## Hospital Inpatient Quality Reporting (IQR) Program

## Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

# Hospital IQR Program Requirements for CY 2023 Reporting (FY 2025 Payment Determination) Question and Answer Summary Document

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**Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.**

**Clinical Process of Care Measures - Sepsis (SEP)-1 and Perinatal Care (PC)-01**

**Question 1:** **For the SEP-1 measure, is the requirement any different than what we are currently doing through a third party vendor?**

The quarterly reporting requirement of the Hospital Inpatient Quality Reporting (IQR) Program SEP-1 patient-level data has not changed.

**Question 2:** **Do the Hospital IQR Program requirements for PC-01 and SEP-1 apply to critical access hospitals (CAHs)?**

CAHs are not included in the Hospital IQR Program. Although they are encouraged to participate in voluntary reporting, they are not required by the Hospital IQR Program to submit data for any Hospital IQR Program measure, including PC-01 and SEP-1.

**Question 3:** **Is it possible to have a link on the CMS QualityNet website that goes to the current list of exclusions for PC-01?**

The QualityNet Web-Based Data Collection web page provides a link to The Joint Commission's specifications manual. Due to the platform that The Joint Commission uses for their specification manual, we are unable to provide a direct link to the PC-01 exclusions.

**Question 4:** **What steps should we take if our facility does not do obstetrics?**

For hospitals that do not have labor and delivery services, there are two options. One, the hospital may submit an IPPS Measure Exception Form and renew it at least annually. Otherwise, the hospital must enter a zero (0) for each of the data entry fields, within the *Hospital Quality Reporting (HQR) Secure Portal* data entry form, for each discharge quarter.

The form pertains only to the PC-01 measure. It is not applicable for the Maternal Morbidity Structural Measure. Hospitals that do not provide labor/delivery care will select N/A to meet the Maternal Morbidity measure requirements.

**Question 5:** **If a hospital chooses to report all their PC measures as eCQMs for The Joint Commission, can they use the numerator/denominator for PC-01 (if it is a quarterly file) to enter the data into the *HQR Secure Portal* data form, or are hospitals required to continue to chart abstract PC-01?**

For the Hospital IQR Program, CMS utilizes the chart-abstracted PC-01 measure. Hospitals can use data that are pulled from the eCQM if it complies with the chart-abstracted measure specifications.

**Influenza Vaccination Coverage Among Healthcare Personnel (HCP Influenza Vaccination)**

**Question 6:** **Is the HCP Influenza Vaccination measure the same as IMM-2, the Influenza Immunization measure?**

No. IMM-2 pertains to the chart-abstracted patient Influenza Immunization measure. IMM-2 is not a requirement of the Hospital IQR Program.

**COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination)**

**Question 7:** **Will the requirement for the HCP COVID-19 Vaccination measure stop once the Public Health Emergency (PHE) declaration ends?**

The HCP COVID-19 Vaccination reporting requirements were implemented via rulemaking and are independent of the PHE declaration. When CMS makes changes to the requirements of the Hospital IQR Program, they do so via the rulemaking process. When proposed rules are posted for public comment, CMS will announce it via Listserve. If you are not signed up for Listserves, you may do so on the CMS QualityNet website: qualitynet.cms.gov > Subscribe to Email Updates. This is the direct link: https://qualitynet.cms.gov/listserv-signup

**Validation**

**Question 8:** **When will feedback from the calendar year (CY) 2021 CMS Data Abstraction Center validation become available? Additionally, will CMS make them available sooner in the future?**

All fiscal year (FY) 2024 (CY 2021) validation results have been received. If you have questions or concerns, you may reach out to the Value,

Incentives, and Quality Reporting Validation Support Contractor at validation@telligen.com.

CMS has been working to update the *HQR Secure Portal* with reports for data validation. Some results for selected cases were delayed during these modernization efforts.

**Question 9:** **When will the validation results for CY 2022 become available?**

It typically takes approximately three to four months after each medical record submission deadline for hospitals to see their validation results for the quarter/reporting period. Hospitals' registered users with the Validation role will receive email notification when their results become available to view on the HQR Secure Portal.

## Other Structural and Process Measures

**Question 10:** **Is the Hospital Commitment to Health Equity (HCHE) a pass/fail measure, and must we meet all five domains? If we answer No and do not meet all the domains, will our hospital be penalized?**

The HCHE measure is required to be reported under the Hospital IQR Program. This is a pay-for-reporting measure; hospitals will receive credit for the reporting of their measure results regardless of their responses to the attestation questions. For public display purposes, a hospital's responses to the attestation questions will be scored as described below.

The HCHE measure includes five attestation-based questions, each representing a separate domain of commitment. For a hospital to affirmatively attest to a domain, and receive credit for that domain, the hospital will evaluate and determine whether it engages in each of the elements that comprise the domain. Hospitals receive one point for each domain to which they attest Yes, stating they are meeting the required competencies; a hospital's score can be a total of 0 to 5 points (1 per domain). For each domain, there are between one and four associated Yes/No sub-questions for related structures or activities within the hospital. Hospitals will only receive a point for each domain if they attest Yes to all related sub-questions. There is no "partial scoring" for sub-questions. For example, in Domain 1, hospitals must attest Yes to sub-questions A–D to earn the point for that domain. If hospitals participate or complete qualifying activities at any time within the reporting year, they may attest Yes for that domain.

**Question 11:** **Is the CY 2023 submission deadline for the HCHE measure May 15 of 2024?**

Hospitals must complete their attestation for the CY 2023 reporting period/FY 2025 payment determination between April 1, 2024, and May 15, 2024.

**Question 12:** **For the HCHE measure, are we required to begin screening for all five of the Health-Related Social Needs (HRSNs) on January 1, 2023, to be able to attest positively?**

If hospitals participate or complete qualifying activities at any time within the reporting year, they may answer Yes to their attestation.

**Question 13:** **Will CMS require a specific tool to be used to report the Social Drivers of Health (SDOH) measures?**

Due to variability across hospital settings and the populations they serve, CMS is allowing hospitals flexibility with selection of tools to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. CMS is not specifying certain questions under each HRSN.

CMS suggests hospitals refer to evidence-based resources for comprehensive information about the most widely used HRSN screening tools. For example, the Social Interventions Research and Evaluation Network (SIREN) website, housed at the Center for Health and Community at the University of California, San Francisco, contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions. In the FY 2023 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule, we noted that we anticipate additional emphasis on standardized and validated screening instruments in future versions of this measure. We encourage hospitals to prioritize screening tools that have undergone adequate testing to ensure they are accurate and reliable.

**Question 14:** **For the SDOH measures, are we only able to do the screening during the inpatient stay? Do we assess all patients or just inpatients? We may screen patients prior to inpatient surgery, there may be a short interim readmission, or we may have assessed them in the clinic and sent them to the hospital the next day. We could receive survey burden complaints from the patients.**

As noted in the FY 2023 IPPS/LTCH PPS final rule, screening can occur at any point during the hospital inpatient stay. To not count patients twice for the same admission, if the year changes during the hospital admission, we recommend hospitals use the discharge date.

Screening should occur during each hospital stay. For patients frequently admitted to the hospital, for example, due to chronic health conditions, the hospital could confirm the current status of any previously reported HRSNs and inquire about other HRSNs not previously reported. In addition, if this information has been captured in the electronic health record (EHR) in the outpatient setting prior to repeat hospital admission, it could be included in hospital reporting of numerator and denominator data, during the measure's reporting period.

Patients should be screened during every admission, but only unique patients should be included in any one reporting period (year). If a patient has multiple admissions in the year, the most recent result (the result closest to the reporting period) should be submitted. For example, if the patient were admitted, screened, and discharged in May 2023 and then admitted, screened, and discharged in December 2023, the results of the December 2023 admission would be used for the CY 2023 reporting period.

**Question 15:** **What is the data collection time-period for the voluntary reporting of the SDOH measures?**

CMS will require attestation to the SDOH measures on an annual basis. The annual submission period for the structural measures is from April 1 through May 15. For the CY 2023 voluntary reporting period, hospitals will be able to report these measures, in the *HQR Secure Portal*, from April 1, 2024, through May 15, 2024.

**Question 16:** **What is the denominator for the Screen Positive Rate for Social Drivers of Health (SDOH-2) measure? Is it the number of patients who answered Yes to that domain question in Screening for Social Drivers of Health (SDOH-1)? For example, the patient only answered the food insecurity question, not housing instability. Are they counted only in the food insecurity question or not included in either since they did not answer all questions?**

For the screening positive rate for the Screen Positive Rate for Social Drivers of Health measure, CMS requires the following:

- Numerator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for an HRSN, and who screen positive for having a need in

one or more of the following five HRSNs (calculated separately): food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety

- Denominator: The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission and are screened for an HRSN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay (87 FR 49216)

CMS calculates the result of this measure as five separate rates. Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for all five HRSN, and who screen positive for each of the five HRSNs. This is divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs (87 FR 49217). Since the denominator for the Screen Positive Rate for Social Drivers of Health measure includes patients screened for all five HRSNs, it should be used for the denominator in each of the five rates.

**Question 17:** **Will there be a separate webinar addressing the voluntary reporting of the SDOH measures so that we may determine what the reporting fields/measure layout looks like?**

CMS will announce via Listserve notification any webinars related to the SDOH measures. Please visit the CMS QualityNet website to join the Listserve notifications and receive important CMS communication updates: https://qualitynet.cms.gov/listserv-signup

Several resources are also available on QualityNet on the Web-Based Data Collection page related to the SDOH measures.

**Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Patient Reported Outcome (PRO)-Performance Measure (PM)**

**Question 18:** **We are constructing the THA/TKA PRO-PM queries into our EHR. Would we be able to submit the patients if we do not have the data available as stipulated by the date ranges?**

Hospitals participating in the voluntary reporting periods for the THA/TKA PRO-PM should submit patients 1) who have procedures during the eligible procedure windows and 2) preoperative and postoperative PRO data collected during the specified data collection

timeframes. For the first voluntary reporting period, the eligible procedure window is January 1 through June 30, 2023. Preoperative PRO and risk variable data will need to be collected 0–90 days in advance of an eligible procedure (October 3, 2022–June 30, 2023). Postoperative PRO data will need to be collected 300–425 days following an eligible procedure (October 28, 2023–August 28, 2024).

Your hospital can submit patients provided they have their procedures during the eligible procedure period with preoperative PRO data and postoperative PRO data collected in the specified timeframes. For voluntary reporting 1, hospitals must submit the preoperative PRO data by October 2, 2023, and postoperative PRO data by September 30, 2024. Hospitals cannot submit data after the data submission deadlines.

In terms of the data submission process, hospitals will use the *HQR Secure Portal*, which allows multiple file formats: comma-separated value (CSV); extensible markup language (XML); and manual data entry as part of data submission. More information regarding the data submission process will be forthcoming and posted on QualityNet.

Please be aware that hospitals can participate in the second voluntary reporting period, which includes the following timeframes:

- Eligible procedures performed: July 1, 2023–June 30, 2024
- Preoperative PRO data collected: April 2, 2023–June 30, 2024
    - Data submission deadline: September 30, 2024
- Postoperative PRO data collected: April 26, 2024–August 29, 2025
    - Data submission deadline: September 30, 2025

**Question 19:** **How will we submit THA/TKA PRO-PM data? Many of these cases are not inpatient. How are facilities going to meet the requirement if patient responses are below 50 percent?**

Hospitals have the flexibility to submit data through multiple approaches. Hospitals can send data to CMS for measure calculation directly or use an external entity (vendor or registry). Hospitals and external entities will use the *HQR Secure Portal* which allows multiple file formats: CSV, XML, and manual data entry as part of data submission.

More information regarding the HQR Secure Portal data submission process will be forthcoming and posted on QualityNet. If you have not already done so, please subscribe to the Hospital IQR (Inpatient Quality

Reporting) and Improvement Listserve offered on QualityNet (https://qualitynet.cms.gov/listserv-signup) to receive notifications about Hospital IQR Program measures.

Please be aware that hospitals are not held to the 50-percent reporting requirement until mandatory reporting in the Hospital IQR Program (FY 2028). CMS believes hospitals will therefore have time to develop their data collection and reporting processes. CMS recommends hospitals collect and submit complete data on more than 50 percent of their eligible inpatient THA/TKA patients for hospitals to maximize the potential for them to be successful in meeting the 50-percent Hospital IQR Program requirement.

CMS will continue to monitor the shift of these procedures towards the outpatient and ambulatory settings and evaluate future consideration in other programs. Although the collection of PRO data for outpatient procedures is not required at this time, we acknowledge it may be easier for hospitals to collect PRO data on both inpatient and outpatient procedures for two reasons: It may be difficult to identify inpatient and outpatient procedures in advance, and it may be advantageous to collect PRO data on the outpatient population in the event CMS adopts the measure for the outpatient settings. Any future adoption of the measure to other settings would be announced during future rulemaking.

**Question 20:** **When is CMS going to provide more guidance on how to submit the THA/TKA PRO-PM data?**

Multiple resources are available on QualityNet on the THA/TKA PRO-PM webpage, under the Methodology and Resources tabs. Additionally, a webinar pertaining to the voluntary reporting of the THA/TKA PRO-PM is on the Quality Reporting Center website.

**Question 21:** **Is there any consideration to retire THA/TKA PRO-PM for the Hospital IQR Program since most of these surgeries are as outpatient or in ambulatory surgery centers?**

CMS will continue to monitor the shift of these procedures towards the outpatient and ambulatory settings and will communicate any changes to reporting requirements via future rulemaking.

**Question 22:** **Is there a possibility that the voluntary measure will eventually become mandatory?**

Yes, after the two voluntary reporting periods (CY 2025 and CY 2026) the THA/TKA PRO-PM will become mandatory in CY 2027 in the Hospital IQR Program. Hospitals that voluntarily submit data for this measure will receive confidential feedback reports that detail submission results from the reporting period.

You can find the data collection and data submission timeframes for voluntary and mandatory reporting of the THA/TKA PRO-PM in *What is the PRO-PM Timeline?* fact sheet on QualityNet: https://qualitynet.cms.gov: Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Resources

**Question 23:** **For FY 2025 voluntary reporting, does this refer to CY 2023 data?**

The 2025 voluntary reporting period for the THA/TKA PRO-PM includes the following:

- Eligible elective primary inpatient THA/TKA procedures performed: January 1, 2023–June 30, 2023
- Preoperative data collection: October 3, 2022–June 30, 2023
- Postoperative data collection: October 28, 2023–August 28, 2024

Hospitals will submit preoperative PRO data by October 2, 2023, and postoperative PRO data by September 2024. CMS will provide hospitals with their results in confidential feedback reports in 2025.

Please note that procedures performed July 1, 2023–December 31, 2023, would be included in the second voluntary reporting eligible procedure timeframe. For the second voluntary reporting period, the eligible procedure period is July 1, 2023–June 30, 2024.

You can find the data collection and data submission timeframes for voluntary and mandatory reporting of the THA/TKA PRO-PM in the *What is the PRO-PM Timeline?* facts sheet on QualityNet: https://qualitynet.cms.gov > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Resources

**Question 24:** **Is the data for the voluntary measures manually abstracted from the medical record?**

The THA/TKA PRO-PM is not a manually abstracted measure. Instead, this is a new measure type. Specifically, hospitals will need to collect PRO and risk variable data preoperatively and PRO data postoperatively for eligible inpatient THA/TKA procedures. You can find details on the data elements, timing of data collection and submission, and measure details in the fact sheets available on QualityNet: https://qualitynet.cms.gov) > Hospitals – Inpatient > Measures > THA/TKA PRO-PM > Resources

The preoperative and postoperative PRO data can be stored in the medical record, but this is not required. Hospitals have the flexibility to submit data through multiple approaches. Hospitals can send data to CMS for measure calculation directly or use an external entity (vendor or registry).

Hospitals and external entities will use the *HQR Secure Portal* which allows multiple file formats: CSV, XML, and manual data entry as part of data submission. More information regarding the data submission process will be forthcoming and posted on CMS' QualityNet website in the future.

## Hybrid Measures

**Question 25:** **The two hybrid measures are almost identical. Why do we need to submit two separate files that contain similar data points? This has doubled our cost for vendor Quality Reporting Document Architecture (QRDA) Category I file creation.**

The submission of the core clinical data elements (CCDEs) for the hybrid measures is like eCQM data submissions. All the CCDEs and the linking variables for the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Mortality (HWM) measures should be submitted in one QRDA Category I file, per patient, per quarter. Each QRDA Category I file submitted should contain all CCDEs for each patient meeting the initial population criteria for each hybrid measure that your hospital is reporting on. It is important to note that the HQR system will reject files that contain both CCDE and eCQM measure data.

**Question 26:** **When will hospitals receive feedback on the 2023 voluntary reporting of the Hybrid HWR measure for last year? How will we receive this feedback?**

Hospitals received confidential feedback on the voluntary reporting of the Hybrid HWR measure (data submitted in 2022) in the Hospital-Specific Reports (HSRs) that were distributed in the Spring of 2023 via the HQR Secure Portal. Please note, the results distributed in the Hybrid

HWR HSR during
Spring 2023 are confidential and will not be shared publicly or impact payment determination.

**Question 27:** **Are the hybrid measures eCQMs?**

Hybrid measures are different than eCQMs as the measure logic to extract electronic clinical data will produce a file containing CCDEs. The collection of these elements alone will not produce measure results since hybrid measures use more than one source of data for measure calculation. Hybrid measures contain both claims-based specifications and electronic specifications. An eCQM uses patient data extracted from certified EHR technology and calculates the measure results based on its electronic specifications.

**Question 28:** **When will CMS require reporting of hybrid measure data?**

Hospitals participating in the Hospital IQR Program are required to submit Hybrid HWR measure and Hybrid HWM measure data beginning with the 2025 mandatory reporting period, which includes data from July 1, 2023, to June 30, 2024. These data will be used to calculate the hybrid measures that will be publicly reported in 2025, impacting the FY 2026 payment determination. For the electronic specifications of the measures, please refer to the 2023 reporting period for the hybrid measures on the Electronic Clinical Quality Improvement Resource Center. It is important to note that these data must be reported using Health Information Technology (Health IT) certified by the Office of the National Coordinator for Health IT (ONC) to the 2015 Edition Cures Update criteria.

**Question 29:** **Since the ONC certification criteria isn't required until this year, would we still be able to participate in the submission of the voluntary Hybrid HWR measure?**

Hospitals voluntarily submitting Hybrid HWR and Hybrid HWM measure data for the 2024 voluntary reporting period, which includes data from July 1, 2022, to June 30, 2023, are required to use technology certified to the 2015 Edition Cures Update criteria.

**Electronic Clinical Quality Measures (eCQMs)**

**Question 30:** **A patient was discharged to an inpatient drug/alcohol facility. The denominator for the Safe Use of Opioids – Concurrent Prescribing eCQM excluded this patient because he was discharged to an acute care facility. Should we have mapped Other Facility (the inpatient drug/alcohol facility) to Acute Care?**

Please submit your question to the ONC Project Tracking System called JIRA, specifically the eCQM Issue Tracker located: https://oncprojectracking.healthit.gov/support/projects/CQM/summary You may search for similar topics that measure experts may have already addressed.

If you are unable to locate information, please submit your own question. To submit your own question for the measure steward to address, please create an account by visiting the ONC Issue Tracking System Dashboard: https://oncprojectracking.healthit.gov/support/secure/Dashboard.jspa. If you require assistance on creating an account or accessing the site, please contact the JIRA Support Team at onc-jira-questions@healthit.gov.

**Question 31:** **Will CMS publicly report data from the Safe Use of Opioids - Concurrent Prescribing eCQM for CY 2022 with the other eCQMs?**

Yes. CMS plans to publicly report all eCQM data successfully submitted to production in the HQR system. These data include the mandatory Safe Use of Opioids - Concurrent Prescribing eCQM and all self-selected eCQMs submitted for the CY 2022 reporting period. CMS anticipates the public reporting of CY 2022 eCQM data will be publicly displayed on the Provider Data Catalog (PDC) for the October 2023 Release.

**Question 32:** **Are we required to submit eCQMs quarterly, or can we submit them at the end of the year as the Medicare Promoting Interoperability Program allows?**

The annual submission of eCQM data is an aligned requirement for hospitals participating in the Hospital IQR and/or Medicare Promoting Interoperability Programs. Once CMS announces that the HQR system is accepting eCQM data for a specific reporting period, data submitters can begin to upload their data as often as needed up until the submission deadline. Patient-level data must be reported using the QRDA Category I file format, which is defined as one file, per patient, per quarter.

CMS recommends that data submitters upload their test files early and often once the HQR system has opened to allow time to correct any errors and resubmit for processing.

Although each QRDA Category I file represents one quarter of data, users may upload a zip file containing QRDA Category I files from different quarters. The HQR system does not permit data to be uploaded after the submission deadline. CMS will announce via Listserve when the HQR system will be ready to accept CY 2023 eCQM data.

For example, CMS announced on October 11, 2022, that the HQR system was accepting CY 2022 eCQM data. Data submitters were able to start uploading their QRDA Category I test and production files for Q1 through Q3 2022 beginning October 11, 2022, through the submission deadline of February 28, 2023. After December 31, 2022, data submitters could upload their QRDA Category I files for all 2022 data through the submission deadline.

**Question 33:** **For CY 2022, we need to submit three quarters of data that do not need to be consecutive. Can you clarify if we must use the same quarters for each measure, or can they be mixed up?**

Specific to CY 2022 reporting, each self-selected quarter must contain four eCQMs which include the Safe Use of Opioids - Concurrent Prescribing eCQM and three self-selected eCQMs. Each quarter must contain the same four eCQMs in each of the three quarters. For CY 2023 reporting, the same will apply except that hospitals are required to submit a total of four quarters of data, instead of three quarters.

**Question 34:** **Can we submit one QRDA Category I file containing all four quarters, or do we submit four separate zip files?**

The QRDA Category I file format is one QRDA Category I file, per patient, per quarter, which includes all episodes of care and the measures associated with that patient in that reporting period. Each QRDA Category I file should contain a low value and a high value, reflecting the quarter of the reporting period you are submitting. A zip file may contain a variety of QRDA Category I files from different quarters; however, each QRDA file represents one quarter of data, and 14,999 is the maximum number of QRDA Category I files within one zip file. If a hospital has more than 14,999 QRDA Category I files to report, additional zip files may be submitted. Please confirm that your zip file does not contain another zip file within it prior to uploading it to the HQR system.

**Question 35:** **When does the eCQM window close for CY 2022 data and open for CY 2023?**

The submission deadline for CY 2022 eCQM reporting was February 28, 2023, at 11:59 p.m. Pacific Time. CMS will announce via Listserve notification once the HQR system has been updated and ready to accept eCQM data for the CY 2023 reporting period. Please make sure to join the Listserve notifications to receive important CMS communication updates: https://qualitynet.cms.gov/listserv-signup

**Question 36:** **When will CY 2021 eCQM data be available for reporting on Care Compare to use as benchmarks for CY 2023 eCQM reporting?**

Currently, CMS is only publishing facility level measure rates, and denominator rates on the PDC. Public reporting of eCQM data began with the CY 2021 reporting period. These data were publicly displayed for the January 2023 release on the Provider Data Catalog located at the following link: https://data.cms.gov/provider-data/. CMS anticipates that CY 2022 eCQM data will be publicly displayed on the PDC for the October 2023 release. As more eCQM data are progressively reported and comparisons of hospital performance is available, CMS will announce when additional information (including state, national and top 10 percent rates) will be displayed on Care Compare.

**Question 37:** **The ST-Elevation Myocardial Infarction (STEMI) Outpatient (OP)-40 eCQM is not listed for CY 2023 voluntary reporting or CY 2024 mandatory reporting. Has the final rule changed from the pre-rulemaking eCQMs?**

OP-40 was finalized as proposed to begin voluntary collection with CY 2023 and mandatory beginning with CY 2024

Voluntary reporting for the OP-40: ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) begins with the voluntary reporting for the CY 2023 reporting period for the CY 2025 payment year and a May 15, 2024, submission deadline. Mandatory reporting begins the following year, CY 2023 reporting period for the CY 2026 payment year. Submission of one quarter of data is mandatory Facilities will gradually work up to submitting a full calendar year of data by the CY 2027 reporting period for the CY 2029 payment year. See the final rule for additional details (FR 87 71748)

For any further questions about the Hospital Outpatient Quality Reporting (OQR) Program. Please submit your question using the QualityNet Question and Answer Tool:

https://cmsqualitysupport.servicenowservices.com/qnet_qa?id=ask_a_question

**Question 38:** **Since the STEMI (OP-40) eCQM is not a part of the Hospital IQR Program, do we still include the measure in the file submitted to HQR in CY 2023?**

Since the STEMI eCQM is part of the Hospital OQR Program, hospitals must submit a separate QRDA file with that measure. The submission deadline for the CY 2023 voluntary reporting period is May 15, 2024.

Your question is specific to the Hospital OQR Program. Please submit your question using QualityNet Question and Answer Tool: https://cmsqualitysupport.servicenowservices.com/qnet_qa?id=ask_a_question.