Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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Candace Jackson: Good afternoon and welcome to the *Hospital IQR Program Requirements for CY 2020 Reporting (FY 2022 Payment Determination)* webinar. My name is Candace Jackson and I am the Hospital Inpatient Quality Reporting Program Support Contactor Lead from the Inpatient, Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting and presenting today's event along with my colleague, Dr. Artrina Sturges. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email a few hours ago. If you did not receive that email, you can download the slides at www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey after today's event, please stay on until the conclusion of today's event. After the question-and -answer session, we will display a link to the survey that you will need to complete to receive the continuing education credit. The survey will no longer automatically be available if you leave the event early. If you do need to leave prior to the conclusion of the event, a link to the survey will be available in the summary email sent out one to two business days after the event. If you have questions as we move through the webinar, please type your question into the Ask a Question window with the slide number associated, and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to the www.QualityReportingCenter.com website in the upcoming weeks. After the event, if you have additional questions, please submit your question through the *QualityNet* Questions and Answers tool.

This event will provide insight into the calendar year 2020 Hospital Inpatient Quality Reporting Program requirements, as well as a review of the calendar year 2020 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 will be able to locate resources that are available for both the Hospital IQR and Medicare Promoting Interoperability Programs.

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

In today's presentation, I will be covering the quarterly and annual Hospital Inpatient Quality Reporting Program requirements for calendar year 2020, except for the electronic clinical quality measure requirements. After addressing these requirements, I will turn the presentation over to Dr. Artrina Sturges to cover the calendar year 2020 electronic clinical quality measure reporting requirements for the Hospital IQR and the Medicare and Medicaid Electronic Health Record Incentive Program requirements.

So, let's start the review of the Hospital IQR Program requirements with our first polling question. The question: Which of the following Hospital IQR Program requirements are submitted on a quarterly basis? A. Clinical process of care measures. B. Aggregate population and sampling. C. HCAHPS Survey data. D. All of the above.

We'll just give you a few more moments here to submit your answer. Can you please close out the poll?

The answer is D. The clinical process of care and 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; the clinical process of care measures,

which are the chart-abstracted measures; and the web-based Perinatal Care Elective Delivery 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 bit 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 application within the *QualityNet Secure Portal* or by submitting an extensible markup language, or XML, file to the CMS Clinical Data Warehouse. 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 tool located within the *QualityNet 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 2020, beginning with January 1, 2020, 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 2020, there are two applicable specification manuals: version 5.7, which covers January 1 through June 30 discharges, and version 5.8, which 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 *QualityNet 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 *QualityNet 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 NHSN, 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 15 of each year. So for calendar year 2020, which would be the flu season from fourth quarter 2019 through first quarter 2020, the data will (need to) be entered by May 15, 2020.

As a reminder, the HAI measures, which are CAUTI, CLABSI, SSI, MRSA Bacteremia, and CDI, have been removed from the Hospital IQR Program. However, these measures will continue to be collected by the Hospital-Acquired Condition Reduction Program and will be used in that program and also in the Hospital Value-Based Purchasing Program. The submission deadlines and submission process will not change for these measures. The HAI data submissions will no longer be included on the IQR Provider Participation Report but will continue to display on the Inpatient Facility, State, and National Report. 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 any of the CMS programs.

For calendar year 2020, there were several changes to the claims-based measures. 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. Hospital-Specific Reports, or HSRs, for the claims-based measures are made available for hospitals via the *QualityNet Secure Portal*. The HSRs contain discharge-level data, hospital-specific results, and state and national results for the Hospital IQR Program. Hospitals will find their HSRs within the *QualityNet Secure Portal* in the Auto Route Inbox of Secure File Transfer. To be able to access the reports you must be registered as a *QualityNet* user and have been assigned both the Hospital Reporting Feedback - Inpatient role and the File Exchange and Search role.

This slide just outlines the reporting periods and submission deadlines for the calendar year 2020 data. Please note that the deadlines for first, second, and fourth quarter 2020 population and sampling, clinical, HAI, and PC-01 data have been extended due to the original deadlines following on a weekend.

Data accuracy is a vital component of the Hospital IQR Program. CMS assesses the accuracy of chart-abstracted and HAI data that are submitted through the validation process. CMS verifies on a quarterly basis that chart-abstracted and HAI data can be reproduced by a trained abstractor using a standardized protocol. For chart-abstracted data validation, CMS performs a random and targeted selection of Inpatient Prospective Payment System hospitals once a year. The random selection of 400 hospitals for fiscal year 2022 occurred in January 2020, and that list of hospitals can be found in the Data Validation section on *QualityNet*. In May of this year, an additional targeted provider sample of up to 200 hospitals will be selected for validation. The quarters included for fiscal year 2022 validation are third and fourth quarter 2019 and first and second quarter of 2020.

All chart-abstracted measures included in the Hospital IQR program, with the exception of PC-01, are included in the validation process. As PC-01 is reported as aggregate data and not patient-level data, it is not included in the validation process. CMS will validate up to eight cases for clinical process of care measures, per quarter, per hospital. Cases are randomly selected from data submitted to the CMS Clinical Data Warehouse by the hospital. For HAI, CMS will validate up to ten candidate cases per quarter, per hospital. The determination of a validation pass or fail status involves CMS calculating a total score across all quarters included in the validation fiscal year. If the calculated confidence interval, or total score, is 75 percent or higher, the hospital will pass the validation requirement. As in past years, a confidence interval document explaining the scoring and calculation will be provided on *QualityNet* at a later date.

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 on 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. Immediately after, the CMS Clinical Data Warehouse will be locked. No updates can be made after the submission deadline and will not be reflected in the data CMS uses. Also, as we denoted on a previous slide, it is highly recommended that hospitals designate at least two *QualityNet* Security Administrators; one to serve as the primary *QualityNet* Security

Administrator and the other to serve a backup. On this same line, it is also recommended again that you have more than one person who is able to do your chart abstractions and submit that data to the CMS Clinical Data Warehouse. We went over this earlier, but we 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 1–5 cases of the Initial Patient Population may be submitted. So, for example, if your sepsis population size is 5, 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, or two cases, or up to all five of the cases.

There are some circumstances in which a hospital may be exempt 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 SSI Colon and Abdominal Hysterectomy, and the CAUTI/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. Hospitals that performed nine or fewer of any of the specified colon and abdominal hysterectomy SSI procedures combined in the calendar year, prior to the reporting year, can request an exception form submitting SSI measures to fulfill the IQR HAI reporting requirements.

Lastly, hospitals that have no units mapped as medical, surgical, medical/surgical, or ICU can request an exception form submitting CAUTI and CLABSI measures to fulfill the HAI reporting requirements. 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 sampling counts, the clinical process of care measures, aggregate PC-01 data, and validation records if they have been selected for validation.

Our next polling question: Which of the following Hospital IQR Program requirements are submitted annually? A. DACA. B. Two active *QualityNet* Security Administrators. C. eCQMs. D. Both A and C. E. All of the above.

We'll just give you a few more moments here to submit your answer. Can you please close out the poll?

The correct answer is D. Annually, the hospitals are required to submit the DACA and eCQMs.

We'll briefly go over the annual requirements. Hospitals are required to maintain an active *QualityNet* Security Administrator at all times. As I stated earlier, it is highly recommended that hospitals designate at least two Security Administrators. It is also recommended that that the Security Administrator 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 Data Accuracy and Completeness Acknowledgement, or DACA, must be completed and signed on an annual basis. The DACA is done via the *QualityNet Secure Portal* and electronically acknowledges that the data submitted for the Hospital IQR Program are 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 the respect to the reporting period of January 1 through December 31 of the preceding year. Additionally, hospitals must submit the electronic clinical quality measures annually which Artrina will cover later on in this presentation.

So, just to reiterate, hospitals are required to complete the DACA on an annual basis via the *QualityNet 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 2020, the submission deadline for the DACA will be May 17, 2021. Just as a note, hospitals will have from April 1, 2020, through May 18, 2020, to enter their DACA for calendar year 2019 data.

So, let's just summarize. The annual IQR requirements are to have at least one active *QualityNet* Security Administrator, sign the DACA, submit the HCP measure, and submit the required eCQMs.

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 IQR Program requirements.

I would now like to turn the presentation over to Dr. Artrina Sturges to cover the calendar year 2020 eCQM reporting requirements for the Hospital IQR Program. Artrina, the floor is yours.

Artrina Sturges: Thank you, Candace, and good afternoon everyone.

We will start with the calendar year 2020 eCQM reporting requirements. The requirements have not changed from calendar year 2019 to calendar year 2020. However, the volume of measures available to report on has changed for calendar year 2020, and we will step through those changes today. Hospitals participating in the Hospital IQR Program will report on

four of the eight available eCQMs and report one self-selected calendar quarter of patient data for calendar year 2020. The submission deadline is March 1, 2021. Just a reminder, successfully meeting the Hospital IQR Program eCQM requirement also fulfills the CQM electronic reporting requirement for the Medicare Promoting Interoperability Program with one submission.

This is a table of the eight eCQMs available for reporting on for calendar year 2020. Just a reminder, this table is available on the *QualityNet* website. Visit eCQM information, which is contained on the eCQM Measures tab.

The calendar year 2020 certification and specification policies continue to require EHR technology certified to the 2015 edition, and EHRs must be certified to report on all available eCQMs. eCQM specifications are published in the CMS eCQM Annual Update, along with the related addenda for the applicable reporting year. This information is posted and available on the eCQI Resource Center. Submitters continue to use the QRDA Category I file format, and we recommend obtaining the QRDA Category I Implementation Guide for the applicable reporting year as a tool to support the file formatting process. This document is also available on the eCQI Resource Center.

The definition for successful submission of eCQMs is a combination of accepted QRDA Category I files with patients meeting the initial population of the applicable measures, zero denomination declaration, and case threshold exemption.

Let's do a quick summarization of the eCQM reporting requirements for calendar year 2020. Hospitals participating in the Hospital IQR Program are required to report on four of the eight available eCQMs, choosing one self-selected calendar quarter of data for the submission deadline of March 1, 2021. The EHR technology used to report this data has to be the 2015 edition of CEHRT and certified to report on all eCQMs. Visit the eCQI Resource Center to obtain the calendar year 2020 eCQM specifications, as well as the corresponding QRDA Category I Implementation Guide. The

definition of successful reporting is based on the program year. For calendar year 2020, the definition of successful submission of any combination of accepted QRDA Category I files with patients meeting the initial patient population of the applicable measures, zero denominator declaration, and case threshold exemption.

A quick review of the calendar year 2020 QRDA Category I file expectations indicates one file, per patient per quarter, which should include all the episodes of care and the measures associated with the patient file for that reporting period. The maximum individual file size is 10 mega bites. Files are uploaded by zip file with a maximum number of 14,999 QRDA Category I files, and, if a hospital has more than that 14,999, you are welcome to submit multiple zip files to represent your patient population for the quarter. Please contact the *QualityNet* Help Desk for additional assistance.

The eCQM validation process is unchanged from last year. Following the close of the calendar year 2020 eCQM submission period, up to 200 hospitals will be randomly selected for eCQM validation of calendar year 2019 data. The slide lists the exclusion criteria for greater details. Keep in mind, the exclusion criteria will be applied before hospitals are randomly selected.

Hospitals selected for eCQM data validation will be required to submit eight cases for one quarter of calendar year 2019 eCQM data for the fiscal year 2022 payment determination. The accuracy of eCQM data submitted for validation will not affect the hospital's validation score. Hospitals will pass or fail validation based on the timely and complete submission of at least 75 percent of the records requested by CMS. To review this and other information, we encourage you to visit the Hospital Inpatient Data Management page and select eCQM Data Validation on the *QualityNet* website. The link is provided on this slide.

At this time, I'd like to do a quick review of the calendar year 2020 eCQM reporting requirements for the Medicare Promoting Interoperability Program.

This slide will feel very familiar to you. The Medicare Promoting Interoperability Program clinical quality measure, or CQM, electronic reporting requirements are aligned with the Hospital IQR Program eCQM reporting requirements that we reviewed earlier. One successful submission of eCQM reporting fulfills the Hospital IQR and the Medicare Promoting Interoperability Program requirement with one submission. Keep in mind, submission of eCQMs does not meet the complete program requirement for the Hospital IQR or the Medicare Promoting Interoperability Programs. Hospitals are still responsible for data submission for all required measures, such as chart-abstracted and web-based.

Hospitals who choose to fulfill the Medicare Promoting Interoperability Program via attestation are permitted to report for the full calendar year, which equates to four quarterly data reporting periods on all eight available CQMs. The submission deadline is March 1, 2021. Again, any questions regarding the Promoting Interoperability Program should be submitted to the *QualityNet* Help Desk.

The reporting form and manner is the same for the Hospital IQR and the Medicare Promoting Interoperability Programs. One additional note: The requirements to have the EHR technology certified to the 2015 edition does not require recertification each time the EHR technology was updated to the most recent version of clinical quality measures, if it continues to meet the 2015 edition certification criteria. Any questions regarding this information should be directed to the *QualityNet* Help Desk.

State Medicaid programs for the Promoting Interoperability Program will continue to determine whether or how electronic reporting of clinical quality measures would occur or if they wish to allow reporting through attestation. We provided the link to the Promoting Interoperability Program's Medicaid State Information page to assist you to obtain additional details.

Often times submitters have questions regarding the attestation process. We encourage you to visit the Eligible Hospital Information page on CMS.gov to obtain additional details regarding updated reference guides and posted webinar materials. Once again, the *QualityNet* Help Desk is the primary resource for assistance.

I would like to take a few moments to review the key points regarding clinical quality measure reporting and the PI Program. Hospitals have two ways to meet the Promoting Interoperability Medicare clinical quality measure reporting requirement: either through successful electronic reporting of clinical quality measures, which fulfills the Hospital IQR and the Promoting Interoperability requirement with one submission; or, by attestation, if the hospital is only participating in the Promoting Interoperability Program. So, for example, this would apply to a Critical Access Hospital. It's important to remember that if the hospital attests for the Promoting Interoperability Program, they are required to attest to all eight measures for all four calendar quarters by the March 1, 2021, submission deadline. The eCQI Resource Center is your source of truth to locate all educational materials regarding eCQM reporting. The CMS.gov Promoting Interoperability webpage is your resource for all materials associated with attestation. Just a quick reminder: State Medicaid PI Program details are available on the CMS.gov Medicaid State Information page.

Hospitals and vendors tend to prepare one year or more ahead for the next calendar year of eCQM reporting to the Hospital IQR Program. We wanted to take a few minutes to review upcoming changes to aid hospitals and vendors as they continually prepare updates for their EHR system and the implementation process as a whole.

CMS announced in the Fiscal Year 2020 IPPS LTCH/PPS Final Rule that they finalized the adoption of the Safe Use of Opioids–Concurrent Prescribing eCQM to the eCQM measure set beginning with the calendar year 2021 reporting period. We'll talk a little about more about what that means on the next slide. The measure focuses on the proportion of patients aged 18 and older who are prescribed two or more opioids, or an opioid and

a benzodiazepine, concurrently at the time of discharge. CMS also clarified in the measure specification to only include inpatient hospitalizations, including emergency department and observation stay patients who are admitted. The measure specification is available on the eCQI Resource Center. The link has been provided for you. Lastly, this measure has been adopted for the Promoting Interoperability Program as well.

I mentioned a little earlier that CMS finalized the adoption of the Safe Use of Opioids–Concurrent Prescribing eCQM to the eCQM measure set beginning with the calendar year 2021 reporting period. What that means is that for calendar year 2021, hospitals can choose to report the measure as one of their self-selected measures for the self-selected calendar quarter, but it is not a requirement. If you take a look at this table of eCQMs for calendar year 2021, you'll notice it will be a requirement to report the Safe Use of Opioids–Concurrent Prescribing measure for the calendar year 2022 reporting period. We will review this in greater detail in the next slide.

For calendar year 2022, hospitals are required to report one self-selected calendar quarter of data for three self-selected eCQMs and the Safe Use of Opioids–Concurrent Prescribing eCQM by February 28, 2023, at 11:59 p.m. Pacific Time.

Some of you remember, the Hybrid Hospital-Wide Readmission measure was voluntarily reported in calendar year 2018. The Fiscal Year 2020 IPPS LTCH/PPS Final Rule finalized implementation steps for the measure, which we will discuss in greater detail in the following slides. At this time, we'll provide a high-level overview of the Hybrid HWR measure. The measure focuses on unplanned readmissions that arise from acute clinical events requiring rehospitalization within 30 days of discharge. Hospitals submit data from certified EHRs for at least 90 percent of their Medicare Fee for Service patients aged 65 and older. The method for data submission is QRDA Category I files. The slide lists the 13 core clinical data elements (which consists of six vital signs and seven laboratory test results) and the six linking variables to match EHR data to the CMS claims data. CMS then merges the EHR data elements with the claims data and calculates the 30-day risk standardized readmission rate.

With regard to implementing the Hybrid HWR measure, there are two voluntary reporting periods. The first is July 1, 2021, through June 30, 2022. That has a September 30, 2022, submission deadline. The second voluntary reporting period is July 1, 2022, through June 30, 2023, with an October 2, 2023, submission deadline. Please keep in mind that the reporting period includes four quarters of data. Hospitals will begin mandatory reporting of the Hybrid HWR measure with the July 1, 2023, through June 30, 2024, reporting period, which impacts the fiscal year 2026 payment determination and for subsequent years.

Although the voluntary reporting periods for the Hybrid HWR measure will not be publicly reported, the Hybrid HWR measure results beginning with the data collected from the July 1, 2023, through June 30, 2024, mandatory reporting period will be reported. CMS anticipates the data will be included in the July 2025 refresh of the public reporting website.

With the adoption of the Hybrid HWR measure, CMS will remove the claims-based Hospital-Wide All-Cause Unplanned Readmission measure. The rationale is that the Hybrid HWR measure provides improvement over the claims-based version by including clinical variables and the risk adjustment, which is at the very start of the inpatient stay and improve face validity of the measure.

We provided a slide to summarize our prior review that details when the claims-based HWR measure reporting will end and when the Hybrid HWR measure will begin as voluntary for two reporting periods and transitions to mandatory reporting.

Lastly, we have provided a table of resources, categorized based on the topic, who to contact for assistance, and the method for reaching out for locating information. That ends my portion of the presentation. I will now hand the call back over to Candace.

Candace Jackson: Great. Thank you, Artrina. Before we go into our Q&A session, I'd just like to make sure everyone knows that we are aware that hospitals have many concerns and questions related to the COVID-19 pandemic.

However, we will not be addressing these questions during this Q&A session. CMS is actively evaluating the situation and determining how this issue may affect the hospital quality programs. Once a decision is made, CMS will communicate their decisions and guidance through the Listserve communication process. So, if you are not signed up for the *QualityNet* Listserves, we would highly recommend that you do that. You can sign up for the email updates by going to the bottom of the *QualityNet* home page, at www.QualityNet.org, and clicking on Join Now. Also, additionally, unfortunately, we do not have subject-matter experts on our call today from the validation support contractor or the measures support contractor. So, if you do have specific questions related to validations, especially the current CDAC validation process that is going on right now, or if there's any measure-specific questions, we would recommend that you, if it's immediate, that you send those to the Q&A tool. Otherwise, there will be responses provided when we post the Q&A summary later on down the line. So, we'll go ahead and go into some questions.

Our first question: When determining the numerator and denominator for eCQMs, are patients that are in observation status for the length of their stay included?

Artrina Sturges: Thank you, Candace. This is Artrina. So, patients that are in observation are only counted as an inpatient encounter if they're admitted. Thank you.

Candace Jackson: Thank you, Artrina. We'll just stick with another eCQM question.

When is the earliest you can test and submit eCQMs for calendar year 2020 data?

Artrina Sturges: Thank you very much. It depends on when the Pre-Submission Validation Application is available to test the file format, and it also depends on when the HQR system opens to receive test submissions. As you know, each year, when the system is ready to receive that data, there's a Listserve that's received, and it's sent out in multiple places. We advertise there. We advertise in newsletters and different places like that to let you know when the system is available to start receiving data. As soon as the PSVA tool is

prepared, and as soon as the Hospital Quality Reporting System is available to accept Test and Production submissions, you will receive notification from CMS.

Candace Jackson: Thank you, Artrina. Our next question: Our vendor has us still collecting the ED measures. Should we continue to do this since it's no longer a mandatory requirement?

For CMS, no, you do not have to collect the ED measures because, as you stated, they have been removed from the program, and they are not allowed to be submitted to the CMS Clinical Data Warehouse. However, keep in mind that, if you are a Joint Commission hospital, for their accreditation process, The Joint Commission is still collecting the ED measures. So, you may want to consult with your vendor to see if they are still collecting that measure to be able to send it to The Joint Commission.

And our next question, just a second here: What hospital would not have a mapped medical, surgical, med/surg, or ICU?

I will answer that question the best I can. I can't tell you exactly what type of hospital or which hospitals, but, as long as a hospital is a subsection (d) Acute Care Hospital, they are eligible for the IQR program. 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 an ICU unit.

Our next question: Can you please clarify calendar year, fiscal years, and reporting program years?

So, I'll go ahead and take this question. The calendar year is usually a past year, and it's used for payment determination. Future years are considered the fiscal year. So, every calendar year is connected to a specific fiscal year. So, calendar year 2020 is connected to fiscal year 2022. So, the data from calendar year 2020 would affect Medicare reimbursement from October 1, 2021, to September 30, 2022. To get a better understanding of calendar year versus fiscal year, you can go out to the Quality Reporting Center website, which is www.QualityReportingCenter.com. If you look

under Inpatient Tools and Resources and under IQR Program Resources, you will find a document that says Calendar Year 2020 and Fiscal Year 2022, and this document explains how those are determined and the differences between them. So, I hope that answers your question.

Our next question, we'll go back to you, Artrina. Must the 2015 CEHRT be installed by January 1, 2020, for reporting?

Artrina Sturges: Thank you, Candace. So, specifically, for hospitals, Hospital IQR and the Promoting Interoperability Program, performing eCQM reporting, hospitals 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. So, for example, for the calendar year 2019 reporting period, hospitals would need to have the CEHRT definition in place by December 30, 2019. Thank you, Candace.

Candace Jackson: Thank you, Artrina. Next question, we will keep with eCQMs: Since hospitals have successfully submitted eCQMs for the past three years that have been technically retired from the chart-abstracted measures, some prior to eCQM, why must hospitals continue dealing with this added cost and burden to submit eCQMs, especially when they are no longer adding to the quality of care to our patients?

Artrina Sturges: Thank you, Candace. I think there's a longer response that I need to provide that I will actually need to provide in writing because there are some other aspects that come into that to give more detail. So, for now, I will recuse myself from answering that on this call, but I will make sure it is included in with the summary questions and answers. Thank you.

Candace Jackson: Thank you, Artrina. Our next question: Are the specs released for the optional opioid eCQM? Our vendor says that specs for hospitals are not available. Will this metric be mandatory for next year?

Artrina Sturges: Thank you, Candace. For this one, the measure specifications are actually posted on the eCQI Resource Center. They have all that information available out there, including any of the additional clarifications that go with the measure. So, that information is currently available and posted.

For the second part of that question, in calendar year 2021, hospitals can choose to report the Safe Use of Opioids–Concurrent Prescribing measure. You are allowed to do that, and it can count as one of your four measures to report, but it doesn't become a mandatory measure for reporting until calendar year 2022 for eCQMs.

Candace Jackson: Thank you, Artrina. I'll kind of stick with eCQMs: In 2021, if a hospital submits CMS [CMS506v2], the opioid measure, will it be counted as one of their four eCQMs?

Artrina Sturges: Yes, it can be counted. It can be one of the four; but, as I indicated, it is not required to be reported in 2021. It will start mandatory reporting in 2022.

Candace Jackson: Thank you. Our next question: Is IQR and eCQM required for CAHs?

We'll do this as a dual, with Artrina and I. For IQR, no, the critical access hospitals are not part of and are not eligible for the IQR program. However, CMS highly recommends that the critical access hospitals submit the data to help them improve their quality processes and the care of their patients. Artrina, I'll kind of let you take over the eCQM part.

Artrina Sturges: Okay. Thanks, Candace. For critical access hospitals, with regards to eCQMs, you are required to participate in the Promoting Interoperability Program. That allows you to either electronic report clinical quality measures or you can attest to clinical quality measures but, you are required to participate for that particular program. Thank you, Candace.

Candace Jackson: Thank you. Our next question: How do you volunteer to participate in the Hybrid Hospital-Wide Readmission measure for 2021?

Artrina Sturges: Thank you, Candace. You don't have to volunteer. Basically, you can make the decision to go ahead and submit the data. Just follow the information that's provided in today's webinar to give you a sense of, you know, the time frame for data collection and the deadline for data submission, depending on if you are participating to volunteer for one year

or for two. Other than that, all of the information is available, and you don't have to signal to anyone that you intend to report. Thank you.

Candace Jackson: Thank you, Artrina. We'll have one last question before we conclude our session for the day. For the global population and sampling, we are required to submit those values even if we do not sample any cases. Correct? We do not have any cases that qualify for sepsis; therefore, we have no population to sample.

So, this kind of has two parts here. Global population and sampling, beginning with January 1, 2020, discharges, have been removed from the Hospital IQR Program because we no longer collect ED or IMM for our programs. So, beginning with January 2020, you would not be submitting global population and sampling counts.

Sepsis has its own sampling requirements and count. It is not part of the global sampling. So, you would still be required to determine what your sepsis population is and then follow the sampling requirements accordingly that's in the specifications manual. If you have no cases that meet the sepsis population requirement, then, in your population and sampling application, you would just enter zero. Otherwise, if you did have populations, say you had one sepsis case then, in the population and sampling tool, you would just enter one. So, the global is no longer required, but sepsis still is.

That concludes our webinar for today. We thank everyone for joining us today and I hope you have a good rest of your day. Thank you.