Reporting Hospital Quality Data for Annual Payment Update
Frequently Asked Questions

Q1: What is Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)?

A1: This new law can affect how much certain hospitals will receive in their yearly payment updates.

Q2: What does the new Medicare law require that a hospital do in order to receive a full payment update?

A2: Section 501(b) of the MMA requires that certain inpatient hospitals submit quality data to CMS on a set of 10 indicators in order to receive a full payment update. Hospitals that do not submit data in a form and manner, and at a time that CMS specifies, will have their payment update reduced by 0.4 percentage points for fiscal years 2005-2007.

Q3: What are the requirements a hospital must meet in order to receive the full annual payment update under the new MMA?

A3: A hospital must do the following three things.

1. Register with QualityNet Exchange by **June 1, 2004.**

2. Notify CMS at the time that it registers, or prior to August 1, 2004, that it will participate in reporting the required data specifically for the purpose of the annual update.

3. Begin submission of its quality data no later than **July 1, 2004**.

Q4: How does the hospital register with QualityNet exchange?

A4: Go to the QualityNet Exchange secure site at www.qnetexchange.org, click on "Getting Started" and proceed with registration using the outlined steps.. The hospital must provide the name of its QualityNet Exchange Administrator. This applies regardless of whether or not they are using a vendor to transmit data. The registration deadline is **June 1, 2004**.

Q5: What if a hospital is already registered with QualityNet exchange as it has been reporting under the National Voluntary Hospital Reporting Initiative (NVHRI)?

A5: Hospitals that have been participating in the NVHRI effort will not have to re-register with QualityNet exchange. However, hospitals that have been voluntarily reporting must notify CMS that they are reporting for purposes of the annual payment update.

Q6: How does a hospital notify CMS that it wants their quality data to be used for purposes of the annual payment update?

A6: Hospitals must explicitly tell CMS the purpose of submitting their quality data. The notification form on www.qnetexchange.org asks the hospital to indicate that it wants the quality data used for the annual payment update.

Reporting Hospital Quality Data for Annual Payment Update
Frequently Asked Questions

Q7: What hospital quality data are required to report for the payment update?

A7: The law stipulates that quality data for the set of 10 indicators for three health conditions are required. The data must be for discharges in the first quarter of 2004 (Discharges occurring between January 1, 2004 and March 31, 2004.). The 10 indicators are the same as the measures contained in the starter set for the National Voluntary Hospital Reporting Initiative (NVHRI). Hospitals participating in the NVHRI who have submitted these 10 quality measures for the fourth quarter of 2003 (October 1, 2003 through December 31, 2003.) will qualify for the update provided they continue to submit the required data for the first quarter of 2004. More detail on the clinical measures outlined below can be found at www.cms.hhs.gov/quality/hospital

- Heart Attack (Acute Myocardial Infarction)
  Was aspirin given to the patient upon arrival to the hospital?
  Was aspirin prescribed when the patient was discharged?
  Was a beta-blocker given to the patient upon arrival to the hospital?
  Was a beta-blocker prescribed when the patient was discharged?
  Was an ACE inhibitor given for the patient with heart failure?

- Heart failure
  Did the patient get an assessment of his or her heart function?
  Was an ACE inhibitor given to the patient?

- Pneumonia
  Was an antibiotic given to the patient in a timely way?
  Had a patient received a pneumococcal vaccination?
  Was the patient's oxygen level assessed?

Q8: Is the hospital to report data only on Medicare patients for these 10 measures?

A8: No, the quality data submitted must be for all payers.

Q9: How does a hospital collect and submit these measures?

A9: A hospital has 3 options for extracting the measures from the patient's medical record and submitting to CMS:

1. The CMS Abstraction and Reporting Tool (CART) offered free to the hospital and supported technically by the Quality Improvement Organization in each state.
2. The Joint Commission on Accreditation of Healthcare Organizations (JCAHOs') ORYX Core Measure Performance Measurement System, which is aligned with the 10 measures and meets the edit requirements for submission to CMS.
3. A third-party vendor who has met the measurement specifications for data transmission (XML file format) into QualityNet Exchange.

Q10: If a hospital submits data using a vendor rather than the CMS CART tool, will it have to take any additional action to ensure CMS receives the data for the annual payment update?

A10: Not necessarily. However, regardless of the option we advise hospitals that, if at all possible, they not wait until the deadline of July 1, 2004 to begin submission. Additionally, the law requires that hospitals have a 30-day period, until August 1, 2004 to make adjustments or edits to their quality data as needed to meet the requirement.

Q11: To meet the reporting requirement for payment update what period of time and for how many patients must the hospital report?

A11: Data must be submitted for all first quarter 2004 discharges (discharges occurring between January 1, 2004 and March 31, 2004,) to meet the payment update requirement. In addition, hospitals participating in the National Voluntary Hospital Reporting Initiative who have submitted these 10 quality measures for the fourth quarter of 2003 (October 1, 2003 through December 31, 2003.) will qualify for the update provided they continue to submit the required data for the first quarter of 2004. For JCAHO accredited hospitals, they must follow the sample size requirements for the Core data sets. Non-JCAHO accredited hospitals must follow the CMS sample size requirements. CMS intends to compare the quality data submitted with the hospital claims data to ascertain a minimum number of eligible patients with these health care conditions.

Q12: Does the submission of hospital quality date for the hospital quality measures meet the payment update requirements under section 501b of MMA replace National Voluntary Hospital Reporting Initiative (NVHRI)?

A12: No. However, these two efforts do interact in the following way. The initial phase of the NVHRI was to publicly report, on a voluntary basis, quality data on a 10 measure starter set. The annual payment update is based upon hospitals providing data specifically for all 10 of these measures. Additional phases of the NVHRI will include additional quality measures and H-CAHPS. When these additional measures are collected, they will be published. For now, hospitals need only submit the 10 measures once. Please see the www.cms.hhs.gov/quality website to review the status of the NVHRI.

Q13: Does a hospital have to provide permission to allow CMS to publish the 10 quality measures to meet the reporting requirements under the MMA?

A13: No. A hospital will not need to provide permission to CMS to publish their 10 quality measures submitted for the Annual Payment Update. The MMA does not prevent the Department of Health and Human Services' Secretary from publishing these measures, and it is the Secretary's intention to publish. The Secretary has the authority, under other provisions of the law, to publish this data. However, as stated, the hospital must explicitly designate that the quality data reported is for the purpose of the annual payment update.

Q14: How will hospitals collect the required quality data?

A14: The information is collected from patient charts. If the hospital is accredited by the JCAHO, the information can be collected through the mechanism the hospital has established to meet the JCAHO reporting requirements. If the hospital is not JCAHO accredited, the hospital can use the CMS Abstraction and Reporting Tool (CART) or another vendor tool that can transmit data in the CMS format or in the XML format as specified by CMS to collect and report

the information to the QIO Clinical Warehouse, via the Quality Net Exchange. For more information on CART and the QIO Clinical Warehouse, see www.qnetexchange.org.

Q15: Will the 10 hospital quality measures specified under MMA be reported for every hospital in the United States?

A15: No. The MMA requirement is for Medicare-certified, acute care hospitals receiving prospective payment reimbursements, i.e., hospitals defined under the Social Security Act, section 1886(d)(1)(B) known as subsection d hospitals. MMA requires that the annual payment update for FY 2005 will be reduced by 0.4 percentage point for hospitals that do not submit the required performance data. However, there is no legal requirement to submit this information. Hospitals that are not impacted by MMA section 501(b)—the annual payment update requirement for section d hospitals—may choose to submit data for the purposes of quality improvement or public reporting.

Q16: Why were these hospital quality measures selected for reporting?

A16: The measures have gone through years of extensive testing for validity and reliability by CMS and its QIOs, the JCAHO, and researchers. Furthermore, the National Quality Forum (NQF), a voluntary consensus-building organization representing providers, consumers, purchasers, and researchers, has endorsed these measures.

Q17: How is data accuracy ensured? Are the data checked?

A17: Yes, measures to ensure data accuracy are in place. There are two phases of data checks. First, the submitted electronic data must pass edits upon submission to the QIO Clinical Warehouse. If the data are submitted through the CMS CART tool, the data will meet those edits. Second, data from selected charts for each hospital that submits data will be audited; a successful audit is not required for the FY 2005 annual payment update. Additional requirements for data accuracy will likely be added for fiscal years 2006 and 2007.

Q18: What assistance will CMS offer to hospitals for public reporting?

A18: CMS will

- provide support for the CMS Abstraction and Reporting Tool (CART), will
- provide assistance to hospitals and vendor contractors to resolve data issues, and,
- will work with hospitals that choose to submit their own data.

In addition, Quality Improvement Organizations, (Medicare contractors that work in each state) will offer support to hospitals to meet the reporting requirements, both in installing and using CART, and in resolving problems that may be revealed after they submit their data. JCAHO-accredited hospitals should not have difficulty meeting the submission standards as they already comply with similar requirements from the JCAHO and they have the contractual relationships in place to obtain the needed support. The CART, is easily installed on a desktop computer and guides hospital staff through the abstraction, automatically edits the data, and electronically transmits the data to the QIO Clinical Warehouse.

Reporting Hospital Quality Data for Annual Payment Update
Frequently Asked Questions

Q19: How does one acquire the CMS Abstraction and Reporting Tool (CART)?

A19: CART is freely available at the Quality Net Exchange web site (www.qnetexchange.org). This application can be downloaded without registration.

Q20: Will QIOs release hospital quality performance data?

A20: No. The DHHS Secretary will request hospital level data from the QIO data warehouse and then publish the data.

Q21: What if a hospital doesn't have any qualifying patients for a required measure or measures? Will a hospital still be eligible for the full annual payment update?

A21: CMS does not expect hospitals to submit data on cases they don't have. CMS is considering a procedure for hospitals to provide notification of a lack of qualifying patients. However, CMS intends to review hospital claims data to ascertain whether Medicare was billed for patients eligible for required measures.

Q22: Which hospitals are required to participate in hospital reporting for the annual payment adjustment? Does this include Indian Health Service, critical access, rehabilitation, or psychiatric hospitals?

A22: Hospitals defined under the Social Security Act, section 1886(d)(1)(B), referred to as subsection d hospitals, are required to participate in data submission and reporting to be eligible to receive the full annual payment update.

Q23: Will hospitals also have the opportunity to check the accuracy of the data before it is published?

A23: CMS will afford hospitals a preview period, which will allow them time before publication to check the data.

Q24: In the preview period for the FY 2005 annual payment update, can a hospital change the to-be-published data?

A24: The preview period is an opportunity for a hospital to be aware of what will be published regarding its calculated aggregate measures**.** Hospitals cannot change submitted data or submit additional data for that publication; additional data will be included in a later publication. During the preview period, hospitals may work to correct publication errors, but data at the record level cannot be changed for the publication.

Q25: Can hospitals submit quality data for the ten quality measures to receive the full annual payment update and then request the data not be published?

A25: No. Once data for the ten quality measures are submitted and the hospital has notified CMS that it will participate in reporting for the annual payment update, it is the Secretary's intention that the aggregate measures calculated from that data be published.

Reporting Hospital Quality Data for Annual Payment Update
Frequently Asked Questions

Q26: Can a hospital use the QIO Clinical Warehouse for its own use to store and manage its own confidential quality improvement data and not have that data used for the annual payment update or public reporting?

A26: Yes. A hospital can use the QIO Clinical Warehouse for its own confidential quality improvement data and the data will not be published. However, if a hospital chooses not to participate in the annual payment update data submission, the hospital will be subject to a 0.4 percentage point reduction to its annual payment update. In the absence of an explicit notification to CMS that a hospital wants its data used for the annual payment update or for voluntary reporting, the data in the QIO Clinical Warehouse remains for the hospital's confidential use in conducting its own internal quality improvement.

Q27: Is the public release/reporting of data required to receive the full annual payment update?

A27: The statute states that the data must be 'submitted' to the Secretary. The Secretary has the authority to publish this data and intends to do so. The Secretary will use the data to fulfill a strong commitment to providing useful information to the public and creating a strong incentive to health professionals to improve care.

Q28: Will the HIPAA Privacy Rule affect a hospital's ability to report data under §501(b) of the MMA?

A28: To some extent; 45 CFR 164.512(d) of the Privacy Rule permits covered entities – in this case hospitals – to make disclosures without patient consent when they are participating in an agency's oversight functions. CMS views the quality initiative as one of its oversight activities. Hospitals can, therefore, submit the necessary information under §501(b) without patient consent. However, there are accounting requirements in §164.512 of the Privacy Rule that do apply, even for oversight activities. Hospitals must maintain an accounting of the information they disclose, as described in that provision. You may want to check the Office of Civil Rights HIPAA website http://www.os.dhhs.gov/ocr/hippa for their latest guidance on this issue.

Q29: Will an April 2004 submission of data for discharges occurring during fourth calendar quarter of 2003 for all ten measures be sufficient to meet the requirements to qualify for the FY 2005 annual payment update? Must submission of data specifically for discharges occurring during the first calendar quarter of 2004 be started by July 1?

A29: An April 2004 submission of data for discharges occurring during fourth calendar quarter of 2003 for all ten measures will not be sufficient to meet the requirements to qualify for the FY 2005 annual payment update. A hospital must also notify CMS of its intent to participate and continue submitting quarterly data, including the first calendar quarter of 2004. By submitting fourth quarter data of calendar 2003, the hospital may use the normal data transmission schedule for all subsequent submissions. In particular, hospitals submitting the ten measures for the fourth calendar quarter of 2003 will have until August 15, 2004 to submit the first quarter of calendar 2004. Otherwise, a hospital must begin submitting first quarter for calendar 2004 by July 1, 2004.

Q30: When CMS states that medical record validation will occur later, what do you mean by "later"?

A30: The validity of the abstracted data is not a requirement for its acceptance or for full payment update in the first year (FY 2005 update); the data must simply pass current data edit checks. In subsequent years, we expect that the submitted data must match and be verified by the data contained in the medical record.

Q31: Will there be regulations regarding the differential payment under section 501b of MMA? If so, when will these regulations be available?

A31: CMS will use the annual Inpatient PPS rule to make the appropriate changes in regulatory language to implement the revised annual payment update. The final rule will be published no later than August 1, 2004.

Q32: When is the preview period for the publication of the data for the FY 2005 annual payment update? When will it be available to view by hospitals?

A32: This is uncertain, but is currently under discussion at CMS. The earliest date for this would be during late fall of 2004.

Q33: After the August 1, 2004 deadline (July 1 plus the 30 day grace period), how long does CMS anticipate it will take to process, review, and correct the quality data?

A33: CMS projects that by August 15, 2004 it will process the data and generate a list of those hospitals whose data met statutory requirements and are eligible for the full annual payment update for FY 2005. The actual publication of the data on the CMS website will follow.

Q34: How will the claims processing system distinguish between hospitals that receive the full annual payment update and those that received the 0.4% reduction?

A34: CMS is beginning to work on the systems changes that will be required to make correction payments. At this time, we anticipate that a file will be developed with the provider numbers of those hospitals that have met the data submission requirement. The PRICER logic will be modified to provide the full update for those hospitals that are on the list, and to use the reduced update for those that are not. However, this is only our preliminary thinking, and it may be subject to change as we work through the systems issues. We anticipate, however, that we will be able to make payments correctly under this provision beginning October 1, 2004.

Q35: Do hospitals need to collect data on patients of any age with pneumonia? Do hospitals need to collect pneumonia (PNE) based on ICD-9 codes? If so, are the current algorithms for PNE, for example, accurate to measure care for children (i.e. medication recommendations, dosage, etc).

A35: Collection of data should be based on the ICD-9CM codes. The pneumonia measure analysis excludes pediatric patients from the antibiotic selection measure (PNE-2) because they

are not appropriate for children; however, they are included in other measures, e.g. the timing of the antibiotic, blood cultures and smoking cessation measures.

Q36: What are the selection and exclusion criteria for the measures?

A36: The three topic areas covered by the ten measures are acute myocardial infarction (AMI), heart failure, and pneumonia. The detailed specifications for these measures are available at www.qnetexchange.org.

Q37: Is Surgical Infection Prevention (SIP) data required for hospitals to meet the requirements for the annual payment update?

A37: No.

Q38: Is the accelerated CMS data submission schedule for the FY 2005 annual payment update a one-time requirement or is it expected that the CMS and JCAHO data submission will be on the same schedule in the future?

A38: The current CMS data submission schedule is expected to be a one-time change in order to respond to the MMA requirements. It is CMS's plan that the schedule can remain the same as JCAHO's once we adjust to meet the fiscal year 2005 update schedule.

Q39: Given that the CMS pneumonia measure set is different from the JCAHO pneumonia measure set, if a vendor has a hospital that is currently submitting the JCAHO pneumonia set, will CMS accept this measure set? Or will the hospital have to enter the full CMS pneumonia measure set through CART.

A39: CMS will accept either the JCAHO or CMS pneumonia measure set for the purposes of meeting the data submission requirements for the payment update.

Q40: Must hospitals make a request in order to be eligible for the 30-day grace period from July 1 to August 1, 2004?

A40: No. To be eligible for the 30-day grace period, hospitals must have at least a partial data submission by July 1, 2004; hospitals then have until August 1, 2004 to complete their data submission. We strongly encourage submission of data as early as possible to allow maximum time to resolve any data transmission or quality issues.

Q41: The CMS memo 04-040-HD indicates that the data for the Medicare annual payment update must be submitted by July 1, 2004 with a 30-day grace period until August 1, 2004. Many hospitals have set up their data systems to accommodate the original CMS August 15, 2004 deadline to submit data to the QIO Clinical Warehouse. Is it possible for CMS to change these deadlines so they are the same?

A41: No. It is not possible for CMS to change the data submission deadlines for the FY 2005 annual payment update as the list of qualifying hospitals must be compiled and finalized by

August 15, 2004 in order to make the necessary calculations. Our intent is to try to align these deadlines in the future.

Q42: If CMS intends to publish the quality measure data submitted for the annual payment update, what will happen to the NVHRI data that is posted on the CMS website? Will the NVHRI data still be posted or will NVHRI go away?

A42: The ten measures currently reported for the NVHRI are the same measures required for the FY 2005 annual payment update; section 501b effectively replaces this first phase of NVHRI. The plan is to publish the quality data for both the annual payment update (the required ten measures) and the NVHRI (any additional quality measures) on the same site.

Q43: What is the earliest discharge quarter acceptable for the data submitted for the annual payment update? Some hospitals are having difficulty with their third and fourth quarter 2003 data, and they want to confirm that data that will be used for the FY 2005 annual payment update will begin with the first quarter of 2004 and not earlier.

A43: For hospitals that have not been participating in the NVHRI the earliest discharge quarter acceptable for the data submitted for the FY 2005 annual payment update is the first quarter of 2004 (discharges occurring between January 1, 2004 and March 31, 2004). Hospitals participating in the NHVRI that also submitted all 10 quality measures for the fourth quarter of 2003 (October 1, 2003 through December 31, 2003) will qualify for the update provided they continue to submit the required data for the first quarter of 2004 as well as notifying CMS of their intent to submit data for the annual payment update. Hospitals that have been participating in the NHVRI that did not submit data for all 10 measure for the fourth quarter of 2003 must submit first quarter 2004 data to qualify for the annual payment update.

Q44: Will the quality data submitted for the annual payment update that gets published on the CMS website use all payer data?

A44: Yes

Q45: Will CMS use the data being submitted for the fiscal year 2005 annual payment update to award top performers with other incentive payments?

A45: No.