Hospital Inpatient Quality Reporting (IQR) Program

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

FY 2025 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs Presentation Transcript

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Donna Bullock: Hello. Welcome to today's event, *FY 2025 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs*. My name is Donna Bullock. I am the [Hospital] IQR Program lead for the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, and I will be your moderator for today's event. Before we begin, I would like to make a few announcements. This webinar is being recorded and will be available in the near future on the Quality Reporting Center website. If you registered for today's event, you received an email with the link to the slides two hours ago. If you did not receive this email, you can obtain the slides from the Quality Reporting Center website or, during the presentation, you can access them from the handout section. This webinar 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 for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program, Quality Measurement and Value-Based Incentives Group, or QMVIG, Center for Clinical Standards and Quality, or CCSQ, Centers for Medicare & Medicaid Services, or CMS; William Lehrman, Government Task Later, Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, Survey, Division of Consumer Assessment and Plan Performance, CMS; Alex Feilmeier, Program Manager at the Value, Incentives, and Quality Reporting Center

Validation Support Contractor; Jessica Warren, Program Lead, Medicare Promoting Interoperability Program, QMVIG, CCSQ, CMS; Jennifer Tate, Program Lead, Hospital-Acquired Condition, or HAC, Reduction Program, QMVIG, CCSQ, CMS; and Lang Le, Program Lead, Hospital Readmissions Reduction Program, or HRRP, QMVIG, CCSQ, CMS.

This presentation will provide an overview of the fiscal year 2025 IPPS/ LTCH PPS proposed 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 2025 proposed rule text, identify proposed program changes within the proposed rule, and understand the time period and methods for submitting public comments to CMS regarding the fiscal year 2025 proposed rule.

Because CMS must comply with the Administrative Procedures Act, we are not able to provide additional information, clarification, or guidance related to the proposed rule. We encourage stakeholders to submit comments or questions through the formal comment submission process as described later in this webinar.

These are some acronyms and abbreviations that may be used during today's presentation.

I will now turn the presentation over to Julia Venanzi.

Julia Venanzi: Thank you, Donna. My name is Julia Venanzi. I am the Program Lead for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Today I will be walking through proposals for both of those programs.

Before I get into the specific proposals for the Hospital Inpatient Quality Reporting Program, I did want to give a quick overview of the program itself.

The program is a pay-for-reporting program for acute care hospitals that are paid under the inpatient prospective payment system, or the IPPS. Pay-for-reporting means that, so long as hospitals report on all requirements in a given fiscal year, they will receive their full annual payment update under the program. Those hospitals that are eligible but do not report on all requirements are subject to a one-quarter reduction in their annual payment update for that given fiscal year. By statute, the program includes acute care hospitals paid under the IPPS. This means that critical access hospitals, Long-Term Care Hospitals, inpatient psychiatric hospitals, inpatient rehab hospitals, children's hospitals, and the 11 PPS-exempt Cancer Hospitals are not required to participate in the program. For more information on the program and eligibility requirements, we direct you to QualityNet.cms.gov. First, to get into the proposals in the FY 2025 IPPS proposed rule, we have a high-level summary of the proposals that were included in the Hospital IQR Program. We are proposing to adopt seven new measures, to remove five measures, and to modify two existing measures. We are also proposing a number of administrative proposals related to electronic clinical quality measures, or eCQMs, including changes to the validation process for eCQMs, as well as proposing to increase the required number of eCQMs that hospitals must report. Lastly, we are making an administrative proposal related to the reconsideration process.

Starting first with measure adoptions, this slide includes all seven of the proposed new measure adoptions, as well as the proposed implementation timelines. Before I go into the individual proposed measure adoptions, I want to highlight HHS' and CMS' focus on patient safety in this year's proposed rule. A foundational commitment of providing healthcare services is to ensure safety. Two decades ago, two key reports, 1) To Err is Human and 2) Crossing the Quality Chasm, surfaced major deficits in healthcare quality and safety. These two reports resulted in widespread awareness of the alarming prevalence of patient harm. Over the past two decades, healthcare facilities implemented various interventions and strategies to improve patient safety, with some documented successes. However, progress has been slow, and preventable harm to patients in the clinical setting, resulting in significant morbidity and mortality, remains common.

Despite established patient safety protocols and quality measures, the COVID-19 Public Health Emergency strained the healthcare system, introducing new safety risks and negatively impacting patient safety in the normal delivery of care. Since the onset of the COVID-19 PHE, the U.S. has seen marked declines in patient safety metrics, as evidenced by considerable increases in healthcare-associated infections, or HAIs. As healthcare facilities struggled to address the challenges posed by the COVID-19 PHE, safety gaps and risks in healthcare delivery were illuminated, revealing a lack of resiliency in the healthcare system. While the COVID-19 PHE may have disrupted routine infection control practices, these key patient safety indicators nevertheless show the importance of addressing gaps in safety in order to save lives, provide equitable medical care, and ensure that the U.S. healthcare system is resilient enough to withstand future challenges. To accomplish these goals, the federal government is taking a multi-pronged approach to improve safety and reduce preventable harm to patients. Specific to our CMS quality programs, in this proposed rule, we are focused on proposing patient safety measures that recommit to better safety practices for both patients and healthcare workers.

Our first proposed new measure is the Patient Safety Structural Measure. This is an attestation-based measure that assesses whether hospitals have a structure and culture that prioritizes patient safety as demonstrated by leaders who prioritize and champion safety; a diverse group of patients and families meaningfully engaged as partners in safety; and, lastly, practices indicating a culture of safety and continuous learning and improvement.

This measure is similar to previously finalized attestation measures like the Hospital Commitment to Health Equity measure, in that hospitals must attest to different statements across the five domains listed here. Each of the five domains include five related attestation statements. Hospitals would need to evaluate and determine whether they can affirmatively attest to each domain.

For a hospital to affirmatively attest to a domain, and receive a point for that domain, a hospital would evaluate and determine whether it engaged in each of the statements that comprise that domain, for a total of five possible points, one point per each domain. Hospitals would attest to this measure annually via the Hospital Quality Reporting System, also known as the HQR System. [Editor's note: This measure will be submitted annually via the NHSN system.]

Moving to the second proposed new measure, the Age-Friendly Hospital Measure, with an aging U.S. population and CMS being the largest provider of healthcare coverage for the 65 years and older population, proposing a quality measure aimed at optimizing care for older patients is important. Although existing quality measures have improved both the rate and reporting of clinical outcomes that are important to older individuals, these measures can be narrow in scope. To address the challenges of delivering care to older adults with multiple chronic conditions from a hospital and health system perspective, we are proposing this attestation measure. The measure assesses how well hospitals have implemented strategies and practices to strengthen their systems and culture for safety.

Hospitals report on the measure by attesting to statements across five domains listed here. Hospitals would report this measure annually through the HQR System.

Our third and fourth proposed new measures are related to healthcare-associated infections, HAIs. HAIs are a major cause of illness and death in hospitals, posing a significant threat to patient safety. One in 31 hospital patients in the U.S. have an HAI at any given time, and the CDC estimated that about 72,000 patients die from HAIs each year. HAIs not only put patients at risk, but also increase the hospitalization days required for patients and considerably add to healthcare costs. Given the high risk to patient safety, we previously adopted the National Healthcare Safety Network, or NHSN, catheter-associated urinary tract infection, CAUTI, and central-line associated bloodstream infection, or CLABSI, measures in various quality reporting programs.

These existing measures measure the annual risk-adjusted standardized infection ratio among adult inpatients. However, in the existing measures, locations that are mapped as oncology wards have previously not been included. In order to complement the existing measures and make sure that we are measuring HAIs for patients with cancer who are particularly vulnerable to infection, we are proposing two additional measures, the CAUTI measure stratified for oncology locations and then the CLABSI measure stratified for oncology locations. These measures include only patients in those locations mapped as oncology locations by the CDC.

These measures will use a similar process to the existing CAUTI and CLABSI measures that are included in the Hospital-Acquired Condition Reduction Program. Data would be submitted to the NHSN quarterly.

The fifth new measure proposal is to add the Hospital Harm–Falls with Injury eCQM. Patient falls are among the most common hospital harms reported and can increase length of stay and patient costs. It has been estimated that there are between 700,000 and 1,000,000 inpatient falls in the U.S. annually, with more than a third of those resulting in injury and up to 11,000 resulting in patient death. There is a wide variation in fall rates between hospitals which suggests that this is an area where quality measurement and further improvement is still needed. This eCQM measures the number of inpatient hospitals stays where the patient has a fall that results in moderate or major injury. This, like all other eCQMs, is an all-payer measure, and it will be submitted annually in the spring following the performance period. This eCQM will be added to the list of eCQMs from which hospitals can self-select to fulfill the self-selected portion of the eCQM requirement.

Next is the proposal to adopt a second Hospital Harm eCQM, the Hospital Harm–Postoperative Respiratory Failure eCQM. Postoperative respiratory failure is defined as unplanned intubation or prolonged mechanical ventilation after an operation. It is considered to be the most serious of the postoperative respiratory complications because it represents the “end stage” of several types of pulmonary complications and non-pulmonary problems.

It often results in negative outcomes, including prolonged morbidity, longer hospital stays, increased readmissions, higher costs, or death. Currently there are no eCQMs that focus specifically on postoperative respiratory failure in the inpatient setting of any of the hospital quality reporting or value-based purchasing programs. The PSI 90 composite measure, which is currently included in the Hospital-Acquired Condition Reduction Program, does include a postoperative respiratory failure component, PSI 11; however, it is a claims-based measure that uses a two-year performance period. It is focused specifically on the Medicare Fee for Service population, and it uses ICD-10 codes. The proposed eCQM is a risk-adjusted eCQM that measures hospitalizations for patients with post op respiratory failure. This eCQM is an all-payer measure, so it is not limited to just the Fee for Service population. This eCQM would be submitted annually in the spring following the performance period, and it would be added to the list of eCQMs from which hospitals can self-select to report.

The last proposed new measure is the Thirty-day, Risk-Standardized Death Rate Among Surgical Inpatients measure, which we also refer to as the Failure-to-Rescue measure. Failure-to-rescue is defined as the probability of death given a postoperative complication. Hospitals and healthcare providers benefit from knowing not only their institution's mortality rate, but also their institution´s ability to rescue patients after an adverse occurrence. Using a failure-to-rescue measure is especially important if hospital resources needed for preventing complications are different from those needed for rescue. This is a claims-based measure of death after hospital-acquired complications. This measure would replace the current Death Among Surgical Inpatients with Serious Treatable Complications measure, also known as the PSI 04 measure that is currently in the Hospital IQR Program. This measure was designed to improve upon the existing PSI 04 measure and has four key differences from PSI 04. The first of which is that it captures all deaths of denominator-eligible patients within 30 days of the first qualifying operating room procedure, regardless of site. Second, it limits the denominator to patients in general surgical, vascular, and orthopedic MS-DRG groups.

Third, it excludes patients whose relevant complications preceded their first inpatient operating room procedure, while broadening the definition of the denominator, triggering complications to include other complications that may predispose patients to death. Examples are AMI or stroke. Then, four, the proposed new measure adds Medicare Advantage patients to the measure. Since this is claims-based measure, the measure does not require additional information to be submitted other than the regularly submitted administrative claims.

Moving now to proposed measure removals, on this slide we have all five of our proposed removals and the proposed removal implementation dates. Starting first, we are proposing to remove PSI [04] and proposing to replace it with the Failure-to-Rescue measure, like I just mentioned. Next, our four related proposals, we are proposing to remove four claims-based, risk-standardized payment measures. We are proposing to remove these measures due to the fact that we have the Medicare Spending per Beneficiary measure in the Hospital Value-Based Purchasing Program. That measure evaluates hospital efficiency and resource use relative to the efficiency of the national median hospital. The MSPB measure is more broadly applicable since it captures the same data as these four individual measures, but it also incorporates a much larger set of conditions and procedures. We are proposing to remove these four measures beginning with the fiscal year 2026 payment determination.

Moving next to refinements, the first refinement we are proposing is to add patients 18 and older to the Global Malnutrition Composite [Score] eCQM beginning with the calendar year 2026 reporting period. Previously, this measure only included patients 65 and older, but here we are proposing to add patients between 18 and 64. We will come to the next refinement later in the presentation, so I'll now move to the administrative proposal.

So, now moving to the administrative proposal related to the increase in eCQMs that hospitals must report, as a bit of context, we began requiring hospitals to report on eCQMs in the calendar year 2016 reporting period, with a stated goal at the time of progressively increasing the number of eCQMs hospitals are required to report while also being responsive to

hospitals' concerns about timing, readiness, and burden associated with increasing the number of eCQMs. So, in order to allow hospitals and their vendors time to gain experience with reporting eCQMs, we gradually increased the number of eCQMs on which hospitals were required to report over several years. We required hospitals to report on certain specific eCQMs that CMS selected, while still retaining an element of choice by allowing hospitals to self-select other eCQMs. We gradually increased the number of reporting quarters to improve measure reliability for public reporting. We started with just requiring one quarter of eCQM data and have moved up to four quarters. So, under our current eCQM reporting policies, hospitals must report on four calendar quarters of data for each required eCQM. That would be the Safe Use of Opioids–Concurrent Prescribing eCQM, Cesarean Birth, and the Severe Obstetric Complications eCQM, and also report on three self-selected eCQMs for a total of six for the calendar year 2024 reporting period, which is associated with the fiscal year 2026 payment determination. In this proposed rule, we are proposing to continue that increase in the number of eCQMs that are reported to CMS, by adding a number of previously finalized Hospital Harm eCQMs to the required eCQMs that CMS selects. So, increasing the number of mandatory eCQMs, specifically to include those five previously adopted Hospital Harm eCQMs, supports our recommitment to better safety practices for both patients and healthcare workers. In the calendar year 2026 reporting period, we are proposing to increase the total number of eCQMs from six to nine by adding the Severe Hyperglycemia, Severe Hypoglycemia, and Opioid-Related Adverse Events eCQMs to the list of eCQMs that CMS selects. Hospitals will still be able to self-select three eCQMs. Then, in the calendar year 2027 reporting, we are proposing to increase the total number to 11, by adding the Hospital Harm–Pressure Injury eCQM and the Hospital Harm–Acute Kidney Injury eCQM.

I'll now pass things off to Bill Lehrman to talk through the second refinement related to the HCAHPS measure.

William Lehrman: I'd like to say a bit about the HCAHPS survey and its use in the Hospital IQR and VBP Programs.

In this year's fiscal year 2025 IPPS rule, we're proposing several changes to the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, survey. These changes are proposed to begin with the calendar year 2025 reporting period, which is the fiscal year 2027 payment determination period for the Hospital IQR Program. These changes will also affect the fiscal year 2030 Hospital VBP Program, but I'm going to just briefly summarize how the proposed changes to the HCAHPS survey will affect the use of HCAHPS in the Hospital IQR Program.

Patient experience measures are included in the Universal Foundation program. One goal of CMS is to bring patient voices to the forefront. To do so, it's critical to collect direct feedback from patients on hospital performance. The HCAHPS survey asks recently discharged patients about key aspects of their hospital experience. This produces systematic, standardized, and comparable information about patient experience of care in hospitals, which allows patients to compare hospitals and informs hospital how well they're doing in terms of patient care. The HCAHPS survey was initially launched in 2006. HCAHPS scores, first, were publicly reported in 2008. The HCAHPS survey became part of the Hospital Value-Based Purchasing Program in fiscal year 2013. The major updates I'm talking about, which will begin with January 1, 2025, discharges, will be the first and biggest update to the HCAHPS surveys since it was launched.

First, I'd like to go over a few terms that can cause confusion. In the Hospital IQR and PCHQR Programs, as well as the Hospital VBP Program, the HCAHPS survey is considered to be one measure. Because the whole survey is called one measure, the elements from HCAHPS that are publicly reported are referred to as sub-measures. HCAHPS sub-measures consist of one or several questions from the survey that are combined and publicly reported on the Care Compare website. However, in the Hospital VBP Program, the HCAHPS sub-measures are referred to as dimensions. We'll be speaking more about that a bit later.

I should also point out that all the changes that affect the HCAHPS survey in the Hospital IQR Program also affect HCAHPS in the PCHQR Program. They're identical changes for both programs.

We're proposing, in this year's IPPS rule, several changes to HCAHPS survey content. Currently, the HCAHPS survey consists of 29 questions about patient experience of care and also about patient demographic information. The updated HCAHPS survey, which will be launched with patients discharged January 1, 2025, and forward, will consist of 32 questions. The way we got from 29 to 32 questions is by first adding eight new questions about patient experience of care and then removing five current questions about patient experience of care. This represents a net increase of three questions on the HCAHPS survey, which is a minimal increase in respondent burden.

Just briefly, here is more about the content changes in the updated HCAHPS survey. The eight new questions form three new sub-measures. These are called Care Coordination, Restfulness of Hospital Environment, and Information about Symptoms. Care Coordination and Restfulness [of Hospital Environment] are multi-item sub-measures, while Information about Symptoms is a single item sub-measure. We identify patients' need to gain more knowledge about this aspect and share more knowledge about this aspect of patient experience through focus groups, interviews, technical expert panels, and literature reviews. We tested the content of these items in a large-scale mode experiment in 2021. So, in addition to adding new questions about three new sub-measures, we're making a couple of other changes to the HCAHPS survey content. We are removing the Care Transition sub-measure from the survey beginning in January 2025, and the Responsiveness of Hospital Staff measure will undergo some changes beginning in January of 2025. So, we will be temporarily removing Responsiveness of Hospital Staff from public reporting until we have collected four quarters data on the new content of that survey sub-measure.

This table represents the number of HCAHPS sub-measures that will be publicly reported and the different public reporting periods.

An important piece of information is that we need four quarters of data on a measure to publicly report it. If we don't have four quarters of data, we do not publicly report that measure. Currently, there were 10 sub-measures publicly reported on Care Compare. We will continue to report these 10 sub-measures until the October 2025 public reporting, which consists of data from Q1 through Q4 of 2024. However, beginning with the January 2026 public reporting, and going through the July 2026 public reporting, we will only report eight sub-measures. Those eight sub-measures will be unchanged from the current HCAHPS survey to the updated HCAHPS survey. Once we have collected four quarters of data from the updated HCAHPS survey, we will report 11 sub-measures. That will occur the first time in the October 2026 public reporting, which will consist of Quarters 1 through 4 of 2025. So, just to recap, the updated HCAHPS survey will take effect with January 1, 2025 discharges. Once we've collected four quarters of data, using the updated survey, which will be Q1 through Q4 2025, we will use that data to report the new measures and revised measures. That first public reporting of the new and revised measures will occur in the October 2026 public reporting on HCAHPS Online. So, at that point, we will have 11 sub-measures to publicly report.

In addition to changing content about patient experience of care while in the hospital, the HCAHPS survey also collects a few pieces of information about a patient's background. We call this the About You section of the HCAHPS survey. We use this information not for public reporting, but for patient risk adjustment of data and also for use in some congressional reports. There is one major change to the About You section. We will be removing the current emergency admissions question and replacing it with a new question about whether or not a hospital stay was planned in advance. We propose to use this new About You question about stays planned in advance in our patient mix adjustment of the updated HCAHPS survey. In addition to adding planned stay and removing emergency room admissions, there will be a few minor changes to item wording in a sequence of the questions in the About You section and a few changes to the response options.

I've gone over this material very briefly, but detailed information can be found on the HCAHPS Online website. We have a new dedicated button on this website. It's a red button called Updated HCAHPS Survey. Under that button, you can find a number of important documents, including the updated HCAHPS survey itself, a crosswalk of the questions from the current survey to the updated survey, a crosswalk of the updated survey questions to the publicly reported sub-measures, and also a crosswalk of the updated HCAHPS survey questions to the Hospital VBP dimensions, which another speaker will go over in much more detail.

Here's a graphic of our HCAHPS Online website. The red button on the left is where we have posted this crosswalk and other information about the updated HCAHPS survey.

Thank you. With that, I will pass it to the next speaker.

Alex Feilmeier: Thanks, William. My name is Alex Feilmeier, Program Manager of the Validation Support Contractor, and I'll be covering proposals related to the data validation efforts.

The first is a proposal to modify the eCQM validation scoring beginning with calendar year 2025 eCQM data validation affecting fiscal year 2028 payment determination. Under the existing eCQM data validation policy, the accuracy of eCQM data, which is the extent to which data abstracted for validation matches the data submitted in the QRDA I file, has not affected a hospital's validation score. Instead, hospitals have been scored on the completeness of eCQM medical record data that were submitted for the validation process. We have assessed agreement rates, or the rates by which hospitals reported eCQM data that agree with the data resulting from the review process that we conduct as part of validation. The agreement rates for validation accuracy, which have been confidentially reported to hospitals selected for eCQM validation in recent years, are consistently robust overall. With the low end of the average accuracy range being well above a passing threshold of 75 percent. We believe it is now appropriate to move forward with scoring hospitals' eCQM data based on the accuracy of that data submitted for the purposes of

determining whether a hospital has met the validation requirements under the Hospital IQR Program. By the time our proposed eCQM validation scoring methodology would go into effect, we will have been validating eCQM data for completeness for eight years, which is ample time for hospitals to have prepared for data to be validated based on its accuracy. We would also note that because hospitals are already required to submit 100 percent of those requested eCQM medical records to pass the eCQM validation requirement, there is no additional burden to hospitals associated with this proposal to begin scoring the submitted records.

We are proposing to remove the existing combined validation score based on a weighted combination of a hospital's validation performance for chart-abstracted measures and eCQMs and replace it with two separate validation scores, one for chart-abstracted measures and one for eCQMs. Based on our current policies, the eCQM portion of the combined agreement rate is multiplied by 0 percent, and the chart-abstracted measure agreement rate is weighted at 100 percent. A minimum passing score for this combined score is set at 75 percent. Separate validation scores are consistent with the distinct requirements and procedures for the reporting of quality measure data. CMS intends to retain an emphasis on data accuracy through the validation efforts across both measure types, that is chart-abstracted measures and eCQMs. It is important to ensure necessary analysis and resources are placed on chart-abstracted measures that are still currently being validated, especially because of their use within the Hospital Value-Based Purchasing Program. Therefore, we are proposing to implement two separate scoring processes, one for chart-abstracted measures and one for eCQMs, for the fiscal year 2028 payment determination and subsequent years. Hospitals would be required to receive passing validation scores from both chart-abstracted measure data and the eCQM data to pass validation. Under our proposal, beginning with the validation of calendar year 2025 data, affecting the fiscal year 2028 payment determination, hospitals would receive separate validation scores for both chart-abstracted measure data and eCQM data, which would be used to determine a hospital's annual payment update.

As established in the previous 2006 IPPS final rule, a hospital that fails to meet the validation requirements may not receive the full annual payment update. Under our proposal, if a hospital fails either the chart-abstracted validation requirements or the eCQM validation requirements, it may not receive the full annual payment update. To be eligible for a full annual payment update, provided all other Hospital IQR Program requirements are met, a hospital would have to attain at least a 75 percent upper bound validation score for chart-abstracted measure validation and at least a 75 percent upper bound validation score for eCQM data validation.

Our existing and newly proposed validation scoring changes are summarized in this table. As you can see, the hospital selection would remain unchanged, with up to 200 random and up to 200 targeted hospitals selected for both chart-abstracted measures and eCQMs, but, beginning with calendar year 2025 discharge data, the selected hospitals would be required to achieve at least a 75 percent validation score on both their chart-abstracted measure data as well their eCQM data in order to receive full APU affecting fiscal year 2028 payment determination.

Separately, we are proposing to remove the requirement that hospitals submit 100 percent of the requested eCQM medical records to pass the eCQM validation requirement, and we are proposing that missing eCQM medical records would be treated as mismatches, beginning with the validation of calendar year 2025 eCQM data, affecting the fiscal year 2028 payment determination. This is the same methodology that is applied for missing medical records in chart-abstracted measure validation to incentivize the timely submission of requested medical records. Because mismatches count against the agreement rate, by treating missing eCQM medical records as mismatches, we can ensure our validation scoring methodology clearly requires that hospitals submit all necessary eCQM data for our review without also requiring medical records submissions. We are proposing that eCQM validation scores be determined using the same methodology that is currently used to score chart-abstracted validation. Hospitals' eCQM data would be used to compute an agreement rate and its associated confidence interval.

The upper bound of the two-tailed 90 percent confidence interval would be used as the final eCQM validation score for the selected hospital. A minimum passing score of 75 percent would be required to pass the eCQM validation requirement.

Now, we are going to go over a proposal related to reconsiderations and appeals.

With the transition to all electronic submission of medical record copies and a process for storage/retrieving of those medical records now established, we believe that the current reconsideration requirement to resubmit records used for validation results is no longer necessary and can create duplicative files and work, especially because CMS limits the scope of data validation reconsideration reviews to information already submitted by the hospital during the initial validation process. Therefore, we are proposing to no longer require hospitals to resubmit medical records as part of their request for reconsideration of validation. This would begin with calendar year 2023 discharges, affecting the fiscal year 2026 payment determination. Under our proposal, hospitals that need to submit a revised medical record may still do so, but those hospitals that would otherwise be resubmitting copies of the previously submitted medical records would no longer be required to submit them. We believe that removing medical record submission as a requirement for validation reconsiderations will reduce hospital administrative burden for the majority of hospitals that do not have revised records to submit. Making this step optional would also reduce the burden for CMS to collect and track all those medical records that are already available.

That's all I have, so I'll pass it off to the next speaker. Thank you.

Jessica Warren: Thank you, Alex. This is Jessica Warren, and I am from the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

For the calendar year 2025 IPPS and PRM, the Medicare Promoting Interoperability Program has several proposals that I'll discuss today.

First, we're proposing to increase the minimum scoring threshold from 60 points to 80 points. After analyzing our data, a vast majority of eligible hospitals and CAHs are consistently scoring over 90 points. With scoring being performance base, we are proposing this increase to more closely align with performance. A reminder that meeting or exceeding the minimum scoring threshold is one requirement of passing the PI Program, with passing meaning that you are considered a Meaningful User of CEHRT. Next, we are proposing to separate the existing Antimicrobial Use and Resistance Surveillance Measure, also known as the AUR Measure, into two separate measures, Antibiotic Use and Antibiotic Resistance. Included, we're proposing an additional exclusion for each of these measures, which will be discussed on the next slide. We're proposing to adopt to new eCQMs and to modify one existing eCQM. Last, we have included a Request for Information.

As mentioned in the last slide, we are proposing to separate the Antibiotic Use and Resistance, AUR, measure into two separate measures. Those would be Antibiotic Use and Antibiotic Resistance. When the AUR measure was initially proposed, we listened to feedback and opted to delay its requirement by one full calendar year, then beginning with the calendar year 2024 EHR reporting period. We've continued to receive feedback from eligible hospitals and CAHs on the difficulties faced with fulfilling the requirements of these two components required in one measure. Therefore, we're proposing to separate the AUR measure into two different measures. The first being Antibiotic Use and the second being Antibiotic Resistance.

With the separation, we're proposing that eligible hospitals and CAHs would submit their level of active engagement separately for each of the two measures. Those are Option 1, pre-production and validation, and Option 2, validated data production. Since the combined AUR measure is required for the calendar year 2024 EHR reporting period, with the submission of one level as an active engagement, the level of active engagement you submit for 2024 would not carry over.

Essentially, what this means is that you could report on Option 1 for AU and Option 1 for AR beginning with the calendar year 2025 EHR reporting period, if our proposals are finalized. A quick reminder of existing policy, eligible hospitals and CAHs may only spend one year in Option 1 before being required to move into Option 2. Again, if this proposal is finalized, you could start with Option 1 for AU, beginning with calendar year 2025 EHR reporting period, and then you would be required to move to Option 2 in 2026.

In addition to proposing the separation of AUR into AU and AR, we're also proposing to add an additional exclusion. In essence, there will be three exclusions available for the AU measure and three exclusions available for the AR measure. A final note on the proposed separation is that we are also proposing that the existing scoring convention for the Public Health and Clinical Data Exchange Objective would remain as is. That is, a score for completion of all requirements under this objective would remain at 25 points altogether. For those filing an exclusion for this objective, point redistribution to the Provide Patients [Electronic] Access to Their Health Information measure would remain.

As mentioned previously, and as discussed in more detail with the Hospital IQR Program, we are proposing to adopt two new eCQMs in alignment with the Hospital IQR Program. Those are the Hospital Harm–Falls with Injury eCQM and the Hospital Harm–Post Operative Respiratory Failure eCQM. In addition, we are proposing to modify one eCQM, also an alignment with the Hospital IQR Program, and that includes screening all patients aged 18 and up for the Global Malnutrition Composite Score eCQM, versus the existing screening for ages 65 and up.

Last, we are soliciting feedback from eligible hospitals and CAHs in the form of a Request for Information, also known as an RFI. Specifically, we're asking for feedback from the public on ways that we can utilize and expand on the Meaningful Use of CEHRT in several areas.

First, continuing to improve and expand upon the exchange of public health data; second, how we can respond to public health threats, being mindful of requirements and limitations; third, how we can continue to support data sharing amongst healthcare providers; fourth and last, how to achieve these goals, while still being mindful of our goal for burden reduction. This completes the Medicare Promoting Interoperability portion of the webinar. Next up, we have Julia Venanzi who will present on the Hospital Value-Based Purchasing Program. Julia?

Julia Venanzi: I will now talk through the proposals for the Hospital Value-Based Purchasing Program. To start with a brief background of the program, . while the Hospital IQR Program is a pay-for-reporting program, the Hospital Value-Based Purchasing Program is a pay-for-performance program. This means that hospital performance on measures in the program impacts whether they receive a bonus or penalty under the Hospital VBP Program. By statute, we must first adopt measures into the Hospital IQR Program and publicly report them for a year prior to proposing to move them over into the Hospital VBP Program. In order to participate in the Hospital VBP Program, hospitals must meet all of the requirements in the Hospital IQR Program in a given year. For additional information and additional eligibility criteria, we again refer you to QualityNet.cms.gov.

I will now cover the proposals in the Hospital Value-Based Purchasing Program for this year. This year, we have a number of proposals related to the modifications to the HCAHPS survey measure that Bill just talked through. Here, we are balancing a few key policy goals while replacing the original HCAHPS survey measure with the modified HCAHPS survey measure. So, first, we must meet our statutory requirement under the Hospital VBP Program to publicly report any new or substantively changed measure for a year before moving it into the Hospital VBP Program. Second, we wanted to reduce provider burden by only circulating one version of the survey at a time. Lastly, we wanted to retain the HCAHPS survey in a pay-for-performance program in order to incentivize improvements on these key patient-reported outcome measures.

So, in order to do this, we have a few interrelated proposals. First, we are proposing the adoption of the modified version of the HCAHPS survey measure. The current version of the measure was previously finalized in the Hospital VBP Program and is part of the Patient and Community Engagement domain in the program. In order to replace that version with the modified version, we must first publicly report the modified version for a year. This means that we cannot adopt the modified version into the Hospital VBP Program until the calendar year 2028 reporting period which is associated with the fiscal year 2030 payment determination.

During that transition period, we did want to retain as much of the original measure as possible without requiring hospitals to circulate two versions of the survey to patients. So, during the transition period, we are proposing that, during that time, fiscal year 2027 through 2029, that we score just the six dimensions of the survey that were unchanged in the modification.

Then, in fiscal year 2030, once we have had the time to publicly report the modified version in the Hospital IQR Program, we are proposing to update the scoring methodology in the Hospital Value-Based Purchasing Program to now include all parts of the modified measure from FY 2030 and subsequent years.

Lastly, for Hospital VBP, I did just want to make a note about Table 16. As a reminder, Table 16 lists out each hospital's payment adjustment factor in a given fiscal year. Table 16, that is posted with the proposed rule, includes proxy adjustment factors based on previous performance and on the most current MedPAR data that we have at the time of the publication of the proposed rule. Table 16A, that comes out with the final rule in August, includes updated MedPAR data. Then, Table 16B, which is the last update, includes actual payment adjustment factors after hospitals have had the opportunity for the review and correction period. Table 16B, which has the actual adjustment factors, will post for fiscal year 2024 this fall. I will now pass it to Lang Le to talk about the Hospital-Acquired Condition Reduction Program.

Donna Bullock: We will now cover the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program.

There are no proposals or updates in this proposed rule for both the HAC Reduction Program and HRRP. All previously finalized policies under these programs will continue to apply. I will now turn it over to Lang.

Lang Le: Good afternoon. My name is Lang Le. I'll be discussing Advancing Patient Safety and Outcomes Across the Hospital Quality Programs Request for Comment. In the Hospital Readmissions Reduction Program, CMS has observed that patient readmission rates for conditions and procedures included in this program have decreased. We note that there is a concurrent increase in patients who, after being discharged from an inpatient stay, visit the emergency department or receive outpatient observation services in an outpatient stay. As a result, we are concerned that our hospital quality reporting and value-based purchasing programs may not be incentivizing hospitals to improve quality of care by accounting for more types of post discharge events from the patient perspective, including a caregiver perspective. This includes returning to an acute care setting, including the ED or receiving observation services after being discharged from the hospital inpatient stay, as not a desirable outcome of care. While these unplanned returns to the hospital impose a significant burden on patients, including caregivers, such visits can often be avoided with greater attention to care coordination. Therefore, we invite public comment on these programs to encourage hospitals to improve discharge processes, such as introducing measures currently in our quality reporting programs into value-based purchasing programs to improve outcomes and payment incentives. For example, in our hospital, inpatient quality reporting program, we have EDAC measures, Excess Days in Acute Care, for patients with a primary discharge of AMI, heart failure, or pneumonia. In our Hospital Outpatient Quality Reporting Program, we have a measure that focused on hospital visits after hospital outpatient surgery that covers patients discharged from outpatient surgery.

However, since both the Hospital IQR and Hospital OQR Programs are both quality reporting programs, the hospital's performance on these measures is not tied to payment incentives. As a result, we're specifically interested in input on developing measures which better represent the range of outcomes of interest to patients, including unplanned returns to the emergency department and receipt of observation services within 30 days of patients discharged from an inpatient stay. That concludes my slide for today. Thank you.

Donna Bullock: Thank you, Lang. This slide contains more detailed resources for the HAC Reduction Program and the HRRP.

We will now cover the page directory and the process to submit comments.

On this slide is the link to the fiscal year 2025 IPPS/LTCH PPS proposed rule on the *Federal Register*. Also included on this slide are the page numbers for each of the programs.

CMS is accepting comments until 5 p.m. Eastern Time on June 10, 2024. Comments can be submitted via three methods: electronically, by regular mail, and by express or overnight mail. CMS will respond to comments in the final rule scheduled to be issued by August 1, 2024. Note: Please review the proposed rule for specific instructions for each method and submit using only one method.

This event has been approved for one continuing education credit. If you registered for this event, an email, with the webinar survey and additional continuing education credit information, will be sent to you within two business days. If you did not register for this event, please use the email from someone who did register. More information about our continuing education processes can be found on the Quality Reporting Center website, using the link provided on this slide.

That concludes today's presentation. Thank you for attending, and we hope you enjoy the rest of your day.