Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

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

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Donna Bullock: Welcome to today's event, *Fiscal Year 2027 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs*. 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. Also during this event, you can download the slides by clicking the Handouts link. This webinar is being recorded. The recording will be available on the Quality Reporting Center website and also on the QualityNet website in the near future.

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

As you are listening to the webinar, we encourage you to email questions related to the webinar to the email address noted on this slide, WebinarQuestions@hsag.com. Please make sure to include the title of the webinar and the slide number as well. If you have additional questions not related to the webinar, we ask that you submit them directly to the Quality Question and Answer Tool. You can use the link that is on this slide.

The purpose of this event is to provide an overview of the proposed rule as it relates to the programs listed on this slide.

At the conclusion of today's event, participants will be able to locate the fiscal year 2027 IPPS/LTCH PPS proposed rule text, identify program-specific proposals within the rule, and understand the timeline and methods for submitting public comments to CMS.

In compliance with the Administrative Procedures Act, we are not able to provide additional information, clarification, or guidance related to the fiscal year 2027 proposed rule. We encourage stakeholders to submit comments or questions through the formal comment submission process as described later in this webinar.

This slide has acronyms and abbreviations that we may use during today's webinar. Now, I'll turn the presentation over to Julia Venanzi.

Julia Venanzi: Hello. I'm Julia Venanzi, and today I will be covering cross-program proposals, the Hospital Inpatient Quality Reporting Program, and the Hospital Value-Based Purchasing Program.

I'll start first with proposals that include multiple programs. First, we have a proposal to add the Advanced Care Planning Electronic Clinical Quality Measure in the Hospital IQR Program, the Promoting Interoperability Program, and the PPS-exempt Cancer Hospital Quality Reporting Program. This measure is being proposed for adoption, beginning with the calendar year 2028 performance period. In the Hospital IQR Program and PI Program, this measure will be added to the list of eCQMs from which hospitals can choose to self-select to report it. Inpatient care teams routinely manage high-stakes decisions and care transitions, making hospitalization an opportune moment to initiate or update advanced care planning documentation and ensure updated directives are accessible to clinicians across subsequent care settings. Many patients assume that their caregivers know their preferences regarding their care, but recent research has found that caregivers incorrectly predict the patient's preferences about one-third of the time. Additionally, care preferences may change over time, particularly if there are changes in an individual's health status or circumstances. From the patient perspective, the benefits of documenting advanced care planning can include increased autonomy, reduced unwanted and unnecessary treatment, reduce length and number of hospitalization, as well as more time with family and loved ones.

With this in mind, we are proposing to adopt the Advanced Care Planning eCQM, which calculates the proportion of adult patients with one or more hospitalizations during the measurement period, who by the time of hospital discharge for at least one encounter, have an advanced care planning document or documentation of an advanced care planning discussion resulting in a documented decision in the patient's electronic health record. This eCQM is intended to promote timely advanced care planning by encouraging communication between patients and providers to elicit and document the patient's care preferences and surrogate decision makers, thereby supporting age-friendly and goal-concordant care.

The measure numerator includes all adult patients with one or more inpatient encounters during the measurement period who have an advanced care planning document or documentation of an advanced care planning discussion resulting in a documented decision in the patient's EHR by the time of the hospital discharge. The numerator includes one of the following: an advanced care planning document, a designated health care agent, an advanced directive or living will, a portable medical order, a physician order for life-saving treatment, or a do not resuscitate order. Alternatively, we also include documentation that an advanced care planning discussion with a documented decision occurred during the measurement period. Further details on this measure can be found on the QualityNet page.

The next cross-program proposal relates to the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Here we are proposing to modify five of the existing mortality measures that are in the Hospital Value-Based Purchasing Program. These are 30-day, all-cause, risk-standardized mortality measures for the following five procedures or conditions: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and coronary artery bypass graft. We are proposing to modify these measures to add Medicare Advantage beneficiaries to the cohort. Since we are adding these MA beneficiaries, this increases the cohort size significantly.

So, we are also now able to propose reducing the performance period from three years to two years without losing any reliability or validity to the measure. This will allow for us to provide data faster. This is a cross-program proposal because of the statutory requirements that require CMS to publicly report any new or substantively modified measure for one year in the Hospital Inpatient Quality Reporting Program before it can be moved to the Hospital Value-Based Purchasing Program. Given this, we are proposing a staged timeline for adoption with the modification first moving into the Hospital IQR Program with the July 1, 2024, through June 30, 2026 performance period, and then subsequently moving it into the Hospital Value-Based Purchasing Program with the July 1, 2028 to June 30, 2030 performance period.

Next, I will be covering a cross-program Request for Information. So, this is not a proposal, but instead an opportunity for CMS to ask for input prior to considering a future possible proposal. Here we're seeking information on addressing emergency room access and timeliness in the inpatient setting. So, ED boarding, or the practice of holding a patient in the ED after the patient is admitted or placed into observation status at a hospital, can lead to patient safety risks, stressful working conditions for healthcare personnel, and poor quality for patients. It also contributes to long wait times in the emergency department. We've adopted a measure into the Hospital Outpatient [Quality Reporting] Program, and here we're requesting information on potential changes that we can make to make it appropriate for the inpatient setting as well, as we recognize that this issue requires coordination across the healthcare delivery system.

The Emergency Care Access and Timeliness eCQM is currently specified for the hospital setting and calculates the proportion of four outcome metrics that quantify access to and timeliness of care in a hospital ED setting against specified thresholds, including 1) patient wait time over an hour, 2) whether the patient left the ED without being evaluated, 3) patient boarding time in the ED as defined by a decision to admit order to ED departure for admitted patients over four hours, and, lastly, 4) the patient ED length of stay over eight hours.

The denominator is all ED encounters associated with patients of all ages for all payers during a 12-month period of performance. Patients can have multiple encounters during a period of performance, and each encounter is eligible to contribute to the calculation of the measure.

So, I'll now move to proposals specific to the Hospital Inpatient Quality Reporting Program.

As an overview, we are proposing to add three new measures, to remove three measures, and to modify three existing measures. We're also proposing to update the form, manner, and timing requirements. We also have two [Hospital] IQR [Program] specific requests for information.

So, looking first specifically at the proposed new adoptions, I note that I covered one of these, the Advanced Care Planning, in the cross-program section.

The second new eCQM we are proposing to adopt is the Excess Days in Acute Care After Hospitalization for Diabetes measure. An estimated one in every three Americans 65 years or older has diabetes. The American Diabetes Association estimated that, in 2022, healthcare expenditures attributable to diabetes for individuals age 65 or older in the U.S. included $67.7 billion for hospital inpatient stays and $7.2 billion for emergency department visits. Diabetes is one of the most expensive conditions billed to Medicare with a wide variation in inpatient utilization among hospitals. Post-discharge ED visits and observation stays are also common and costly for patients with diabetes, often reflecting gaps in discharge coordination, patient education, medication management, as well as standardized post-discharge support. The proposed new measure supports the CMS and HHS priority to address chronic illness while aiming to improve disease-specific outcomes, reduce avoidable acute care utilization, and to improve care transition. The measure assesses the number of days a patient spends in acute care within 30 days of a discharge from the inpatient hospitalization for a diagnosis of diabetes with complications.

The numerator is the number of days a patient spends in acute care for any cause within 30 days of a discharge from the index hospitalization for diabetes. The denominator of the measure includes principal diagnosis of diabetes, Medicare Fee for Service or Medicare Advantage, age of 65 or older, being discharged alive from a non-federal short-term acute care hospital, and then lastly not being transferred to another acute care facility. The proposed measure is a similar setup to our existing EDAC measures that we have for other conditions and uses only claims. The proposed adoption is using the July 1, 2025, through June 30, 2027, performance period which would be associated with the fiscal year 2029 payment determination.

The final proposed new measure is the Hospital Harm - Postoperative Venous Thromboembolism eCQM. Post-op VTE includes both deep vein thrombosis and pulmonary embolism. VTE is considered to be a leading cause of preventable death following surgery with as many as 70% of cases considered to be preventable. Non-fatal postoperative VTE can lead to adverse health consequences, including chronic thromboembolic pulmonary hypertension, a potentially fatal condition. Long-term complications such as pain and swelling in the affected limb occur among one-third to one-half of people who have a VTE. There are established therapies that can reduce the risk of a VTE, but failure or delay in prescribing appropriate VTE prophylaxis can result in higher risk of postoperative VTE. This measure assesses the proportion of inpatient hospitalizations for patients age 18 and older who have at least one surgical procedure performed inside the operating room during the admission and who suffer the harm of a postoperative VTE during hospitalization or within 30 days after the first surgical procedure. The numerator includes the number of inpatient hospitalizations for adult patients who had a surgical procedure performed in the operating room during the hospitalization and experienced a VTE within 30 days of the procedure. The denominator is the number of adult patients who had a surgical procedure performed in the operating room during an inpatient hospitalization. This is an electronic clinical quality measure similar to the other previously adopted Hospital Harm eCQMs.

We're proposing to adopt this eCQM, beginning with the calendar year 2028 performance period, which is associated with the fiscal year 2030 payment determination. Now, I'll move to our proposed removals.

Here we are proposing to remove three measures, beginning with the calendar year 2028 reporting period and the fiscal year [20]30 payment determination. The first two, VTE Prophylaxis and ICU VTE Prophylaxis, are being removed given that we're proposing the more outcome-focused Hospital Harm - VTE eCQM. The last measure that we're proposing to remove is Discharge on Antithrombotic, which is being proposed for removal because it is reaching topped-out status.

We are also proposing to modify three existing EDAC measures in the program: AMI, heart failure, and pneumonia. Here, we're proposing to modify these measures to add MA beneficiaries. Then, again, because the cohort will increase, we're able to reduce the performance period from three years to two years.

Our next proposal is related to previously adopted eCQMs. Here, we are making proposals to make certain eCQMs that were previously available for hospitals to self-select report mandatory to report in the future. First, we are proposing to require mandatory reporting of the Malnutrition Care score, beginning with the calendar year 2028 performance period/fiscal year [20]30 payment determination. Second, we're establishing a policy that, once Hospital Harm eCQMs have been available for self-selection for two years in the program, they automatically become mandatory in the third year.

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

Here we are proposing an administrative update to the Maternal Morbidity Structural Measure. The current measure asks hospitals whether or not they participate in and implement practices from a nationwide or state perinatal quality collaborative.

Here, we are just proposing to add a sub-question for hospitals that attest Yes to the measure to ask the name of the specific quality collaborative that they participate in.

Next, I'll cover two Requests for Information that are specific to the Hospital IQR Program. First, CMS is requesting information and comment on the potential future use of the Adult Community Onset Sepsis Standardized Mortality Ratio measure in the Hospital IQR Program. While this is not a direct replacement for the existing SEP-1 measure, CMS is considering potentially adopting this measure in the future to replace that measure in the Hospital IQR Program. The numerator of this measure is the number of annually observed adults with community onset sepsis who died during hospitalization or were discharged to hospice. The denominator is the number of annually predicted adults with community onset sepsis who died during hospitalization or were discharged to hospice. This is a measure that would use FHIR®, the Fast Healthcare Interoperability Resources® API. Hospitals would submit this electronically to the National Healthcare Safety Network, the CDC's platform.

The second RFI is about the potential expansion of the Birthing Friendly hospital designation. CMS is seeking input on adding two additional outcome-based quality measures, the Cesarean Birth eCQM and the Severe Obstetric Complications eCQM. Right now, the Birthing Friendly designation is solely based on the Maternal Morbidity Structural Measure that I mentioned previously. If we were to add these two additional eCQMs, we are also seeking feedback on how we could potentially create a scoring methodology that could weight the three measures together to create a new Birthing Friendly hospital designation score. So, here CMS is seeking feedback on potentially adopting those measures, as well as seeking feedback on this composite scoring methodology.

So, I'll now cover up topics related to the Hospital Value-Based Purchasing Program.

As an overview, we are not proposing to add or to remove any measures from the program.

We are proposing to modify five of the existing measures. We are also providing various required annual updates to the performance standards in the program.

So, the only measure-related proposal is the modification to those five existing mortality measures that I mentioned in the cross-program section. As a reminder, we are proposing to adopt those into the Hospital Value-Based Purchasing Program with a July 1, 2028, through June 30, 2030, performance period, which would be associated with the fiscal year 2032 payment determination in this program.

Here we just note that, while this is not a proposal, we just wanted to take the time to note here that we will display an updated Table 16B in the fall with the final rules that reflect actual payment adjustments for the fiscal year 2027 payment adjustment.

We also wanted to note that, in the proposed rule, we provided updated performance standards for a number of measures listed here in this table.

So, I will now pass it over to Jessica Warren to cover the Promoting Interoperability Program.

Jessica Warren: Thank you, Julia. This is Jessica Warren, and I'll be speaking about proposals under the Medicare Promoting Interoperability Program included in the fiscal year 2027 IPPS proposed rule.

Let's start with a quick overview. First, we're proposing to revise the definition of Certified Electronic Health Record Technology, or CERT. We are proposing to remove two attestations and two measures. We are proposing to remove three eCQMs and adopt one eCQM in alignment with the Hospital IQR Program. We are proposing to adopt one new measure. Last, we are proposing to modify one measure.

ONC's [Health Data, Technology, and Interoperability (HTI):] Deregulatory Actions to Unleash Prosperity proposed rule, the HTI-5 proposed rule, appeared in the Federal Register on December 29, 2025.

Included were updates focused on deregulatory actions and burden reduction, offering flexibility to developers and providers and supporting innovation through the removal and revision of certain certification criteria and regulatory provisions. Several proposals in the HTI-5 proposed rule are relevant to eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. In response to the HTI-5 proposed rule and other considerations, we have proposed to revise our definition of CEHRT to ensure consistency between ONC and CMS.

While we continue to support the ONC Direct Review and ONC ACB Surveillance activities, we also recognize the need to reduce administrative burdens in our program when feasible. We recognize the importance of the ONC Direct Review and the ONC ACB Surveillance activities and believe these mechanisms are important for mitigating issues with health IT products that may pose serious risks to public health. We will continue to cooperate with ONC in supporting the ONC Health IT Certification Program. We do not believe that, by proposing to remove the required attestation and optional attestation, this will affect participation from eligible hospitals and CAHs. Therefore, we are proposing to remove the ONC Direct Review attestation and the optional ONC Authorized Certification Body Surveillance attestation effective with the EHR reporting period in calendar year 2026. This means you wouldn’t need to report on the attestations in 2027.

We are also proposing to remove the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, beginning with the EHR reporting period in calendar year 2028. After reviewing the number of hospitals that are selecting these measures under the Health Information Exchange objective, we believe that the community is ready to move towards bi-directional data exchange in the next few years. Under this proposal, the send and receive measures would remain available for use in calendar year [20]26 and calendar year [20]27.

In calendar year [20]28, eligible hospitals and CAHs must choose between the bi-directional measure or participate in TEFCA measures to earn points for the HIE objective.

In the CMS Interoperability and Prior Authorization final rule released in 2024, the Medicare Promoting Interoperability Program finalized the Electronic Prior Authorization measure, beginning with the EHR reporting period in calendar year 2027. CMS, in partnership with ONC, has listened to stakeholder feedback, In response, released the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule and subsequently proposed Electronic Prior Authorization measure modifications in this IPPS proposed rule. First, we propose to modify the measure description to more clearly articulate the use of CEHRT for reporting on the measure. Second, we are proposing that the measure would be optional for reporting during the EHR reporting period in calendar year 2027 and then required, beginning with the EHR reporting period in calendar year 2028. For those eligible hospitals in CAHs who opt to participate in calendar year 2027, they would earn 10 bonus points for attesting Yes to ePA. Last, we are requesting information from stakeholders asking for feedback on the ePA measure. We encourage listeners to read through our proposals and submit feedback for future consideration.

CMS has partnered with the FDA on proposing the Unique Device Identifiers measure under the Public Health and Clinical Data Exchange objective. We are proposing that, beginning with the EHR reporting period in calendar year 2027, eligible hospitals and CAHs would be required to electronically capture and store the complete UDI in a patient's electronic health record. This would be applicable to and required for each implantable medical device subject to existing UDI requirements for patient care delivery. We are also requesting information from stakeholders asking for feedback on this measure. We encourage listeners to read through our proposals and submit feedback for future consideration.

Although covered under the Hospital IQR [Program] presentation, we would like to highlight proposals to eCQMs in the Medicare Promoting Interoperability Program. First, we are proposing to adopt the Hospital Harm - Postoperative Venous Thromboembolism and Advanced Care Planning eCQM. Next, we are proposing to remove the Discharge on Antithrombotic Therapy, Venous Thromboembolism Prophylaxis, and Intensive Care Unit Venous Thromboembolism Prophylaxis eCQM. Last, we are proposing to require both the Hospital Harm - Postoperative Respiratory Failure and the reporting of the Malnutrition Care Score eCQMs. This concludes the Medicare Promoting Interoperability [Program] portion of this presentation. Next up is John Green. He will speak to the PCH Quality Reporting Program. Thank you.

John Green: Thank you. My name is John Green, and I'm here today to summarize the changes in the Prospective Payment System-exempt Cancer Hospital Quality Reporting Program that are currently under consideration in this year's proposed rule.

In the fiscal year 2027 proposed rule for the 11 hospitals in the PCH program, we're proposing adopting two new measures, removing one measure, and revising some program language to support adding electronic clinical quality measures, better known as eCQMs.

Both of the new measures we are proposing are electronic clinical quality measures, the first inclusion for this measure type in the PCH Quality Reporting Program. First off, we have the Advanced Care Planning eCQM being proposed for the calendar year 2028 reporting period. Julia already covered this in more detail at the beginning of the presentation, as this is a cross-program proposal, and we would be implementing it on the same timeline for PCHs if we finalized as proposed.

Our second measure being proposed for PCHs, also an eCQM, is the Malnutrition Care Score measure. Some of you may recognize this measure from its use on the eCQM self-select list for the Hospital Inpatient Quality Reporting Program in recent years.

Given the unique nutritional challenges that cancer patients may face, and at higher rates in the general population, we believe this is a good measure to bring into the PCH program where proposals around eCQM submission are finalized.

Folks interested in this measure should consult the proposed rule language for all the details. Basically, the measure has four steps of malnutrition care reactions appropriate to the level of risk and severity by patient. The denominator comprises adult patients who are admitted for at least 24 hours.

I'm going to try to read it through this slide, but we see the breakdown of what I referenced a moment ago with four separate components reacting to findings of malnutrition. This starts with simply screening for malnutrition and ends with a documentation of a nutrition care plan. Full specifications can be seen on the eCQI Resource Center or in the proposed rule.

Our third proposal for the PCH program is removing the health care provider COVID-19 vaccination measure, starting in the calendar year 2026 reporting period. The clinical guidance has evolved over the past year to shared clinical decision making on this measure, which means that both vaccination and non-vaccination would be appropriate to satisfy the numerator. Should we finalize removal, we would not publicly report data received during calendar year 2026 for this measure.

Lastly, we have a proposal to set the standards for PCHs to use eCQMs and CMS quality reporting. Proposed requirements, including deadlines, are intended to largely align with other programs to minimize potential confusion from inconsistent deadlines. At a high level, the three proposals implement ONC standards for relevant data systems, use of measure specifications from the eCQI Resource Center, and transmitting these files to CMS in the QRDA I format. There are some other smaller eCQM details in our proposals that set case threshold minimums and zero denominator case policies for eCQMs in the PCH Quality Reporting Program. With that, I'll hand it over to Lang for the Hospital Readmissions Reduction Program.

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

Starting on the program overview slide, this section of the presentation focuses on the proposed policies for the program in this year's rule. CMS is proposing to adopt the Sepsis Readmission measure for the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization. As discussed previously, CMS proposed to adopt the Sepsis Readmission measure, beginning with the fiscal year 2029 program year. As finalized, CMS will provide hospitals with an early look of their Sepsis Readmission measure results and estimated payment reductions with the addition of the Sepsis Readmission measure for the fiscal 2028 program year. CMS proposes adding the Sepsis Readmission measure to HRRP to reduce unplanned readmissions on sepsis hospitalization to promote patient safety and to support informed decision-making across patients, clinicians, hospitals, and policy makers.

As discussed previously, CMS proposed to adopt the Sepsis Readmission measure, beginning with the fiscal year 2029 program year. If finalized, CMS will provide hospitals with an early look of the Sepsis Readmission measure result and estimated payment reduction with the addition of the Sepsis Readmission measure for the fiscal year 2028 program year.

This concludes the full review for the Hospital Remissions Reduction Program. I'll quickly review the Hospital-Acquired Condition Reduction Program.

In the next slide, in our HAC Reduction Program proposal review, CMS did not propose any changes or make updates to the HAC Reduction Program. All previously finalized policies in the HAC Reduction Program will continue to apply. This concludes the presentation for the HAC Reduction Program.

Donna Bullock: Thank you, Lang.

To assist with finding the program-specific proposals, the fiscal year 2027 proposed rule page directory is on this slide.

CMS is accepting comments on the proposed rule until 5 p.m. Eastern Time on June 9, 2026. You can submit comments electronically, by regular mail, or by express or overnight mail. Please review the proposed rule for specific instructions for each method and please submit your comment using only one method.

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