Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program Requirements for CY 2020 Reporting (FY 2022 Payment Determination)

Questions and Answers

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March 19, 2020
2 p.m. ET

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses. The questions and answers have been edited for grammar and/or clarity.

Hospital IQR Program

Question 1: **Can you please clarify calendar year (CY), fiscal years (FY), and reporting program years?**

The CY is usually a past year and used for a specific payment determination. Future years are considered FYs. Every CY is connected to a specific FY; CY 2020 is connected to FY 2022. The data from CY 2020 would affect Medicare reimbursement from October 1, 2021, to September 30, 2022. To get a better understanding of CY versus FY, visit the Quality Reporting Center website, www.QualityReportingCenter.com, and look under Inpatient Tools and Resources and IQR Program Resources. You will find a CY 2020 and FY 2020 document. This document explains the ways they are determined and the differences between them.

Question 2: **Are the Hospital IQR Program and electronic clinical quality measures (eCQMs) required for critical access hospitals (CAHs)?**

The CAHs are not part of and are not eligible for the Hospital IQR Program. However, CMS highly recommends CAHs submit data to help them improve their quality processes and the care of their patients.

CAHs are required to participate in the Medicare Promoting Interoperability Program. Electronic clinical quality measures (eCQMs) are required to be reported and the CAH can choose to electronically report the measures or attest to the measures. Visit the CMS.gov website to locate the Promoting Interoperability Program information posted for Eligible Hospitals and CAH reporting requirements. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 3: **How do we enter the population and sampling counts if we have no population to report?**

For the sepsis measure set, if you do not have any cases that meet the measure set initial patient population, then you should enter zeros into each of the data fields, except for the *Sampling Frequency*. For *Sampling Frequency*, you would enter Value "4." These fields may not be left blank. Failing to enter zeros would be deemed as not meeting this IQR

requirement. For PC-01, if you do not have any cases that meet the "mother" initial patient population, then you should enter zeros for each of the data fields within the web-based application. Hospitals that do not deliver babies may opt out of reporting PC-01 measure data by submitting an IPPS Quality Reporting Program Measure Exception Form. Hospitals that do not submit this form and do not enter a zero for each of the data-entry fields would be deemed as not meeting this IQR requirement.

Question 4: **For the global population and sampling, are we required to submit those values even if we do not sample any cases? We do not have any cases that qualify for sepsis; therefore, we have no population to sample.**

Global population and sampling, beginning with January 1, 2020 discharges, were removed from the Hospital IQR Program as CMS no longer collects the emergency department (ED) or immunization (IMM) measures. Beginning with January 2020, you would not submit global population and sampling counts.

Sepsis has its own sampling requirements and counts. It is not part of the global sampling. You would still be required to determine your sepsis population and follow the sampling requirements that are in the specification manual. If you have no cases that meet the sepsis population requirement, then in your population and sampling application you would enter zero. These fields may not be left blank. Failing to enter zeros would be deemed as not meeting this IQR requirement. Otherwise, if you did have populations, for example, one sepsis case, then in the population and sampling tool, you would enter 1.

Question 5: **Our vendor has us still collecting ED measures. Should we continue to do this even though they are no longer required?**

For CMS, you do not need to collect ED measures. CMS removed them from the Hospital IQR Program, and hospitals cannot submit them to the CMS Clinical Data Warehouse. The ED measure specifications continue to be included in the Specification Manual for Joint Commission National Quality Measures. You will need to consult The Joint Commission to determine if it is required or not.

Question 6: **I do not see ED as measure requirements for The Joint Commission in 2020. Did you say the ED measures are still a requirement for The Joint Commission?**

Beginning with January 1, 2020, discharges, the ED measure specifications, which were previously in the aligned CMS/Joint Commission aligned specification manual, have been moved to the Specification Manual for Joint Commission National Quality Measures, version 2020A, for hospital use. You will need to consult The Joint Commission to determine if it is required or not.

Question 7: **If an observation patient is bedded in an inpatient location, aren't they included in patient days?**

The inclusion of patients in the Hospital Inpatient Quality Reporting Program is not based on the patient's location within the hospital. Hospital IQR Program measures include only patients that are billed as an acute inpatient discharge. Observation patients are not included as observation stays are billed as an outpatient service.

Question 8: **Will mortality rates for pneumonia (PN), heart failure (HF), and acute myocardial infarction (AMI) still be required?**

The Mortality (MORT)-30-AMI, PN, and HF measures have been removed from the Hospital IQR Program. However, these measures will still be included in the Hospital Value-Based Purchasing (VBP) Program and publicly reported on the *Hospital Compare* website or its successor website.

Question 9: **Slide 17: Is the mortality outcome of stroke (STK) measure new?**

The Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Ischemic Stroke (MORT-30-STK) claims-based measure has been required for the Hospital IQR Program since CY 2014 (FY 2016). Measure refinements were made for the FY 2023 payment determination and subsequent years [FY 2018 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, 82 FR 38342]. This included the refinement of the risk-adjustment model to include stroke severity, based on the National Institutes of Health (NIH) Stroke Scale obtained from International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes in claims.

Question 10: **What hospital would not have a mapped medical surgical, med/surg, or intensive care unit (ICU)?**

The Hospital IQR Program includes all acute care subsection (d) hospitals paid under the Inpatient Prospective Payment System (IPPS) except for the following:

- Psychiatric hospitals (as defined in section 1861(f) of the Social Security Act)
- Rehabilitation hospitals (as defined by the Secretary)
- Hospitals with inpatients who are predominately individuals under 18 years of age (e.g., children's hospitals)
- Hospitals designated as long-term acute care
- Hospitals recognized as a comprehensive cancer center or clinical cancer research center
- Hospitals designated as critical access hospitals

As an example, within those subsection (d) hospitals, there are some behavioral health hospitals that are IQR-eligible. In those cases, those hospitals may not have a medical, surgical, med/surge, or ICU unit.

Question 11: **Do we still need to use [measure] exception forms for catheter-associated urinary tract infection (CAUTI) and central-line associated blood stream infection (CLABSI) as hospital-associated infections (HAIs) are not part of the Hospital IQR Program for CY 2020?**

Yes, for CY 2020, the IPPS Quality Reporting Programs Measure Exception form is still effective for the HAI measures since these measures are still used under the Hospital-Acquired Condition (HAC) Reduction Program and the Hospital Value-Based Purchasing Program.

Validation

Question 12: **When will we know if we passed or failed validation and our score?**

Annual payment update (APU) results, including confidence interval reports for data validation, are generally released each spring in April or May. (For FY 2021, this will be May 2020; for FY 2022, this will be April or May 2021.)

Question 13: **How do the Security Administrators (SAs)/Security Officers (SOs) receive notification of the CMS Clinical Data Abstraction Center (CDAC) validation records selected for quarter (Q)3 2019? I have not received an email, and I understand some have this week.**

Questions regarding the initial request or receipt of your medical records can be answered by contacting the CDAC Help Desk at

CDACHelpDesk@hcqis.org. Please include your six-digit CMS Certification Number (CCN)/Provider Identification (ID) when inquiring to ensure they are providing information about your facility.

Question 14: **We received notification regarding the case selections. We were able to run the report, but our Health Information Management (HIM) has not received the request yet. How long will it take before our HIM department will be contacted with the request?**

Questions regarding the initial request or receipt of your medical records can be answered by contacting the CDAC Help Desk at CDACHelpDesk@hcqis.org. Please include your six-digit CCN/ Provider ID when inquiring to ensure they are providing information about your facility.

Question 15: **For chart abstracted validation, if there is a mismatch in the final report, are those data fields modified to match the CDAC abstraction or are the data kept the same as originally reported?**

Data submitted by a hospital or vendor to the CMS Clinical Data Warehouse are not altered in any way during the validation process; submitted data remain the same, even if the CDAC determines a mismatch during the validation process.

Question 16: **How are the May 2020 targeted provider samples selected for validation?**

CMS targets hospitals based on the criteria established in the FY 2014 IPPS/LTCH PPS Final Rule (78 FR 50833–50834). The FY 2022 targeting criteria as outlined in the rule are summarized as:

- Failure to meet validation requirements in FY 2021;
- Lower bound confidence interval (CI) less than or equal to 75 percent in FY 2021;
- Failure to report at least half of the HAI events detected during FY 2021 to the National Healthcare Safety Network (NHSN);
- Rapidly changing data patterns;
- Abnormal or conflicting data patterns;
- Submission of data to NHSN after the Hospital IQR Program submission deadline; and/or
- Not having been validated in the previous three years.

All random and targeted hospitals selected for FY 2022 validation are subject to the same requirements. CMS will validate two types of measures for the FY 2021 APU determination: Chart-Abstracted clinical process of care measures and HAI measures.

Question 17: **For patients selected for IQR validation, will HAI cases be validated for Q1 and Q2 2020? Do the HAI templates need to be submitted for Q1 and Q2 2020?**

CMS HAI Validation Templates will not be requested through the Hospital IQR Program for Q1 or Q2 2020; however, hospitals are still responsible for appropriately reporting their HAI data to the Centers for Disease Control and Prevention (CDC) via the NHSN, per the FY 2019 IPPS/ LTCH PPS Final Rule (83 FR 41475–41484). CMS will request HAI Validation Templates through the recently adopted HAC Reduction Program validation process beginning with 3Q 2020 discharges, per the FY 2020 IPPS/LTCH PPS Final Rule (84 FR 41483).

Question 18: **For eCQM validation, can a hospital submit medical records as printed copies?**

For the eCQM validation program, the only acceptable method of medical record submission is Portable Document Format (PDF) via the *QualityNet Secure Portal* Secure File Transfer application, per the FY 2017 IPPS/LTCH PPS Final Rule (81 FR 57174–57178).

Question 19: **Is there ever a validation of the inpatient psychiatric facilities (IPFs)?**

IPFs are not included in the CMS data validation process at this time.

eCQM

Question 20: **When determining the numerator and denominator for eCQMs, are patients that are in observation status for the length of their stay included?**

Patients that are in observation are only counted as an inpatient encounter if they are admitted.

Question 21: **When is the earliest you can test and submit eCQMs for CY 2020 data?**

The *QualityNet Secure Portal*, within the Hospital Quality Reporting (HQR) System, is scheduled to receive test and production QRDA Category I file submissions for eCQM Reporting fall 2020.

CMS will announce the HQR System availability through Listserves, webinars, and newsletters. Visit *QualityNet* to join the Listserve to receive updates: https://www.qualitynet.org/listserv-signup

Question 22: **How can we find out the results of the eCQM performance?**

The equivalent of the EHR Hospital Reporting – eCQM Performance Summary Report in the legacy version of HQR (which provided summary-level measure performance calculations) is the Measure Results Outcomes Tab in the Next Generation of HQR System available for CY 2019 eCQM data and beyond. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 23: **Must the 2015 Certified Electronic Health Record Technology (CEHRT) be installed by January 1, 2020, for reporting?**

Hospitals participating in the Hospital IQR and the Promoting Interoperability Programs are required to have the entire CEHRT definition applicable for their program participation by the close of the calendar year in which the reporting period occurs. For example, for the CY 2019 reporting period, hospitals would need to have the CEHRT definition in place by December 30, 2019. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 24: **If the hospital inpatient module is 2015 electronic health record (EHR)-certified but the ED module is not 2015 EHR certified, can a hospital submit an eCQM?**

All products used to meet the CEHRT definition must be certified to the 2015 edition and include the base EHR items and quality reporting criteria (c1 – capture and export; c2 – calculate; c3 – report). See 45 CFR 170 for the full CEHRT definition. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 25: **Since hospitals have successfully submitted eCQMs for the past three years (technically retired from the chart-abstracted measures, some prior to eCQM), why must hospitals continue to deal with the added**

cost and burden to submit eCQMs, especially when they are no longer adding to the quality of care to our patients?

Electronic clinical quality measures (eCQMs) help measure the quality of health care provided and help identify opportunities for clinical quality improvement. Since 2016, hospitals have been required to report eCQM data as part of the Hospital Inpatient Quality Reporting (IQR) and Medicare Promoting Interoperability Programs.

Section 3014 of the Affordable Care Act of 2010 (ACA) (P.L. 111-148) created a new section 1890A of the Social Security Act which required that the U.S. Department of Health and Human Services (HHS) established a federal pre-rulemaking process for the selection of quality and efficiency measures for use by HHS. Each year, CMS invites measure developers/stewards to submit candidate measures which are then reviewed and selected for inclusion to the Measures Under Consideration (MUC) list. The list is then published that HHS is considering adopting through the federal rulemaking process. Multi-stakeholders' groups provide recommendations to HHS and the group considers that feedback before selecting quality and efficiency measures. Those measures are included in a notice of proposed rulemaking in the Federal Register, which allows additional public comment and further consideration before a final rule is issued. As a result, measures such as the Safe Use of Opioids, the Hybrid Hospital-Wide Readmission Measure and other future eCQMs, are in development with public knowledge.

The Meaningful Measures Initiative identifies the highest priorities for quality measurement and improvement and fills critical gaps in measurement. For more information, please visit CMS' Meaningful Measures page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.

Question 26: **Were the specifications released for the optional opioid eCQM? Our vendor says it is not ready to report the measure. Will this metric be mandatory for next year?**

The specifications are posted on the eCQI Resource Center. Access the CY 2021 reporting period and click the Apply button. At the bottom of the page to the right, there is a Pre-Rulemaking eCQMs button. Click on the button to access the Safe use of Opioids – Concurrent Prescribing eCQM measure specification information. The availability of the measure specification now supports an EHR vendor's ability to prepare and properly test the system to report the Safe Use of Opioids – Concurrent Prescribing measure.

For CY 2021, hospitals can choose to report the Safe Use of Opioids – Concurrent Prescribing measure as one of the four measures, but it is not mandatory; the measure is mandatory for CY 2022 and beyond as part of the eCQM reporting requirement for the Hospital IQR and Medicare Promoting Interoperability Programs.

Question 27: **How do you volunteer to participate in the Hybrid Hospital-Wide Readmission (HWR) measure for CY 2021?**

Hospitals are not required to signal CMS in advance that they intend to participate in voluntary reporting of the Hybrid HWR measure in CY 2021. Submission of the data by the September 30, 2022 deadline notifies CMS of your interest. We recommend reviewing the information in today's webinar for the data collection timeframe and the data submission deadline to decide if your hospital intends to volunteer for one year or two.

Question 28: **Will the new Hybrid HWR measure replace the claims-based Hospital-Wide All-Cause Unplanned Readmission measure used now in the Merit-based Incentive Payment System (MIPS) and the Medicare Access and CHIP Reauthorization Act (MACRA) programs?**

Reference to the Hybrid HWR measure for today's webinar is specific to the Hospital IQR Program. Please contact QPP@cms.hhs.gov or (866) 288-8292 for additional assistance regarding the status of the claims-based Hospital-Wide All-Cause Unplanned Readmission measure for the MIPS and MACRA programs.

Question 29: **Is the Medicare Promoting Interoperability Program Clinical Quality Measure (CQM) Reporting requirements for attestation different for CY 2020? Did 2019 require all eight CQMs and all four quarters of data?**

For CY 2019, the CQM reporting requirement via attestation required all 16 measures for four quarterly data reporting periods by the March 2, 2020, submission deadline.

In CY 2020, hospitals that choose to meet the CQM reporting requirement for the Medicare Promoting Interoperability Program using attestation are required to report on all eight measures for four quarterly data reporting periods by the March 1, 2021 submission deadline. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 30: **What are the current penalties for not reporting the Medicare Promoting Interoperability Program objectives?**

Reporting the objectives is a portion of the overall Medicare Promoting Interoperability Program requirement. The Medicare Promoting Interoperability Program also requires reporting on CQMs. Reporting on CQMs is reviewed in this webinar session. The fact sheet for the CY 2020 Promoting Interoperability Program is available on CMS.gov.

The penalty or downward payment adjustment chart for the Medicare Promoting Interoperability Program is posted on the CMS.gov website at https://www.cms.gov/newsroom/fact-sheets/2019-medicare-electronic-health-record-ehr-incentive-program-payment-adjustment-fact-sheet-hospitals.

The CAH Payment Tip Sheet is available for download as well at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH-Payment-Tip-Sheet.pdf. Eligible Hospitals (EHs) and CAHs should direct any questions to the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 31: **For the CY 2020 eCQM submission, will the legacy reports and PSVA Tool be retired and we will have to use the HQR Next Generation (NG) file upload and reports?**

You are correct. The PSVA tool, legacy reports and prior methods for accessing the HQR System are no longer available. CY 2020 and beyond, the Next Generation of HQR System will be available to data submitters for reporting eCQM data. Data submitters will review eCQM data submissions using the new user interfaces for File Upload History, Submission Accuracy and Measure Results Outcomes, and their corresponding CSV files for closer inspection of accepted and rejected QRDA Category I files. Users will also generate Program Credit Reports to determine if they have completed successful eCQM reporting for the Hospital IQR and the Promoting Interoperability Programs.

Visit the Quality Reporting Center website Archived Events page to review the webinar materials from the November 20, 2019, session entitled *Submitting CY 2019 eCQM Data Using CMS' Next Generation Hospital Quality Reporting System*.

Question 32: **When will the Fast Healthcare Interoperability Resources (FHIR) standards be applied to eCQMs?**

CMS is currently exploring the use of FHIR for electronic quality reporting. CMS is still in the testing and piloting phase with implementers to ensure measures are developed, implemented, exchanged and calculated successfully. A timeline has not been specified for FHIR implementation for Quality Reporting Programs, however, testing results and stakeholder readiness is informing CMS' decisions on an implementation timeline.