Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program Requirements for CY 2018 (FY 2020 Payment Determination)

Presentation Transcript

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Candace Jackson: Thank you everyone for joining today's presentation tilted Hospital Inpatient Quality Reporting Program Requirements for Calendar Year 2018, Fiscal Year 2020 Payment Determination. I am Candace Jackson, the Project Lead for the Hospital Inpatient Quality Reporting Program with the Hospital Inpatient Values, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator and one of the speakers for today's event. In addition to myself, our other speaker for today's event will be Dr. Artrina Sturges, who is the Project Lead for the IQR-Electronic Health Record Incentive Program Alignment with the Hospital Inpatient VIQR Outreach and Education Support Contractor. Before we begin, I would like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers will be posted to the inpatient website, *www.QualityReportingCenter.com*, and to the *QualityNet* site, at a later date. If you registered for this event, a reminder email, as well as the slides, were sent out to your email about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website, www.qualityreoportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window. For presenters to best answer your questions, we request that, at the beginning of your question, please type the slide number into the chat window with it. Questions submitted during the presentation today will be responded to and posted to the *QualityReportingCenter.com* website at a later date. So, let's begin.

This event will provide insight into the calendar year 2018 Hospital Inpatient Quality Reporting Program requirements, as well as a review of the calendar year 2018 Hospital Inpatient Quality Reporting Program and Medicare Electronic Health Record Incentive 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 IQR Program, be familiar with the areas of alignment between the Inpatient Quality Reporting and Medicare Electronic Health Record Incentive Program

requirements, and locate resources that are available for both the IQR and Medicare Electronic Health Record Incentive Program.

Here's 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 IQR program requirements for calendar year 2018 except for the electronic Clinical Quality Measures requirements. After addressing these requirements, I will turn the presentation over to Artrina Sturges to cover the calendar year 2018 electronic Clinical Quality Measures reporting requirements for the Hospital Inpatient Quality Reporting Program and the Medicare and Medicaid Electronic Health Record Incentive Program 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 sample counts for the chart-abstracted measure sets or measures; the clinical process of care measures; the National Healthcare Safety Network, or NHSN, healthcare-associated infection measures; and the web-based perinatal care elective delivery measure. Additionally, those who 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 slide.

Hospitals must submit aggregate population and sample size counts from Medicare and non-Medicare discharges for the chart-abstracted measures only. So, this would include the counts for the global, severe sepsis and septic shock, and other venous thromboembolism 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 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.

And, as a note, the perinatal care electives 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 is collected through the web-based tools located within the *QualityNet Secure Portal*.

There are six chart-abstracted clinical process of care measures that will be required for the Inpatient Quality Reporting Program for calendar year 2018, beginning with January 1, 2018 discharges. Hospitals must chart abstract and submit complete patient level data for the ED-1, ED-2, IMM-2, SEP-1, and VTE-6 measures. The measure specification abstraction guidelines can be found within the *Specifications Manual for National Hospital Inpatient Quality Measures* located on the *QualityNet* website. And, please note, that for calendar year 2018, there are two applicable specification manuals, version 5.3A, which covers January 1 through June 30 discharges, and version 5.4, 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 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 specification 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's website.

There are no changes in the healthcare -associated infection, or HAI, measures that are required for the IQR Program. Hospitals will continue to submit the CAUTI, CLABSI, CDI, SSI, and MRSA Bacteremia measures to the National Healthcare Safety Network.

Although not a quarterly requirement, I would just like to take a few moments to 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 each year. So, for calendar year 2018, which would be the flu season from fourth quarter 2017 through first quarter 2018, the data will need to be entered by May 15 of 2018.

For calendar year 2018, there were no changes to the claims-based measures. The Centers for Medicare and 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 from Medicare fee-for-service patients. No additional hospital data submission is required to calculate the measure rate. Each measure set is calculated using a separate distinct methodology and, in some cases, separate discharge periods. 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 AutoRoute_inbox of Secure File Transfer. To be able to access the reports, you must be a registered *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 2018 data. Data accuracy is a vital component of the IQR program. CMS assesses the accuracy of chart-abstracted and HAI data that is 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 2020 occurred in December of 2017 and that list of hospitals can be found in the data validation section of *QualityNet*. In April or 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 2020 validations are third and fourth quarter 2017 and first and second quarter of 2018.

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 and data submitted to the CMS Clinical Warehouse by the hospital. For HAI, CMS will validate up to 10 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 competence interval or total score is 75% 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 later date.

As it is our goal to have all hospitals meet their 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 is to submit data early and not wait until submission deadline. Hospitals can't update and/or correct their submitted clinical data until the CMS submission deadline, immediately after which the CMS Clinical Warehouse will be locked. Any updates made after the submission deadline will not be reflected in the data CMS uses and cannot be changed. This also includes data submitted to NHSN. Data that are modified in NHSN after the submission deadline are not sent to CMS and will not be used in any of the CMS programs. Secondly, 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 as a backup. We went over this a little 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. Before the quarter, if you look at your provider participation reports and your population size and your Medicare claims count is five or less for any of the measure sets, you're not required to submit patient-level data for that measure set. However, even though you are not required to submit the data, CMS still encourages the submission of that data. So, 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 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 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, ED-1 and ED-2, the SSI colon and abdominal hysterectomy, and the CAUTI/CLABSI measures. So, if your hospital has no emergency department and does not provide emergency care, you can submit the measure exception form for ED-1 and ED-2. Otherwise, hospitals that do not have an ED and does not submit a measure exception form must abstract and submit patient-level ED files for each discharge quarter. If your hospital has no obstetrics department, and does not deliver babies, you can submit the measure exception form for PC-01. Otherwise, again, hospitals that do not deliver babies and does 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 from submitting SSI measures to

fulfill the IQR HAI reporting requirement. Lastly, hospitals that have no units mapped as medical, surgical, medical/surgical, or ICU can request an exception from submitting CAUTI and CLABSI measures to fulfill the IQR HAI reporting requirements. Please remember that, if you do submit the measure exception form, it must be renewed at least annually.

There were no changes to the IQR requirements that are due on an annual basis. Just to go over them briefly: Hospitals are required to maintain an active *QualityNet* Security Administrator at all times, and, as I started earlier, it is highly recommended that hospitals designate at least two Security Administrators. It is also recommended that the Security Administrator log into their account at least once a month to maintain an active account. Any accounts that have been inactive for 120 days will be disabled. The structural measures must be completed, which I will discuss in the next few slides, and the Data Accuracy and Completeness Acknowledgement, or DACA, must be completed and signed on an annual basis. The DACA is done via the *Quality Net Secure Portal* and 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 or May 1, with 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.

Hospitals participating in the Hospital IQR Program are required annually to complete the structural measure question. There are two structural measures that will need to be completed for calendar year 2018. The first one is Safe Surgery Checklist Use, which documents if the hospital uses a safe surgery checklist. This is just a yes or no question and there are no right or wrong responses. The second structural measure is the Hospital Survey on Patient Safety Culture. This measure assesses whether a hospital administers a detailed assessment of patient safety culture using a standardized collection protocol and structured instrument. Again, this is a yes or no question. However, if the hospital answers yes, that they do

administer a patient safety culture survey, then they will be required to respond to several more questions, including the name of the survey, how frequently the survey is administered, if the facility reports survey results to a centralized location, how many staff members were requested to completed the survey, and how many completed surveys were received.

So, just to reiterate, hospitals are required to complete the structural measures and 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 2018, the submission deadline for the structural measures and DACA will be May 15, 2019.

This slide just provides you with some resources that are available to you for assistance with the 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 IQR Program requirements.

Now, I would like to turn the presentation over to Artrina to cover the calendar year 2018 eCQM Reporting Requirements for the Hospital IQR Program. Artrina, the floor is yours.

Artrina Sturges: Thank you very much, Candace. As we begin a review of the calendar year 2018 eCQM reporting requirements for the Hospital IQR Program, I want to quickly point to the Clinical Quality Measures available for reporting to the IQR and the Medicare EHR Incentive Program. I'll draw your attention to the last field on this document, which talks about the ED-3 measure, which is an outpatient measure and only available for reporting to the EHR Incentive Program.

The calendar year 2018 reporting requirements have not changed from the calendar year 2017 reporting requirements. Hospitals will be reporting on at least four of the 15 available eCQMs for one self-selected calendar quarter by the February 28, 2019 submission deadline. The technical requirements for calendar year 2018 eCQM reporting are the utilization of

the electronic health record technology, which is certified to the 2014 edition, the 2015 edition, or a combination of both, Office of the National Coordinator of IT Standards, and the EHR system must be certified to report all of available eCQMs.

Hospitals are also required to use the eCQM specifications published in the 2017 eCQM annual update for calendar year 2018 reporting and all applicable addenda, as well as the 2018 CMS Implementation Guide for QRDA Category I Hospital Quality Reporting. The specifications and implementation guide are posted on the eCQM Resource Center.

Our definition of successful reporting also remains the same from calendar year 2017. The definition of successful submission of eCQMs is a combination of accepted QRDA I files, with patients meeting the initial patient population of the applicable measures, zero denominator declarations, and case threshold exemptions. The calendar year 2018 QRDA Category I file format expectations are also consistent with calendar year 2017 requirements: One QRDA Category I file per patient per quarter that encompasses all the episodes of care and measures associated with the patient file for the hospital selected reporting period. The maximum file size is 5 megabytes. If you have file sizes larger than 5 megabytes, please contact the *QualityNet* Help Desk for tips to reduce the file size. Files are then uploaded by ZIP file into the *QualityNet Secure Portal*. The maximum number of QRDA Category I files within a ZIP file is 15,000. Hospitals are welcome to submit more than one ZIP file.

eCQM data submitted for calendar year 2018 reporting will not be publicly displayed on *Hospital Compare*. The intent to publicly display eCQM data will be indicated in a future CMS IPPS rule. In Spring 2018, hospitals may be notified they have been chosen for calendar year 2017 eCQM data validation activities. As a brief review, up to 200 hospitals will be randomly selected to participate for eCQM data validation. The following criteria will be applied before the random selection takes place. So, any hospital meeting one of the criteria stated below will not be eligible for eCQM data validation. That criteria includes: a hospital is chosen for chart-abstracted measure validation, a hospital has been granted

a Hospital IQR eCQM Extraordinary Circumstances Exception, or an ECE, for the applicable eCQM reporting report, the hospital does not have at least five discharges or at least one reporting eCQM, episodes of care are longer than 120 days, and cases with a zero denominator for each measure.

Hospitals selected for participation in eCQM data validation will be required to submit eight cases from one quarter from calendar year 2017 eCQM data. Please keep in mind, the accuracy of the eCQM data submitted for validation will not affect the hospital's validation score for the fiscal year 2020 payment determination. Visit the *QualityNet* Data Validation page for more details and updates regarding chart-abstracted and eCQM data validation activities.

Several hospitals have expressed interest in voluntarily reporting the Hybrid Hospital-Wide 30-Day Readmission measure. Hospitals who choose to participate are being asked to voluntarily submit data for at least 50% of these patients utilizing a QRDA Category I file submitted via the *QualityNet Secure Portal*. The data would include 13 core clinical data elements and six linking variables to assist CMS to match EHR data to the CMS claims data. CMS then mergers the EHR data elements with the claims data and calculates the risk-standardized readmission rate.

The measurement period for the Hybrid HWR measure is January 1 through June 30, 2018, with a submission period of late summer through fall 2018. CMS will provide greater details at a later date regarding the submission timeframe. The measure pool is Medicare fee-for-service patients age 65 or older who have been discharged from non-federal acute care hospitals. CMS intends to also provide Hospital-Specific Reports.

And just a couple of reminders associated with the volunteer reporting on the HWR measure: Reporting the voluntary Hybrid HWR measure will not impact a hospital's annual payment update determination and the reported data will not be publicly displayed on *Hospital Compare*. Outreach and education webinars were held in December of 2017 and future webinars are being planned for this spring. Visit the *QualityNet.org*

website to obtain webinar materials, key measure specifications, and additional details. The *QualityReportingCenter.com* website is also a good resource to register for upcoming webinars and locate archived webinar materials.

Now, we will talk briefly about the eCQM reporting requirements for the Medicare and Medicaid EHR Incentive Program. For Eligible Hospitals and Critical Access Hospitals who are electronically reporting, the reporting period is one self-selected quarter of CQM or Clinical Quality Measure data if the hospital is demonstrating meaningful use for the first time or if the hospital demonstrated meaningful use any year prior to 2018. Hospitals are required to report on at least four self-selected eCQMs by the February 28, 2019 submission deadlines.

Attestation is only an option to meet the 2018 Medicare EHR Incentive Program Clinical Quality Measure reporting requirements under specific circumstances when electronic reporting is not feasible. If permitted by CMS to attest, hospitals are required to report the full calendar year (four quarterly data reporting periods) on all 16 available Clinical Quality Measures via the *QualityNet Secure Portal* by the February 28, 2019 submission deadline. For details regarding attestation options, please visit the *CMS.gov* EHR Incentive Programs Eligible Hospital Information page.

Now, many of you are aware of the transition to begin submitting meaningful use attestation data via the *QualityNet Secure Portal* beginning with the calendar year 2017 reporting period. Please visit the CMS EHR Incentive Programs web page to obtain additional details regarding the transition and submit any questions to the *QualityNet* Help Desk.

As we discussed earlier in the IQR portion, the reporting form and manner remains the same and this is what we reviewed during the Hospital IQR Program information. So, I'd like to draw your attention to the requirement to have the EHR technology certified to report all 16 available Clinical Quality Measures. This does not require recertification each time the

submission is updated to the most recent version of Clinical Quality Measures and continues to meet the 2015 edition certification criteria.

The state Medicaid programs continue to be responsible for determining whether electronic reporting of Clinical Quality Measures needs to be completed and how they would like the information reported, whether it's electronic or via attestation. We have a link for you to access the Medicaid state information page on the *CMS.gov* website.

Now, on this slide we've included a few links for reporting tools and tips associated with calendar year 2018 reporting. Some of the details will include information such as links to the 2018 CMS QRDA I Schematrons and sample files for Hospital Quality Reporting, and the value sets and data element catalog that's available on the VSAC website. The last piece of information that we have here for you is phone support to assist with your questions. So, thank you very much for your time and attention, and I will now turn the presentation over to Candace.

Candace Jackson: Thank you, Artrina. That concludes our webinar for today. We hope you learned something that was beneficial to you. All questions will be answered and posted to our *QualityReportingCenter.com* website at a later date. Enjoy the rest of your day. Goodbye.