Centers for Medicare & Medicaid Services
Hospital Quality Initiative Open Door Forum
Moderator: Jill Darling
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2:00 pm ET

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections, you may disconnect at this time. All participants are in listen-only mode until the question-and-answer session of today's call. At that time, you may press star 1 to ask a question. I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, Kelly. Good morning and good afternoon, everyone. I'm Jill Darling.in the CMS Office of Communications, and welcome to today's Hospital Quality Initiative Open Door Forum.

We appreciate your patience in waiting. We know it was a little longer than expected just waiting for more folks to get in, as well as speakers. So, again, we thank you for your patience.

Before we get into today's agenda, I have one brief announcement. This open-door forum is open to everyone. But if you are a member of the press, you may listen in, but please refrain from asking questions during the Q-and-A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And I'll hand the call off to our chair, Emily Forrest.

Emily Forrest: Thanks, Jill, and thanks, everyone, for joining us today. Appreciate your patience as we were working to get started. We have a full agenda. So, we'll be providing an overview of the proposed policies within the FY 2023 IPPS/LTCH PPS proposed rule that was issued on April 18th of this year.

I do want to highlight that the comment period for the proposed rule does close at 5:00 p.m. on June 17th. So, I just want to note that.

I also wanted to highlight that on April 4th, CMS announced the new initiative that will cover and pay for over-the-counter COVID-19 tests for Medicare beneficiaries. Under this initiative, Medicare beneficiaries are eligible to receive eight over-the-counter COVID-19 tests per calendar month from healthcare providers that are participating in the initiative.

So, the healthcare providers and suppliers that are eligible to participate in this initiative would include Medicare enrolled entities that can furnish ambulatory healthcare services such as vaccines, tests or clinic visits. And this would include some types of hospitals.

So, for more information on this initiative and some different resources, to identify whether or not your entity is able to participate, please see this website: https://www.cms.gov/COVIDOTCtestsProvider. Again, that's https://www.cms.gov/COVIDOTCtestsProvider. So that website will provide billing and payment information, again, along with some additional information on the initiative.

So, as I mentioned, we do have a full agenda, but we do have some time reserved at the end to take some questions on the issues that were presented today. So, without further ado, I will turn it over to Jim for the FY 2023 IPPS and LTCH update. So, Jim?

Jim Mildenberger: Thanks, Emily. So, I'm Jim Mildenberger, and I will be presenting on a few different topics today from the proposed rule, first of which is the proposed payment updates for IPPS and long-term care hospitals.

So, for IPPS, we are proposing to increase operating payment rates by 3.2% for IPPS hospitals that participate in the inpatient quality reporting program successfully and are meaningful electronic health record users. This reflects the projected hospital market basket update of 3.1%, reduce by a proposed 0.4% productivity adjustment, and increase by 0.5% adjustment required by legislation.

We are also proposing to increase the capital payment rate by 1.6% for IPPS hospitals. We estimate this proposed increases in the IPPS operating and capital payment rates will increase IPPS hospital payments by about $1.6 billion in fiscal year 2023.

We estimate that the total amount available to make uncompensated care payments in fiscal year 2023 to IPPS hospitals will be $6.5 billion. This is approximately $654 million less than last year. This decrease is due to a lower projection in the Office of the Actuary's estimate of payments that otherwise would be made for Medicare DSH.

In the rule, we also bring to light that under current law, additional payments for Medicare dependent hospitals and the temporary change in payments for low-volume hospitals are set to expire in fiscal year 2023.

In the past, these payments have been extended by legislation, but if they were to expire, CMS estimates that payments to these hospitals would decrease by $0.6 billion.

For the LTCH PPS, we are proposing a 2.7% annual update to the LTCH PPS standard federal payment rate based on our current estimate of the LTCH market basket increase of 3.1% and a proposed 0.4% adjustment for productivity.

For fiscal year 2023, CMS expects LTCH PPS payments to increase by approximately $25 million. This estimated change in payments reflects an estimated increase in payments to standard federal payment rate cases of $18 million and a projected increase of $8 million in payments to site-neutral payment rate cases.

So, the next topic I'm going to discuss is the RFI on resource costs for N95 masks. So, in this proposed rule, we are also seeking comment on the appropriateness of payment adjustments under the IPPS and OPPS, that would account for additional costs hospitals incur when purchasing surgical N95 respirators that are produced in the United States versus those that are foreign assembled or include foreign-sourced components.

At times during the COVID-19 pandemic, the supply of surgical N95 respirators has been strained in hospitals. In a future pandemic or COVID-19 surge, hospitals need to be able to count on domestic manufacturers of NIOSH approved N95 respirators to deliver the equipment they need on a timely basis.

Sustaining a level of wholly domestically produced surgical NIOSH-approved N95 respirators is integral to maintaining that assurance. In the proposed rule, we specifically seek comments on two potential frameworks for which payment adjustment might be provided.

The first framework would provide biweekly interim lump sum payments to hospitals that would be reconciled at cost report settlement. Under this framework, a hospital would separately report on its Medicare cost report the aggregate cost and quantity of NIOSH-approved N95 respirators it purchased that were wholly domestically made and those that were not. This information could be used to calculate a Medicare payment for the estimated cost differential specific to each hospital.

The second framework is a claims-based approach wherein Medicare could establish an MS-DRG add-on payment that could be applied to each applicable Medicare IPPS discharge. Under this framework, hospitals would have to meet or exceed a domestic sourcing threshold of 50% for wholly domestically sourced N95 respirators purchased by or for the hospital.

If we were to adopt the claims-based approach for IPPS, we believe that it would be appropriate to adopt a similar claims-based approach for face-to-

face Medicare encounters under the OPPS. Similar to the MS-DRG add-on payment approach, for OPPS Medicare could establish an ambulatory payment classification add-on payment for each non-telehealth OPPS service.

So, CMS realizes that there may be different ways payment adjustments could be made. And so, we seek comments on these frameworks as well as other frameworks.

So that concludes my topics, and I'll turn it over next to (Michael Treitel) to discuss the IPPS wage index timeline update.

(Michael Treitel): Hi, good afternoon, everybody. Just changing gears a little from the proposed rule. This Friday, April 29th, we'll be posting the final public use file for the inpatient hospital wage index. And that file will include all updates since January.

So, to clarify a little, the proposed rule wage indexes that were published, were based on data that was locked in January. But since that time, there have been many updates that providers were able to appeal in February (unintelligible) revisions, and other updates to the wage index. And all of those updates will be included in the public use file that will be posted this Friday, April 29th. So that's going to be different data than what we used in the proposed rule.

Hospitals will then have a process of one month to verify their data, submit corrections requests to both CMS and their MACs to correct any errors due to CMS or the MAC mishandling the final wage and occupational mix data, in

this April 29th file. The deadline to submit a request for a correction to the data in the April 29th public use file is May 27, 2022. And those appeals for corrections can be sent to wageindexreview@cms.hhs.gov.

And with that, I'm going to turn it back over to Dr. Tiffany Wiggins and Julia Venanzi to talk about the hospital quality update from the IPPS proposed rule.

Jill Darling: Hi, this is Jill Darling. We'll turn it over to Julia.

Julia Venanzi: Okay. Thank you, Jill. So, I'm Julia Venanzi, the program lead for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program.

Today I will cover some of the proposals that were included in the fiscal year 2023 IPPS proposed rule for the various hospital quality reporting and value-based purchasing programs.

I will note that we are holding our typical proposed rule Webinar where we go over every single proposal for each of the hospital programs in mid-May. And if you're not already signed up for the QualityNet hospital listserv, I encourage you to do so to get more information on that Webinar, as well as any other news we have related to hospital quality reporting.

So, to start first with some of the measure proposals for the Hospital IQR Program. As a reminder, the Hospital IQR Program is a hospital pay-for-reporting program for Subsection D acute care hospitals. Hospitals that fail to

meet all requirements in a given year have their Medicare fee-for-service payment reduced by one-fourth of the annual payment update.

So, moving to the measure proposals. First, we are proposing the hospital commitment to health equity structural measure, beginning with the calendar year 2023 reporting period, which impacts fiscal year '25 payment. We believe that strong and committed leadership from hospital executives is essential and can play a huge role in shifting organizational culture and advancing health equity goals.

So, therefore, we proposed this measure, which assesses hospital leadership commitment to collecting and monitoring health equity performance data. The measure includes attestations across five domains, including equity as a strategic priority, data collection, data analysis, quality improvement, and then leadership engagement.

Next are two related health equity measures, the screening for social drivers of health measure, and then the screen positive rate for social drivers of health measure. We are proposing that these two measures to have a voluntary period in calendar year '23. And then we are proposing that they become mandatory in calendar year 2024.

These two measures support the identification of health-related social needs. For the first measure, the screening for social drivers of health, this measure looks at the rate of inpatient admissions for patients who are 18 or over who have been screened for each of five health-related social needs, including food

insecurity, housing instability, transportation needs, utility difficulties, and then interpersonal safety.

The second related measure is the screen positive rate for social drivers measure. This will be calculated as five separate rates. Each rate is derived from the number of patients admitted for an inpatient hospital stay who are screened for one of those five health-related social needs and who screen positive for any of those five. That number is then divided by the total number of patients 18 or older who were screened for those five health-related social needs.

Next, I wanted to highlight our proposal to adopt the total hip arthroplasty, total knee arthroplasty patient reported outcome measure, also known as the THA/TKA PRO-PM. We are really excited to propose this patient reported outcome measure and highlight patient experience within the Hospital IQR Program.

We've previously received stakeholder feedback that encouraged us to include more patient experience measures, and we are really excited to propose this measure this year. The measure assesses the hospital-level risk standardized improvement rate in patient-reported outcomes following elective primary hip or knee arthroplasty.

And then, lastly, I wanted to highlight some measure proposals related to another high-priority topic for us, maternal health. We are proposing two maternal health related electronic clinical quality measures, or eCQMs, the Caesarean birth ECQM which measures the rate of Caesarean births, and then

the severe obstetric complications eCQM, which measures the proportion of patients with severe obstetric complications which occurred during in-patient delivery hospitalization.

And then in addition to the two maternal health-related measures, we are also proposing the creation of a hospital designation related to maternal health, that would be posted on a public-facing CMS website in order to assist consumers in choosing hospitals that have demonstrated a commitment to maternal health.

Initially, we're proposing that the designation would be awarded to hospitals based on their attestation to the previously finalized maternal morbidity structural measure, which was finalized in the FY22 IPPS last year. Data collection on that measure began in October 2021 and will be submitted by hospitals for the first time next month, in May. If finalized, this proposal for the designation would begin to be displayed in the fall of 2023.

Moving now to some of the cross-program requests for information, we've requested stakeholder comment on a number of topics in this proposed rule and really encourage stakeholders to comment as we consider these topics for potential future rule-making.

So, first off, climate change. We are seeking stakeholder input on how providers in a variety of care settings, which include hospitals, can better prepare for the harmful impacts of climate change on their patients, and how we can support them in doing so. So, we're specifically looking for information on how hospitals may currently be determining the impacts of

climate change on their patients, as well as how they are developing plans to potentially mitigate that impact.

The second topic related to health equity, we are building on the RFI that was in last year's rule. This year we are specifically looking for stakeholder feedback on our outlined goals for measuring disparities as well as our outlined approach for how to prioritize, which measures that we may report - do disparity reporting on.

And then, lastly, the last topic related to the hospital designation that I mentioned, we are also seeking stakeholder input on other maternal health related activities that could potentially be included in the designation in the future. So, including but not limited to adding additional maternal health related measures, or potentially making changes to the conditions of participation.

So, I will now move to some COVID-19 related measure suppression proposals in the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and then the Hospital-acquired Conditions Reduction Program.

As many of you probably remember, in last year's rule we finalized a measure suppression policy to ensure that the Hospital VBP program did not penalize hospitals based on factors that the program's measures were not designed to accommodate, such as the COVID-19 public health emergency. We also finalized that we would continue to publicly report measure data under these suppression policies.

So, we'd note that the suppression policies were designed as a non-permanent approach to provide flexibility for changing conditions outside of participating hospital's controls, and to avoid penalizing hospitals on measure scores that we believe are impacted by the pandemic.

So, with that in mind, we have made some related proposals in this year's rule. So, first, for the Hospital VBP program, we are proposing to suppress measures from the calculation of the total performance score, including the (HCAHPS) measure and then these five hospital acquired infection related measures. As a result of this proposed suppression, if finalized, all hospitals would receive a net neutral payment adjustment for fiscal year 2023, similar to what we did last year for fiscal year 2022.

For the HAC Reduction Program, we are proposing to suppress six measures from the calculation of the CMS PSI90 results, the hospital acquired infection measure results, and then the total (HAC) score. If this policy were finalized, no hospital will be penalized for the fiscal year 2023 program year.

And then lastly, for the Hospital Readmissions Reduction Program. In the rule last year, we finalized the suppression of the 30-day pneumonia readmission measure from program calculations for the fiscal year 2023 program year. In this year's proposed rule, we are proposing to resume the use of that measure beginning with the fiscal year 2024 program year.

And with that said, I'd also like to highlight too that we do know in the rule that we do intend to resume using measure data for scoring and payment adjustments in fiscal year 2024.

So, I will stop there and I want to check, is Dr. Wiggins on?

If not, I will - oh, go ahead.

Jill Darling: Yes. I think we can pass that to Elizabeth.

Julia Venanzi: Okay, perfect. I'll pass to Elizabeth Holland to go over the Promoting Interoperability Program.

Elizabeth Holland: Thank you, Julia. I'm going to discuss the proposals for the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals. All of our proposals are effective beginning - would be effective beginning with the calendar year 2023 EHR reporting period.

First, we are proposing to modify the Query of PDMP or prescription drug monitoring program measure, making it mandatory and worth 10 points. We are further proposing to expand the scope of reporting to include additional drugs schedules. Right now, it's limited to schedule II opioids, but we want to expand it to include Schedule III and Schedule IV drugs. And we are adding exclusions for this measure since it is now proposed to be required.

We are proposing the adoption of a new anti-microbial use and anti-microbial resistance surveillance measure under the Public Health and Clinical Data Exchange objective.

This measure will assess whether eligible hospitals and CAHs are in active engagement with the Centers for Disease Control and Prevention's National Healthcare Safety Network to submit data and receive a report from the National Health Safety Network, indicating their successful submission of anti-microbial use and anti-microbial resistance data for the EHR reporting period.

We're proposing to modify the levels of engagement for the measures under the Public Health and Clinical Data Exchange objectives. Currently we have three levels of active engagement. So, hospitals can pick one of the three options. The first option is completed registration to submit data. Option two is testing and validation. And option three is production.

We are proposing to combine options one and two into a single option called Pre-Production and Validation, and to rename option three Validated Data Production. We are also proposing that eligible hospitals and CAHs will be required to submit their level of active engagement to CMS.

We are proposing an additional option under the Health Information Exchange Objective called Enabling Exchange Under the Trusted Exchange Framework and Common Agreement, also known as the TEFCA.

We are proposing to publicly record Medicare Promoting Interoperability Program total scores for eligible hospitals and CAHs as well as their CMS EHR certification ID. And we're proposing that they would have a 30-day data review period prior to posting.

We are proposing to modify the Medicare Promoting Interoperability Program scoring methodology to redistribute the 100 points among the four objectives. For eCQMs which are acquired, we are proposing to align with proposals that Julia discussed for the hospital IQR program. We are including a request for information requesting stakeholder input on barriers and opportunities to increase patient access and patient portal.

In addition, we have a global RFI or request for information on the Trust Exchange Framework and Common Agreement. We are asking a series of questions to determine if there may be other opportunities for CMS to incentivize participation in TEFCA through programs that incentivize high-quality care or through program features and value-based payment models that include certain activities which can increase care delivery.

That concludes the Promoting Interoperability Program portion. I think I'm turning it over to (Dawn).

Jill Darling: Yes, that's correct. Thanks, Elizabeth. Our next speaker is (Dawn Linn).

(Dawn Linn): Hello and good afternoon. I hope everyone is doing well today. My name is (Dawn Linn). I am happy to have the opportunity to join the call to provide

an overview of the proposed requirements for COVID-19-related reporting and reporting for future public health emergencies.

We are proposing to revise the hospital and critical access hospital Conditions of Participation to require these facilities to continue to report COVID-19-related data and to establish data reporting requirements for future public health emergencies involving infectious diseases.

Under the current regulations, the existing COVID-19-related reporting requirements will expire at the end of the public health emergency. Consequently, COVID-19-related data reporting will no longer be required through the Conditions of Participation once the public health emergency declaration ends.

These current data reported by hospitals have been, and continue to be, important in supporting surveillance of, and response to, COVID-19 and other respiratory infectious diseases. Therefore, in this proposed rule, we would require hospitals to continue to report COVID-19-related data after the end of the public health emergency, with a sunset date of April 30, 2024, unless the Secretary determines an earlier end date.

The proposed rule also notes the current data reporting requirements, while appropriately focused on the COVID-19 pandemic, are too limited in scope for future use. Given our experience throughout the current public health emergency, CMS, in conjunction with other federal partners, particularly the CDC and ASPR, are considering ways to ensure a more flexible regulatory

framework, so that we are able to respond more effectively and efficiently to future infectious diseases.

Therefore, we are also proposing to establish data reporting requirements for future local, state, and national public health emergency declarations related to an infectious disease. Both of these reporting proposals allow flexibility to enable requirements regarding frequency of reporting and required data elements to change as the situation changes.

CMS recognizes that the health and safety benefits associated with any reporting requirements must be carefully weighed against the potential burden they impose on facility operations, particularly in situations like a public health emergency where staff resources are stretched.

These proposed requirements balance these imperatives by allowing the specific data elements and reporting frequency to be adjusted by the Secretary in response to specific triggers and signals.

For example, if case counts are low and have been for some time, it may be reasonable to reduce reporting frequency, potentially even to zero, which would effectively turn off reporting for a given data element. At the same time, if case counts were increasing, it may be necessary to increase the scope and frequency of data reporting.

Moreover, under both of these reporting requirements, we are proposing that hospitals would submit the data to the CDC's National Health Safety Network or other CDC-supported surveillance system as determined by the Secretary.

We are soliciting comments on these proposed requirements given the intended flexibility provided in reducing or limiting the scope and frequency of reporting based on the state of the public health emergency and ongoing circumstances.

And I'll turn things back over to Jill Darling.

Jill Darling: Thank you, (Dawn), and thank you to all of our speakers today. Kelly, will you please open the lines for Q-and-A?

Coordinator: Sure. If you would like to ask a question, please press star 1. Unmute your phone and record your name. If you would like to remove your question, press star 2. And again, to ask a question, press star 1.

Our first question comes from (Ina Banter). (Ina), your line is open.

(Ina Banter): Yes, good afternoon. I'm asking actually a question unrelated to the topics today, so, hopefully somebody can maybe provide some clarification.

There was a new edit that came out in the IOC (unintelligible) relating to the use of (PT) modifier for (unintelligible) colonoscopies (unintelligible) diagnostics. Does anybody have any clarification what that edit is actually looking for? I could not find information anywhere on CMS Web site, other than, you know, you have to (seek to modify) for those conditions. But what exactly is that edit looking for?

Emily Forrest: Thank you for the question. This is Emily Forrest. We don't have someone on the call today that could address that question, but if you can email us, we can direct that to someone who can provide an answer. The email inbox is hospital_odf@cms.hhs.gov. So, thank you.

(Ina Banter): Okay. Thank you.

Jill Darling: Next question?

Coordinator: Our next question comes from (Nikki Hobbs). (Nikki), your line is open.

(Nikki Hobbs): Hi. Yes. I was wondering if the person who was talking about the new screening questions for healthcare equity could repeat the five element items that she addressed.

Julia Venanzi: Yes. This is Julia Venanzi. So, the - for the two social drivers of health measures, so the Screening [for Social Drivers of Health] and then the Screen Positive Rate [for Social Drivers of Health], there are the five separate domains. So, it's food insecurity, housing instability, transportation needs, utility difficulties, and then interpersonal safety.

And if you want, I guess, like, more detailed information on that, I would point you to the rule itself, provides a little more detail on each of those five categories.

(Nikki Hobbs): Thank you.

Coordinator: Our next question comes from Tim Walters. Tim, your line is open.

Tim Walters: Thank you very much. I appreciate the discussion in the proposed rule about the N95 cost issue, and we are evaluating that at our hospital to try and provide some comments on that. At the end of that section, CMS does say - ask about are there other types of respiratory devices or PPE that should be considered for adjustments?

And I guess in the broader context, when I - looking at the 2.7% proposed payment update, our costs for virtually everything, whether it's supplies or drugs or labor, is going up dramatically faster than that rate.

And I know it's hard to measure things with the, you know, unprecedented times that we're still in right now, as we come out of the pandemic, but is CMS considering any other special payment adjustments like that for other issues beyond the PPE category to consider the, you know, significant inflation factors we're all experiencing right now?

Don Thompson: So, this is Don Thompson. You can make that comment on the proposed rule. There is nothing in the proposed rule itself. There's the proposed market basket update, and there's the N95 comment solicitation. There are not any other proposals like that in the (NPRM). But you are of course free to make a comment either on the market basket or the N95 or the subject in general as part of the comment period.

Tim Walters: Okay. Thank you.

Coordinator: The next question comes from (Dee Rogers). (Dee), your line is open.

(Dee Rogers): Yes. I have a question related to the addition of health equity. How exactly is that planned to be collected? Is that going to be manually abstracted, or collected via electronic, or what's the goal on that?

Julia Venanzi: Hi, this is Julia Venanzi. I'm sorry, you cut out just when you're saying which measure. Are you talking about the hospital commitment to health equity…?

(Dee Rogers): You're talking about that is an attestation and that's easily - that's easy to tell, that's the one-time shot during the end of the year thing. But the equity measures themselves where you're screening the patients and reporting that on your in-patients to gather a rate, that's got to be collected somehow, so that's sounding like a manual abstraction or somehow collected through the EHR? So, what is the…

Julia Venanzi: Got it. Okay, thank you. Yes. Thank you for the clarification. So, I will mostly point you to the rule for more specifics, but sort of speaking generally, that measure will be reported into CMS using the Hospital Quality Reporting system, so the HQR system.

We intentionally left some flexibility around how hospitals are able to collect that using different screening tools. But the measure will be reported into the HQR system similar to how other measures have been reported in the past.

(Dee Rogers): And do you have any idea, are there standardized tools for this out there? I have seen some things about this type of information gathering, but there are

so many different things, different products and, you know, materials out there when you're trying to get a nurse to screen a patient for their dietary needs, and then to have them add this much additional question or who this would typically fall to screen and what the timeframe is, especially with the turnaround on patients right now.

Julia Venanzi: Yes. In the rule text itself, we do point out to a number of different screening tools that would work in the reporting of this measure. You can go there, or if you want to email the hospital ODF email, I can also send you, you know, the links to what we point to in the rule, if you're having a hard time finding it.

(Dee Rogers): All right. I'll go into the rule and see what I can see. Thank you.

Julia Venanzi: Yes.

Coordinator: Our next question comes from (Sheila Newquist). (Sheila), your line is open.

(Sheila Newquist): Thank you. Yes, hi. I look for health plan and we have hospital quality programs that are tied to payments for performance. And I'm just wondering, with the measures that you're suppressing for your payment programs, I understand that the calculations will - they will not be included for the calculations for those programs. But will the data itself still be reported for those measures in the IQR program?

Julia Venanzi: Yes. So, we did not in this rule make any proposals related to measure suppression for the Hospital IQR Program. So those measures would still be reported as they typically are. And I did also just want to clarify, for the three

value-based purchasing programs where we do have measure suppressions about Hospital Value-Based Purchasing, (HAC) Reduction [Program] and then the Hospital Readmissions Reduction Program, in all three of those cases, the measure data still would be reported. We are just suppressing it from the actual, like, measure calculation.

So, for example, in like the Hospital (VBP) Program, hospitals would still report the data. We are just not including it in the calculation of the total performance score. That is linked to the payment adjustment.

(Sheila Newquist): Thank you. Do you have a recommendation for how health plans might consider the use of these measures in their own payment programs? Obviously, if you selected - decided from CMS to not use the calculations in your payment programs, is there, you know, is there a recommendation for health plans in the use of those measures?

Julia Venanzi: This is Julia. I'm not sure I would feel comfortable giving a recommendation. I think I would maybe point you to the rule to see sort of the discussion around how we decided to come to the measure suppression policy, that may be sort of helpful in informing your thinking. But I wouldn't want to give any sort of recommendation.

(Sheila Newquist): Okay. Thank you.

Coordinator: Our next question comes from Dr. James Kennedy. Dr. Kennedy, your line is open.

James Kennedy: Thank you so much. I would like to ask if you could give us some insight into the global malnutrition composite score the (NQF 3592EE) that was in the proposed rule, and its impact on the value-based payments. If you could give us some insight on that, I'd be grateful.

Julia Venanzi: Sure. So, I didn't cover that on the call today, but yes, you are right, in this rule, we did propose to add the Global Malnutrition eCQM to the list of eCQMs that hospitals are able to self-select from for the Hospital IQR Program, beginning with the calendar year 2024 period.

So, couple of clarifications. So, for the Hospital IQR Program, that is a pay-for-reporting program. So, so long as hospitals meet the reporting requirements under the [Hospital] IQR Program, they get their full annual payment update. It is not a value-based purchasing program. So that's the first point.

And then the second point I wanted to make, for [Hospital] IQR, the eCQM requirement is to report on four eCQMs. And I just wanted to note that again we added this to the list of eCQMs that hospitals are able to self-select on. So, it is not required that you have to report on this specific measure if the hospital meets the requirement by selecting the other measures from the list of eCQMs. So, just want to clarify that too.

James Kennedy: Thank you so much.

Coordinator: As a reminder, if you would like to ask a question, please press star 1.

And our next question comes from (Valerie Rinkel). (Valerie), your line is open.

(Valerie Rinkel): Thank you. I was wanting to know the request for information on social determinants of health, why you ended the range of Z codes at Z65, because there are other Z codes, for example, history of falling, Z91.81, that would, in my opinion, fall under social determinants of health, right, somebody is having the history of falling outside in the community, for example. So, can you elaborate on that a little bit more?

Emily Forrest: This is Emily Forrest. Julia, is that something you can elaborate on or someone else from CCFQ is able to elaborate on?

Julia Venanzi: I believe that part of the CM RFI that's separate from the health equity RFI that CCSQ included that they attach on. So, I'm not sure if anyone from CM that we have on the call is able to speak to that.

Emily Forrest: This is - I don't think we have someone on the line to address that specific question. But if you don't mind sending us an email, then we can again point you in the right direction. And the email again is hospital_odf@cms.hhs.gov. Thank you.

(Valerie Rinkel): Okay. Thank you.

Coordinator: There are no other questions in the queue.

Jill Darling: Emily, I'll pass it to you for closing remarks.

Emily Forrest: Thanks, Jill. And thanks, everyone, for the questions today and for understanding of the delays at the top of the call.

As a reminder, the comment period for the FY 2023 IPPS and LTCH PPS proposed rule does close at 5:00 p.m. on June 17th. But if you have any questions about the topics that we discussed today, please feel free to email us again at hospital_odf@cms.hhs.gov. And this is also included on the agenda as well if you haven't been able to write that down.

But to that, that concludes today's call, and I hope everyone has a great day. Take care.

Coordinator: That concludes today's call. Thank you for participating. You may disconnect at this time.

Speakers, please allow a moment of silence and stand by for your post-conference.

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