Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

FY 2025 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs

Presentation Transcript

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other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Donna Bullock: Hello. Welcome to today's event, *Fiscal Year 2025 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Final Rule Overview for Hospital Quality Programs*. My name is Donna Bullock. I am the Hospital Inpatient Quality Reporting Program lead for the Hospital IQR Program Inpatient and Outpatient Healthcare Quality Systems Development and Program Support. 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. 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. That's www.QualityReportingCenter.com. 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 Health Care Providers and Systems Survey, CMS; Alex Feilmeier, Program Manager, Hospital Quality Reporting Validation Support Contractor; Jessica Warren, Program Lead, Medicare Promoting Interoperability Program, CMS; Jennifer Tate, Program Lead, Hospital-Acquired Condition Reduction Program, CMS; and Lang Le, Program Lead, Hospital Readmissions Reduction Program, CMS.

This presentation will provide an overview of the fiscal year 2025 IPPS/LTCH PPS final rule as it relates to the Hospital IQR Program, the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, the Hospital Readmissions Reduction Program, and the Medicare Promoting Interoperability Program.

At the conclusion of today's event, participants will be able to locate the fiscal year 2025 final rule text and identify finalized program changes within the rule.

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

As does this slide, and I would now like to turn the presentation over to Julia Venanzi.

Julia Venanzi: Thank you, Donna. Before I go through the policies that we finalized in the FY 2025 IPPS rule, I did want to first give a brief overview of the Hospital Inpatient Quality Reporting Program. The program is a pay-for-reporting program for acute care hospitals that are paid under the Inpatient Prospective Payment System. 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, but, in some cases, they are able to voluntarily submit data and have that data publicly reported. For more information on the program and eligibility requirements, we point you to QualityNet.cms.gov.

I also wanted to mention a Hospital Inpatient Quality Reporting Program related proposal that is currently out for public comment in the Outpatient Prospective Payment System proposed rule. We have been closely monitoring the results of voluntary reporting for the Hybrid Hospital-Wide Readmission measure and the Hybrid Hospital-Wide Mortality measure, including most recently the results of the second voluntary period for the Hybrid Hospital-Wide Readmission measure and the first voluntary period for Hybrid Hospital-Wide Mortality measure. During these reporting periods, approximately one-third of IPPS hospitals participated. The data currently indicate that about three-fourths of the participating hospitals would not have met the reporting thresholds for the Core Clinical Data Elements and linking variables if the reporting requirement had been

mandatory. Accordingly, they would have been subject to a one-quarter reduction to their annual payment update under the Hospital IQR Program.

Based on this, as well as a number of comments and outreach from providers about challenges specifically around submitting those linking variables and CCDEs, we have proposed in the OPPS rule that the CCDE and linking variables be voluntary for another year. Under our proposal, a hospital's annual payment determination for fiscal year 2026 would not be affected by the voluntary reporting of CCDEs and linking variables, although we would still evaluate and assess the claims data portion of these measures. The Hybrid Hospital-Wide Readmission and Hybrid Hospital-Wide Mortality measures would still be publicly reported based just on claims data. This proposal would allow us to publicly display hospital information on these important clinical areas as well provide patients with visibility into hospital performance, while providing hospitals with more time to improve reporting on CCDEs and linking variables. I wanted to mention it here as we encourage you to submit public comment on this proposal in the OPPS rule. The final rule for OPPS will be posted later this fall.

Moving now to what we finalized in the fiscal year 2025 IPPS rule, first, we finalized the adoption of seven new measures, the removal of five measures, and the modification of two existing Hospital IQR measures. We also finalized a number of administrative proposals related to electronic clinical quality measures, or eCQMs, including changes to validation and increasing the number of eCQMs that hospitals must report. Lastly, we finalized an administrative proposal related to the reconsideration process.

Moving first to the measure adoptions, this slide includes the seven measures that we are finalizing, along with the implementation timing for each of those measures. I wanted to note and highlight some of the themes of the new measures that we have adopted. 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 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. Since the onset of the COVID-19 PHE, the U.S. has seen declines in patient safety metrics, as evidenced by considerable increases in the number of healthcare-associated infections. 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 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 and specific to the Hospital IQR Program, we are focused on adding patient safety measures that recommit to better safety practices for both patients and healthcare workers.

Our first 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 practices indicating a culture of safety and continuous learning and improvement. Here, I want to note that we did finalize a slightly modified version of the measure. During public comment, we received a number of comments specifically

about Domain 4 Statement B. Specifically, commenters had concerns that data submitted by Patient Safety Organizations, the Network of Patient Safety Databases, would be identifiable.

We want to clarify that before any Patient Safety Work Product is shared with the Network of Patient Safety Databases, a Patient Safety Organization submits the data to the PSO Privacy Protection Center to ensure all identifying information has been removed and that the data are aggregated before transferring it to the NPSD. There is no cost to PSOs for these privacy protections. Nonetheless, the revisions to Domain 4 Statement B mean that a hospital need not attest that its PSO voluntarily submits data to the NPSD. Although we are modifying Domain 4 Statement B, we do continue to encourage PSOs to voluntarily report serious safety events, near misses, and precursor events to the NPSD to increase the amount of nationally representative safety data for research and analyses. I will just note that for the full updated specifications, we refer you to QualityNet.cms.gov.

This measure is similar to previously finalized attestation measures, for example 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, therefore, 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 per domain. Hospitals will attest to this measure annually. For this measure, hospitals will attest via the CDC's National Healthcare Safety Network System.

Moving to the next finalized 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, adding quality measures aimed at optimizing care for older adults is important. Although existing quality measures have improved both the rate and reporting of clinical outcomes that are important to older adults, these measures can be

narrow in scope, for example, focusing on specific conditions or procedures.

To address the challenges of delivering care to older adults with multiple chronic conditions from a hospital and health system perspective, we are finalizing the age friendly hospital attestation measure. The measure assesses how well hospitals have implemented strategies and practices to strengthen their systems and culture for safety.

Again, hospitals here report on the measure by attesting to statements across five domains listed here. For this measure, hospitals will report this measure annually through the Hospital Quality Reporting, or HQR, system.

Our third and fourth new measures are related to healthcare-associated infections, or 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 a 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 they also increase the hospitalization days required for patients and add considerably to healthcare costs. Given the high risk to patient safety, we previously adopted two HAI measures, one related to Catheter-Associated Urinary Tract Infections, or CAUTI, and one related to Central Line-Associated Bloodstream Infection, or CLABSI, in various quality reporting programs. These two measures assess the risk-adjusted standardized infection ratio among adult inpatients. However, locations mapped as oncology wards have not previously been included in those measures. 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 finalized the addition of two measures. The CAUTI and CLABSI measures include stratified for oncology locations. These measures include only patients in locations that are mapped as oncology locations by the CDC and the National Healthcare Safety Network.

These measures use a similar process to the existing CAUTI and CLABSI measures and will be submitted to NHSN on a quarterly basis.

The fifth measure adoption is 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 7,000,000 and 1 million inpatient falls in the U.S. annually, with more than one-third resulting in injury and up to 11,000 resulting in patient death. There is 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 particularly measures the number of inpatient hospitalizations where the patient has a fall that results in moderate or major injury. This, like all other eCQMs, is an all-payer measure. I want to note that this eCQM will be added to the list of eCQMs from which hospitals can self-select to report. eCQMs are submitted annually in the spring following the performance period.

Next, is the adoption of 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 it often results in negative outcomes, including prolonged morbidity, longer hospital stays, increased readmissions, higher costs, and death. Prior to the finalization of this eCQM, there were no eCQMs that focused specifically on postoperative respiratory failure in the inpatient setting in any of the hospital quality reporting programs or value-based purchasing programs. The PSI 90 composite measure, which is currently included in the Hospital-Acquired Conditions Reduction Program, does include a postoperative respiratory failure related component; however, it is a claims-based measure that uses a two-year performance period, and it is focused on the Medicare Fee for Service population, and it is also dependent on ICD-10-CM codes. The newly finalized eCQM is a risk-

adjusted eCQM that measures hospitalizations for patients with post op respiratory failure. Again, like all eCQMs, this is an all-payer measure. This measure will be added to the list of eCQMs from which hospitals can self-select.

The last new measure is the 30-Day Risk Standardized Death Rate Among Surgical Inpatients with Complications measure. 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 this 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. This measure was designed to improve upon the existing PSI 04 measure and has four major differences. First, the new measure captures all deaths of denominator-eligible patients within 30 days of the first qualifying operating room procedure, regardless of site. Second, the new measure limits the denominator to patients in general surgical, vascular, and orthopedic MS-DRGs. Third, it excludes patients whose relevant complications preceded their first inpatient operating room procedure, while broadening the definition of denominator-triggering complications to include other complications that may predispose patients to death. Lastly, the new measure includes Medicare Advantage patients. Since this is claims based measure, the measure will not require any additional information outside of those regularly submitted claims.

Moving now to the measure removals, as I just noted, here we are removing PSI 04 and replacing it with the death rate among surgical inpatients measure. Next, we are removing four claims-based, risk-standardized payment measures. We are removing these measures due to the fact that we have Medicare Spending per Beneficiary measure currently in the Hospital Value-Based Purchasing Program that evaluates hospitals' efficiency and resource use relative to the efficiency of the national median hospital. The MSPB measure is a more broadly applicable

measure because it captures the same data as the four clinical episode-based payment measures, but it also incorporates a much larger set of conditions and procedures. We are removing these four measures beginning with the fiscal year 2026 payment determination.

Moving now to refinements of currently used Hospital IQR Program measures, the first refinement is to add patients 18 and over to the Global Malnutrition Composite eCQM beginning with the calendar year 2026 reporting period. We will come to the second refinement a bit later in the presentation.

Moving now to the administrative policies related to the increase in eCQMs that hospitals must report. For a little bit of history, 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 that hospitals are required to report while also being responsive to hospitals' concerns about timing, readiness, and burden associated with the increased number of measures. 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 the course of several years. We required hospitals to report on certain specific eCQMs that CMS prioritized while also retaining an element of choice by allowing hospitals to self-select some eCQMs. We also gradually increased the number of reporting quarters to improve measure reliability for public reporting. So, under our previously finalized eCQM reporting policies, hospitals must report on four calendar quarters of data for each required eCQM: Safe Use of Opioids-Concurrent Prescribing eCQM; the Cesarean Birth eCQM; and the Severe Obstetric Complications eCQM; as well as three self-selected eCQMs; for a total of six eCQMs for the CY 2024 reporting period. In the IPPS rule this year, we proposed 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 that list. We received many comments about burden and about challenges that some hospitals may face working with their EHR vendor to be prepared to work on these eCQMs. After consideration of

those comments that we received about this proposal, we have finalized a modified version of the proposal. Specifically, we decided to stretch the implementation timeline for the increase in the number of eCQMs out further into the future.

Specifically, we finalized the number of mandatory eCQMs to include the five previously adopted Hospital Harm eCQMs. First, in the calendar year 2026 reporting period, we are finalizing an increase to the total number of eCQMs reported to go from six to eight by adding the Severe Hyperglycemia eCQM and the Severe Hypoglycemia eCQM. Then, in calendar year 2027, we finalized adding the Opioid-Related Adverse Events eCQM. Then, lastly in 2028, we finalized the addition of the Pressure Injury and Acute Kidney Injury eCQMs.

I will pass things off now to Bill Lehrman to talk through the modifications to the HCAHPS measure in the Hospital IQR Program.

William Lehrman: Thank you, Julia. I am Bill Lehrman, the Government Task Leader of the HCAHPS Survey at CMS, and I'd like to talk about some of the updates that are being made to the HCAHPS Survey with the finalization of the rule.

In the final rule, we finalized a number of modifications to the HCAHPS Survey measure, beginning with the calendar year 2025 reporting period for the Hospital IQR Program and through to the 2030 program year for the Hospital VBP Program.

We finalized a number of changes to the Patient Experience of Care measure in these programs. Just as a reminder, patient experience measures are included in the universal foundation, and one goal of CMS's National Quality Strategy is to bring patient voices to the forefront. As such, it is critical to collect direct feedback from patients on hospital performance. The HCAHPS Survey asks recently discharged patients about key aspects of their hospital experience. The survey produces systematic, standardized, and comparable information about patient experience of hospital care, which promotes person-centered care, allows

for public reporting of hospital performance, and allows for a vital measure of hospital value-based purchasing.

There are a few things to note about the terminology associated with the HCAHPS Survey.

HCAHPS as a whole is considered to be one measure in the Hospital IQR Program and also in the PPS-Exempt Cancer Hospital Quality Reporting Program and also in the Hospital VBP Program. So, HCAHPS is one measure in these programs. The publicly reported HCAHPS elements are called sub-measures in the rule, and we'll use that terminology in this presentation. The HCAHPS sub-measures are composed of single or multiple survey questions, and these questions or sub-measures are publicly reported on the Care Compare website. However, in Hospital VBP, HCAHPS, while it's called one measure, the HCAHPS sub-measures are called Dimensions. So, what we call sub-measures in Care Compare and in Hospital IQR are called Dimensions in Hospital VBP. I should remind you that both IQR and PCH adopted the same changes in the HCAHPS Survey.

The current HCAHPS Survey, sometimes we call it the legacy survey, consists of 29 questions or items. The updated HCAHPS Survey has 32 questions. What we did was to add eight new questions to the survey and remove five current questions from the legacy survey. These changes in survey content will begin with patients discharged on January 1, 2025. This is a fairly minimal increase in respondent burden, a net change of just three questions, and it'll take about one minute longer on average for patients to complete the survey. It's important to also note that patients who are discharged in January 2025 will receive the updated survey, but those patients who are discharged in December and earlier will continue to receive the legacy survey. The survey takes a number of weeks to administer, collect the data, etc. So, patients who were discharged in 2024 will continue to receive the legacy HCAHPS Survey until they finish the survey. However, patients beginning in January 2025 will receive the updated HCAHPS Survey.

Here's a quick overview of the changes we finalized for the HCAHPS Survey. Those eight new questions I mentioned earlier form three new sub-measures: Care Coordination, which consists of three questions; Restfulness of Hospital Environment, which also consists of three questions; and Information about Symptoms, which is a single item measure, just one question. Care Coordination asks patients about how well doctors, nurses, and other hospital staff coordinated on the patient's hospital care. Restfulness of Hospital Environment asks about whether the patient was able to rest and recover during the patient's hospital stay. Information about Symptoms asks whether the patient's family or caregiver received information about the patient's symptoms or healthcare needs after discharge. In addition, we are dropping the Care Transition sub-measure in January 2025, and we're temporarily removing the Responsiveness of Hospital Staff sub-measure. That will be removed while we add a new question to that sub-measure and then return to the survey and return to public reporting once we have collected enough data on the revised Responsiveness of Hospital Staff sub-measure.

I apologize for the busyness of this slide, but let me point out a couple of important details about the timeline for rolling the new questions into the updated survey and then public reporting those sub-measures. You will notice for the first four, from January 2025 through October 2025 public reporting, we will be using the legacy HCAHPS Survey which consists of 10 sub-measures. As a reminder, we need four quarters of data on a measure to publicly report the measure. So, all the measures have four quarters in of data before we create scores and publicly report them. Beginning in the January 2026 public reporting, we go down from 10 to eight sub-measures. These eight sub-measures that we continue to report from January through July are unchanged from the legacy survey to the updated survey. So, we continue to publicly report the unchanged measures while the content of the survey itself has been changed. So, as a reminder, while we're adding, say, Care Coordination as a sub-measure in the surveys with patients beginning in January 2025, we won't have four quarters of data on that sub-measure until we get to the end of 2025. So, we won't report the new sub-measures until we have collected four

quarters of data on each sub-measure. On the other hand, once we have fewer than four quarters of data on Care Transition, we will drop that measure from public reporting.

The same is with Responsiveness because we're changing the items in the Responsiveness sub-measure. We will drop that sub-measure from public reporting until we have four quarters of data on the revised sub-measure. So, you can see, from January 2026 through July 2026, there will only be eight unchanged sub-measures in public reporting. Then, when we get to October of 2026, we will have data for the entire calendar year of 2025, Quarters 1 through 4. So, we'll have data on all the measures in the revised updated HCAHPS Survey. So, we'll have 11 sub-measures for public reporting. So, beginning October 2026 public reporting, we will publicly report all 11 sub-measures from the updated HCAHPS Survey.

In addition to changing some of the items and adding some new items about the content of the patient experience in the hospital, we're also making a couple changes to the About You questions at the end of the survey. The About You questions are used to collect demographic information about the patient, such as the patient's level of education, language preference, race, and ethnicity. These data are not publicly reported, but they are used for patient-mixed adjustments and also to construct some congressional reports.

We're making an important change to the About You section. We are removing the current question about whether the patient was admitted through the emergency room and adding a new question which asks the patient whether this hospital stay was planned in advance. We will use the new planned in advance question for patient mix adjustment of the updated HCAHPS Survey. In addition, there are several minor changes in the About You section to item wording, the sequence of the items, and some of the response options to the items.

We spoke about this when we finalized last year's rule. As you may recall, in last year's rule, IPPS rule for fiscal year 2024, importantly, we added three new modes of survey administration. Each of these three new modes

began with a web survey followed by either a mail survey or telephone survey or mail and telephone surveys. That is the preface of this slide.

We encourage participating hospitals to carefully consider the impact of mode of survey administration on response rates and the representativeness of survey respondents. As a reminder, high response rates for all patient groups promote CMS's health equity goals. The HCAHPS project team has done a lot of work, a lot of research, using its mode experiments and analyzing data from the field and has found very strong evidence that there were pronounced differences in response rates by mode of survey administration for some patient characteristics, including patient race and ethnicity, patient language preference, patient age, and patient service line. Briefly, patients who are Black, Hispanic, prefer Spanish, are younger, and are maternity patients are more likely to respond to a telephone survey than to a mail survey. On the other hand, older patients are more likely to respond to a mail survey. This is important because hospitals should consider the impact of the survey, the mode of survey implementation they select on who is likely to respond to the survey. Hospitals that have significant patient populations in those categories I just mentioned should consider using a telephone survey or, at least, a mixed mode survey. That is one mode followed by another mode. Choosing a mode that is easily acceptable to the diversity of a hospital's patient population provides a more complete representation of patient care experiences, and the whole idea behind the HCAHPS Survey is to understand how patients, all patients, experience hospital care. I'd like to refer you to a podcast on our HCAHPS Online website entitled *Improving Representativeness of the HCAHPS Survey*. This will give you more information about how choice of survey mode, which is up to the hospital, is likely to affect who will respond to the survey. Finally, a reminder again, the three web-first modes of survey administration will become available with patients discharged in January 2025.

For more information about the changes we've made to the updated HCAHPS Survey, there are a number of sources available on our HCAHPS Online website, including the updated HCAHPS Survey in all

modes. That is the web mode, the telephone mode, and the web mode, and all translations of the HCAHPS survey, a crosswalk of questions from the current survey to the updated survey, and a crosswalk of the updated survey questions to the publicly reported sub-measures. Again, those sub-measures are what we publicly report on the CARE Compare website. [There is] a crosswalk of the updated HCAHPS Survey questions to Hospital VBP dimensions for both for fiscal year 2027 to 2029 and then for fiscal year 2030 and forward. So, there are a lot of changes that are kind of staggered into, especially the [Hospital] VBP Program. Those details can be found at this website.

It looks just like this. So, when you click on that link, you'll come to this website. You'll see a button on the left column. It's red. It says Updated HCAHPS Survey. You click that, and you can access all these detailed pieces of information about the updated HCAHPS Survey. With that, I'd like to hand it over to the next speaker. Thank you.

Alex Feilmeier: Thanks. This is Alex, and I'll get started on the Hospital IQR Program validation finalizations.

Finalize the modification to the eCQM validation scoring beginning with calendar year 2025 eCQM data, affecting the fiscal year 2028 payment determination, is what we'll go over first. 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 the hospitals selected for eCQM validation in recent years, are consistently robust overall, with the low end of the average accuracy range being well above the passing threshold of 75 percent. It is now appropriate to move forward with scoring hospitals' eCQM data based on the accuracy of data submitted for the purposes of

determining whether a hospital has met the validation requirements under the Hospital IQR Program.

By the time the new finalized eCQM scoring methodology will go into effect, we will have been validating eCQM data for completeness for eight years, which is ample time for hospitals to have prepared data to be validated based on accuracy. We also do want to note that, because hospitals are already required to submit 100 percent of the requested eCQM medical records to pass the eCQM validation requirement, there is no additional burden to hospitals associated with this change to begin scoring the submitted records.

We also finalized the modification of the combined scoring process, beginning with calendar year 2025 data affecting the fiscal year 2028 payment determination. Based on the 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. The modification we've made is to remove the existing combined validation score based on a weighted combination of the 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 that has been finalized. The separate validation scores are consistent with the distinct requirements and procedures for the reporting of quality measure data, and CMS intends to retain an emphasis on data accuracy through the validation efforts across both measure types; that is chart-abstracted 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 VBP Program. Therefore, it was finalized to implement those two separate scoring procedures, one for chart abstracted and one for eCQMs, for fiscal year 2028 payment determination and subsequent years. The hospitals will be required to receive passing validation scores for both chart-abstracted measures and eCQM data to pass the validation requirement. Beginning with that fiscal year 2028 payment determination,

hospitals will receive separate validation scores for both chart-abstracted measure data and eCQM data, which we'd use to determine the overall annual payment update.

To be eligible for the full annual payment update, provided all other Hospital IQR Program requirements are met, a hospital would have to attain that 75 percent upper bound validation score for chart-abstracted and eCQM data validation.

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

We also finalized the modification to remove 100 percent medical record submission requirement. So, this is a separate finalization to remove that requirement. The hospitals had to submit 100 percent of the requested eCQM medical records to pass the eCQM validation requirement. Any missing eCQM medical record will be treated as mismatches beginning with the validation of calendar year 2025 eCQM data, affecting fiscal year 2028 payment determination. This is the same methodology that is applied for missing medical records in the chart-abstracted measure validation efforts, and it does incentivize the timely submission of requested medical records. Because mismatches count against the agreement rate by treating the missing eCQM medical record as mismatches, we can ensure our validation scoring methodology clearly requires that hospitals submit all of the necessary eCQM data for review without also requiring medical record submission as before.

We do have one other finalization. This is part of the reconsideration and appeals process. I'll go over that one now.

This one is about the transition to all electronic submission copies of medical records and a process for storage and retrieving of those medical records now being established.

We believe that current reconsideration requirement and resubmission of records used for validation is no longer necessary and actually creates duplicative files and work, especially because CMS limits the scope of data validation reconsideration reviews to the information already submitted by the hospital during the initial validation process. Therefore, it was finalized to no longer require hospitals to resubmit medical records as part of their request for reconsideration of validation, and that would begin with calendar year 2023 discharges, affecting fiscal year 2026 payment determination. The hospitals that need to submit revised medical records may still do so, but those hospitals that would otherwise just be resubmitting copies of previously submitted records are no longer required to submit them. By removing the record submission as a requirement during the reconsideration process, we will reduce hospital administrative burden for the majority of those hospitals that do not have any revised records to submit. Making this step optional would also reduce the burden for CMS to have to collect and medical records that are already available. That is all I have related to validation, so I'll pass it off to the next speaker. Thank you.

Jessica Warren: Hello. This is Jessica Warren, and I'll be presenting on the fiscal year 2025 IPPS final rule updates for the Medicare Promoting Interoperability Program.

A quick overview of policies finalized in the FY 2025 IPPS final rule for the Medicare Promoting Interoperability Program, first, we are finalizing increasing the minimum scoring threshold with modifications. Next, we finalized separating the Antimicrobial Use and Resistance, or AUR, measure into two new measures. Last, in alignment with the Hospital IQR Program, we finalized the adoption of two new eCQMs and modification of one eCQM.

In the fiscal year 2025 IPPS final rule, we finalized the separation of the AUR measure into two new measures. Those new measures are the Antibiotic Use, or AU, measure and Antibiotic Resistance, or AR, measure.

Each of these new measures will be reported through the CDC's NHSN with data from the self-selected 180-day EHR reporting period. The Medicare Promoting Interoperability Program requires that eligible hospitals and CAHs indicate their level of active engagement when reporting on public health measure-level data to the CDC. There are two levels: Option 1 is pre-production and validation, and Option 2 is validated data production. Our policy indicates that eligible hospitals and CAHs may spend no longer than one year in Option 1 before needing to advance to Option 2. For calendar year 2024 data reporting, also the first year where the AUR measure became a requirement, eligible hospitals and CAHs may select Option 1 of active engagement. With the separation of the AUR measure into the AU measure and the AR measure in calendar year 2025, these are now considered new measures. Therefore, in calendar year 2025, you may select Option 1 of active engagement before moving to Option 2 for 2026 reporting.

With the separation of the AUR measure into the AU measure and the AR measure, we have also separated and modified the exclusion criteria for each of the two measures to be measure-specific. One final note that the objective scoring has not changed. The points associated with the completion of the Public Health Objective Requirements remain at 25.

Once again, as discussed during the Hospital IQR presentation, the Medicare Promoting Interoperability Program finalized, in alignment with the Hospital IQR Program, two new eCQMs available for self-selection. They are, one, the Hospital Harm-Falls with Injury eCQM and, second, Hospital Harm-Postoperative Respiratory Failure eCQM. We also finalized modification of the Global Malnutrition Composite Score eCQM to now include patients aged 18 and older versus the existing 65 and older. This concludes the Medicare Promoting Interoperability Program presentation, and I'll hand it off to the next speaker. Thank you.

Julia Venanzi: I will start here with a brief background of the program. While the Hospital Inpatient Quality Reporting Program is a pay-for-reporting program, the Hospital Value-Based Performance 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. By statute, we must first adopt measures into the Hospital IQR Program and publicly report them for a year prior to moving 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 for additional eligibility criteria, we refer you to QualityNet.

I will now cover the policies we finalized in the Hospital VBP Program for this year. This year, we have a number of policies that are related to the modifications to the HCAHPS Survey measure that Bill just talked through earlier. Here, we balanced a few key policy goals in replacing the original HCAHPS Survey measure with the modified version of the measure in the Hospital VBP Program. First, we had to meet our statutory requirement under Hospital VBP to publicly report any new or substantively changed measures for a year before moving into Hospital VBP Program. Second, we wanted to reduce provider burden by only circulating one version of the survey at a time. Lastly, we did want to retain the HCAHPS Survey in a pay-for-performance program. In order to meet all of those goals, we adopted a few related proposals.

First, we adopted the modified version of the HCAHPS Survey measure. There is a previously finalized version of the measure in Hospital VBP that 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 in the Hospital IQR Program for a year. This means that we cannot adopt the modified version in the calendar year 2028 reporting period, which, for Hospital VBP is associated with the fiscal year 2030 payment determination.

During that transition period, we wanted to retain as much of the original measure as possible without requiring hospitals to circulate two versions of the survey. So, here we finalized a policy that, during that transition time, to score just the six dimensions of the survey that were unchanged in the modification in the Hospital VBP Program.

Then, in 2030, once we have had the time to publicly report the modified version in Hospital IQR Program, we are finalizing an update to the scoring methodology to include all parts of the modified measure in the Hospital VBP Program.

Here, I want to make a note about Table 16. Table 16 lists out each hospital's payment adjustment factor for a given fiscal year. Table 16 is posted with the proposed rule. That version included proxy adjustment factors based on previous years of performance. Table 16A is the table that posted with the final rule. That included updated MEDPAR data. Lastly, Table 16B includes actual payment adjustment factors for fiscal year 2025 after hospitals have had the opportunity for review and correction. That table will be this fall.

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

CMS did not propose and is not finalizing any changes to the Hospital-Acquired Condition Reduction Program in the fiscal year 2025 final rule. We note that all previously finalized policies under this program will continue to apply and refer readers to the fiscal year 2024 final rule for information on these policies. I will now turn the presentation over to Lang Le with the Hospital Readmissions Reduction Program.

Lang Le: Hi, everyone. My name is Lang Le, and I am the Program Lead for the Hospital Readmissions Reduction Program. For today, I'll review the HRRP slide overview along with the request for comment. The Hospital Readmissions Reduction Program, or HRRP, is a type of value-based purchasing program that reduces payments to hospitals with excess readmissions. For the fiscal year 2025 IPPS final rule, we did not propose

and we are not finalizing any changes to the program for the fiscal year 2025 program. We note that all previously finalized policies under this program will continue to apply and refer readers to the fiscal year 2023 final rule.

For the request for comment, Advancing Patient Safety and Outcomes Across the Hospital Quality Programs, CMS requested feedback on ways the agency can encourage households to focus on care coordination and improve the post-discharge outcomes for patients. Specifically, CMS called for public feedback on ways to build on current measures in the QRP programs and leverage those measures in the QRP programs for the VBP programs. These measures could account for unplanned post-discharge hospital visits to account for the full range of post-discharge outcomes beyond just thinking of inpatient remissions, whereby we could consider including measures that will factor in unplanned returns to the emergency department, or ED, visits and receipt of observation services within 30 days of a patient discharge from an inpatient stay. The final rule highlights and provides a summary of the responses that we received on the request for comment.

Donna Bullock: Thank you, Lang. More information about the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program can be found on the CMS.gov and QualityNet websites. This slide provides links to some of those resources.

We will now quickly review the final rule page directory.

You can download the final rule from the *Federal Register* website using the link provided on this slide. For easier access to the information you are searching for, page numbers are also provided here.

We are near the end of the time allotted for our webinar. However, we can take a few minutes now to answer some questions we received from our audience. If we do not get to your question, remember that there will be a question-and-answer summary posted to the Quality Reporting Center website in the near future. This is our first question. I believe it pertains to

validation. For the fiscal year 2025 eCQM validation final rule, we are using our facility's EHR and our CMS-approved eCQM programming with correct value sets along with timestamps per the logic.

We are finding differences when reviewing our manually abstracted results compared to what is being electronically captured. Will this result in a mismatch if we are chosen for validation?

Alex Feilmeier: Hey. This is Alex with the validation team. So, the objective of eCQM data validation efforts is to verify that eCQM data that are submitted by the hospitals to CMS meet the measure's intent of the eCQM specifications. So, when validating the cases, the CDAC reviews the data found in both discrete and non-discrete fields in the medical records submitted that are submitted electronically as PDFs. So, if the CDAC reaches a different conclusion when reviewing the PDF medical record than what was reported to CMS initially within the QRDA file, then, yes, a case mismatch could occur.

Donna Bullock: Thanks, Alex. Our next question pertains to IQR. Will the Patient Safety [Structural] Measure attestation be done on the HQR site? I thought I heard otherwise.

Julia Venanzi: Hi there. This is Julia Venanzi. I saw actually a number of similar questions like this. The Patient Safety Structural Measure will be reported through the National Healthcare Safety Network system, so, the NHSN system, where hospitals currently report on the HAI measures like CAUTI and CLABSI. I did see a related question asking if there would be additional guidance that would get posted on how to submit to NHSN, and I can answer that, yes, there will be some additional guidance documents posted on the NHSN site coming up this fall.

Donna Bullock: Thank you, Julia. Our next question: When it says that the reporting period is calendar year 2026, does that mean we are reporting calendar year 2025 data in 2026?

Julia Venanzi: Yes. I believe this question was asked during the eCQM portion. So, to answer that question specifically, eCQMs, yes, run on a calendar year

performance period basis. So, when we say calendar year 2026, we're talking about all data from January to December 31 of 2026.

For eCQMs specifically, that data get reported into CMS in the spring of the following year, the spring of 2027. To answer that question more generally, on the QualityNet website, we do have some resources that outline the performance period versus the data submission timing, just because it does differ depending on the measure type.

Donna Bullock: Thanks, Julia. We have enough time for just a couple of more questions. Calendar year 2025, fiscal year 2027, will stay at six eCQMs with three required and three to self-select.

Julia Venanzi: Yes. So, this again was asked during the eCQM portion where we talked through our policy to increase the number of eCQMs. I did see a couple of similar questions. I did want to confirm that. Yes, for both calendar year 2024, so the data that's currently being collected and for calendar year 2025, the eCQM requirement is to report on six total eCQMs, three of which that hospitals are able to self-select and then three of which that CMS has selected. Those three are the Safe Use of Opioids eCQM, the Severe Obstetric Complications eCQM, and then the Caesarian Birth eCQM.

Donna Bullock: Thank you, Julia. This is the last question we're going to have time for. We are a critical access hospital that reports to Promoting Interoperability [Program], but we have been having a hard time understanding if we need to submit IQR measures as well. Can you please clarify or point me to the right place?

Julia Venanzi: Yes. So, answering the last part first, I would point you to QualityNet.cms.gov for a number of resources, but, to answer the first part of the question, critical access hospitals are excluded from the [Hospital] IQR Program by statute. However, critical access hospitals are able to voluntarily report on IQR measures and then have that data publicly reported on the Care Compare site. Critical access hospitals are not

required to submit on that data, and they wouldn't face any sort of financial penalty under the Hospital IQR Program for not submitting those.

Donna Bullock: Thank you, everyone. That is all the time we have for questions today.

This program has been approved for one continuing education credit. If you registered for today's event, an email with the link to the survey and continuing education information will be sent to you within two business days. If you did not register for the event, please obtain this email from someone who did register. More information about our continuing education processes can be found by clicking the link on this slide.

That concludes today's presentation. Thank you for joining us, and enjoy the rest of your day.