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) Presentation Transcript

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Candace Jackson: Good afternoon. Welcome to the *Hospital Inpatient Quality Reporting Program Requirements for Calendar Year 2023 Reporting/Fiscal Year 2025 Payment Determination* webinar. My name is Candace Jackson, and I am with the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting and speaking on today's event. Along with myself, today's speakers also include Donna Bullock, Operations Manager, and Veronica Dunlap, eCQM Program Lead, both from the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with a question-and-answer summary, will be posted to the inpatient website, QualityReportingCenter.com, in the upcoming weeks. If you are registered for this event, a link to the slides was sent out a few hours ago. If you did not receive that email, you can download the slides. Again, that is www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey for today's event, please stand by after the event. We will display a link for the survey. At the conclusion of today's event, we will have a live question-and-answer session, as time allows. If we are unable to get to your question today, it will be responded to and posted at a later date.

This event will provide insight into the calendar year 2023 Hospital Inpatient Quality Reporting Program requirements, as well as review of the calendar year 2023 Hospital Inpatient Quality Reporting Program and Medicare Promoting Interoperability Program areas of alignment.

At the conclusion of today's event, participants will be able to identify the quarterly and annual requirements for the Hospital Inpatient Quality Reporting program. They'll be familiar with the areas of alignment between the [Hospital] Inpatient Quality Reporting and Medicare Promoting Interoperability Program requirements and be able to locate resources that are available for both the Hospital Inpatient Quality Reporting and Medicare Promoting Interoperability Programs.

Here is a list of the acronyms that we will use throughout the presentation.

In the first part of today's presentation, I will be covering the quarterly [Hospital] Inpatient Quality Reporting Program requirements for calendar year 2023.

So, let's start the review of the [Hospital] IQR Program requirements with our first polling question. That question is: Which of the following Hospital IQR Program requirements are submitted on a quarterly basis? Is it clinical process of care and Healthcare Personnel COVID-19 Vaccination measures, aggregate population and sampling, Hospital Consumer Assessment of Healthcare Providers and Systems Survey data, or all of the above? The answer is D, the clinical process of care, including PC-01 and the COVID-19 Vaccination Coverage Among Health Care Personnel [measures], HCAHPS Survey measures, and the aggregate population and sampling data are required on a quarterly basis.

We'll begin by going over the quarterly requirements. On a quarterly basis, IQR-eligible hospitals are required to submit their Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, Survey data; their aggregate population and sampling counts for the chart-abstracted measure sets or measures; and the clinical process of care measures, which are the chart-abstracted measures, the web-based Perinatal Care Elective Delivery measure, and the Healthcare Personnel COVID-19 Vaccination measure. Additionally, those that are selected for validation will need to submit their medical records. We will go through each of these requirements in a little more detail in the upcoming slides.

Hospitals must submit aggregate population and sample size counts for Medicare and non-Medicare discharges for the chart-abstracted measures only. So, this would include the counts for only the Severe Sepsis and Septic Shock initial patient populations. The aggregate counts can be submitted either by accessing the population and sampling data entry form within the *Hospital Quality Reporting Secure Portal* or by uploading an extensible markup language, or XML, file within the HQR System. Hospitals are required to submit the aggregate population and sample size counts, even if the population is zero.

Leaving the field blank does not fulfill the requirement. A zero must be submitted even when there are no discharges for a particular measure set. As a note, the Perinatal Care Elective Delivery, or PC-01, aggregate population and sample size are not broken down by Medicare and non-Medicare discharges, and data for this measure set are collected through the web-based data entry form located within the *Hospital Quality Reporting Secure Portal*.

There are two chart-abstracted clinical process of care measures that will be required for the [Hospital] Inpatient Quality Reporting Program for calendar year 2023, beginning with January 1, 2023, discharges. Hospitals must chart-abstract and submit complete patient-level data for the SEP-1 measure. The measure specifications and abstraction guidelines can be found within the *Specifications Manual for National Hospital Inpatient Quality Measures,* located on the QualityNet website. Please note that, for calendar year 2023, there are two applicable specification manuals: Version 5.13 covers January 1 through June 30 discharges; Version 5.14 covers July 1 through December 31 discharges. So, as you are abstracting for the different quarters, you will want to make sure that you are using the correct specifications manual. The patient-level data for these measures are submitted via an XML file through the *Hospital Quality Reporting Secure Portal*. Although it is considered a chart-abstracted measure, only the aggregate data, not patient-level data, for PC-01 is submitted manually via the *Hospital Quality Reporting Secure Portal* online tool. Data for PC-01 cannot be submitted via an XML file. The measure specifications and abstraction guidelines, for the PC-01 measure, can be found within the *Specifications Manual for Joint Commission National Quality Measures*, located on The Joint Commission website.

Although not a quarterly requirement, I would just like to take a few moments and address the Influenza Vaccination Coverage Among Healthcare Personnel measure. Hospitals must collect and submit annually to the Centers for Disease Control and Prevention through the National Healthcare Safety Network, the HCP Influenza Vaccination Coverage Among Healthcare Personnel measure.

The submission period corresponds to the typical flu season, which is October 1 through March 31, and data for this measure are due annually by May of each year. So, for calendar year 2023, which would be the flu season from fourth quarter 2022 through first quarter 2023, the data will need to be entered by May 15, 2023. As per the Fiscal Year 2022 Inpatient Prospective Payment System Final Rule, hospitals or facilities will collect the numerator and denominator for at least one self-selected week during each month of the reporting quarter and will need to enter that data into the NHSN Healthcare Personnel Safety Component before the quarterly deadline to meet the quality reporting program requirements. Although, hospitals or facilities are only required to submit one week each month, CMS and the CDC encourage weekly reporting of the data. As I noted, you will only be required to submit the data by the quarterly submission deadline. For example, for the Quarter 1 2023 reporting period, you will be required to submit all three months of data, January, February, and March, by the August 15, 2023, submission deadline. The hospital or facility meets the program submission requirements if the CDC can calculate a quarterly rate. You will be able to find additional information regarding the healthcare personnel COVID-19 measure on the Quality Reporting Center website which is www.QualityReportingCenter.com. Under the Inpatient Archive tab, you will be able to find the 2022 COVID-19 webinar, and, under the Inpatient Resources and Tools tab and IQR Program Resources, you will find a frequently-asked-questions document.

We would still encourage you to submit your data early, prior to the submission deadline, to allow ample time to correct any errors that have been identified. Any data modified in NHSN after the CMS submission deadline will not be sent to CMS and will not be used in CMS programs.

The Centers for Medicare & Medicaid Services, or CMS, uses a variety of data sources to determine the quality of care that Medicare beneficiaries receive. For the quality of care claims-based measures, CMS uses Medicare enrollment data and Part A and Part B claims data submitted by hospitals for Medicare fee-for-service patients. No additional hospital data submission is required to calculate the measure rates.

Each measure set is calculated using a separate, distinct methodology and, in some cases, separate discharge periods. This slide shows the claim-based measures that will be collected for the [Hospital] IQR Program. In the FY 2023 Inpatient Prospective Payment System Final Rule, there were two new claims-based measures that were added to the Hospital IQR Program, beginning with FY 2024. These are the Hospital-Level Risk-Standardized Complication Rate Following Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty and the Medicare Spending Per Beneficiary measures. Hospital-Specific Reports, or HSRs, for the claims-based measures are now available for hospitals within the *HQR Secure Portal*. The HSRs contain discharge-level data, hospital-specific results, and state and national results for the Hospital IQR Program.

This slide just outlines the reporting periods and submission deadlines for the calendar year 2023 data.

Beginning with fiscal year 2024, CMS aligned the data submission quarters for the chart-abstracted and electronic clinical quality measure validation, all associated with a full calendar year, instead of crossing calendar year quarters, like it did previously under the chart-abstracted validation program. So, as you can see in the table on this slide, CMS will use Quarter 1 through Quarter 4 of calendar year 2022 for data validation efforts, affecting fiscal year 2025 payment determination.

Just briefly, I would just like to point out a couple of the common issues that we see as to why a hospital may not be able to submit data or meet one or more of their IQR requirements. One of the most common issues is staffing turnover. If at all feasible, it is very important and highly recommended that you have at least two personnel that can abstract and submit data to CMS. Another common issue is vendor-related issues. It is important to remember here that, even though a hospital may be having a vendor submit data upon their behalf, it is ultimately the hospital’s responsibility to ensure that they are meeting the IQR requirements.

As it is our goal to have all hospitals meet their [Hospital] Inpatient Quality Reporting Program requirements, we do have a few best practices or helpful tips to help you meet those requirements.

The first best practice, as we denoted on the previous slide, is to submit data early and not wait until the submission deadline. Hospitals can update and/or correct their submitted clinical data until the CMS submission deadline, which, immediately afterwards, the *HQR Secure Portal* will be locked. No updates can be made after the submission deadline and will not be reflected in the data CMS use. Also, as we denoted on the previous slide, it is highly recommended that hospitals designate at least two QualityNet Security Officials: one to serve as the primary QualityNet Security Official and the other to serve as a backup. On this same line, it is also recommended that you have more than one person who is able to do your chart-abstractions and submit that data to the *HQR Secure Portal*. We went over this earlier, but I just want to reiterate that hospitals are required to submit the aggregate population and sample size counts, even if the population is zero. Leaving the fields blank does not fulfill the requirement. A zero must be submitted even when there are no discharges for a particular measure set. Lastly, hospitals with five or fewer discharges, both Medicare and non-Medicare combined, in a measure set in a quarter are not required to submit patient-level data for that measure set for that quarter. So, for the quarter, if you look at your Provider Participation Report and your population size and your Medicare claims count is five or less for sepsis, you are not required to submit patient-level data for the SEP-1 measure. However, even though you are not required to submit the data, CMS still encourages the submission of that data. If you do choose to submit the data, then one to five cases of the Initial Patient Population may be submitted. So, for example, if your sepsis population size is five, you would not be required to submit the sepsis patient-level data but, if you choose to submit it, you could submit just one case, two cases, or up to all five of the cases.

There are some circumstances in which a hospital may be excepted from submitting data for a few of the required measures.

If the hospital meets the criteria for any of these measures, then they can submit a Measure Exception Form. The Measure Exception Form may be used for the PC-01, the Surgical Site Infection Colon and Abdominal Hysterectomy, and the CAUTI and CLABSI measures. If your hospital has no obstetrics department and does not deliver babies, you can submit the Measure Exception Form for PC-01. Otherwise, hospitals that do not deliver babies and do not submit a Measure Exception Form must enter zero for each of the data entry fields in the PC-01 web-based data entry tool for each discharge quarter. The IPPS Measure Exception Form also includes the SSI, CAUTI, and CLABSI exceptions used in the Hospital-Acquired Condition Reduction Program. Please remember that, if you do submit the Measure Exception Form, it must be renewed at least annually. The IPPS Measure Exception Form can be found on the QualityNet website under the Hospital – Inpatient link, then under the Hospital Inpatient Quality Reporting Program link, and then Resources.

So, let's just summarize what we have gone over so far. On a quarterly basis, hospitals are required to submit their HCAHPS Survey data, the chart-abstracted population and sample counts, the clinical process of care measures, aggregate PC-01 data, the COVID-19 Vaccination Coverage Among Healthcare Personnel, and validation records, if they have been selected for validation.

I will now turn the presentation over to Donna to go over the [Hospital] IQR Program annual requirements. Donna, the floor is yours.

Donna Bullock: Thank you, Candace. Our next polling question is: Which of the following Hospital IQR Program requirements are submitted annually? Is it Data Accuracy and Completeness Acknowledgement, or DACA; two active QualityNet Security Officials; eCQMs; structural measures; A and C; A, C, and D; or all of the above? The correct answer is F. Annually, the hospitals are required to submit the DACA, structural measures, and eCQMs.

We'll briefly go over the annual requirements. Hospitals are required to have registered a QualityNet Security Official. As stated earlier, it is highly recommended that hospitals designate at least two Security Officials.

It is also recommended that that the Security Official log into their accounts at least once a month to maintain an active account. Any accounts that have been inactive for 120 days will be disabled. The DACA must be completed and signed on an annual basis. The DACA is done via the *Hospital Quality Reporting Secure Portal*, and it electronically acknowledges that the data submitted for the Hospital IQR Program is accurate and complete to the best of the hospital's knowledge. The open period for signing and completing the DACA is April 1 through May 15, with respect to the reporting period of January 1 through December 31 of the preceding year. The structural measures are also completed on an annual basis. These measures are also done via the *HQR Secure Portal*. As with the DACA, the open period for completing these measures is from April 1 through May 15, with respect to the reporting period of January 1 through December 31 of the preceding year. So, for fiscal year 2025, the submission period will be from April 1 through May 15, 2024, with respect to January 1 through December 31, 2023. Additionally, hospitals must submit the electronic clinical quality measures annually, which Veronica will cover later on in this presentation.

So, just to reiterate, hospitals are required to complete the DACA on an annual basis via the *Hospital Quality Reporting Secure Portal*. The data submission period is between April 1 and May 15, with respect to the reporting period of January 1 through December 31 of the preceding year. So, for calendar year 2023, the submission deadline for the DACA will be May 15, 2024. Just as a note, hospitals will have from April 1, 2024, through May 15, 2024, to enter their DACA for calendar year 2023.

To meet IQR requirements, hospitals will submit their responses or data once a year via a web-based tool that will be located within the *Hospital Quality Reporting Secure Portal*. To reiterate, the submission period will follow our other annual submission requirements and will be from April 1 through May 15. For calendar year 2023, which will be fiscal year 2025, the reporting period will be January 1 through December 31, and it will occur from April 1 through May 15 of 2024. For FY 2025 there are two required structural measures:

the Maternal Morbidity Structural Measure and the Hospital Commitment to Health Equity measure. For the Maternal Morbidity Structural Measure, if you participated in a collaborative and meant the intent of the measure anytime between January 1 of 2023 and December 31 of 2023, then you would be able to enter Yes to the structural measure question. The Hospital Commitment to Health Equity measure includes five attestation domains and the elements within each of those domains that a hospital must attest to for the hospital to receive credit for that domain. Each of the domains would be represented in the denominator as a point, for a total of five points, one per domain.

For the Maternal Morbidity Structural Measure, if you do not have an OB unit and/or provide labor/delivery care, the IPPS Measure Exception Form, that is used for the PC-01 measure, cannot be applied to this measure. You will be required to go into the data form, within the *HQR Secure Portal*, and provide a response to the question. In this case, if you do not provide OB services, you would select NA, Not Applicable.

So, let's just summarize. The annual IQR requirements are to have at least one active QualityNet Security Official, sign the DACA, complete the HCP and Maternal Morbidity Structural Measure, and submit the required eCQMs.

The next few slides will go over the voluntary measures that can be submitted for fiscal year 2025. For fiscal year 2025, hospitals will be able to voluntarily report the Screening for Social Drivers of Health and the Screen Positive Rate for Social Drivers of Health process measures and the Hospital-Level, Risk Standardized, Patient-Reported Outcome-Based Performance Measure. Additionally, the hybrid measures, which include the Hospital-Wide All-Cause Readmission and Hospital-Wide All-Cause Risk Standardized Mortality Measures, can be voluntarily reported. Again, these are not mandatory for FY 2025; however, CMS strongly encourages hospitals to participate in the voluntary reporting.

The two social drivers of health measures will follow the established annual structural measure submission and reporting requirements.

So, as we indicated earlier, the structural measure responses are done once a year via a web-based tool within the *HQR Secure Portal*. The submission period would from April 1, 2024, through May 15, 2024, for the January 1 through December 31, 2023, reporting period.

The Screening for Social Drivers of Health measure assesses whether a hospital implements screening of all patients that are 18 years or older at time of admission for health-related social needs, known as HRSNs, including food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. When reporting this measure, the hospital will provide the number of inpatients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

The Screen Positive Rate for Social Drivers of Health measure provides information on the percent of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, were screened for an HRSN, and who screen positive for one or more of the five health- related social needs. Hospitals will report this measure as five separate rates.

The Total Hip and Total Knee Arthroplasty Patient-Reported Outcome [-Based] Performance measure reports the hospital-level, risk-standardized improvement rate in patient-reported outcomes following elective primary THA/TKA for Medicare Fee For Service beneficiaries aged 65 years and older. The measure uses four sources of data to calculate the measure including patient-reported outcome data; claims data; Medicare enrollment and beneficiary data; and U.S. Census Bureau survey data. The patient-reported outcome data would be collected 90 to 0 days prior to surgery and 300 to 425 days following surgery. The measure result is calculated by aggregating all patient-level results across the hospital.

This slide provides the pre-operative and post-operative collection periods, the submission periods for each of those, and when the Hospital-Specific Reports will be provided.

This slide just provides you with some resources that are available to you for assistance with the [Hospital] Inpatient Quality Reporting Program.

This slide provides you with some tools, resources, references, and training materials that are available to assist you in meeting the Hospital Inpatient Quality Reporting Program requirements.

I would now like to turn the presentation over to Veronica Dunlap to cover the voluntary reporting of the hybrid measures.

Veronica Dunlap: Thank you, Donna. Let's begin with our next polling question. For which of the following programs can hospitals voluntarily submit hybrid measure data? Is it A, the Medicare Promoting Interoperability Program; B, the Quality Payment Program; C, the Hospital Readmissions Reduction Program; D, the Hospital IQR Program; or E, both the Medicare Promoting Interoperability and [Hospital] IQR Programs? Go ahead and take a moment and please submit your answers. For those who answered D, the Hospital Inpatient Quality Reporting Program, you are correct. The Hybrid Hospital-Wide Readmission and Hybrid Hospital-Wide Mortality measures are two separate measures available for hospitals participating in the [Hospital] IQR Program to voluntarily report data on for the fiscal year 2025 payment determination. The submission of hybrid measure data is a voluntary requirement specific only to the Hospital IQR Program. It is not a requirement for hospitals participating in the Medicare Promoting Interoperability Program. Just a note: Hospitals and critical access hospitals may voluntarily submit these data for the fiscal year 2025 payment determination; however, beginning next year, with the fiscal year 2026 payment determination, hospitals participating in the [Hospital] IQR Program will be required to report data for both hybrid measures.

This slide outlines some of the key components surrounding the voluntary reporting of the Hybrid Hospital-Wide Readmission measure and the Hybrid Hospital-Wide Mortality measure.

Although this will be the first year that hospitals may voluntarily report data for the Hybrid Hospital-Wide Mortality measure, it is the second year of voluntary reporting for the Hybrid Hospital-Wide Readmission measure. Again, hospitals participating in the [Hospital] IQR Program, along with critical access hospitals, may voluntarily submit data for either of the hybrid measures, for one, both of them, and it is up to the hospital to decide. CMS does strongly encourage that all hospitals participating in the [Hospital] IQR Program voluntarily submit these data in preparation for next year's mandatory reporting.

The measurement period here does not fall within a calendar year for the hybrid measures and began on July 1, 2022, and will go through June 30, 2023. This timeframe is known as the 2024 Voluntary Reporting Period. These data will not affect a hospital's annual payment update and will not be publicly reported; however, for fiscal year 2026, hospitals participating in the [Hospital] IQR Program are required to submit data for both hybrid measures, and these data will be publicly reported. CMS will announce when the HQR System is open and available to accept test/production QRDA Category I files for the hybrid measures in preparation for the October 2, 2023, submission deadline. The hybrid measure data follow the same certification and file format requirements as eCQMs. Core Clinical Data Elements, referred to as CCDEs, are extracted from the EHR for the risk model for the hybrid measures and uploaded to the *HQR Secure Portal* via QRDA Category I files. As a reminder, although the submission of these data are voluntary, CMS has specified that hospitals are required to use certified technology to the 2015 Edition Cures Update. Included here on the slide are the links to each of the hybrid measure's specifications and additional reporting resources available on the eCQI Resource Center.

A hybrid measure is a quality measure that uses more than one source of data for measure calculation. Hybrid measures contain claims-based specifications and electronic specifications. They are different than an eCQM as the measure logic to extract electronic clinical data will produce a file containing these CCDEs.

The collection of these elements alone will not produce measure results, which is not like an eCQM. Instead, it will produce a file containing the data that CMS will then link with administrative claims to risk adjust each of the hybrid outcome measures. The hybrid measures differ from the claims-only measures as they merge electronic health record CCDEs with claims data to calculate the risk-standardized readmission and mortality rates, respectively. For further information, there is a colorful one-page resource document you may reference for the 2024 voluntary reporting of the Hybrid Hospital-Wide Readmission and Hybrid Hospital-Wide Mortality measures that is available on the QualityNet website. The link is provided for you here.

Hospitals voluntarily reporting hybrid measure data this year are required to submit QRDA Category I files containing the Core Clinical Data Elements and linking variables to help CMS match the data that are pulled from the electronic health record to the claims data. There are six linking variables required for the Hybrid Hospital-Wide Readmission, and the same six linking variables are required for the Hybrid Hospital-Wide Mortality measure. These include the CMS Certification Number, or CCN; the Health Insurance Claim Number or Medicare Beneficiary Identifier; date of birth; sex; admission data; and discharge date.

If you look at the left-side of the slide, there are 13 Core Clinical Data Elements required for the Hybrid Hospital-Wide readmission measure. The breakdown there is six vital signs and seven lab test results. Shown on the right-side, there are 10 Core Clinical Data Elements required for the Hybrid Hospital-Wide Mortality measure, broken down as four vital signs and six lab test results. For details on each of the hybrid measure's Core Clinical Data Elements, please refer to the eCQI Resource Center. For hospitals to successfully report these data, they will need to submit a certain percentage for each component here, as listed on the slide. Hospitals are expected to receive a confidential Hospital-Specific Report, or HSR, with their performance results the following spring.

Just a note: The HQR System is not currently available nor accepting hybrid measure data at this time. CMS will announce when the system is open and ready for the 2024 Voluntary Reporting Period. That is anticipated to be sometime this summer.

As many of you are familiar with, reporting eCQM data is a requirement for the Hospital IQR Program. It is also one of many requirements for the Medicare Promoting Interoperability Program. Hospitals, with a single submission, can meet the eCQM reporting requirement for both programs. Let's discuss the changes and review the requirements specific to eCQM reporting for the calendar year 2023 reporting period.

Our next polling question: Which of the following eCQMs are mandatory to report four quarters of data to successfully meet the calendar year 2023 reporting requirement for the Hospital IQR and Medicare Promoting Interoperability Programs? Is it A, Exclusive Breast Milk Feeding (PC-05); B, Safe Use of Opioids–Concurrent Prescribing measure; C, Cesarean Birth (ePC-02); D, Severe Obstetric Complications (ePC-07); or E, which includes the Safe Use of Opioids, Cesarean Birth, and the Severe Obstetric Complications? Please take a moment and submit your responses. For all those who selected B, Safe Use of Opioids–Concurrent Prescribing eCQM, you are correct. This measure was introduced into the calendar year 2021 eCQM measure set and was mandatory beginning with calendar year 2022. It will remain mandatory for this year's reporting of calendar year 2023 data and subsequent years. Not to confuse you, but the Cesarean Birth and Severe Obstetric Complications eCQMs are a few of the new measures that have been added to the calendar year 2023 measure set; however, they will not be mandatory to report on until the calendar year 2024 reporting period.

Let's review the calendar year 2023 eCQM reporting requirements, shown here. Hospitals participating in the Hospital IQR Program and/or the Medicare Promoting Interoperability Program are required to report a total of four eCQMs for four quarters of data. Hospitals must report the mandatory Safe Use of Opioids–Concurrent Prescribing eCQM plus three self-selected three eCQMs from the calendar year 2023 measure set.

Again, that is four quarters total. That will be our first year that hospitals are required to submit a full calendar year worth of data. Please note that each quarter must contain four eCQMs, and the eCQMs must be the same across all four quarters. The eCQM submission deadline for calendar year 2023 data is February 29, 2024. Just an important change I would like to point out for calendar year 2023 reporting includes the requirement that hospitals must submit the data for a total of four quarters, rather than three. They still must submit the Safe Use of Opioids as a mandatory eCQM. As a reminder, successfully submitting eCQM data will meet the eCQM reporting requirement for both programs.

This table provides the eCQMs within the calendar year 2023 eCQM measure set. Please note, listed at the top, the Safe Use of Opioids–Concurrent Prescribing eCQM is mandatory, and hospitals are required to submit patient-level data or declare a denominator declaration for this measure for each of the four quarters. Four new eCQMs have been added to that measure set, as you see here. Last year, there were a total of nine eCQMs. For calendar year 2023 reporting, there are a total of 13 eCQMs in the measure set. The four newly added eCQMs include Cesarean Birth, Severe Obstetric Complications, Hospital-Harm Severe Hypoglycemia, and Hospital-Harm Severe Hyperglycemia. Beginning with calendar year 2024 reporting next year, the Cesarean Birth and Severe Obstetric Complications will join the list of mandatory eCQMs that hospitals must report data on. In addition, I wanted to bring to your attention as you think ahead for next year's reporting that three of the eCQMs noted here on this slide, will be removed. These include ED-2, PC-05, and STK-06. A list of the eCQMs and specifications are all available on the eCQI Resource Center, located under the Eligible Hospitals and Critical Access Hospitals section.

New for calendar year 2023 reporting, hospitals participating in the Hospital IQR and Medicare Promoting Interoperability Programs must report their data using certified EHR technology that has been updated to meet the 2015 Edition Cures Update criteria. To learn more about the 2015 Edition Cures Update, please review the link on the slide on the ONC's 21st Century Cures Act final rule.

Hospitals are required to maintain that their EHRs are certified to report on all the eCQMs that are specified in the measure set. As mentioned earlier, the calendar year 2023 eCQM specifications, the 2023 Implementation Guide, Schematron, and sample files are posted on the eCQI Resource Center.

The format of the QRDA Category I file has not changed, and it remains one QRDA Category I file, per patient, per quarter. If the file contains data for more than one reporting quarter, the file will be rejected when uploaded to the HQR System. Each file, for the applicable quarter, should include all the measures that your hospital will be submitting for on a patient and to include all the episodes of care that occurred within that discharge quarter. With hospitals being required to submit a full calendar year of data, the HQR System allows batches of files to contain QRDA Category I files from different quarters. That's not within each individual file, that's within a zip file or a batch of files that your facility may be uploading. Also, vendors may upload a zip file that may have a mix of QRDA I files for different facilities. If a hospital has more than 14,999 QRDA Category I files, additional zip files may be uploaded. An important note is to remind your data submitters to verify your zip file does not contain a zip file within it, prior to uploading to the HQR System. This can cause a significant processing delay. So, please make sure that you don't have a zip within a zip.

The definition for successful submission of eCQMs has not changed and is defined as a combination of accepted QRDA Category I files, zero denominator declarations, and case threshold exemptions. If your hospital selects to submit a zero denominator or case threshold for a particular measure, it is important to note that their EHR must still be certified to report that measure. As hospitals are transitioning their EHR systems and/or vendors, CMS is continuing to allow hospitals to use abstraction or pull data from non-certified sources into certified EHR technology in order to capture and report their QRDA Category I files for a full calendar year. As a reminder, the submission of eCQMs does not complete program requirements.

Although eCQM reporting is an aligned requirement for hospitals participating in the Hospital IQR Program and the Medicare Promoting Interoperability Program, there are other requirements for each individual program that must be met. Hospitals participating in the Hospital IQR Program that do not meet the calendar year 2023 requirements of the Hospital IQR Program, including the eCQM reporting requirement, are at risk of having their annual payment update reduced by one-fourth of the applicable market basket update for the fiscal year 2025 payment determination. Pertaining to the Medicare Promoting Interoperability Program, the submission of calendar year 2023 eCQM data will affect the fiscal year 2025 payment determination for eligible hospitals; however, for critical access hospitals, it will affect the fiscal year 2023 payment determination.

A list of program resources specific for calendar year 2023 eCQM reporting for each program has been compiled here for you to reference. These include helpful one-page quick reference guides, along with training materials available, to assist you as you prepare yourself and your staff for calendar year 2023 reporting. On the left-side, tools for the [Hospital] IQR Program are provided. On the right-side, resources for the Medicare Promoting Interoperability Program are provided as well.

Displayed are the calendar year 2023 implementation resources specific to eCQM reporting for eligible hospitals and critical access hospitals, published in 2022. Visit the eCQI Resource Center to ensure you are using the most current versions of these standards as you are updating your systems and workflows in preparing for the submission of calendar year 2023 data. Just a heads up that all the calendar year 2023 eCQM reporting, resources, and tools have all been posted to the Quality Reporting Center and QualityNet websites. This also includes the calendar year 2023 eCQM technical specifications and tools, and those versions have all been posted and are all available on the eCQI Resource Center. Finally, here we have the eCQM and hybrid measure support resources slide that we continually update as needed. So, please reference eCQM and hybrid measure resources and the contact numbers and links found here on this slide. That concludes my part of the presentation. I will go ahead and turn it back over to Donna.

Donna Bullock: That concludes our presentation today. As stated earlier, we did not have time for a question-and-answer session. However, all submitted questions and responses will be posted to the Quality Reporting Center website at a later date. As stated earlier, this program has been approved for one continuing education credit. To obtain your continuing education credit, please click on the link on this slide. Thank you to all of you for joining us today. We hope that you have a great rest of your day.