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PROGRAM & SUBMISSION	MEASUREMENT INFORMATION	ADDITIONAL INFORMATION
Medicare Promoting Interoperability **Annual Submission** **Start of New Calendar Year** **Attesting to the Year Prior** **Hospital Quality Reporting via HARP** ↓ **Data Submissions** ↓ **Web Based Measures** ↓ **Data Form** ↓ **PI** ↓ **Enter data from Epic report labeled Meaningful Use Eligible Hospital (EH) Objectives – Summary**	Report on the 4 objectives and their associated measures: 1. Electronic Prescribing 2. Health Information Exchange 3. Provider to Patient Exchange 4. Public Health and Clinical Data Exchange Eligible hospitals and CAHs may use (1) existing 2015 Edition certification criteria, (2) the 2015 Edition Cure Update criteria, or (3) a combination of the two in order to meet the CEHRT definition as finalized in the CY 2021 Physician Fee Schedule final rule (85 FR 84818 through 84828). Attest to the following: 1. Security Risk Analysis measure 2. Safety Assurance Factors for EHR Resilience (SAFER) Guides measure 3. Actions to limit or restrict the compatibility or interoperability of CEHRT attestation 4. Office of the National Coordinator for Health IT (ONC) direct review attestation	The scores for each of the individual measures are added together to calculate the total Medicare Promoting Interoperability Program score of up to **115 possible points** for each eligible hospital or CAH. **A total score of 60 points or more will satisfy** the requirement to report on the objectives and measures of meaningful use, which is one of the requirements for an eligible hospital or CAH to be considered a meaningful EHR user and **avoid a downward payment adjustment**. The eligible hospital or CAH must report on all of the required measures across all of the objectives in order to earn any score at all. Failure to report any required measure or reporting a "no" response on a yes/no response measure, unless an exclusion is claimed, will result in a score of zero.

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Electronic Clinical Quality Measures eCQM's **Annual Submission** **Start of New Calendar Year** **Hospital Quality Reporting via HARP** ↓ **Data Submissions** ↓ **eCQM** ↓ **File Upload** ↓ **Production** ↓ **Select File** ↓ **The file must be a QRDA* (xml zip) file from the U of I** **Pick 3 self-selected measures (out of the 9 available)** **+ the required safe use of opioid meaure** **Each measure must be > 5 patients** **Pick 3 self-selected quarters**	The eCQMs are tools that help measure and track the quality of healthcare services provided by eligible hospitals and CAHs within our healthcare system. These measures use data reported from electronic health records that are associated with healthcare providers' ability to deliver high-quality care or relate to long-term goals for quality healthcare. eCQMs help ensure that our healthcare system is delivering effective, safe, efficient, patient-centered, equitable, and timely care. Must report on 3 self-selected measures + opioid use: 1. Anticoagulation therapy for a-fib 2. Antithrombotic therapy 3. D/C on antithrombotic therapy 4. D/C on statin 5. Exclusive breast feeding 6. ICU venous thromboembolism 7. Median admit decision time to ED departure time for admitted patients 8. Safe use of opioids (required) 9. Venous thromboembolism prophylaxis *QRDA = Quality Reporting Document Architecture	Health care providers are required to electronically report eCQMs, which use data from EHRs and/or health information technology systems to measure health care quality. To report eCQMs successfully, health care providers must adhere to the requirements identified by the CMS quality program. To successfully participate in the Medicare and Medicaid Promoting Interoperability Programs, CMS requires EPs, eligible hospitals, CAHs, and dual-eligible hospitals to report on eCQMs. These eCQMs are determined by CMS and require the use of certified electronic health record technology (CEHRT)

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Hospital Inpatient Quality Reporting Program **Combination of Reporting Via The Below** ↓ **NHSN Site** ↓ **Chart Abstraction (quarterly)** ↓ **Patient Survey** ↓ **HARP** ↓ **Claims**	**Nat'l Healthcare Safety Network Measure** Influenza Vaccination Healthcare (via NHSN) COVID-19 Vaccination Coverage (via NHSN) **Chart-Abstracted Clinical Process of Care** PC-01 Elective Delivery (via chart abstraction) Sepsis & Shock: Bundle (via chart abstraction) **EHR-Based Clinical Process of Care** eCQM's (via QRDA file - see above) **Patient Experience of Care Survey** HCAHPS (patient survey) **Structural Measure** Maternal Morbidity (web-based via HARP) **Claims-Based Patient Safety** Death Rate Among Surgical Inpatients with Serious Treatable Complications (claims) **Claims-Based Mortality Outcome** Hospital 30-Day, All-Cause Mortality Rate Following Acute Ischemic Stroke (claims) **Claims-Based Coordination of Care** Unplanned Readmission Measure (claims) AMI Excess Days in Acute Care (claims) HF Excess Days in Acute Care (claims) PN Excess Days in Acute Care (claims) **Claims-Based Payment** 30-Day Episode-of-Care for AMI (claims) 30-Day Episode-of-Care for HF (claims) 30-Day Episode-of-Care for PN (claims) Episode-of-Care for Primary Elective THA and/or TKA (claims) (total hip/knee)	The Hospital Inpatient Quality Reporting Program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points. This was modified by the American Recovery and Reinvestment Act of 2009 and the Affordable Care Act of 2010, which provided that beginning in fiscal year (FY) 2015, the reduction would be by one-quarter of such applicable annual payment rate update if all Hospital Inpatient Quality Reporting Program requirements are not met

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Hospital Outpatient Quality Reporting Program	*OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (n/a)* OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention *OP-8: MRI Lumbar Spine for Low Back Pain (n/a)* OP-10: Abdomen CT—Use of Contrast *OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery (n/a)* OP-39 Breast Cancer Screening Recall Rates OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients OP-22: Left Without Being Seen OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (not yet reporting) *OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (voluntary)** OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy OP-36: Hospital Visits after Hospital Outpatient Surgery	The Hospital Outpatient Quality Reporting Program (Hospital OQR) is a pay for quality data reporting program implemented by CMS for outpatient hospital services. The program was mandated by the Tax Relief and Health Care Act of 2006, which requires subsection (d) hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome, and efficiency. Under the Hospital OQR Program, hospitals must meet administrative, data collection and submission, validation, and publication requirements, or receive a **2 percentage point reduction in payment** for failing to meet these requirements, by applying a reporting factor of 0.980 to the Outpatient Prospective Payment System (OPPS) payments and copayments for all applicable services. In addition to providing hospitals with a financial incentive to report their quality of care measure data, the Hospital OQR Program provides CMS with data to help Medicare beneficiaries make more informed decisions about their healthcare. Hospital quality of care information gathered through the Hospital OQR Program is available on the *Care Compare on the Medicare website*.

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SAFER GUIDES
Safety Assurance Factors for EHR Resilience
 	
NEW CMS REQUIREMENT
CY 2022 Requirement
	The SAFER guides consist of nine guides organized into three broad groups:
	
	   1. Foundational Guides
	High Priority Practices
	Organizational Responsibilities
	   2. Infrastructure Guides
	Contingency Planning
	System Configuration
	System Interfaces
	   3. Clinical Process Guides
	Patient Identification
	Computerized Provider Order Entry
	Test Results Reporting and Follow-Up
	Clinical Commuication
	
	They were designed by Health IT safety researchers and informatics experts to help healthcare organizations conduct self-assessments to optimize the safety and safe use of EHR's.
	
	*ONC =
	Office of the National Coordinator for Health Information Technology
		August 2021: The SAFER Guides, a set of checklist-based self-assessment tools to improve safety of how EHRs are used, have seen limited uptake so far, but a recently released final rule from CMS makes attestation to having completed an annual assessment of all nine guides in the SAFER Guides measure **a requirement** under the Protect Patient Health Information objective. The (SAFER) Guides were released in 2014 to help health systems conduct proactive risk assessment of electronic health record (EHR)- safety related policies, processes, procedures, and configurations. A 2018 study published in the *Journal of the American Medical Informatics Association,* found that health systems were not fully implementing the guides.
		
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Quality Payment Program (QPP) **Annual Submission but review QPP once a quarter** ↓ **Log into QPP.CMS.Gov** ↓ **Report as a Group** **APP – APM Performance Pathway** **MIPS APM (Alternative Payment Model)** ↓ **Edit Submission – Upload File** **QRDA III from Katie Tunning (U of I)** **Report entire Calendar Year** **EHRT ID (get from Mary every year)** ↓ **Take #'s of MIPS manager by Tin except the Lab. PH data on PI dashboard or MUEH summary** ↓ **Send payment adjustment > performance feedback > data download to CFO + Revenue Manager**	Performance category weights for APM: • Quality: 50% • Cost: 0% • PI: 30% • Improvement Activities: 20% Receive **full score for improvement activities** for being in an ACO. MIP and MIPS APM are different: MIPS APM is a reporting ACO We are a reporting ACO *QRDA = Quality Reporting Document Architecture *MUEH = Meaningful Use Eligible Hospital *MIPS Merit-based incentive payment system *APM Alternative Payment Model *APP APM Performance Pathway	What is a good MIPS score for 2021? If you are an EC, MIPS performance in 2021 will determine your MIPS payment adjustment in 2023. Therefore, in 2021, you must achieve **at least 60 points** through your performance in the four MIPS performance categories to avoid a negative payment adjustment in 2023. What is MIPS eligibility? In order to be MIPS eligible as an individual clinician, you must: Be identified as a MIPS eligible clinician type on Medicare Part B claims, have enrolled as a Medicare provider before 2022, Not be a Qualifying Alternative Payment Model Participant (QP), and exceed the low-volume threshold as an individual. MIPS eligible clinicians within an APM are required to report to MIPS. Clinicians participating in a MIPS APM have the APP as one option for reporting to MIPS. If they do not wish to report through the APP, then they are required to report under traditional MIPS. Clinicians have two tracks to choose from in the QPP based on their practice size, specialty, location, or patient population: MIPS (MIPS) or AAP Models *EC = Eligible Clinician

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Iowa Healthcare Collaborative IHC = Compass **Monthly Submission** ↓ **Log into Compass Data Portal** ↓ **Monthly Submission** ↓ **Facility: Monthly Data** ↓ **Open IHC Month on the 5th of q month** ↓ **Data Submission Deadline is 45 days following end of month i.e. January is due March 15** **Work plan (annual) and HEOA (quarterly)**	Data Submission Measures: High-dose opioid prescribing Adverse Drug Events INR > 5 Stat Narcan (Inpat & ED) Blood Glucose < 50 Post-hospital f/u appointment Unnecessary urinary catheter Hand hygiene compliance Pressure ulcer risk assessment 3 hour sepsis bundle Falls with and without injury Fall assessment on admission Falls with injury VTE prophylaxis All ED transfer composite • Home Meds • Allergies and/or reactions • Medication in ER • ED provider note • Mental Status/Orientation • Reason for transfer • Tests and/or procedure performed • Test and/or procedure results Early Elective Deliver Antimicrobial days of therapy	Department managers enter their department specific information Some measures are also claims based Report: Run Charts – Monitor data submissions and results This data is entered into the compass portable by MMC Staff: Pharmacy (Nancy Gau) OB (Michele Monson) Infection Prevention (Cathy Buman) ER (Received from Jenny Lefeber; entered by Laura Freund) Med/Surg (Christie Matthies)

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Accountable Care Organization ACO **Monitor & Record Monthly For Operating Committee Email to Providers Quarterly** ↓ **IN EPIC MIPS Manager by TIN (or)** ↓ **My Reports** ↓ **MMC MIPS Eligible Clinician RHC** ↓ **Click to RUN Filter to 15 RHC providers Export** ↓ **Enter on RHC ACO Excel Spreadsheet U Drive All Use**	Measures: CMS 2 Depression Screen and F/U plan CMS 122 Hgb A1c CMS 125 Breast CA Screening CMS 130 Colorectal CA Screening CMS 138.3 Tobacco Screening CMS 139 Fall Screening CMS 147 Influenza Immunization CMS 165 Controlling Hypertension Problem List/Med List/Allergies Print AVS or MyChart SignUp Annual Well Visit *MIPS = Merit-based Incentive Payment System *TIN = Tax Identification Number	MedLink Advantage Nancy Scroggs 888.600.9263 ext 104 Amy Dias: 888.600.9263 ext 103

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Electronic Initial Case Reporting (eICR) **Annual Submission by February 28th** ↓ **https://idph.iowa.gov/cade/idss** ↓ **On-line registration for eICR**	What is Electronic Case Reporting (eCR)? **The automated generation and transmission of case reports from electronic health records to public health agencies for review and action.** Much of the capability for electronic initial case reporting (eICR) depends on the EHR system. Can your EHR system: 1. flag a record that meets specific criteria 2. generate an HL7 CDA message 3. attach the HL7 CDA message to a Direct Secure Messaging e-mail, and 4. send the e-mail automatically (without manual intervention)? Does your EHR system have a way to consume 'Trigger Yes Codes' (LOINC, SNOMED, ICD-10 codes) downloaded from an external source which are used to define the specific reporting criteria? Is there a mechanism in your EHR to check for Yes 'Trigger Code' updates on a periodic schedule (monthly, quarterly, semi-annually)?	Electronic initial case reporting (eICR) is a new Meaningful Use objective that began in 2018. The state of Iowa uses the HL7 electronic initial case report (eICR) standards (R1.1 and R3) for electronic case reporting (eCR) and to support the new CMS Promoting Interoperability regulations for eCR. It is these standards that will used to eventually eliminate manual reporting requirements. Also require the use of APHL (Association of Public Laboratories) AIMS (APHL Informatics Messaging Services) and the Reportable Condition Knowledge Management System (RCKMS) to ensure appropriate reporting.

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Digital Quality Measures dQM's **IMPLEMENTATION DATE 1/1/25**	dQMs were introduced in the most recent PFS final rule (starting on page 1159 of PDF version of final rule) noting that full implementation will be expected starting 1/1/2025. dQMs are intended to be transmitted to CMS via interoperable systems – meaning no manual abstraction and no manual upload to a CMS portal. **What this does mean is that all our measure level data points must be well known and documented internally** so that we are fully aware of what patient level data will be (auto) transmitted to CMS and will be used by them for measure rate calculations	We are currently receiving information now regarding the transition to dQM's The link between documentation, coding, claims, and quality will significantly increase

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References:

https://www.cms.gov/regulations-guidance/promoting-interoperability/2022-medicare-promoting-interoperability-program-requirements

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU

https://www.healthcarecompliancepros.com/blog/understanding-safer-guides-obligations-for-mips-eligible-clinicians

https://www.ohsu.edu/sites/default/files/2019-04/ONC-Issues-Guides-for-SAFER-EHRs.pdf

https://qpp.cms.gov/about/qpp-overview

https://idph.iowa.gov/Portals/1/userfiles/113/Documents/eICR%20Registration%20PDF%20Version%20of%20Question%20Set_1.pdf

https://www.cdc.gov/ehrmeaningfuluse/docs/ehr-vendors-collaboration-initiative/2018-02-20-ph_vendor_ecr-standards-1-20-18-v7-508.pdf

https://idph.iowa.gov/cade/idss

https://idph.iowa.gov/Portals/1/userfiles/113/Documents/eICR%20Registration%20PDF%20Version%20of%20Question%20Set_1.pdf

https://blog.medisolv.com/articles/understanding-safer-guides-review-2022-pi-requirements

https://www.healthit.gov/topic/safety/safer-guides

QRDA

Quality Reporting Document Architecture – standard format for reporting eCQM⑦ data in a structured, consistent representation. QRDA⑦ I is used for individual patient data and QRDA III for aggregate patient data.