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The Hybrid Measure Reboot: What's Changed, What's Next, and Why It Matters

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Hello, everyone, and welcome to today's webinar, The Hybrid Measure Reboot. What's changed, what's next, and why it matters. We're really excited to have you guys here today to talk about the hybrid measures. So thank you all for being here today. We're excited to get started. My name is Aaron Heilman, I'm the SVP of Regulatory Affairs, and I'm joined by my colleague Kristen Beatson, who's the SVP of Clinical Quality Improvement. And today we have a great presentation for you today, even though it seems like maybe it's an old topic, we really got a lot of content that Christians put together because there's been so many changes.

So we're going to talk about the evolution of these hybrid measures, Obviously, why preparation matters. You're going to get a ton of really good content around the specification changes, which is super, super helpful. The stuff that Kristen and I looked at beforehand, I learned a lot just from what Kristen put together. Today's presentations, couple of lessons learned, considerations moving forward. So as we begin, just to finish the housekeeping, this is being recorded, so you'll have a chance to come back and do this. You should see the slides in the download section. Now we can we have the chat enabled because that's been kind of a fun feature for people who've been joining us monthly on these webinars.

We've enjoyed seeing some of the comments that have rolled through and people answering other people's questions. So thank you all for interacting. Feel free to jump into that chat and start using that. If you have a very specific question that you want answered by us, something that's been on your mind, add it into the Q&A box and we will. Which our new thing is that we are doing our radio show that to research and answer these questions. So I feel like I said it's every time, but basically there's been a lot of questions that have come in onto these webinars because people have been participating and that's been awesome.

But it means that some of these questions which are difficult or take some time and research, we don't have the answers right away. And also we can't get to it in the presentation. So we do a radio show in coordination with these webinars to get those questions answered for you guys. And I have details about that one as well. So we got a really great packed show, but let's just start with the basics for anybody who's just joining us, Hybrid measures. I think most of us get into a certain place with measures and we start looking around and we say, how do we get here?

What, what are we talking about? How, how do we get here? Why is the hybrid measure set up the way it is? And especially if you come in like if this is your first year ever dealing with a hybrid measure, it's under easy enough to understand the concept of a hybrid measure. That's what you're looking at on the screen there. The hybrid measure is a hybrid because it takes claims data, which is the traditional measures have been sourced for readmission and mortality. With claims measure, they have something called linking variables and that's all found within the claims files and what CMS gets from you whenever you submit those claims.

And then the core clinical data elements, which is essentially a type of ECQM, but it's all those core elements like labs and vitals within your EHR system and those are paired together after the claims have been submitted and after all that information has been submitted to CMS to create a hybrid measure. It is technically the first DQM. And I remember Kristen and I laughing about this digital quality measure future back in, I can't remember what year it was, but they were like 2025, all digital measures. And here we are in 2025 struggling with a hybrid measure. But it's a good first step.

So if somebody's asking you if you're what you're thinking about digital quality measures to say, I'm already doing digital quality measures because it uses two different sources. So just real quick, as a reminder, the whole reason why CMS wants these hybrid measures is because you all for many years said the claims measures are not good enough. And really when it started out, it was just sort of claims measures. And you all said this is not good enough. You're not taking into account our claims, our patients, how sick they are. So CMS said, OK, OK, yeah, we'll throw in all these codes.

We'll throw in HCC codes on the ambulatory side and CC codes and MCC codes, and you all just code and do it in a certain order and then blah, blah, blah. We'll risk adjust and you'll have a readmission measure and a mortality measure, and that will accurately reflect your quality of care. And that was not good enough. And also what a nightmare with all this coding. And there's, and then some of you might be saying, well, I like the coding. Well, you can just see your way on out of this webinar.

No, I'm kidding this, this is not, it's not about the coding. It's actually really trying to assess the patient when they come into your facility. That was the key piece. So coding is fine, gives you the conditions, it gives you those places in the ambulatory, what they've had previously. But what you all were saying to CMS was when they come in, we feel like there's a certain level of patience and you're not you're not clear on how sick they are when they come into our facility. That was truly the whole concept of why they developed these hybrid measures.

And really this whole process started back in 2014. Some of you remember, but Kristen, I know remembers because we Metasol was actually kind of a sub and we did the feasibility testing on whether these core clinical data elements lived in the EHR. So it's been a while, around a while. And I guess Kristen, to you, OK, it's 2025. Why are we still talking about these hybrid measures? I think we should ask CMS. No, they're complex, you know, and they're constantly changing. I think, you know, our standard kind of ECQMS are changing every year when it comes to specifications. But with hybrid measures, not only are the specifications changing, the requirements are changing and sometimes those requirements are changing outside of the standard Ipps rolling, right.

And we'll talk a little bit about that. But it is, you know, I know that CMS wants to get these right. They want to be able to use clinical data in order to augment that claims data so that there is a more accurate risk adjustment for those measures. But they haven't gotten it right yet. I should say we haven't gotten it right yet. And that's what they're really trying to do, right. They want to get to a point that the data is usable both for the hospitals so that you have, you know, a clear idea of your readmissions and mortality. But CMS also obviously wants to use this data to understand how hospitals are doing, you know, with these measures as well.

Yeah. And I think you know on our next slide here, this was kind of the jaw-dropping moment for everyone at Metasol. We sort of saw this because they put it in the ruling and we were like no way, like and I'll just read it and then you can comment. Three quarters, 3/4 of hospitals that submitted measure data during the 2024 voluntary period from 7/1/22 to 6/30/2023 did not meet the submission thresholds, which we were pretty, pretty flabbergasted about that, certainly not medical hospitals. So it has to be the quarter that. And I, I mean, and this is what we'll talk about today, right?

You do not know where you're sitting when it comes to those submission thresholds until you get your HS Rs six months later, right? You can do all the tracking of your CCD ES and your linking variables, submit those files, but you get no information. And you know, we have some, a couple slides about, you know, just submitting in the dark, submitting blind because you don't you get 0 information. So it really feels like a crapshoot. And I know with our customers, many of them were meeting those thresholds. But then for various reasons, after for submission, after link to claims, when you get the HS Rs, everything looks very different.

How frustrating. Yeah, well, I'm going to pass it over to you to begin. I'll see you at the end of the presentation. Everybody join in on the chat. I see a lot of great already. Again, get your questions in there and then we'll we'll see you at the end. Yeah. Thanks, Aaron. So I will mention, you know, when we're talking about, you know, 3/4 of hospitals not meeting those 90% thresholds for CCD ES and 95% threshold for linking variables, it feels very much like that statement lands on the hospital shoulders, but it really doesn't, right.

These measures if you look at a specification face value look simple, but they're, they're not, you know, beyond collecting the clinical data, the electronic data, the rest of it is, is super complex. The methodology behind the hybrid measures very complex. On top of that, there have been errors and issues with the way CMS's measure engine has evaluated the data. If you've participated in previous submissions, voluntary submissions, I think two years ago, there was a platelet unit of measure that didn't get evaluated correctly when everyone did the submission of files. And because they didn't evaluate that unit of measure, all of those platelet results were tagged as missing.

So that's, you know, really a failure and impacts that overall threshold. And if you participated in the last voluntary reporting period and got your HS Rs this past spring, you're probably aware that CMS had issues with their calculation engine in the way that they actually calculated that submission threshold. They sent at least 2 emails saying that they had issues and you had to re re, you know, get your HSR. You had to go back in and pull the data again because there's actual thresholds had been miscalculated. Super frustrating. But again, CMS is trying to get this, you know, right?

And sat in, I sat in on the CMS Quality Conference listening to Doctor Oz's keynote speech. And one of the things that just struck me is I think he said CMS only has 13 IT staff for 13 developers for all of CMS and all of the work they do. So it didn't make me feel a little bad for them just knowing the amount of work that we do here at Metasol and the amount of developer work and expertise that it takes to think this huge organization of CMS only has 13. So it's a big effort for them. But again, it's not going to go away.

And that's what we're going to talk about today, because CMS has really got their eye on these measures and using that clinical data along with the claims data. So as I was thinking about what this has felt like for the last, you know, 5-6, ten years, it, it really to me has been like a little bit of, of whiplash, right? In the beginning 2018, they had a pilot and then there were several voluntary years. And so I just did this one back to the 2022-2023 voluntary year and, and, and you know, everyone that wanted to submit could submit their hybrid measures voluntarily that year and then the following year 2324.

So July 123 to June 3024 was designated as the first mandatory year where you had to spend submit both of your hybrid measures. Everyone gets ready, everyone's having stress, everyone's making sure that they've got all the data they need to get these measures submitted. And then the OPPS proposed rule drops with a a little statement in there that they are proposing to reverse the first mandatory year. But in the meantime, all of the hospitals still had to submit because that OPPS final rule didn't get published until after the end of that first mandatory year. So they did end up reversing that mandatory requirement and the hybrid measures became voluntary again for the 2023-2024 reporting year and then 2024-2025 reporting year.

So if you're participating in that 2024-2025 reporting year, you are most likely either prepping to submit or have already submitted because that submission window is open. But again, those were both changed and are voluntary. But here we are in July, almost August of 2025 and this is your first mandatory year. So starting July 1, this past July 1, the data that you're collecting for hybrid measures will be fingers crossed or not crossed if you're, if you're worried about it the first mandatory year of hybrid measure reporting. So confusing to say the least, just keeping up with kind of this start, stop history of voluntary required, voluntary required, but you know, that's just part of it.

And again, the reason we're talking about this today. So not sure what's going to happen. I would expect based on some of the information I'm going to share today that they will stick with this year as being the first mandatory year. But CMS can always change their mind as we know. So starting this past July 1st kicked off the first mandatory every year of data collection for your hybrid measures. That reporting year is July 125 through 63026. There are two hybrid measures, the readmission measure and the mortality measure. Both are required. Now if you're not familiar with hybrid measures, if you haven't submitted before or haven't participated in that submission process, you have to submit four quarters of data, but that four quarters of data is submitted at one time, 4 separate submissions, but you do it all at the same time at the end of after the end of the reporting year.

So that window for submission is July 126th to about 10126. And the good news, if there is any good news, is you can combine the data for the readmission and the mortality measures and submit them all together in each of those quarter files. So you don't have to submit 8 different files, it's just 4. You can combine the data for both of those measures. The threshold requirements as of right now are still the same CCD, ES. So those are going to be your vital signs and your lab results have to be at least 90% or greater meaning of all of your patients discharged and included in the population for the hybrid measures.

Those patients have to have at least 90% of the the link, I'm sorry, the vital signs and the labs associated with their stay. And then linking variables, we're looking at 95% or more. And here's the big caveat to all of that. The IPPS 2026 proposed rule, which dropped a couple months ago has proposed to decrease the hybrid measure CCDE and linking variable submission thresholds beginning with the reporting period we're in, right, we're in right now. So until the final rule is published, which I would expect to be relatively soon, we're still in that 90% and 95% threshold. But if this is finalized and I expect it will be because of all the historical issues that we've talked about, they will be are proposing to reduce the thresholds for both your core clinical data elements, so your labs and your vital signs as well as your linking variables to 70% or greater.

So lowering that threshold a significant amount to hopefully make it easier for hospitals to hit that threshold. So you have that option again if it's if it's finalized to hit that 70% or greater threshold. They are also including in this and it's an OR statement. They are lowering the number of required CCDE data elements to allow for up to 2 missing lab results and two missing vital signs. I am not 100% sure of how that is defined. I don't I don't think it's per patient 'cause that per patient would be covered in the one above. And the way it's written, it makes it sound like this is maybe you submit your QRDA files and you don't have any creatinine results on any of the patients, right?

And you don't have, you know, any white blood cells on any of the patients that you would be given some wiggle room with that. So if you're missing those all together, then that wouldn't

impact your ability to meet requirements. I think that's what it means. We will learn more when and if this is finalized and when CMS puts out additional documentation, does their webinars, updates their methodology. But for now, I believe that's what we're looking at with these proposed rule changes if they're finalized. So super helpful. You know, we won't know how helpful until we get through this mandatory reporting year and get those HS Rs back, but certainly is going to be helpful with lowering those thresholds for hospitals to meet the 70% requirement.

They are also proposing to remove the COVID-19 exclusion from the hybrid measure. This was an exclusion that would have been applied after submission by CMS, but I, I am sure this one is going to go through and it will apply to, to the 2024-2025 reporting period. They have removed COVID-19 or proposing to remove COVID-19 from all other, you know, measures where it shows up. So I expect this one will be finalized. The other reason we continue to talk about hybrid measures is that CMS continues to talk about and use these hybrid measures in other programs for other purposes. So if you are familiar with the team model, if your hospital was selected for participation in the team model, you may already know that the hybrid hospital wide all 'cause readmission measure HWR.

So this is the readmission measure is a part of the team model and will be evaluated within that model. So this to me is a big indicator that these aren't going away. CMS is, you know saying, yeah, you have to submit hybrid for IQR. If you participate in IQR and if you're a team participant, the results of your hybrid measure, your readmission measure. So that hybrid or standardized readmission rate will be used in part in calculating your quality composite score in the team model. So if you're in this model, if you were selected, you want to pay even more attention to this hybrid readmission measure, making sure you have data accuracy and data completeness and that the popular align so that when CMS does that calculation to get your readmission rate, that it helps you in getting a better quality composite score.

For the team model. I'm not going to go into all the details. That's a whole other webinar. You can check our website. We've got blogs and other information posted. I'm sure we'll do another webinar and on team and I, I don't have the time today, but just to give you a little bit more information on how this hybrid readmission measure will be considered. There will be a baseline period that they use to compare future hybrid readmission results against, but for the first year, it will be your first performance year will also be your baseline year, so July 125.

Through June 30th of 26th, the reporting you're in right now, the data you're collecting if you're a part of the team model this year will be the data you collect this year. And the results of that data will be used for baseline as well as the first performance period. And then future years, it will just use, you know, the the next year for those hybrid readmission measure results and, and calculating that quality composite score. If you want to know what to aim for, the best we can

kind of come up with is looking at the national result for comparable claims based measures. This is from Care compare.

It's around 14%. So if you want to set some goals, you may already have some goals around readmission, but that is what is that the national average there on care compare if you want something to aim for. This is the other big reason that certainly here at Metasol we talked about and you know, get frustrated over is submitting these measures is like submitting in the dark. I mentioned that earlier, there's very little visibility to what you've submitted and if it's accurate and complete and there literally is no efficient way to do good validation and thorough validation. So I wanted to, as I know not everyone is going to be familiar with what submission looks like maybe done by your IT department or by a corporate entity.

So I want to kind of compare with you what the submission process looks like hybrid versus ECQM. So here at Metasov, we do these submissions for all of our customers and the ECQM submission process took us a little bit to get used to, but now it's pretty much a well oiled machine. We know the process and for both hybrid and ECQMS, it looks like this. You get to the submission window, submission window opens and you create QRDA files. Those QRDA files are basically the same whether you're talking about hybrid or ECQM. There are these big long files with all of the data for all of your ECQM.

So all of the patients that qualified for the measures you submitted, all of the data elements, all of the results associated with those patients and those measures are in these big QRDA files. Same thing for hybrid. So there are these massive files, multiple files with all of the patients that qualified, all of your Medicare patients 65 and older, all of the CCD ES, all of the linking variables. Very similar files, little bit different format, but basically the same thing. We take these files and we submit. Or you take these files and submit to HQR.

Same process. You upload the files, ECQMS, you upload the files, it tells you if you have errors or rejections. Hybrid. It does the same on the ECQM side though. It runs those measures through CMS calculation engine. And that's just a fancy way of saying they calculate the results of the measures for you. When you submit them, they show you not just your results, they show you each of the populations for each of the measures, All of the patients that populated or qualified for each of those populations, you can drill into them.

You can then take that data and this is what we do, take the data that you get when you upload HQR and compare to the results in our encore application. So if we have 100 patients in the numerator for VT1, the CMSHQR calculation should have 100 patients in the numerator for HQR should have the same populations, the same performance rate. If it doesn't, we go in and validate it. We drill in, try to understand which patients there's an issue with, and then we fix it.

Or we talk to our customers and ask them to fix it if it's a data issue, and then we can resubmit, right?

So you submit one that doesn't have great data, There's some gaps, there's some mismatches. You just fix it and resubmit. As long as you do that before the submission window, you're good on the HQ. On the hybrid side of things, when you're submitting to HQR, after you submit to HQR, it will tell you if you have projections and errors and then you can go back and fix that. A lot of times it's with the cert ID or something similar. But basically all you get when you submit those hybrid measures is you submitted, you know, 110 patients.

And here's a spreadsheet. And that spreadsheet you can download and it does have a list of all of the patients and it does include all of the CCDS. So all of the labs, all of the vital signs, all of the linking variables you can get from the spreadsheet. But it's super complicated. It is a long spreadsheet. If anybody has worked in Excel and had to look at thousands and thousands of rows and columns of data, that's what it is. So it is very hard to use that and efficiently and get it done before the end of the submission window to confirm that what you submitted aligns with the data that you have in the report that are your tracking tool for hybrid.

So very little opportunity to fix anything or to know how you did. It doesn't tell you, yeah, you submitted 110 patients and that is equivalent to the number of claims we have for those patients. You know, good job. It doesn't tell you any of that. So you really are just submitting this data and then waiting, right? You're waiting around for six months and hoping that when you get those HS Rs that you have met, this says 7070% submission threshold. We're crossing our fingers and hoping that that's what it's going to be, but you really are just waiting and hoping that it it went through OK.

I mean, that's kind of how we feel at Metasol for like hope we got it all right. Hope we included all the data. And then hospitals, obviously you're thinking that even more than us as you're waiting to see those results, especially now that they're going to be mandatory. And unfortunately we learn all those lessons too late because by the time you get those high hospital specific reports, we're 3/4, sometimes almost all the way through the next reporting year. So you don't have any time to go back and fix the reporting year before you have to submit that one.

It is extremely difficult to do. And really that is a big part of the reason that we continue to talk about these hybrid measures and that CMS continues to address and fix them. And we continue to be frustrated with them because there's not a lot of not a lot of leg room to get those changes in place before you have to submit them again. And you don't know what changes you need to get in place until you have those HS Rs. So now I'm going to walk through all of the changes within the hybrid specification. So this is where we're talking about the specification with all that logic, your value sets, your mapping, those types of things that change year to year.

And really, I thought, you know, the statement sums it all up. The only constant with hybrid reporting is change. That's really changing constantly all the time and hard to keep up with every year. We have seen pretty significant annual updates to these hybrid measures, whether it's updates to linking variable requirements. There's been a lot of back and forth. Stop and start with the different linking variables, the logic, the CCD ES, the mapping, all of that. If you are not keeping up with those changes, if you miss any of those, it can absolutely impact your ability to meet the threshold requirements.

If you aren't capturing certain data elements, if you're missing a linking variable, all of those things will impact your ability to meet the threshold requirements. And especially now that this is mandatory, you want to pay attention. Makes sense that maybe, you know, as things were switched back to voluntary and fell down the list on the To Do List, then hybrid measures, everyone was probably like, OK, if you don't have to worry about that, we'll get to it later. So understanding that hybrid, you know, may have, you know, left your mind for a little bit. So we're going to talk about that.

Your annual specification updates require active monitoring. We say this about all ECQMS, any of these electronic measures. You have to be keeping up with the changes to these specifications and get those changes in place as close to day one of that reporting year as possible. Looking at the mapping, looking at logic changes, making sure you have the mapping changes in place, that you adjust any workflow that's necessary and super important to make sure you're ready for submission, that your QA QRDA files are ready to go. QRDA file format can change every year, so if you're IT and you've been submitting these, you probably are aware of that.

If you're on the quality side of things or on the clinical side of things, make sure whoever is doing your hybrid submissions is updating any changes in the QRDA file format. Very technical, but you have to make sure it's done. So we're going to talk about the specification changes for this year. So we're talking about the reporting year we're in right now, July 125. That's a typo on there through 630 of 26. And so this is the data you're collecting today. So if you haven't made these changes, you're going to want to make them as soon as possible so that you're collecting complete data, accurate data.

I'm going to say this multiple times today, even though there potentially will be some wiggle room if the proposed rule is finalized, Your best bet is to try to capture every single linking variable, every single lab, every single vital sign. That's the, you know, the, the best effort you can make to try to meet the, the measure requirements. So when you're thinking about these data elements that I'm going to talk about today, I would really suggest your goal is to collect all of them on every patient, of course, if it's applicable. So all encounters submitted to CMS in the hybrid QRDA files must include linking variables.

If you have all of these linking variables, we can guarantee that CMS is going to be able to match that QRDA file with the claim. If you're missing the MBI, if you're missing the admission and discharge dates, they may not be able to link that data. So for this year 2025, there are 5 linking variables, CCN, MB, I, inpatient admission date and inpatient discharge date. NPI is not in bold because even though it's a part of the specification, there was a lot of pushback, a lot of commentary to CMS when they published this requirement in the specification. And they later came out and said you don't have to submit the NPI as long as the CCN is submitted.

So don't worry about the NPI, but just make sure you have your CCN, your the patient's NBI, inpatient discharge date, and inpatient admission date. That MBI is probably the most important item here. So you want to make sure you're capturing those accurately, that they're making it to your reports, that you're tracking it throughout the year. If it's missing, you want to address it. If it there's a typo like a space in it or the wrong character, those are things that can throw it off and 'cause CMS not to be able to link your CCDE data to the claim. So talk about the readmission measure first.

The changes are very similar. So I'll go through readmission and then I'm going to kind of skim through mortality. So we're still talking about 7/1/25 to 6/30/26. They have made several changes to the the reporting year and the data collection process that we're in today. First change is they have added an encounter type of outpatient surgery. Adding this encounter type will allow data that you're documenting when the patient is in outpatient surgery to be evaluated for hybrid and included if they're admitted in, they have to be an inpatient to be in the measure population. So if you have a patient that comes in to outpatient surgery and then gets admitted in, as long as you have that outpatient outpatient surgery encounter mapped in your EHR, that data documented in the outpatient area will be considered for CCDE data collection.

And really any, any of those kind of scenarios right there, I don't know that all of them would come into play. It's probably typically going to be outpatient surgery to in. So you need to make sure you have that outpatient surgery location mapped. Again, if you do the mapping, great. You can put this in place. If someone else does it, you want to make sure that they have it mapped for this year. They have removed the time frame for weight documentation, so this is a good thing. Historically, you had to document your weight within a certain period of time.

I think you got to get it documented within 24 hours after admission. Now you can document the weight anytime. They've lifted those timing requirements so they will capture the first documented weight that is recorded during the hospitalization. So once that weight is recorded for the first time on that encounter, it doesn't matter when it occurred. If it's two days later or three days later, as long as it's documented and it's that first instance, it will be used. They have added logic to exclude CCDE documentation if the first result is null. So if there's a result that is evaluated and it's blank, or maybe someone has spaced in that field, they won't use that data.

Thankfully they will move on to the next result that actually has data that can be used. They changed the OID for heart rate. This really isn't a big deal, but for anyone that does mapping or is kind of living in value sets and looking at all of this, the code that identifies the value set has changed, but nothing in the value set for heart rate has changed. So none of the actual codes that you map have changed. They have removed some units of measure from their suggested units list. I'll get in the units of measure here in a little bit 'cause more trouble than you would think.

But they have a suggested list of units of measure within these specifications and they say it's suggested. But you really should do your best, if at all possible, to use the units of measure on that list. So from the previous year, they have removed the 2 units here for creatinine and white blood cells. If you use those units, don't stress. CMS has I, I hate to say it, but it's like a secret list in the background that they will reference as other acceptable units of measure and I'm pretty sure these will be on there. Super confusing, but basically they have to be able to convert what you send, and if it's not a standard unit of measure, if it's not a unit of measure that their calculation engine can understand, they won't be able to use it.

And then that date element gets flagged as missing. So I'll talk about it a little bit more on the next screen, but you really want to make sure your units of measure are where they need to be and as close to the standard as possible. Linking variables, I talked about, they added that NPI, but then they came back and said you don't need it if you have the CCN. And they removed date of birth and sex from the linking variables list from the previous year. And I also included down there at the bottom the new value set that needs to be mapped and the new Snow Med codes that are in that value set that you want to map to your outpatient surgery encounter so that that data gets captured.

These are the units of measure. Again, we're talking about this data collection year someone 25 to 63026. And I'll just point out give you an example. If you submit weight and you have a unit of measure of, of LB, right, But you have a space between the L and the B, or the L is capitalized, or the G is capitalized and it doesn't align with a standard unit of measure, CMS's measure engine won't be able to convert it to anything because it doesn't understand the unit of measure, right? We're talking about a computer here that's looking at it and trying to figure out what is that unit of measure.

I don't understand what that is. So it can't be used and it's flagged as missing. So that can hurt you in the wrong long run and keep you from meeting those threshold requirements. So really do a close review of all your units of measure and make sure there's no typos, no extra spaces, no caps where there shouldn't be that type of thing. But this is the full list for the readmission hybrid measure. The hybrid readmission measure initial population is capturing patients 65 and older with an acute care hospital inpatient encounter, length of stay less than 365, and they have to have Medicare FFS or Medicare Advantage.

Medicare Advantage was added last year. So you want to make sure you have that set up and then the patient has to be discharged during the measurement period. So we've talked a lot about those CCDE's. Those labs and vital signs are listed there at the bottom of the page. Those are specific to the readmission measure. And above that are the timing requirements that must be met for each of these CCDE's. So for labs and vitals, you are given 24 hours prior to the start of the inpatient admission to capture that data and capture the first instance.

If it's a direct admission or for some reason it doesn't get captured in the ER, they give you 2, two hours after the start of the inpatient encounter to get vitals documented and 24 hours after the start of the inpatient encounter to get labs documented. And then I mentioned wait, they've lifted that timing. So it's really just the first resulted. Remember they are looking for the 1st result of each of these CCD ES. You can document, you know, in in the case of of we'll use vital signs. You can document vital signs, you know, five times within the first two hours of the inpatient encounter.

They're only going to use the first instance of that documentation. And the same thing goes if you document, you know, let's say you document the temp five times a day later, a day after the start of the inpatient encounter. None of those are going to count has to be within the first two hours of the start of the encounter. Laid this out. This is what we typically do in a way that you can think about how this data is captured within your workflow and what we typically see for all of these items.

So again, your inpatient encounter, Ed encounter, observation encounter, and that new outpatient surgery encounter need to be mapped. Typically captured in admission registration process and then that payer mapping and again make sure you have all of your payer mapping correct for both fee for service and for Medicare Advantage, specifically Medicare Advantage because it's newer. Those get mapped to source of payment codes. And then below that are all of your CCD ES vitals obviously would typically get documented in clinical documentation. Your labs come from labs. Clinical documentation of those vital signs are going to be mapped to low Inc codes and, and as well as the the the lab results as well.

So again, if that isn't a language you speak, your IT team should definitely be aware of it and understand that those are things that have to get mapped and be reviewed to make sure if those codes change every year that you have them up to date. So for the same time frame, we're going to talk about the mortality measure. Basically the same stuff, basically the same changes. So the outpatient surgery, the OID change for heart rate, addition of the logic for CCDCCDE documentation if null changes to the link of variables in the units of measure. All the same changes when we're talking about mortality, except for that weight change because weight is not collected within the CCD ES for the mortality measure.

Here are those units of measure for the mortality measure. Mortality has fewer CCD ES than readmission, so you're not going to see as many units listed here, but the same rules apply that you want to make sure that you get those units of measures standard as possible within your documentation and data capture population for the mortality measure is a little bit different. It's got a cap on the age, so it's 65 years of age to 94 years of age. But everything else is the same and the timing is the same again, except for the weight, which isn't a part of this measure. And you can see down there at the bottom, there are only 10 CCDS compared to I think there's 13 on readmission.

And the difference here is they have added platelet as one of the lab tests that they're looking for in association with the mortality measures. So you want to make sure in addition to what you do for readmission and making sure you have all of that set up and data being collected and mapped, that you also have your platelet count mapped correctly and that that's being captured for the mortality measure. And that's really the biggest difference right there. OK, So now we're going to get into next year. So this is going to be the data that you start collecting next July, July 126th through 630 of 27. And again, very easy to say that's a long way off and who knows what CMS is going to do.

But really important, as we've talked about, to make sure you stay on top of these changes and you have it in place as early as possible so that you're prepared when that first day of data collection starts. You all want to be ready to go on July 1, 2026 so that you don't have any gaps in the data and you don't have any potential places where you know you're going to have, you know, data that can't be linked to the claim missing data, etcetera. So going to say the same thing here. You want to make sure you're capturing all linking variables. So for 26 to 27 at CCN MB I inpatient admission and discharge date, you can see they removed NPI completely from next year.

So it's those four items that you want to have in every patient's record so that they can link it to the associated claim that is key. So talk about the readmission measure here first for 26 to 27 and I'll fix the the date issues. It is 7/1/26 to 6/30/27. So we'll get that right on this presentation and get it get it out to you some really good changes, believe it or not, I think you'll be happy with for this year. They have, like I mentioned removed the NPI. They have added a new supplemental data element. So they have added to the measure specification oxygen therapy.

It is not used in the calculation of the results that you would track throughout the year or think of it as like a risk variable. They label it as an SDE, but it is basically going to be data you're submitting in your QRDA files in association with the patient, data that CMS will then use to risk adjust your results. So they are going to be capturing or want to capture patients who arrive at the hospital on oxygen therapy. They want to flag those patients so that they can incorporate

that data into the risk adjustment model. They will be looking for oxygen start time within 60 minutes of the start of the Ed visit.

Obviously, if the patients on oxygen when they come in, that can impact their O2 SAT and they want to take that into consideration when they're looking at the data and trying to kind of put a severity on that specific admission. They have new value sets for the oxygen therapy. So you want to make sure you got a look at those and that you get those mapped. No reason not to map those now. It's not going to hurt anything. It's not going to impact your results that you're working on and tracking this year, but get those mapped now so that next July they're in, they're ready to go and as soon as July one hits, you're capturing that oxygen data.

They have now designated the hybrid measures as outcome measures. Historically there was no measure type on the specification. Now they're calling them outcome measures. I'll let that sit with you for a little bit and we'll talk about it towards the end of the presentation. They are going to be ignoring bad values. So any text values, you know, quality not sufficient or quantity not sufficient, etcetera, will just be ignored and they'll take the next value that pops up as the first. They are changing units of measure. Again, never thought units of measure would be so complicated. So for every CCDE, as I mentioned, they recommend that hospitals use the units that are suggested in the specification.

And you can submit any unit you want, right? So if you submit that pound unit of measure and you have L space, space, space B, you can submit that. It's not going to throw a rejection, but if it's not easily converted to one of the units in the specification, that value, right. So that weight value will be set to missing and they will use the national median value for that weight for that CCDE, whatever it is to calculate your risk adjusted and including your risk adjusted process for these measures. So again, what that means, you want to get your units of measure right, you want to make sure there's no extra spaces, that it is a standard unit of measure and that it is included in the QRDA files correctly.

Really something unfortunately that you need to look at closely and validate ahead of submission. Because if those units are wrong, your data is not going to be looked at and they'll use the national median. And again, that can throw off your entire, you know, rate that they give you because it won't consider the severity of illness of your patients that will use that national median instead. I saved the best for last. This is I think the most exciting thing. But, you know, I love these measures. So when they make changes like this, I'm happy for hospitals and I'm happy for us.

It makes it a lot easier. They have removed all timing requirements. Again, this doesn't start until July 126th. Not not the day you're collecting now, next year. So starting July 126th, it doesn't matter when you document your vitals and your labs can be anytime during that hospitalization.

Still, we'll use the first instance of documentation. That first instance will be what is evaluated and reported. But this is great because you don't have to worry about those times anymore. They have lifted those times which cause so many issues for everyone in data collection.

As long as it's associated with that encounter, that inpatient hospitalization, it doesn't matter what when it's documented. So it can be documented in the Ed, it can be documented pre op. So again, a lot of those pre op labs haven't come in because they're done three days before. As long as it's associated with the encounter based on the way we're reading the specification, as long as it is associated with that inpatient encounter, it will count as the first instance and be evaluated and used in the QRDA file and then the risk adjustment. So great news and stop worrying about it next year won't matter what what time things get documented.

So that should make life easier. Units of measure are the same. They're not changing for next year. And so you don't have to worry about that other than what we've talked about. And I'm just going to kind of breeze through this. All of the changes that I mentioned are here. The populations are the same. The timing is lifted. So that's not in here anymore. And you can see down there at the bottom, you have to include or you want to include if the patient was on oxygen therapy.

And you can get that oxygen therapy in either clinical documentation on an order. There's two different value sets for this oxygen therapy again. So look at those value sets, look at the codes, make a decision on which of those codes you want to map to your documentation so you get that set up ahead of time. Same changes. No, no different changes on the mortality measure for 20/26/2027. So I'm not going to read through this again. The units of measures remain the same. No new units, no removed units. But again, you need to keep in mind making sure those units are correct.

Again, populations are the same for the mortality measures. Timing is lifted here and this one also does include that new data element of oxygen therapy. And again, just make sure you have that mapped. It will be picked up in both measures and included in the QRDA file. I wanted to speak a little bit to inclusions and exclusions. We get this question a lot. We have been asked numerous times, you know, if this measure is excluding patients that have an admission for a primary psychiatric diagnosis, can't you just exclude those from the reports you're showing us in Encore?

The answer to the question is we can only do that if it's in the specification logic and these things are not in the specification logic. We are certified to the measure logic. We can only include in that logic and in our results what is within that specification. Now could we do some customs and add some things in and show that these are the number of patients that had psych primary diagnosis. These are the number of patients that were in your population but left AMA. We could

do that, but it is also not necessarily going to be accurate because again, everything will be based on that claim that CMS gets.

So not knowing if the data we would be attributing to these measures, if that's accurate, final complete would make it super complicated and and honestly be misleading. So just know there are inclusions, additional inclusions for the population and exclusions for the hybrid measure populations that are not in the specification that CMS applies. After you submit your QRDA files, after you submit your claims, they then apply those exclusions. They're all listed here. Not going to read through every one of them. I've also included a link to the methodology for both of these measures. The next slide has the same for mortality.

If you're feeling crazy and want to read that methodology, It really has a lot of good information on the measures, how they risk adjust the cohorts, all of that good stuff is in there. So if you need a good reference, that would be it. And these are your inclusions and exclusions for the mortality measure again applied after you submit. I will mention this is from the 2025 version of the methodology. So I would expect we will see this updated for 2026 and there will be even more changes based on you know, what history is telling us.

So again, those methodology documents will be helpful to you, but what gets submitted in the QRDA files is just the electronic data that is pulled from vitals from labs and those linking variables. The rest CMS applies after you submit. So you can probably guess all of these lessons learned and we continue to learn and the big lesson is all of this keeps changing. So don't stop paying attention. Just because the requirements are changing doesn't mean the measures optional. I would really try to keep up with these measure changes as much as possible so that you continuously capture this, this data, you refine it.

Because again, the goal is not just to check a box and get this to CMS is for you to start using this data to actually understand where you're at with readmissions and shine more of a light on that. You really want to make sure you know your Medicare populations and compare your Medicare population to the populations in your hybrid report. So if you know you have 500 patients that have come in this year that are 65 and up and have Medicare, you should have 500 patients in your population for the hybrid measure report. I would start with simply that if you're just getting started on validating and understanding your hybrid data, make sure your Medicare population based on the data you have in your EHR matches the the initial population for these measures to start there to make sure the populations match.

As step one best approach, as I've mentioned a couple of times, is to have a goal of documenting all CCD, ES and all linking variables on every patient. That way you know you know you've got it all and the risk of missing any of that data is going to be lower. Track your results regularly. I'm not just saying this because we have reports in our application. You really need to look at the

data you're capturing ahead of submission. You don't get a lot of information on submissions. So the best you can do is understand those Medicare populations, track those populations and the CCD ES on each and every patient and the linking variables on each and every patient.

So you know where you're missing data, where your units of measure may be problematic. You want to be doing that throughout the year again, so you don't have a lot of surprises when you get those HSR. So know your Medicare population, do some audits as a part of this process. If you do audits on your ECQMS or any other measures to treat these the same, you know, pick 10 patients from your hybrid population and go through and make sure all the data is accurate in aligns with what you see in your EHR. You need those reports.

Give feedback to CMS. You know, we've, we've given a lot of feedback. We've actually had some meetings with them, submit requests for them to give you more data when you submit the QRDA files. That would be something that would be super helpful if you could submit that data. And you also have a list of all of the patients from CMS that were 65 enough and had a Medicare claim, right? So more data upon submission will help hospitals meet the threshold and make that data that you get from this HSR is more valuable to you.

Validate your payer mapping, make sure it includes those Medicare Advantage patients. Audit your mappings every year, ECQMS, hybrid, it's all the same. Make sure you're mapping your codes lines up with the new value sets and any changes to codes in that value set. And then I would work with whoever does your submissions, make sure that those QRDA files, the format is up to date. Again, there's an implementation guide that guides how that needs to be done and what needs to be included. And then make sure you're linking variables when they're captured in the QRDA file, don't get changed.

And really you should do that with all of your data. You know, sometimes when that QRDA file is being created, if there's some issue with the format, it could, you know, override a unit of measure or throw a space somewhere in that file that it shouldn't be. And that can cause problems when that data is uploaded to CMS. So definitely want to get your IT team involved in this future considerations. Hybrid measure specs are going to be adjusted as CMS learns more. So they'll learn more from this submission period, from next year's submission period and so on.

And I would expect they'll continue to make changes. And with that the continued the role of hybrid measures will continue to grow. They're using these measures in in the team model. They have emphasized that they're going to use more and more digital data to augment those claims measures. And they are now calling those hybrid measures outcome measures. I think that's a big change. They didn't have a type before, but for them to start calling them outcome measures, I think is a big hint that they're going to really start emphasizing these more, that they're going to put more meaning to the results. So definitely keep that in mind.

And I'll just say, is there a fire based ECQM, hybrid ECQM on tap? When I was doing research for this presentation, I was like wonder if there's any other hybrid measures out there. And lo and behold I came across a draft specification was from a couple years ago of hybrid measure for community onset sepsis, 30 day mortality. I haven't heard anything about it. I haven't done anything except find that spec. But there are other specs out there that have been drafted at least, which means they're considering additional hybrid measures down the road. So hi, Aaron, just dropping that bomb on us at the end.

Oh, by the way, this. Might. Be coming. Back I went very quickly to the CE credit, the credit slide. Was like, wait, what are you what are you talking about? No, that was super great. So many changes. I honestly like blown away. Thank you for walking through. I just I did want to there. There were some questions that came in chats, but one thing I was wondering you could just give us your perspective on since you did such deep research between the two, you know, reporting years and the changes in the specifications.

Just an opinion here. What do you think that's going to look like? Like how drastically do you think the performance will be year to year for hospitals? Like those changes of timing, do you think that's going to make a massive change or or is it less, I think. It'll be really interesting. I, I, you know, it's hard to say if it's going to be a massive change because to be honest, and I think CMS would agree with me, you can't really trust any of the previous year's data, right? There's been so many issues.

I would guess most hospitals and not saying this to, to put anybody down, but I would guess most hospital hospitals are looking at this and saying we can't trust this data. There's problems every year. You know, the platelet units weren't used. CMS has made calculation issues. So it's hard to know how much it will change the results. I do think it will allow for more accurate results by lifting those timing because there's, there's been, probably not probably there have been first instances of CCDE documentation that haven't been picked up historically because of those time limits.

Patients spend more than 24 hours in the ER sometimes, right? So if they came into the ER and had their first blood pressure done, that shows, you know, extremely high blood pressure, hypertension, but that was, you know, 28 hours before inpatient admission, that one wouldn't be picked up. So I do think it's going to give more accurate results. And honestly, now that I've thought about it and looked at it so much, I'm not quite sure where they included the timing to begin with, because this really just opens it up to get a lot more accurate data, I think.

Yeah, well, we are at time. So as you all can see on the screen there, you do get a credit CE credit. If you have CPHQ, you can claim that credit. You do have to self report. So you'll you enter it in self report using the certificate of attendance. So a couple of questions about the

recording. This is recorded, you're going to get a follow up e-mail and in that you'll get a certificate of attendance. So if you have a CPHQ and and want to claim this for one credit, you may. And then the last thing is the Metasol minute.

So there were some questions that came in. If you didn't get a chance to get your question answered and you have something else on your mind, put it in the Q&A box. But we'll read through all the chats and on August 22nd. So in a couple of weeks, takes us some time to do the research. We will, Kristen and I will meet for the radio show and we will answer the questions from today's webinar. So keep an eye out because in that follow up e-mail, if you, you know, say you want to come to that, we'll there's a link so you can add it to your calendar because it's a radio show.

It's it's not like a Yeah, see if. You can see if you can stump us, How about that? Yeah, exactly. I'm. Looking that up now. That's nuts. OK, well, thank you all so much for your time today, Kristen. Thanks so much for all that great information. It was really, truly interesting and a lot of really good stuff in there. And thanks to our audience.

Thanks so much for attending, being part of this interacting. I loved watching and interacting with you all. So thank you so much. And we will be back next month with the ambulatory side. We've got a new one coming up on the changes to the ambulatory side for the quality payment program and all that fun and brand new ambulatory specialty model. Can't wait to get into it. So we'll see you guys next month. And until then, you guys? Have a great rest of your week. Thanks everyone.