in the proposed rule to seek comment on using other factors such as the Area of Deprivation Index or the receipt of low-income subsidies to consider using those variables in the future. We want to thank commenters for submitting so many thoughtful comments on this RFI and note that we will continue to consider them in the expansion of this scoring methodology in the future.

Lastly, I wanted to note that, since we are now returning to normal scoring, after two years of COVID-19 related suppressions of certain measures from the scoring methodology, we will be posting our regular Table 16 updates this year. That will include Table 16B, which has the actual payment adjustment values for each hospital for fiscal year 2024. Table 16 B will be posted in mid-October.

I will now pass things over to Ora Dawedeit.

Ora Dawedeit: Thank you, Julia. Hello, my name is Ora Dawedeit. I'm the PCHQR Program lead. Today, I'm going to provide you an overview of the Hospital-Acquired Condition Reduction Program in the fiscal year 2024 final rule as Jennifer Tate, the HAC Reduction Program lead, is on leave.

Summary of the fiscal year 2024 finalized proposals, we finalized two updates to the healthcare-associated infection, HAI, validation process for the HAC Reduction Program. We added a validation reconsideration process, and we updated targeting criteria to include hospitals with a granted ECE, or Extraordinary Circumstances Exception, that received a failing validation score.

So, we sought public comment on whether to potentially adopt patient safety-focused eCQMs to promote further alignment across CMS quality reporting and value-based purchasing programs. Adoption of eCQMs in the HAC Reduction Program also supports the CMS Meaningful Measure 2.0 priority to move fully to digital quality measurement.

Out of six eCQMs, five are Hospital Harm: Opioid-Related Adverse Events, Severe Hypoglycemia, Severe Hyperglycemia, Acute Kidney Injury, and Pressure Injury. The sixth one is Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eCQM.

So, this slide goes over the fiscal year 2024 and 2025 performance period. So, CMS previously finalized that Quarter 3 and Quarter 4 2020 claims would be excluded from future program calculation. We also previously finalized that the calendar year 2021 HAI data would be excluded from the fiscal year 2024 program year calculation. These data exclusions result in abbreviated CMS Patient Safety Indicator, PSI, 90 and HAI measure performance periods for the fiscal year 2024 program year. The typical two-year performance period will resume in the fiscal year 2025 program year.

So, as you see on this slide, this is a beautiful chart. The red is the excluded. The gray is the HAI performance period, and the blue is the PSI 90 period.

That is it for the HAC Reduction Program for the final rule. For more information on this program, you can go to CMS.gov and QualityNet websites using the links on the slide. You can also submit questions about the HAC Reduction Program via the QualityNet Question & Answer Tool by using the link and instructions on the slide. I'm passing it over to Lang. Thank you.

Lang Le: Hi, my name's Lang Le. I am the CMS Program Lead for the Hospital Readmissions Reduction Program.

For this year's rule, there are no updates in the rule for the Hospital Readmissions Reduction Program. All previously finalized policies on this program will continue to apply.

On this slide, we list a few HRRP resources. Each bullet point has a link to the program resources page that we recommend you utilize.

I'm passing on the program to Donna Bullock. Thank you.

Donna Bullock Thank you, Lang.

Use the link on this slide to access the fiscal year 204 IPPS/LTCH PPS final rule on the *Federal Register* website. Details regarding various quality programs can be found on the pages listed on this slide.

This program has been approved for one continuing education credit. If you registered for today's webinar, you will receive an e-mail that includes the required survey and information about how to claim your credit. If you did not register for the webinar, you may still obtain the e-mail from someone who did and get your continuing education credit. For more information about our continuing education process, click the link on this slide. Next slide, please.

We now have time for a few questions from the audience. If we do not get to your question, don't worry. Remember, there will be a question-and-answer summary posted to the webinar page on the Quality Reporting Center website in the near future.

Our first question, is, "What if a hospital does not have an obstetrics or labor and delivery department or provide obstetric care?

John Green: Yes, thank you. My name's John Green, I'll be stepping in for Julia Venanzi. She has a technical issue, unfortunately, and is not able to access the Q&A tool. So, I believe, in that case, what you're referencing are the previously finalized eCQMs, Severe Obstetric Complications and Cesarean Birth. For those two eCQMs as well as all finalized eCQMs, hospitals that have a zero denominator for a measure can meet the eCQM requirement by submitting a zero denominator declaration, and you can find more information on the zero denominator declaration on QualityNet.

Donna Bullock: Thank you, John. Here's our next question. Can you please clarify what is the payer mix for the newly selected eCQMs?

John Green: Sure. So, all three of the new eCQMs, as well as all the previously finalized eCQMs, use all payer data.

Donna Bullock: OK. Here's our next question. What is the weight of the sepsis measure within the Safety domain?

John Green: Yes. So, the measures in the Safety domain are equally weighted. That specific weight depends on the number of safety measures for which a hospital meets the minimum data requirement within the Safety domain. So, for example, if a hospital meets the minimum for all six of the measures, the weight of each measure within that domain would be about 16 percent. If a hospital were only able to score five out of six measures, each measure would then be weighted about 20 percent of the domain score. Hospitals must score on at least five of the six measures within that domain to get a score.

Donna Bullock: OK. Thanks again, John. Our next question: As eCQM PC-01 is going away for the Hospital IQR Program for calendar year 2024, does this also include the removal of the chart-abstracted measure for PC-01?

John Green: To clarify, I think the measure that we're removing in the fiscal year 24 Inpatient Prospective Payment System rule is the chart-abstracted measure.

The eCQM version of PC-01 was removed from the Hospital Inpatient Quality Reporting Program a number of years ago.

Donna Bullock: Great. Thank you. Next question: Where can we find an example calculation of the health equity scoring referenced on slides 45 to 62?

John Green: Yes. So, there is a more detailed explanation and an example of that scoring methodology in the text of the fiscal year 24 IPPS final rule. Additional resources about scoring are forthcoming and will be posted on the QualityNet website.

Donna Bullock: OK. Those are the only questions that have come through the system so far. So, we will pause for a minute to see if any new questions become available..

Since we have no further questions that have come through the system yet, we will close the question-and-answer session. Next slide, please.

That concludes today's webinar. Thank you all for joining us.