Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Hospital Quality Program Updates in the FY 2026 Inpatient Prospective Payment System Final Rule Presentation Transcript

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Donna Bullock: Hello. Welcome to today's event, *Hospital Quality Program Updates in the FY 2026 Inpatient Prospective Payment System Final Rule*. My name is Donna Bullock. I am with the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support team. I will be your moderator for today's event. Before we begin, I would like to make a few announcements. If you registered for today's event, we emailed you a link to the slides a short time ago. If you did not get this link, the slides are available on the Quality Reporting Center website. That's www.QualityReportingCenter.com, and, during this event, you can download the slides by clicking the Handouts link. This webinar is being recorded. The recording and a transcript of the event will be available on the Quality Reporting Center website and on the QualityNet website in the near future.

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

This presentation will provide an overview of the fiscal year 2026 IPPS/LTCH PPS final rule as it relates to the programs on this slide.

At the conclusion of today's event, participants will be able to locate the fiscal year 2026 IPPS/LTCH PPS final rule text and identify program-specific changes within the rule.

If we do not answer your question during the webinar, please submit your question to the QualityNet Question and Answer Tool using the link provided on this slide.

This slide includes acronyms and abbreviations that may be used in today's webinar. I will now turn the presentation over to Julia Venanzi.

Julia Venanzi: Thank you for joining the call today. My name is Julia Venanzi, and I'm the Program Lead for the Hospital Inpatient Quality Reporting Program and for the Hospital Value-Based Purchasing Program. Today I'll be providing an overview of the policies that have been finalized in the fiscal year 2026 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System final rule.

I'll start first with a cross-program policy related to our current Extraordinary Circumstances Exception, or ECE, policy. This finalized policy will apply to the Hospital Inpatient Quality Reporting Program, the Hospital Readmissions Reduction Program, the PPS-exempt Cancer Hospital Quality Reporting Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Value-Based Purchasing Program. In the proposed rule, we had proposed to update and codify our policy in order to clarify that CMS has the discretion to grant an extension in addition to a full exception in response to ECE requests. This is in response to situations that have come up where hospitals have reached out to us to say that they have accurate data, but, because of the extraordinary circumstance, they were unable to submit it by the deadline due to that extraordinary circumstance. So, here we're just clarifying that in certain operationally feasible situations, we will be able to grant extensions in addition to exceptions. Hospitals may request ECEs within 60 days of the extraordinary circumstance.

Additionally, we have a Request for Information, or an RFI, that crossed several programs as well. Previously, CMS had issued other RFIs in previous rules around CMS's modernization of our digital quality measurement enterprise as part of our intention to transition to a fully digital landscape. This year in the proposed rule, we provided an update on our progress, as well as a request to gather further comment on continuing advancements in digital quality measurement, specifically with our use of Health Level 7, or HL7, with the Fast Healthcare Interoperability Resource, or FHIR, standards.

In the RFI, we asked a number of questions about the specifics around eCQM FHIR conversion activities, around data standardization for quality measurement and reporting, the timeline under consideration for FHIR-based eCQM reporting, as well as measure development and reporting tools. We did receive feedback from a number of commenters. Many commenters supported the transition to FHIR-based eCQMs to improve data standardization and collection and believed that it would allow digital quality reporting to be less burdensome on providers. We did have a few commenters that added that the DQM transition would achieve broader interoperability goals and would ultimately support timely insights that could drive patient outcomes. We had many commenters share overarching challenges that they believe may impact the DQM transition, specifically the need for clear FHIR versioning policies, for backwards compatibility, and for adequate notice periods for a transition between the standards. Many commenters provided feedback on the FHIR-based eCQM transition timeline. We did have some commenters express concern that the 24-month timeline would not be sufficient, and they recommended a longer timeline that would allow for technical assistance and resources to be integrated, to resolve any troubleshooting delays, and ultimately to permit testing and validation prior to full implementation. We received a number more comments that are fully described in the final rule.

We also sought feedback on new measure concepts related to well-being, prevention, and nutrition. Here we received supportive feedback on the idea of measuring these topics generally, as well as many suggestions on how to do so in the most effective way across the multiple care settings that our quality reporting programs and value-based purchasing programs cover.

So, I'll now move on to the Hospital IQR Program-specific policies that were finalized.

At a high-level overview, in the final rule, we refined four current measures. We removed four existing measures, and we made technical updates to existing measures related to COVID-19.

So, starting first with the refinements, we’re refining these four measures. The refinements will begin with the payment determinations listed in this right-hand column.

For the first measure, the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization, we modified this measure to add Medicare Advantage patients to the current cohort of patients. We shortened the performance period from three years to two years, and we made some changes to the risk adjustment methodology. These modifications will be adopted beginning with the fiscal year 2027 payment determination, which is now associated with the July 1, 2023, to June 30, 2025, reporting period.

For the Hospital-Level Risk-Standardized Complication Rates Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure, we’re making the same modifications. So, we are adding Medicare Advantage patients; we’re shortening the performance period from three years to two years; and we’re making some changes to the risk adjustment. For this measure, our goal is to replace the existing version of this measure in the Hospital Value-Based Purchasing Program with this modified version. However, there is a statutory requirement to publicly report measures for one year in the Hospital IQR Program prior to being able to move them into the Hospital Value-Based Purchasing Program. So, with that in mind, we’re adopting the modification in fiscal year 2027 in the Hospital IQR Program, which is now associated with the July 1, 2023, to June 30, 2025, reporting period. Then, we’re finalizing removing it from IQR and moving it into the Hospital Value-Based Purchasing Program, beginning with the fiscal year 2030 program year.

The next two measures, the Hybrid Hospital-Wide Readmission Measure and the Hybrid Hospital-Wide Mortality Measure, are both being modified to reflect challenges that we’ve heard from hospitals around the submission of linking variables and core clinical data elements. Here we’re modifying the two measures to lower the submission thresholds in order to allow for up to two missing lab results and up to two missing vital signs.

We're also reducing the core clinical data elements, or CCDEs, and linking variable submission requirement to 70 percent or more discharges. These proposed refinements begin with the fiscal year 2028 payment determination.

So, next, I'll cover the measure removals.

CMS has finalized the removal of four measures from the Hospital IQR Program beginning with the calendar year 2024 reporting period, which is associated with the fiscal year 2026 payment determination. These measures were proposed for removal because the costs associated with these measures outweighed the benefit of its continued use in the program.

So lastly, for the Hospital IQR Program, we announced technical updates to the specifications for several measures listed here on the screen, beginning with the fiscal year 2027 payment determination. The technical updates include removing the COVID-19 exclusions from all of the measures on the screen. We had previously included these exclusions in a previous year. The technical update would modify these measures to remove the exclusion of COVID-19 diagnosed patients from the index admissions and readmissions, including the removal of the exclusion of certain ICD-10 codes that represented patients with a secondary diagnosis of COVID-19 and the history of COVID-19 risk variable.

So, we are moving now to the Hospital Value-Based Purchasing Program.

As a reminder, the Hospital Value-Based Purchasing Program is a budget-neutral program that is funded by reducing participating hospitals' base operating DRG payments in a given fiscal year by 2 percent and then redistributing that entire amount back to hospitals as value-based incentive payments, depending on their performance on the quality measures. So, starting first at a high level in the Hospital Value Based Purchasing Program, we modified one existing measure. We made technical updates on measures. We removed the health equity adjustment. Lastly, we updated the ECE policy that I mentioned before.

We also provided updated performance standards for fiscal year 2027 through the fiscal year 2031.

As noted in the Hospital Inpatient Quality Reporting [Program] section, we modified the existing version of the hip/knee complication rate measure to include MA patients, to shorten the performance period from three years to two years, and to make some changes to the risk adjustment methodology.

This slide provides an overview on the different versions of the measures and then how they will work through the Hospital IQR Program through to the Hospital Value-Based Purchasing Program.

So, to start first with a bit of context on this, these exclusions began as a response to the COVID-19 Public Health Emergency. That Public Health Emergency expired on May 11 of 2023. So, we at CMS believe that hospitals have had adequate time to adjust to the presence of COVID-19 as an ongoing virus and that the inclusion of COVID-19 patients supports a more complete measure of the hospital's quality of care post-pandemic.

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

Our last proposal under the Hospital Value-Based Purchasing Program was our finalized policy to remove the health equity adjustment points from the Hospital Value-Based Purchasing Program beginning with the fiscal year 2026 payment determination.

The health equity adjustment plans were originally adopted in the fiscal year 2024 rule for implementation beginning in fiscal year 2026.

That concludes the Hospital Value-Based Purchasing Program-related finalized proposals. I'll now turn things over to Jessica Warren to cover the Promoting Interoperability Program.

Jessica Warren: Thank you, Julia. This is Jessica Warren from the Medicare Promoting Interoperability Program for eligible hospitals and CAHs. I'll be talking about what was finalized in the fiscal year 2026 IPPS final rule.

In this presentation, we'll cover the EHR reporting period, measure modifications, a new optional bonus measure under the Public Health objective, and a review of our Request for Information.

For calendar year 2026 and subsequent years, we finalized continuing with the 180-day EHR reporting period, a reminder that you may self-select any continuous 180 days from which data are collected and subsequently reported to the Hospital Quality Reporting, or HQR, system in 2027.

Beginning with the EHR reporting period in calendar year 2026, we finalized modifications to the Security Risk Analysis measure and the Safety Assurance Factors for Electronic Health Record Resilience, or simply the SAFER Guides measure.

The Security Risk Analysis measure requires eligible hospitals and CAHs to attest Yes to having conducted or reviewed a security risk analysis at any time during the calendar year in which the EHR reporting period occurs. New for calendar year 2026 is a secondary requirement that eligible hospitals and CAHs must attest Yes to having conducted security risk management activities, implement security updates as necessary, and correct identified security deficiencies as part of the risk management process. These activities may occur at any time during the calendar year in which the EHR reporting period occurs. When reporting in HQR, there will be two attestations requiring a Yes response to be considered a meaningful user.

The Safer Guides measure requires that eligible hospitals and CAHs conduct an annual self-assessment using the SAFER Guides at any time during the calendar year in which the EHR reporting period occurs. When conducting the self-assessment, we do not require that you meet or implement any of the practices to any degree. The guides are meant to offer recommendations for consideration while addressing EHR safety in your facility. In February of 2025, ASTP ONC released the 2025 version of the SAFER Guides. This version includes updated practices for consideration, streamlined content, fewer guides for review, and updates to the implementation status portion. For the EHR reporting period in calendar year 2025, for activities reported to HQR in 2026, we ask that you continue to use the 2016 version of the SAFER Guides. For the EHR reporting period in calendar year 2026, for activities reported to HQR in 2027, we ask that you use the 2025 version of the SAFER Guides. Both versions are currently available on the ASTP ONC website, and we encourage everyone to review the 2026 version of the SAFER Guides and become familiar with the new content and layout.

Under the Public Health and Clinical Data Exchange Objective, we are offering a new optional bonus measure beginning with the EHR reporting period in calendar year 2026. This is called the Public Health Reporting Using TEFCA measure. TEFCA stands for the Trusted Exchange Framework and Common Agreements. To claim the bonus points, the eligible hospital or CAH must be a signatory to a TEFCA Framework Agreement, transmit health information electronically, and use CEHRT to exchange data with a public health agency, PHA. One key to be mindful of is that you must be actively exchanging data for one of the six required measures under the objective. The required measures are Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, Electronic Laboratory Reporting, Antimicrobial Use Surveillance, and/or Antimicrobial Resistance Surveillance. More simply, you must be exchanging data under Option 2, Validated Data Production, with data exchange during the self-selected EHR reporting period.

Beginning with calendar year 2026, the Public Health Objective will have three optional bonus measures. You are welcome to report on the Public Health Registry, Clinical Data Registry, and/or the Public Health Reporting Using TEFCA measures, but only five points will be distributed. Once again, or said another way, whether you report on one, two, or all three bonus measures, you will only receive five points.

We would like to thank those who submitted public comment on our request for information. We read and take suggestions into consideration when developing future policies. So, we encourage you to continue sharing your feedback. We requested information on the Query of Prescription Drug Monitoring Program, or for short, PDMP measure, looking at expanding drug eligibility to include all Schedule II drugs versus Schedule II opioids only, as well as considering moving towards a numerator-denominator approach versus the current attestation. We requested information on moving away from attestation-based reporting in general towards a numerator-denominator, performance-based reporting approach for all measures in the program. Last, we requested feedback on how to define and gauge data quality for the program. While we do not typically respond to feedback we've received, we once again thank those who did submit comments. We read all of them. Lastly, for the Medicare Promoting Interoperability Program, I'd like to encourage eligible hospitals and CAHs to review the calendar year 2026 PFS proposed rule for MIPS-eligible clinicians, submit comments for our review, and keep an eye out over the next few months for the calendar year 2026 PFS final rule. Thank you for listening to the presentation. Next, we have Lang who will discuss the HACRP program. Thank you, again.

Lange Le: Thank you, Jess. My name is Lang Lee. I'm the Program Lead for the Hospital-Acquired Condition Reduction Program. This section of the presentation focuses on the final policies of the HAC Reduction Program for the fiscal year 2026 IPPS/Long-Term Care Hospital PPS final rule.

In this slide, similar to the technical updates discussed for the Hospital Value-Based Purchasing Program, CMS announced a technical update to the CDC's National Healthcare Safety Network healthcare-associated infection measures to use standardized population data from calendar year 2022 for the HAC Reduction Program. As information, CMS finalized the cross-program updates to the ECE policy.

CMS anticipates that the new 2022 standard population data will affect the HAC Reduction Program, beginning with the fiscal year 2028 program year. The rationale for the updates includes providing timely, comparable, and clinically relevant evaluation of HAIs; promoting accurate risk adjustment and valid comparisons across hospitals since standard population data are used to calculate the expected infection rates; and, lastly, align with the routine CDC measure maintenance. In slide 36, you can see the HAC Reduction Program year and related performance period along with the standard publication data used for the program. This slide concludes the HAC Reduction Program slide overview.

For the Hospital Readmissions Reduction Program, this section of the presentation focuses on the finalized policies for the Hospital Readmissions Reduction Program in the fiscal year 2026 IPPS/LTCH PPS final rule.

In the final rule, CMS finalized a modification to the readmission measures to include Medicare Advantage, or MA, data. CMS also finalized to shorten the applicable period from three to two years. Additionally, as mentioned previously, CMS finalized the cross-program updates to the ECE policy with modification. CMS also discussed a technical update to remove COVID-19 exclusions and risk adjustment covariance from the readmission measures. Lastly, CMS is now finalizing its proposal to modify the calculation of aggregate payments for excess readmissions to include MA data.

First, CMS finalized a proposal to expand the readmission measures inclusion criteria to include MA beneficiaries beginning with the fiscal year 2027 program year.

The addition of MA data to the measures doubles the cohort size and more accurately reflects the quality of care for both Medicare Fee for Service and Medicare Advantage, or MA, beneficiaries. CMS also provides a non-substantive update to re-specify the risk model for each measure to primarily use individual ICD-10 codes in place of the previously used HCCs.

CMS also finalized a proposal to shorten the applicable period from three to two years, beginning with the fiscal year 2027 program year. The applicable period is the data period used to calculate the Excess Readmission Ratio, or ERRs, aggregate payments for excess readmissions in the dual proportions for the fiscal year. The applicable period will be the two-year period beginning one year advance from the previous program fiscal year start of the applicable period. For example, for the fiscal year 2027, the applicable period will be July 1, 2023, through June 30, 2025. The finalized update allows for more recent data to be used when assessing performance. Including MA patients in the cohort improved the hospital variance with the two-year combined Fee for Service and MA cohort, compared to the current three-year period and Fee for Service-only cohort. This concludes the presentation for the Hospital Readmissions Reduction Program presentation slides. Thank you, and I'm passing on the presentation to John.

John Green: Thank you, Lang. My name is John Green, and I am the CMS Program Lead for the Prospective Payment System-exempt Cancer Hospital Quality Reporting Program, which is more commonly known as PCHQR.

Most of our policy activity for the PCHQR Program this year is shared with other quality programs, specifically, several measure removals and an update to the program ECE policy. Much of this information has already been covered by my colleagues, but I will provide a quick recap on the next slide for anyone joining this webinar late.

We do have one unique provision for PCHQR in this year's rule, and that involves public reporting. I'll go into a little more detail on that later.

Starting off with the updates we share with other quality programs, we finalized our proposal to remove three measures from the PCHQR Program, effective with the fiscal year 2026 program year. So, more details have already been discussed earlier in the webinar by Julia, but to be clear for PCHQR, these removals include three measures. We have the Screening for Social Drivers of Health, the Screen Positive Rate for Social Drivers of Health, and the Hospital Commitment to Health Equity measures. We also had the update to the ECE policy, which has also already been covered in more detail earlier in this webinar. There are going to be two changes. One is we have 60 days to receive an ECE, and we also will now be offering extensions rather than the full exceptions, which gives us more flexibility in processing ECE requests.

As I mentioned earlier, we do have one unique policy that we finalized for the PCHQR Program in this year's rule, and that's related to public reporting improvements. I'm going to provide a little more detail about the implications of this. Currently, the data we collect by facilities under this program is only published on the PDC, or the Provider Data Catalog. Our change that we finalized is to begin reporting this on the Compare tool. Just to be clear, the Provider Data Catalog isn't going away. It's more that the Compare tool complements what's available on PDC. By adding data on the Compare tool, the goal is we can present this already collected information in a format that's more user-friendly and easily understood by the public. The addition of the Compare tool not only supports increasing this public access to the data, but it also places PCH facilities in the same context as most other quality reporting programs. We're working on implementing the system updates for the Compare tool, and we hope to have some more details and updates for that soon.

With that, I would like to hand things back to Donna, who will share some closing remarks to this webinar.

Donna Bullock: Thank you, John. This slide contains the link to the final rule and the page directory for all the programs. That concludes today's presentation. Thank you for joining us. Enjoy the rest of your day.