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The Future of MBQIP – Are You Ready?

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Michigan Rural Health Center
January 12th, 2024

Objectives

- Identify the 2025 MBQIP measures
- Understand 2025 MBQIP data elements, submission mechanisms, and deadlines
  - OP-22 Left without being seen
- Identify resources and available technical assistance to support MBQIP in your state

About Telligen

50 years providing expertise and solutions that produce true, measurable results

Team Telligen is made up of more than **600 clinical and technical** professionals supporting clients nationwide

As a **100-percent employee-owned** company, our employee-owners drive our business, our solutions and share in our success

RQITA Team

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Role of Rural Quality Improvement Technical Assistance Center (RQITA)

- RQITA's goal is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of Federal Office of Rural Health Policy (FORHP) quality initiatives, which are focused on quality measure reporting and improvement:
  - Medicare Rural Hospital Flexibility (Flex) Program Medicare Beneficiary Quality Improvement Project (MBQIP)
- Intended to add expertise related to quality reporting and quality improvement, not to replace technical assistance support already in place

- **Resources and Services:**
- Monthly Newsletter
- Up-to-date resources, guides, and tools
- 1:1 technical assistance
- Learning and action webinar events
- Recorded trainings
- TASC Rural Center website here

Current MBQIP Measure Re-cap

What is the benefit of MBQIP to CAHs?

- **Demonstrate value and quality of care to the community**
- Engage in quality improvement initiatives with rural peers and experts
  - Improve patient experience
  - Empowering persons and clinicians to make decisions about their health care
- Establish a common set of rural-relevant measures for quality improvement (Patient Safety/Inpatient, Patient Engagement, Care Transitions, Outpatient)
  - Data that drives action
- Increase hospital level capacity for participating in Federal and State reporting programs
  - Value-Based payment programs
- Access to flex program resources and assistance
- Aligns with CAH conditions of participation

Current Core MBQIP Measures

Core MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
HCP/IMM-3 (formerly OP-27): Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**Emergency Department Transfer Communication (EDTC)** 1 composite; 8 elements • **All EDTC Composite** • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results	**ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients • **OP-22:** Patient Left Without Being Seen **The AMI Outpatient measures, OP-2 and OP-3 are being removed by the center for Medicare & Medicaid Services (CMS) following submission of Quarter 1 2023 data.*

2025 MBQIP Measure Core Set

Implementation Timeline

2023:
Hospitals continue reporting the existing MBQIP core measures.

2024:
Hospitals continue reporting the existing MBQIP core measure set.
Hospitals put processes in place so they can collect and report data from the 2025 calendar year.
Hospitals are encouraged to start reporting on the measures that will be new in MBQIP 2025 as soon as they are able.

2025:
Hospitals collect data to reporting on the MBQIP 2025 core measure set as part of the flex program.

MBQIP Implementation Timeline for State Flex Programs for the 2025 MBQIP Core Measure Set

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SEPT 2023
FORHP shares new MBQIP core set with State Flex Programs

State Flex Programs share feedback and questions with FORHP

FORHP assesses TA needs, begins building resources

DEC 2023
Access FLEX NOFO

Strategize work plan for upcoming program cycle

MAR 2024
Submit Flex NOFO application

SEPT 2024
Prepare CAHs to participate in new MBQIP core measure reporting

Share questions and feedback from hospitals with FORHP

Support hospitals in reporting MBQIP core measures

SEPT 2025
Start tracking non-reporting CAHs in spreadsheet provided by FORHP (to be released spring of 2024)

Start collaborative and/or state specific QI cohort projects

***NOTE: Reporting timeframes for hospitals vary by measure. Please check the MBQIP Measure Reporting Chart for all specific measure reporting submission deadlines**

SEPT 2026
Continue tracking non-reporting CAHs in reporting template (states)

Continue collaborative and/or state specific QI cohort projects

NOV 2026
Submit tracking spreadsheet for non-reporting CAHs from September 1, 2025, to August 31st, 2026, with FLEX end of year report

Plan and Prepare for Reporting | **Begin Reporting** | **Continue Reporting**

- Moving from 4 domains to 5 domains
- Align with existing quality reporting programs
- Final “launch” date: September 1, 2025

2025 MBQIP Core Measure Set

- 6 new measures (noted in blue)
- 12 Total Measures
  - 9 submitted annually
  - 3 submitted quarterly

2025 MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
• **CAH Quality Infrastructure *(annual submission)***	• Healthcare Personnel Influenza Immunization *(annual submission)*	• Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	• **Hybrid Hospital-Wide Readmissions *(annual submission)***	• Emergency Department Transfer Communication (EDTC) *(quarterly submission)*
• **Hospital Commitment to Health Equity *(annual submission)***	• Antibiotic Stewardship Implementation *(annual submission)*		• **SDOH Screening *(annual submission)***	• OP-18 Time from Arrival to Departure *(quarterly submission)*
	• **Safe Use of Opioids (eCQM) *(annual submission)***		• **SDOH Screening Positive *(annual submission)***	• OP-22 Left without Being Seen *(annual submission)*

Global Measures

CAH Quality Infrastructure

CAH Quality Infrastructure

Measure Description: Specifications for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the National CAH Quality Inventory and Assessment.

Structural measure to assess CAH quality infrastructure based on the nine core elements of CAH quality infrastructure:

1. Leadership Responsibility & Accountability
2. Quality Embedded within the Organization's Strategic Plan
3. Workforce Engagement & Ownership
4. Culture of Continuous Improvement through Behavior
5. Culture of Continuous Improvement through Systems
6. Integrating Equity into Quality Practices
7. Engagement of Patients, Partners, and Community
8. Collecting Meaningful and Accurate Data
9. Using Data to Improve Quality

CAH Quality Infrastructure Continued

Measure Rationale: This measure will provide state and national comparison information to assess your CAH infrastructure, QI processes, and areas of improvement for each facility. Using this measure, SFPs can plan quality activities to improve CAH quality infrastructure. Data will provide timely, accurate, and useful CAH quality-related information to help inform state-level technical assistance for CAH improvement activities. This measure will provide hospital and state-specific information to help inform the future of MBQIP and national technical assistance and data analytic needs.

Calculations: Hospital score can be a total of zero to nine points (one point for each element, must meet each of element's criteria to receive credit).

CAH Quality Infrastructure Continued

Measure Submission and Reporting Channel: Annual submission through National CAH Quality Inventory and Assessment via FMT-administered Qualtrics platform

Resources to support you:

****Specifications for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the National CAH Quality Inventory and Assessment.****

More information about the Core Elements of Quality Infrastructure and the Assessment can be found below:

Building Sustainable Capacity for Quality and Organizational Excellence | National Rural Health Resource Center (ruralcenter.org)

MBQIP 2025 Information Guide

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Global Measures

Hospital Commitment to Health Equity

Hospital Commitment to Health Equity

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Measure Description: This structural measure assesses hospital commitment to health equity.

Hospitals will receive points for responding to questions in five (5) different domains of commitment to advancing health equity.

- Domain 1 – Equity is a Strategic Priority
- Domain 2 – Data Collection
- Domain 3 – Data Analysis
- Domain 4 – Quality Improvement
- Domain 5 – Leadership Engagement

Hospital score can be a total of zero (0) to five (5) points (one point for each domain, **must attest "yes" to all sub-questions in each domain**, no partial credit).

Hospital Commitment to Health Equity

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Measure Rationale: The recognition of health disparities and inequities has been heightened in recent years and it is particularly relevant in rural areas. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid. The intent of this measure is to help ensure hospitals are considering and addressing equity in the care they provide to their community.

Calculation: Hospital score can be a total of zero to five points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial credit)

Improvement Noted As: Increase in the total score (up to 5 points).

Hospital Commitment to Health Equity

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Data Elements:

Domain 1 – Equity is a Strategic Priority

Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all the following elements (note: attestation of all elements is required to qualify for the numerator).

A. Our hospital strategic plan identifies priority populations who currently experience health disparities.
B. Our hospital strategic plan identifies healthcare quality goals and discrete action steps to achieve these goals.
C. Our hospital strategic plan outlines specific resources which have been dedicated to achieve our equity goals.
D. Our hospital strategic plan describes our approach for engaging key stakeholders such as community-based organizations.

Hospital Commitment to Health Equity

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Data Elements:

Domain 2 – Data Collection

Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator):

A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.

B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.

C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology.

Hospital Commitment to Health Equity

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Data Elements

Domain 3: Data Analysis

Please attest that your hospital engages in the following activities (note: attestation in all elements is required to qualify for the numerator)

A. Our hospital strategies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

Domain 4: Quality Improvement

Select all that apply (note: attestation in all elements is required to qualify for the numerator)

A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Hospital Commitment to Health Equity

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Data Elements

Domain 5: Leadership Engagement

Please attest that your hospital engages in the following activities. Select all that apply. (note: attestation in all elements is required in order to qualify for the numerator).

A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for health equity.

B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Hospital Commitment to Health Equity

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Encounter Period: Calendar year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (AKA measurement period) is January 1, 2025, through Dec 31, 2025. The first MBQIP submission deadline date is May 15, 2026.

Data Source: Multiple sources

Data Collection Approach: Attestation

Measure Submission and Reporting Channel: This is an annual attestation measure submitted through the Hospital Quality Reporting (HQR) secure portal.

Resources to Support You

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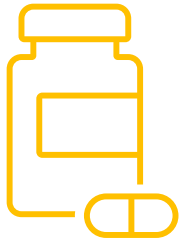
- Attestation Guidance for Hospital Commitment to Health Equity Measure
- Rural Health Disparities Overview – Rural Health Information Hub
- Rural Health: Addressing Barriers to Care
- MBQIP 2025 Information Guide

Patient Safety

Patient Safety Domain



Safe Use of Opioids – Concurrent Prescribing

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Measure Description: Proportion of inpatient hospitalizations for patients 18 years or older, prescribed or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.

Measure Rationale: Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten (10) times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.

Improvement noted as: Decrease in rate

Safe Use of Opioids – Concurrent Prescribing

RQITA RESOURCE CENTER

Encounter Period: Calendar Year (January 1 – December 31)
First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (AKA measurement period) is January 1, 2025, through Dec 31, 2025. The first MBQIP submission deadline date is February 27, 2026.

Data Source: Certified electronic health record technology (CEHRT)

eCQM Identifier: 506v6

Data Collection Approach: Chart extracted via QRDA category I file

Measure Submission and Reporting Channel: Annually, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

Safe Use of Opioids – Concurrent Prescribing

Measure Population (determines the cases to submit): Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.

Exclusions: Exclusions include patients with cancer that begin prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.

Numerator: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.

Denominator: Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.

Resources to Support You

- NQF: Quality Positioning System
- Safe Use of Opioids – Concurrent Prescribing | eCQI Resource Center (healthit.gov)
- Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)
- MBQIP 2025 Information Guide

Care Coordination

Care Coordination Domain

Screening for Social Drivers of Health

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Measure Description: The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.

To report on this measure, hospitals will provide:

(1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; **and**

(2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

A specific screening tool is not required to be used, but all areas of health-related social needs must be included.

Screening for Social Drivers of Health

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Measure Rationale: The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement noted as: Increase in rate

Screening for Social Drivers of Health

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Measure Population (determines the cases to abstract/submit): The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Exclusions:

(1) Patients who opt- out of screening; and

(2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Numerator: The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay

Denominator: The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Screening for Social Drivers of Health

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Encounter Period: Calendar Year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (AKA measurement period) is January 1, 2025, through December 31, 2025. The submission deadline date is May 15, 2026

Data Source: Chart abstraction

Calculation: The Screening for Social Drivers of Health measure is calculated by dividing the total number of hospital inpatients who are 18 and older and screened for all five health HRSNs by the total number of patients admitted to a hospital inpatient stay who are 18 or older at the time of admission.

Measure Submission and Reporting Channel: Annual numerator and denominator submission through Hospital Quality Reporting (HQR) system

Resources to Support You

- Screening for Social Drivers of Health Measure Specification
- Frequently Asked Questions: SDOH Measures (August 2023)
- Listing of Various Screening Tools
- Guide to social needs screening (aafp.org)
- Rural Health Disparities Overview - Rural Health Information Hub
- MBQIP 2025 Information Guide

Screen Positive for Social Drivers of Health (SDOH Screening Positive)

Measure Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five health-related social needs (HSRNs): Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Measure Rationale: The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement noted as: This measure is not an indication of performance

Screen Positive for Social Drivers of Health (SDOH Screening Positive)

Measure Population (determines the cases to abstract/submit): The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Numerator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety.

Denominator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Screen Positive for Social Drivers of Health (SDOH Screening Positive)

Encounter Period: Calendar Year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (AKA measurement period) is January 1, 2025, through December 31, 2025. The submission deadline date is May 15, 2026.

Data Source: Chart abstraction

Calculations: The result of this measure would be calculated as **five separate rates.**

Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Measure Submission and Reporting Channel: Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

Resources to Support You

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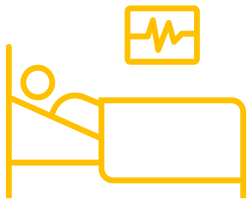
- Screen Positive Rate for Social Drivers of Health Measure Specification
- Frequently Asked Questions: SDOH Measures (August 2023)
- Listing of Various Screening Tools
- Guide to social needs screening (aafp.org)
- Rural Health Disparities Overview - Rural Health Information Hub
- MBQIP 2025 Information Guide



Hybrid Hospital-Wide Readmissions (Hybrid HWR)

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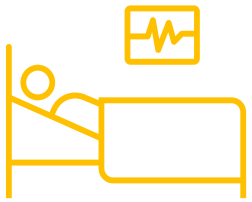
Measure Description: Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone. The Hybrid HWR uses EHR data including clinical variables and linking elements for each patient.

What does hybrid mean? Hybrid measures differ from the claims-only measures in that they **merge electronic health record (EHR) data elements with claims-data** to calculate the risk-standardized readmission rate. **CMS will link elements from claims to the electronic medical record data clinical variables.**



Hybrid Hospital - Wide Readmissions (Hybrid HWR)

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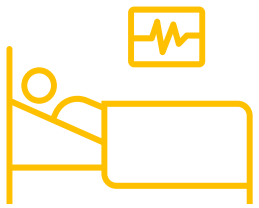
Measure Rationale: Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections, and results in higher costs absorbed by the health care system. High readmission rates of patients with clinically manageable conditions in primary care settings, such as diabetes and bronchial asthma, may identify quality-of-care problems in hospital settings. A measure of readmissions encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions and costs.

Improvement noted as: Decrease in the rate



Hybrid Hospital-Wide Readmissions (HWR)

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(This will come from electronic medical record)

Core Clinical Data Elements

- Heart Rate
- Systolic Blood Pressure
- Respiratory Rate
- Temperature
- Oxygen Saturation
- Weight
- Hematocrit
- White Blood Cell Count
- Potassium
- Sodium
- Bicarbonate
- Creatinine
- Glucose

(This will come from claims data)

For each encounter, please also submit the following Linking Variable:

- CMS Certification Number
- Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
- Date of Birth
- Sex
- Inpatient Admission Date
- Discharge Date

Hybrid Hospital-Wide Readmissions (HWR)

Encounter Period: First MBQIP encounter period - July 1st, 2024 - June 30th, 2025. The submission deadline date is September 30, 2025.

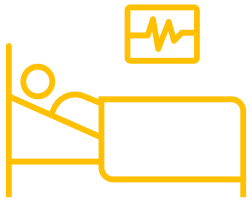
Data Source: Chart abstraction and administrative claims

eCQM Identifier: 529v1

Data Collection Approach: Hybrid – chart extraction of electronic clinical data and administrative claims data.

Measure Submission and Reporting Channel: Annual-Hospital Quality Reporting (HQR) via patient-level file in QRDA I format

****Currently available for submission****



Resources to Support You

- Hybrid Hospital-Wide Readmission Measure Specification | eCQI Resource Center (healthit.gov)
- Reporting the Hybrid Hospital-Wide Readmission Measure to the Hospital IQR Program
- (qualityreportingcenter.com)
- QualityNet hybrid methodology
- Hybrid Measure Overview (cms.gov)
- MBQIP 2025 Information Guide

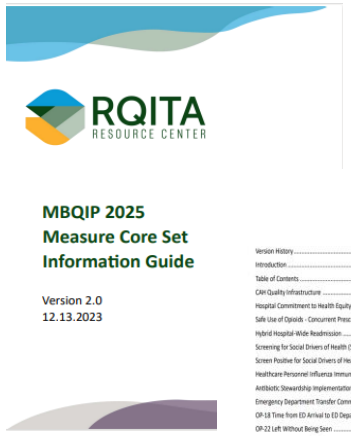
In Summary

Measures in blue are the 2025 MBQIP measures

Measures available for reporting

2025 MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
• **CAH Quality Infrastructure *(annual submission)***	• Healthcare Personnel Influenza Immunization *(annual submission)*	• Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	• **Hybrid Hospital-Wide Readmissions *(annual submission)***	• Emergency Department Transfer Communication (EDTC) *(quarterly submission)*
• **Hospital Commitment to Health Equity *(annual submission)***	• Antibiotic Stewardship Implementation *(annual submission)*		• **SDOH Screening *(annual submission)***	• OP-18 Time from Arrival to Departure *(quarterly submission)*
	• **Safe Use of Opioids (eCQM) *(annual submission)***		• **SDOH Screening Positive *(annual submission)***	• OP-22 Left without Being Seen *(annual submission)*

Hot Off The Press!



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MBQIP 2025
Measure Core Set
Information Guide

Version 2.0
12.13.2023

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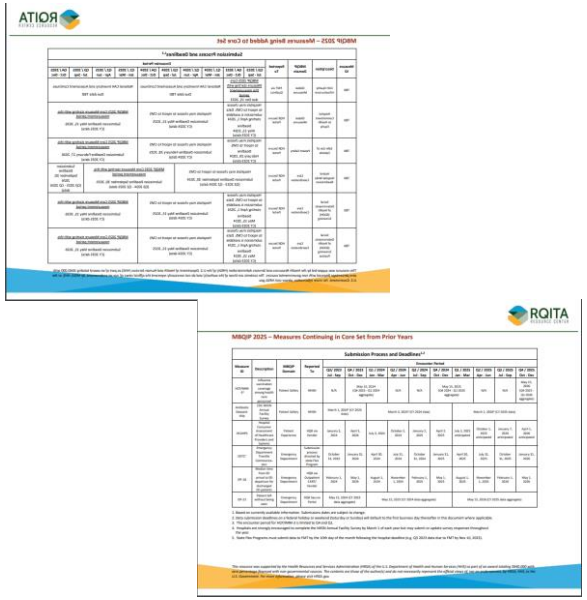
[MBQIP 2025 Information Guide]



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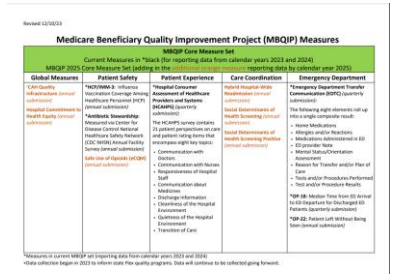
MBQIP 2025 – Measures Being Added to Core Set

MBQIP 2025 – Measures Continuing in Core Set from Prior Years

[MBQIP 2025 Submission Deadlines]



Revised 12/12/23

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

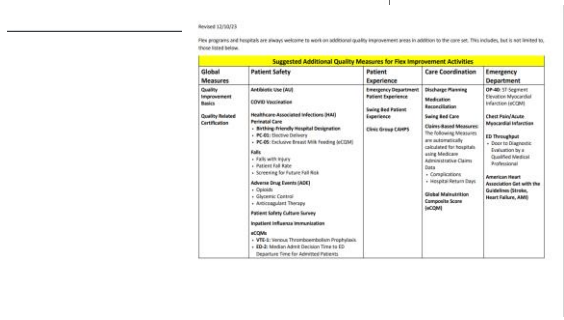
MBQIP Core Measure Set

Current Measures in *black (for reporting data from calendar years 2023 and 2024)
MBQIP 2025 Core Measure Set bolding in the additional six years measures reporting data by calendar year 2025).

Global Measures	Patient Safety	Patient Experience	Care Coordination	Emergency Department
CAH Quality Infrastructure (annual submission) Hospital Commitment to Health Equity (annual submission)	*HCP/HMM-3: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (annual submission) *Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey (annual submission) Safe Use of Opioids (eCQM) (annual submission)	*Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (quarterly submission) The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics: • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care	Hybrid Hospital-Wide Readmission (annual submission) Social Determinants of Health Screening (annual submission) Social Determinants of Health Screening Positive (annual submission)	*Emergency Department Transfer Communication (EDTC) (quarterly submission) The following eight elements roll up into a single composite result: • Home Medications • Allergies to Medications • Medications Ordered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results *OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients (quarterly submission) *OP-22: Patient Left Without Being Seen (annual submission)

*Measures in current MBQIP set (reporting data from calendar years 2023 and 2024)
•Data collection began in 2023 to inform state flex quality program. Data will continue to be collected going forward.

[State Flex Program Key Resources]



Revised 12/12/23

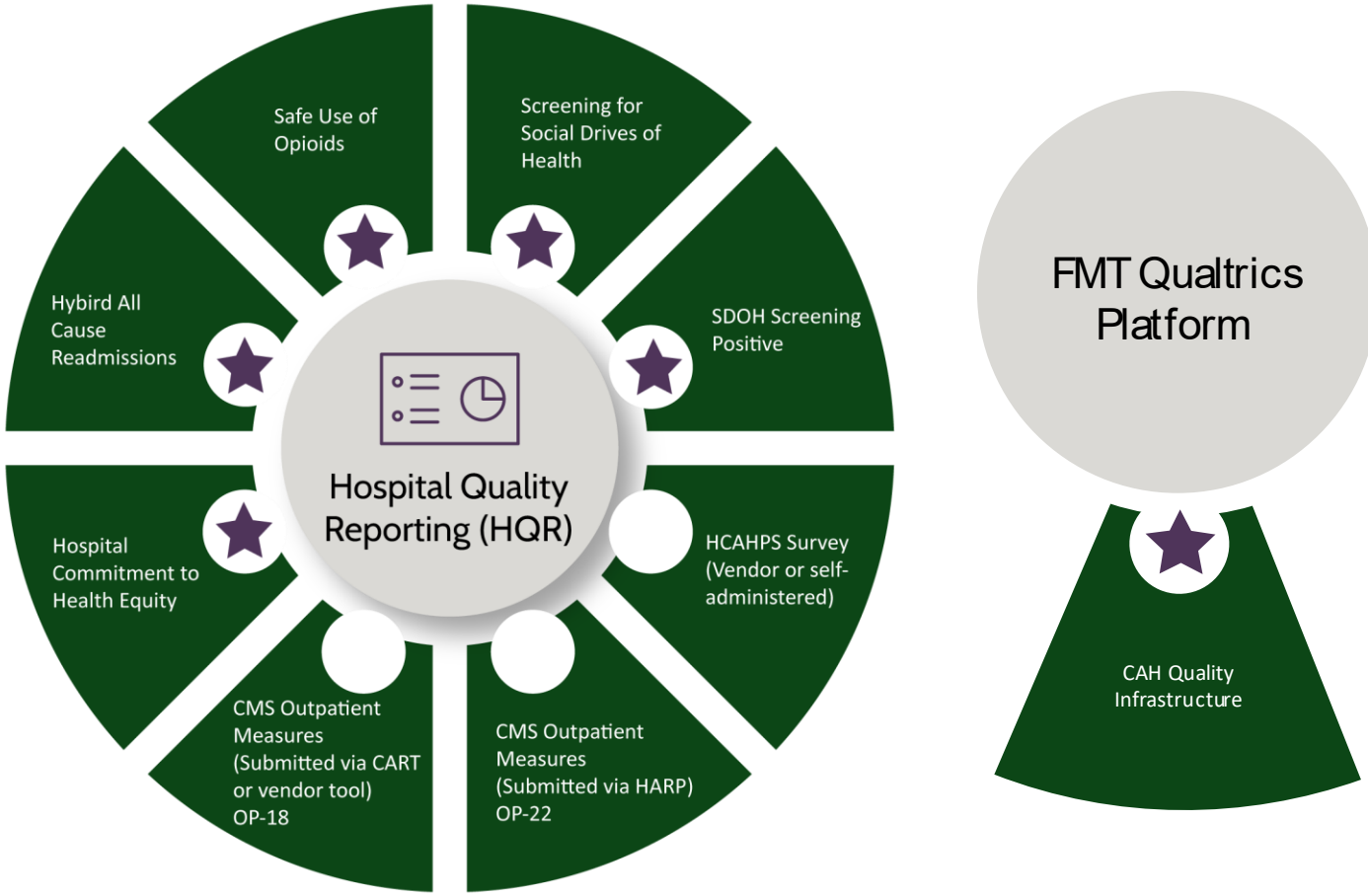
Flex programs and hospitals are always welcome to work on additional quality improvement areas in addition to the core set. This includes, but is not limited to, those listed below.

Suggested Additional Quality Measures for Flex Improvement Activities

Global Measures	Patient Safety	Patient Experience	Care Coordination	Emergency Department
Quality Improvement Rubric Quality Related Certification	Antibiotic Use (AU) COVID Vaccination Healthcare-Associated Infections (HAI) Perinatal Care • Birthing-Friendly Hospital Designation • PC-01: Elective Delivery • PC-05: Exclusive Breast Milk Feeding (eCQM) Falls • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk Adverse Drug Events (ADE) • Opioids • Glycemic Control • Anticoagulant Therapy Patient Safety Culture Survey Inpatient Influenza Immunization eCQMs • VTE-1: Venous Thromboembolism Prophylaxis • ED-1: Median Admit Decision Time to ED Departure Time for Admitted Patients	Emergency Department Patient Experience Swing Bed Patient Experience Clinic Group CAHPS	Discharge Planning Medication Reconciliation Swing Bed Care Claims-Based Measures: The following Measures are automatically calculated for hospitals using Medicare Administrative Claims Data • Complications • Hospital Return Days Global Malnutrition Composite Score (eCQM)	OP-40: ST Segment Elevation Myocardial Infarction (eCQM) Chest Pain/Acute Myocardial Infarction ED Throughput • Door to Diagnostic Evaluation by a Qualified Medical Professional American Heart Association Get with the Guidelines (Stroke, Heart Failure, AMI)

Reporting the Data

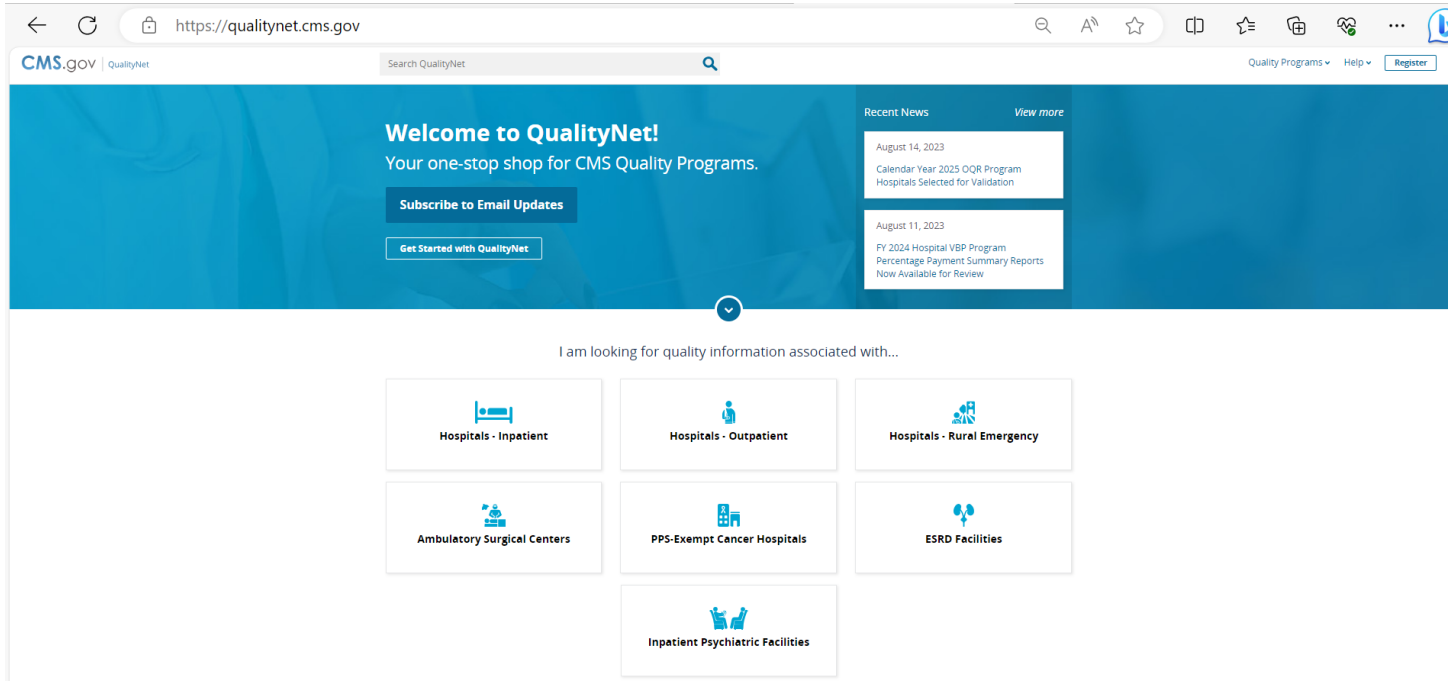
Reporting Channels for 2025 MBQIP Measures



Quality Reporting Center

https://www.qualityreportingcenter.com

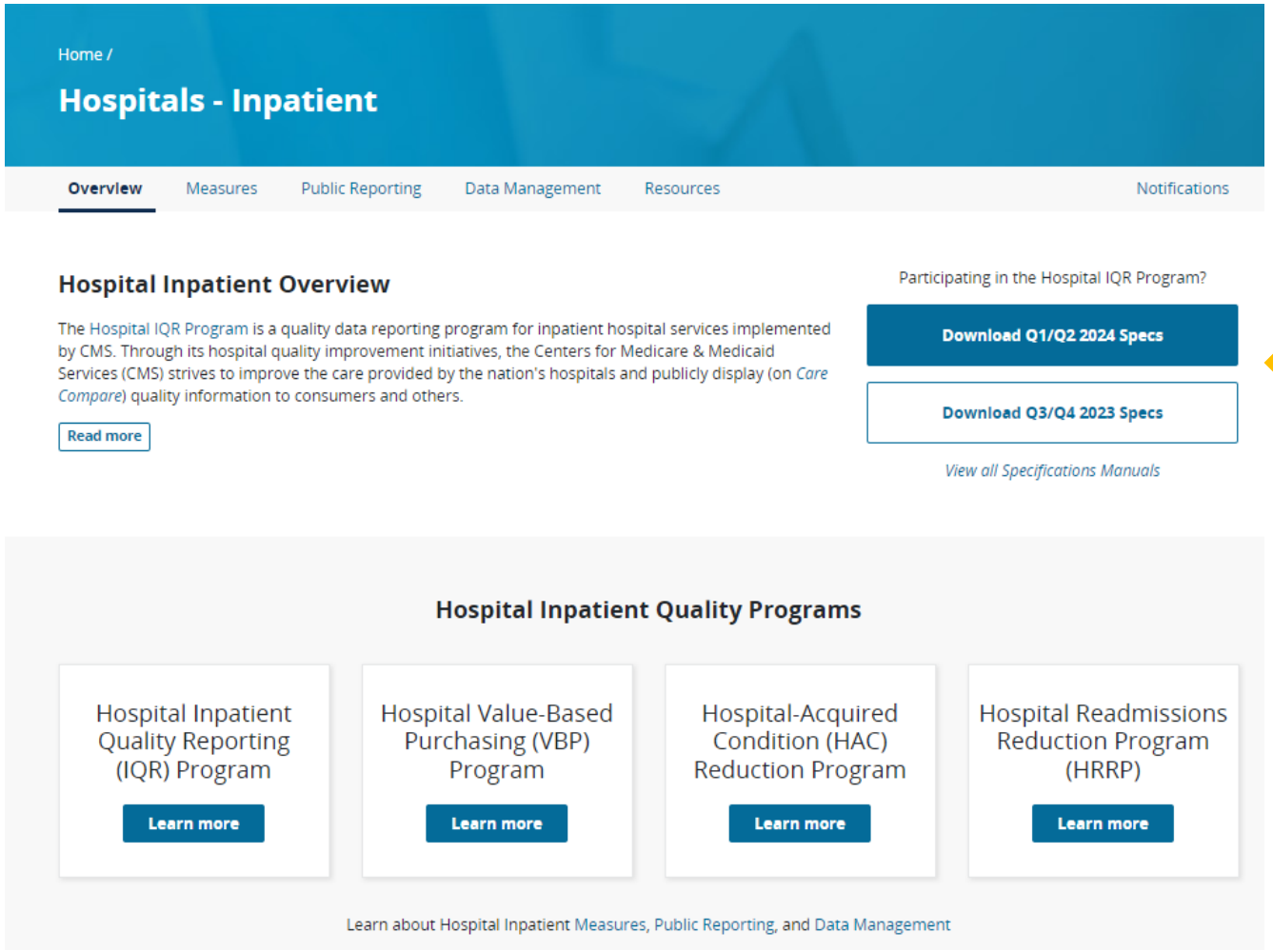
Quality Net



www.qualitynet.cms.gov

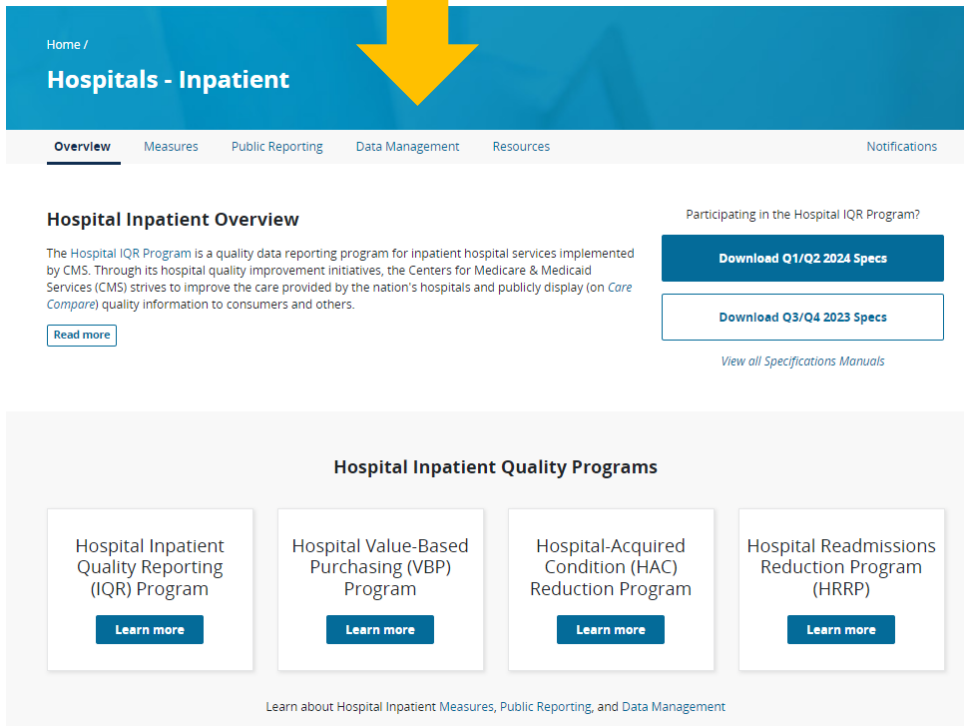
- **Subscribe to Email Listervs**
  - HARP Notify
  - Quality Net Notifications
  - CART Notifications (if you use CART)
  - HIQR and HOQR
- **Locate Measure Specification Manuals**
- **CART Tool**
- **Register for HARP account**

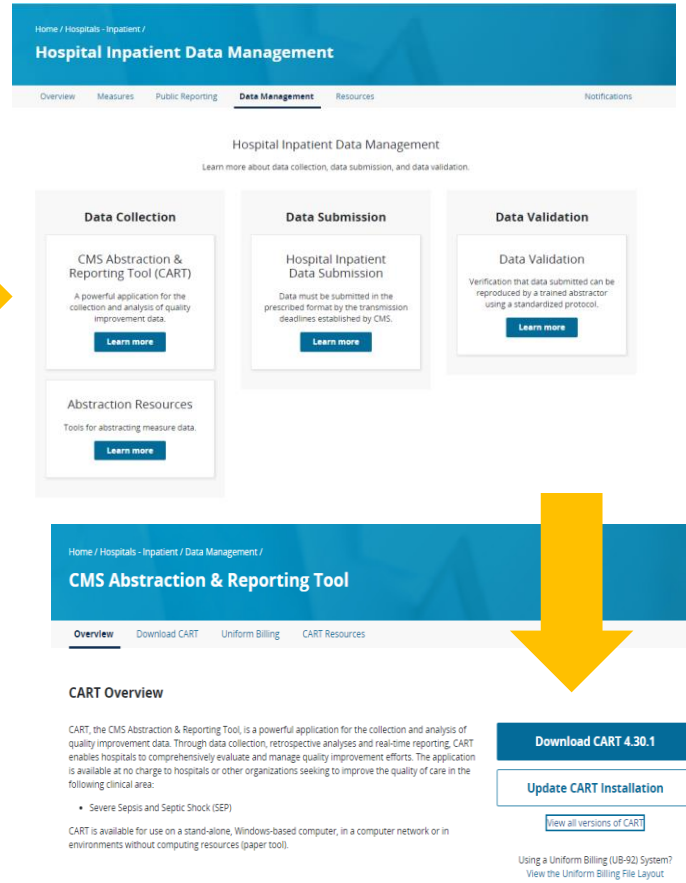
Measure Specification Manual



Locating the CMS Abstraction & Reporting Tool (CART)

(not required for data reporting and submission)





CART Tip!

To see which CART tool version you currently have, click on the ‘About Quality Management System’ link on the ‘Log-In’ screen

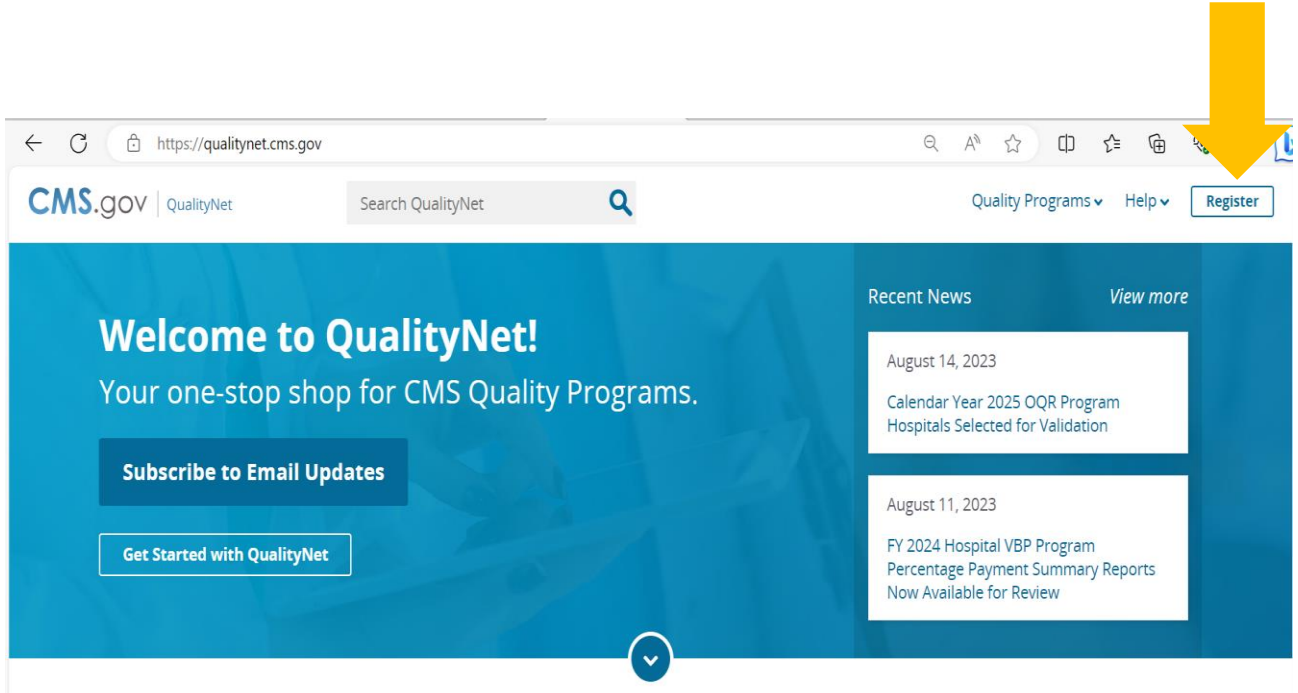
Navigating through CART

There are (5) windows within CART

- Provider
- User
- Patient
- Abstraction Search
- Abstraction

HARP Account (**HCQIS** **A**ccess **R**oles and **P**rofile)

HCQIS (Healthcare Quality Information System): The CMS system responsible for various quality reporting applications

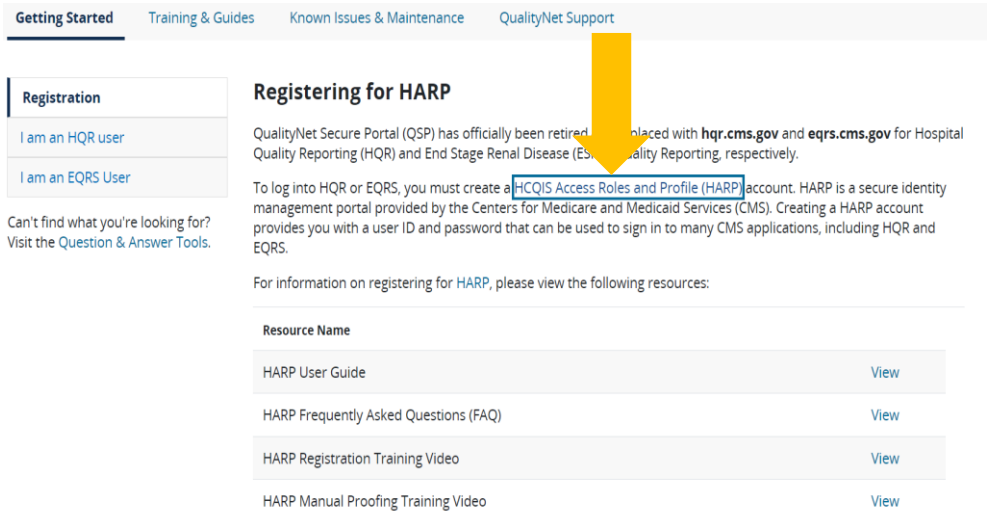


HARP streamlines identify management by:

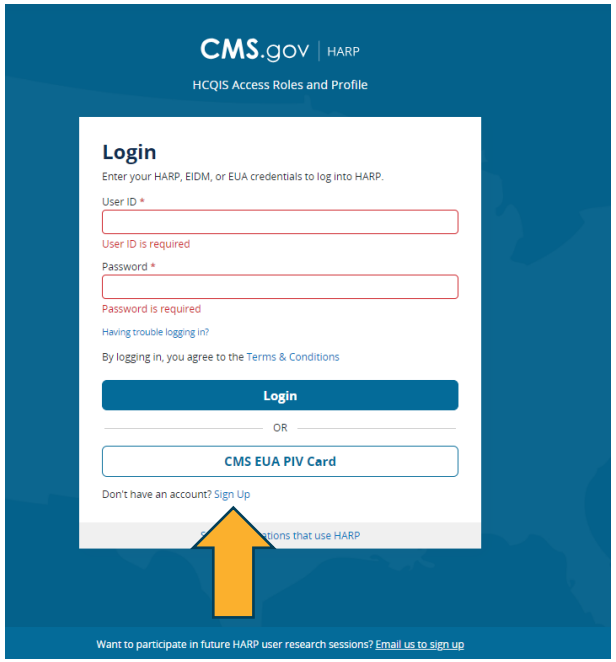
- Allowing users to link and access all their CMS quality organizations with one login
- Authenticating users prior to accessing the portal
- Using one HARP account to access other CMS applications

Register for HARP Account

Step 1: Click on HQIS Access Roles and Profile link

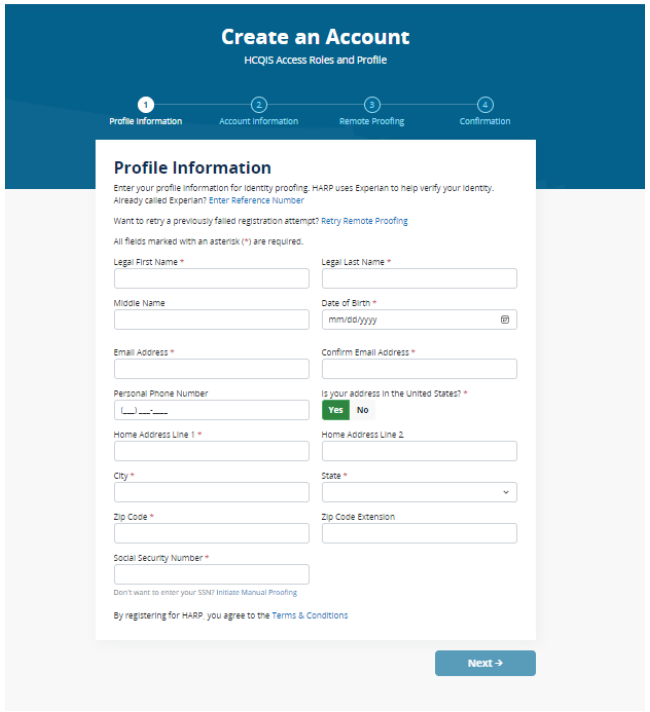


Step 2: Click on 'Sign up' link at the bottom of the login screen

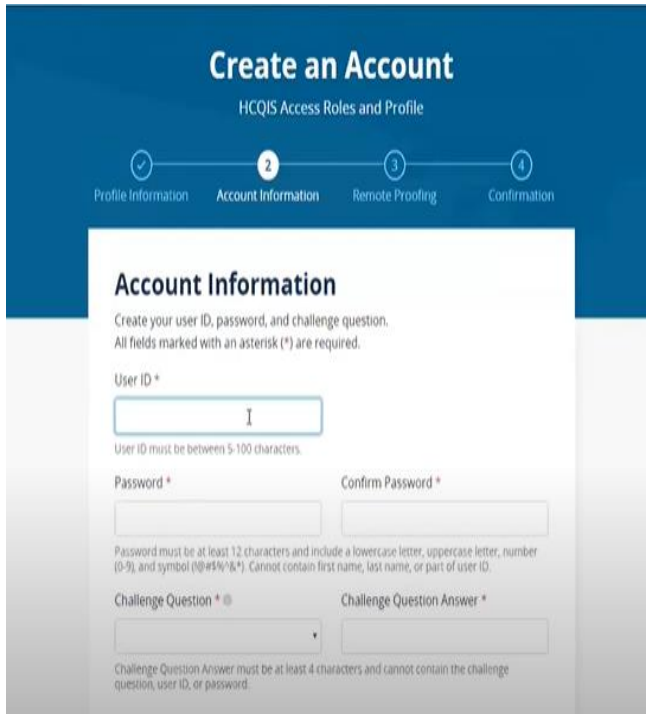


Register for HARP Account

Step 3: Create an Account

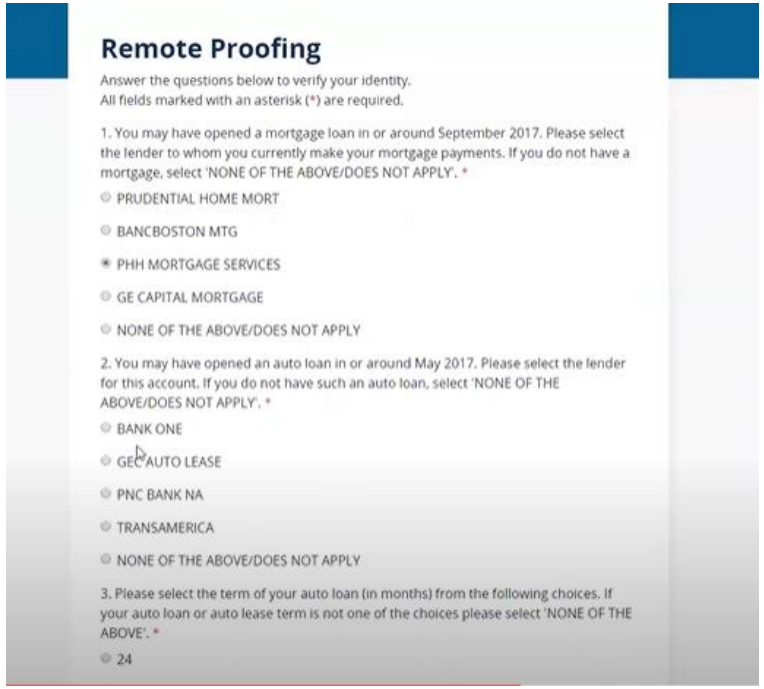


Step 4: Create User ID, password and challenge question

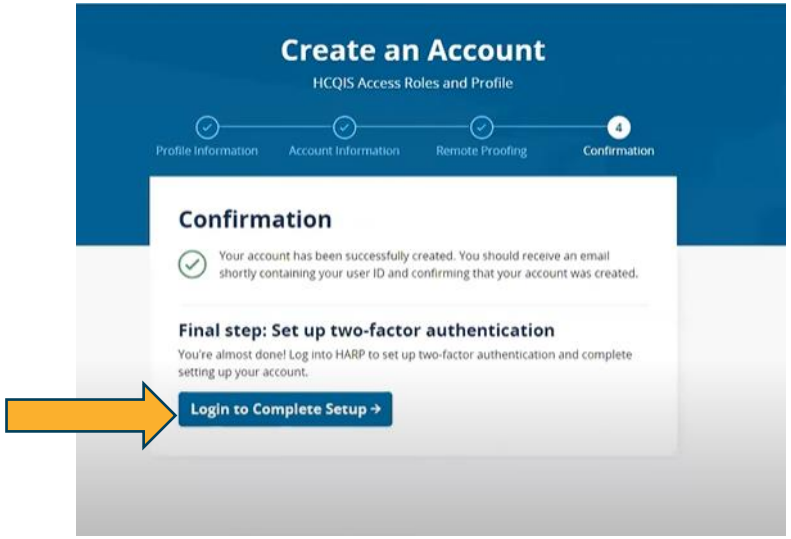


Register for HARP Account

Step 5: Remote Proofing (answer the questions to verify identity)

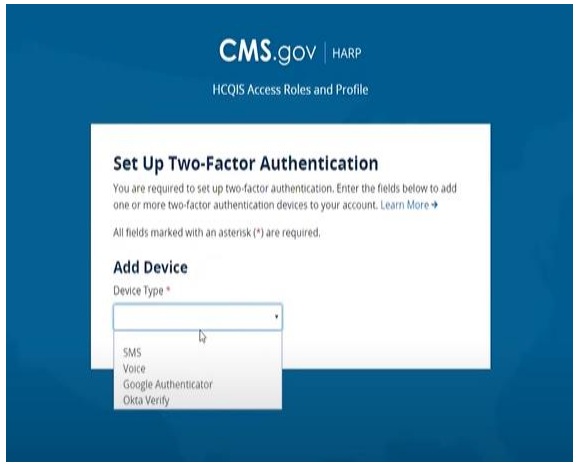


Step 6: Confirmation indicates account creation is complete. Login to complete setup!

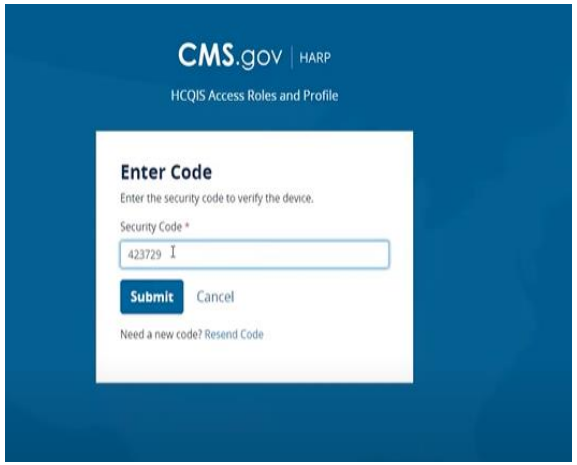


Register for HARP Account

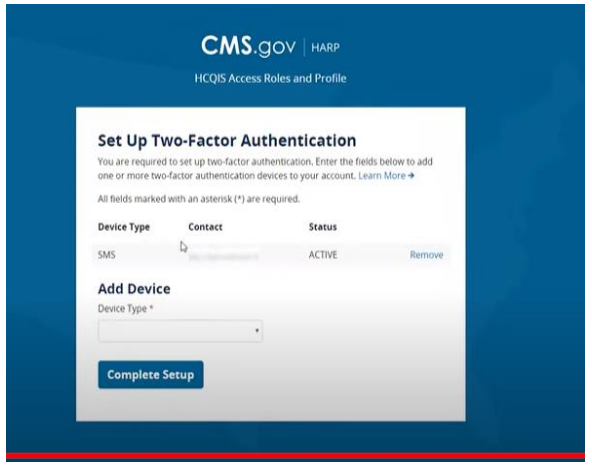
Upon initial login you will be required to set up two-factor authentication.



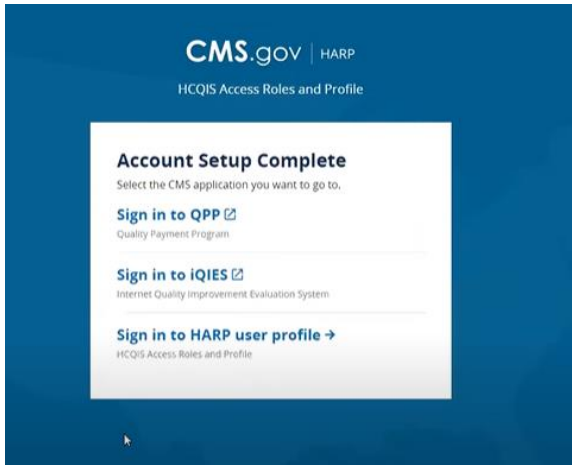
Add device type, and click ‘send code’



Enter code



If you choose, you can add additional devices. This is not required. Click on ‘Complete Setup’



Select the CMS application you want to go to

OP-22 Left Without Being Seen

- Submission Steps

OP-22 Left Without Being Seen

- **Measure Specification Manual**: Hospital OQR **(Starting on page 1-33)*

- **Description**: Percent of patients who leave the Emergency Department (ED) without being evaluated* by a physician/advanced practice nurse/physician's assistant* (physician/APN/PA).

- Annual data submission period **(January 1st – December 31st of reporting year)**

- Data submitted through the Hospital Quality Reporting (HQR) secure site via an online tool

OP-22 Description Definitions

“Evaluated” =

Patients who presented to the ED are those that signed in to be evaluated for emergency services*

“Physician/APN/PA” =

- Patients who are seen by a resident or intern are to be considered as seen by a physician.
- An institutionally credentialed provider, acting under the direct supervision of a physician for healthcare services in the emergency department (e.g., an obstetric nurse providing assessment of an obstetric patient) are to be considered as seen by a physician.
- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are: Nurse Practitioner (NP)
- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist (CNS)
- Certified Nurse Midwife (CNM)

OP-22 Left Without Being Seen

- OP-22 is a Web-Based measure and data can be submitted by file upload **OR** data form.

***Note: The **OP-22** Data Form has only 2 questions:*

***Numerator** – What was the total number of patients who left without being evaluated by a physician/APN/PA?*

***Denominator** – what was the total number of patients who presented to the Emergency Department?*

Hospital Outpatient Clinical Data File Layout

OP-22 Left Without Being Seen
Quick Instructions

To submit via File Upload

- Log into HQR
- Select Data Submission
- Select Web-Based Measures
- Select File upload
- Upload the file

See slides 72-75 for screenshots

To submit via Data Form

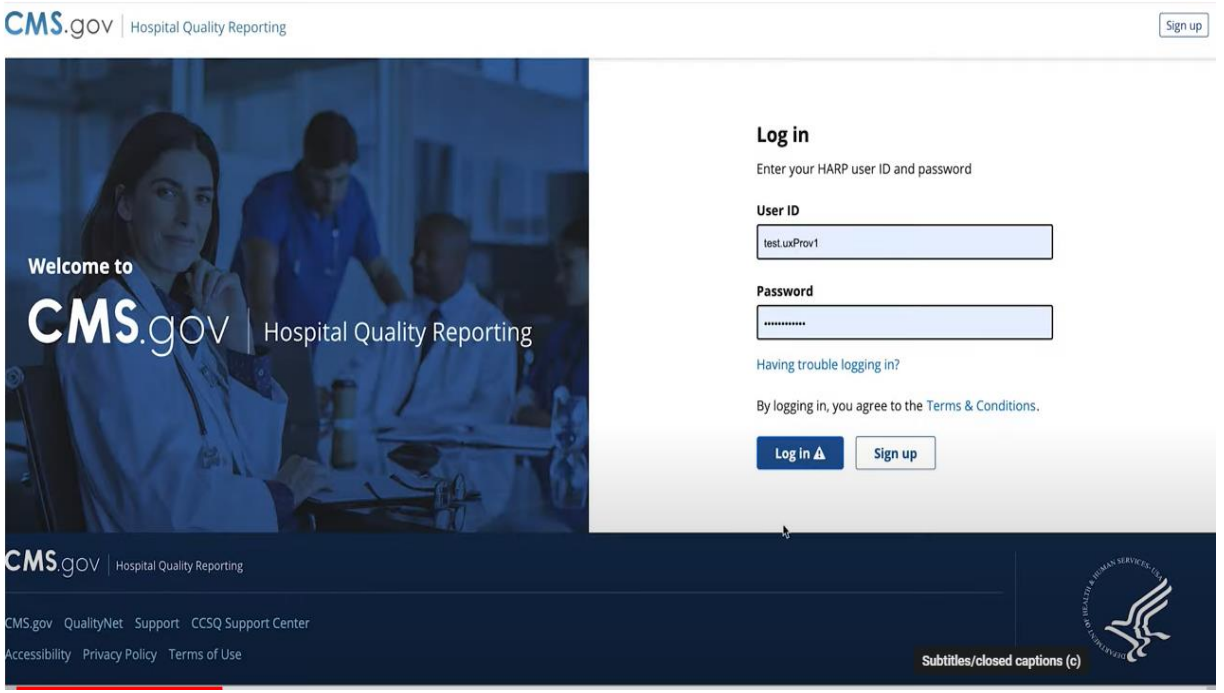
- Log into HQR
- Select Data Submission
- Select Web-Based Measures
- Select Data Form
- Select OQR Launch Data Form and Start Measure
- Enter in the data

See slides 76-82 for screen shots

OP-22 Left Without Being Seen

Step 1

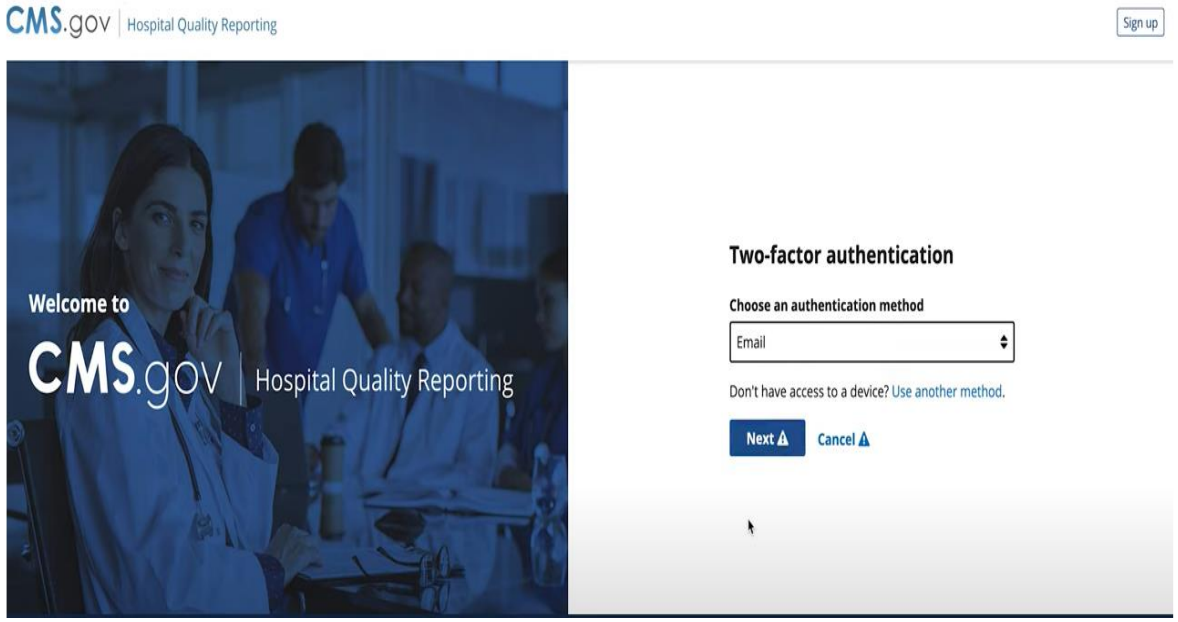
- ❑ Log in to the Hospital Quality Reporting home page using your HARP ID and password



OP-22 Left Without Being Seen

Step 2

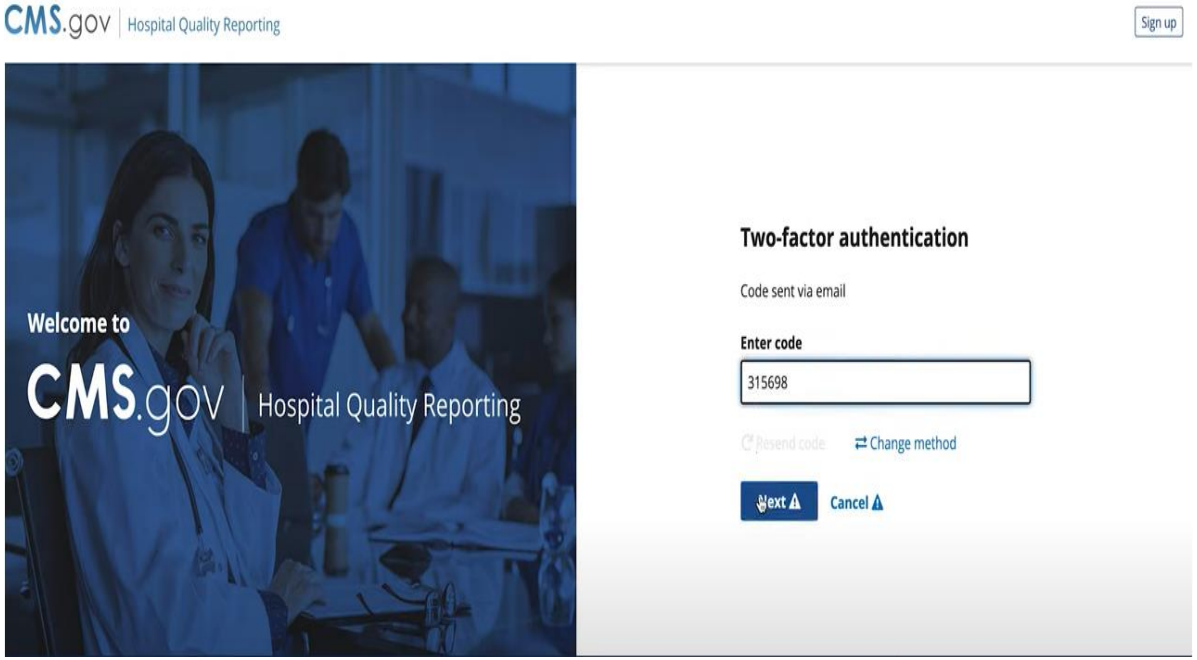
- ❑ Select how you want to receive your two-factor authentication code *if you don't have two-factor authentication set up, you can do so in HARP*
- ❑ Once you chose your method, select 'Next'



OP-22 Left Without Being Seen

Step 3

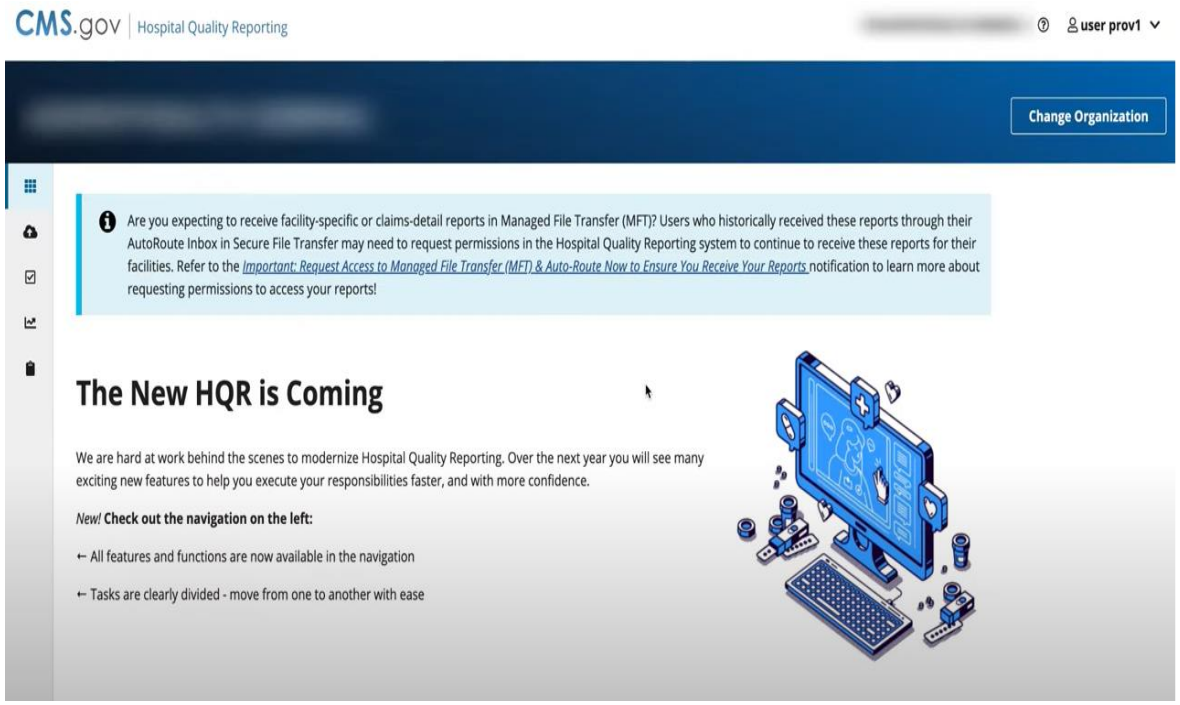
- ❑ Enter in the code you received
- ❑ Select 'Next'



OP-22 Left Without Being Seen

Step 4

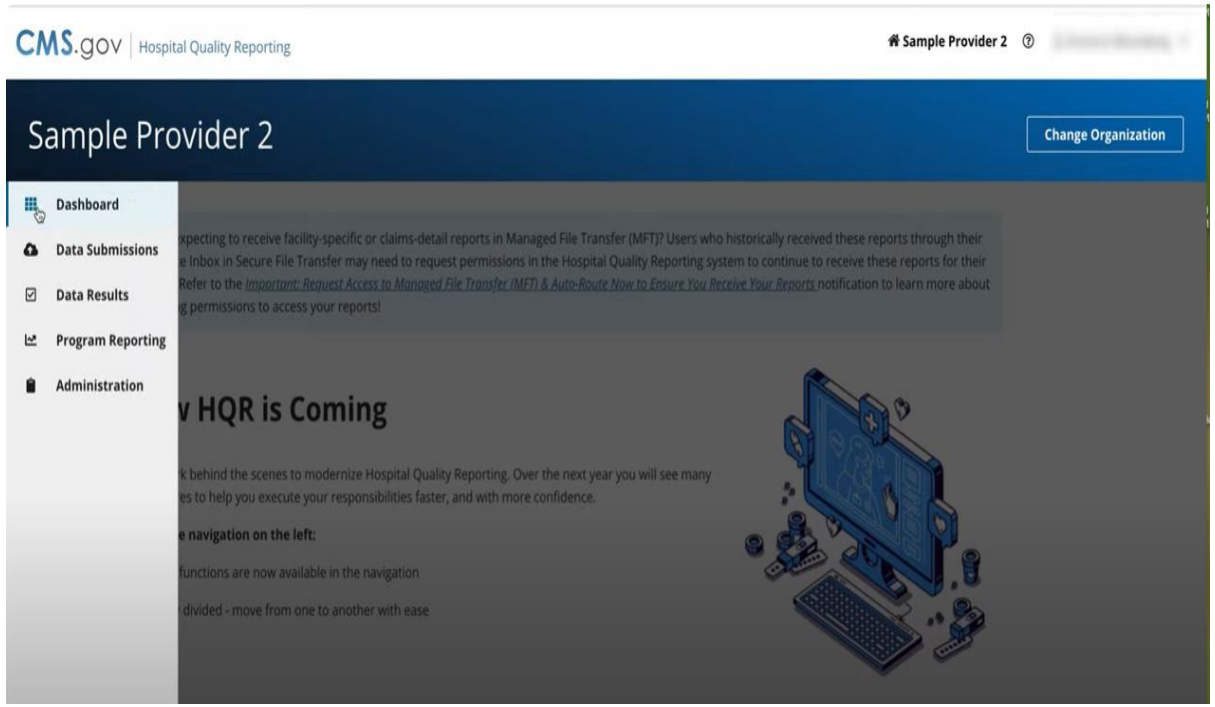
- Once system verifies your code you will be brought to the HQR dashboard (stay tuned for the new HQR) dashboard
- You're now ready to submit by **file upload** or **data form**



To submit OP-22 by File Upload

From the dashboard you'll find data submissions on the left menu

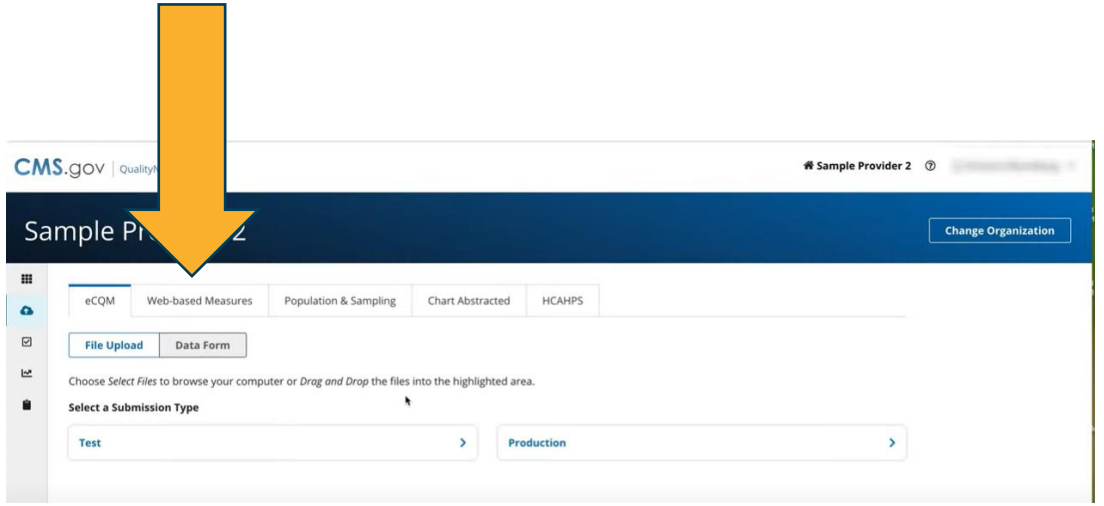
❑Click Data Submission



To Submit OP-22 by File Upload

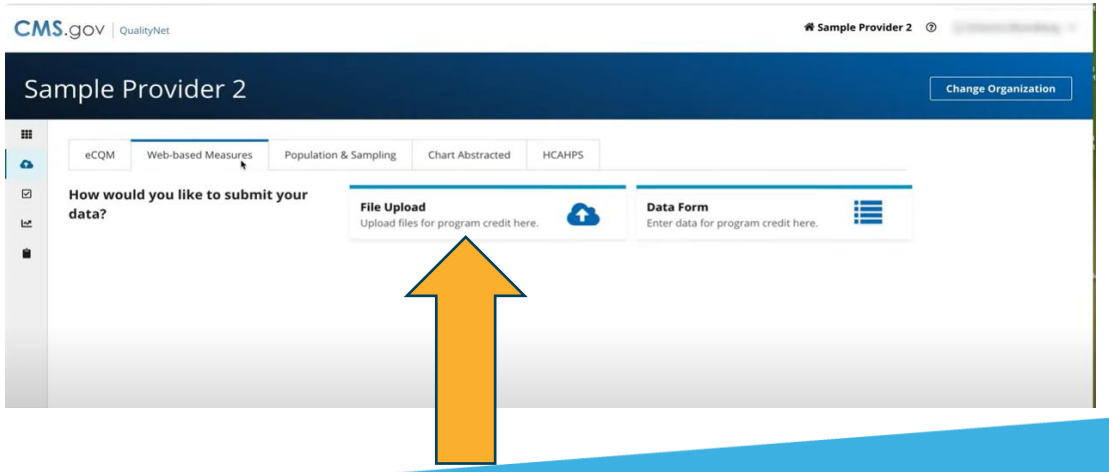
Step 1

- ❑ Select Web-based Measures Tab



Step 2

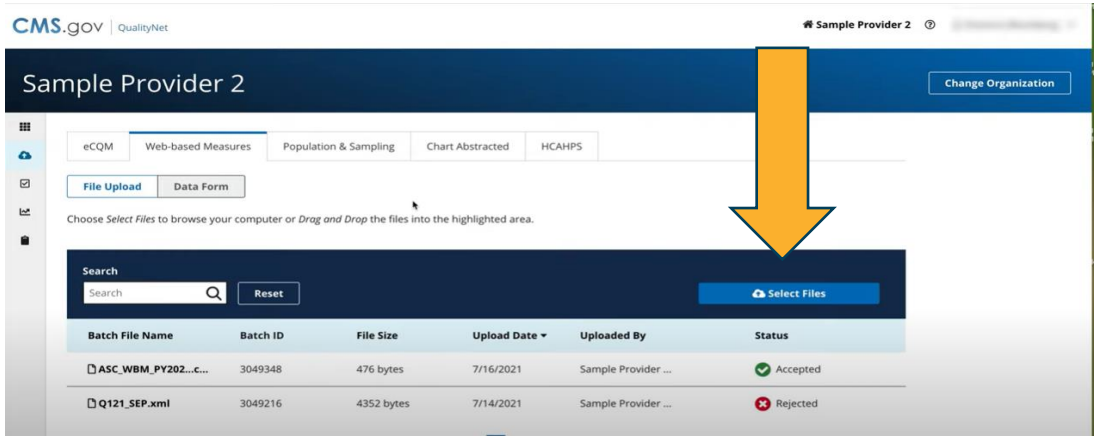
- ❑ Select File Upload



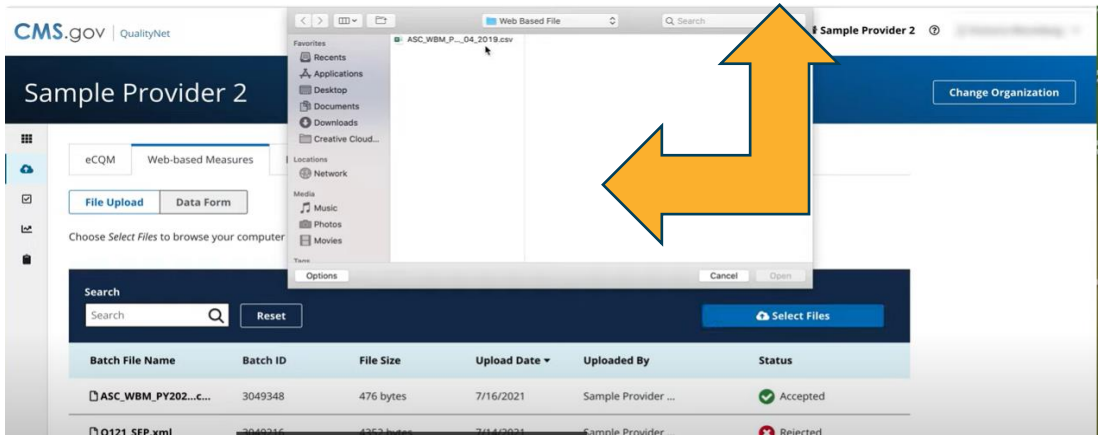
To Submit OP-22 by File Upload

Step 3

- ❑ Choose *Select Files* to browse your computer or *Drag and Drop* the files into the highlighted area here on the upload page



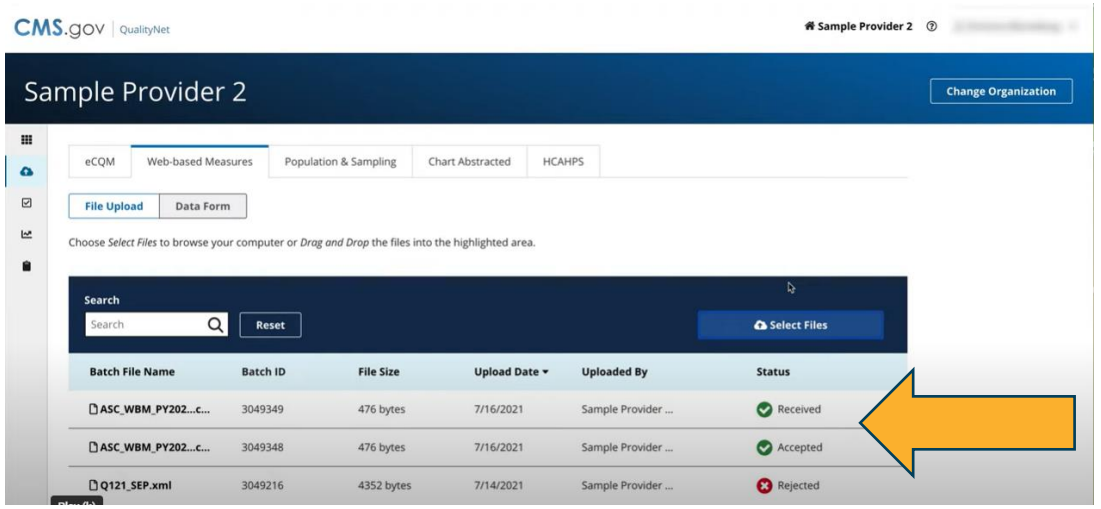
- ❑ Select File from your computer, then open it, you'll see the file processing on the right-hand side of your screen



To Submit OP-22 by File Upload

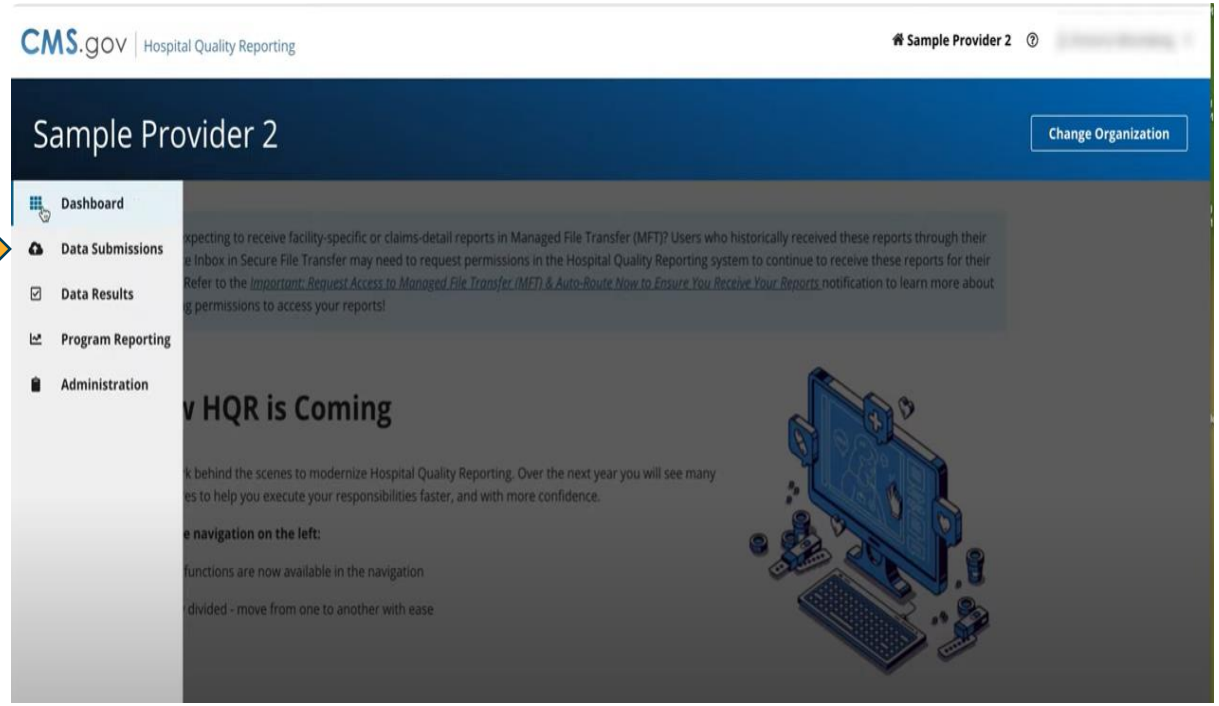
- Once the file is finished processing, it will confirm acceptance with a **'green checkmark'. (First it will say 'Received' and then it will say 'Accepted')**

You're all set!



To submit OP-22 by Data Form

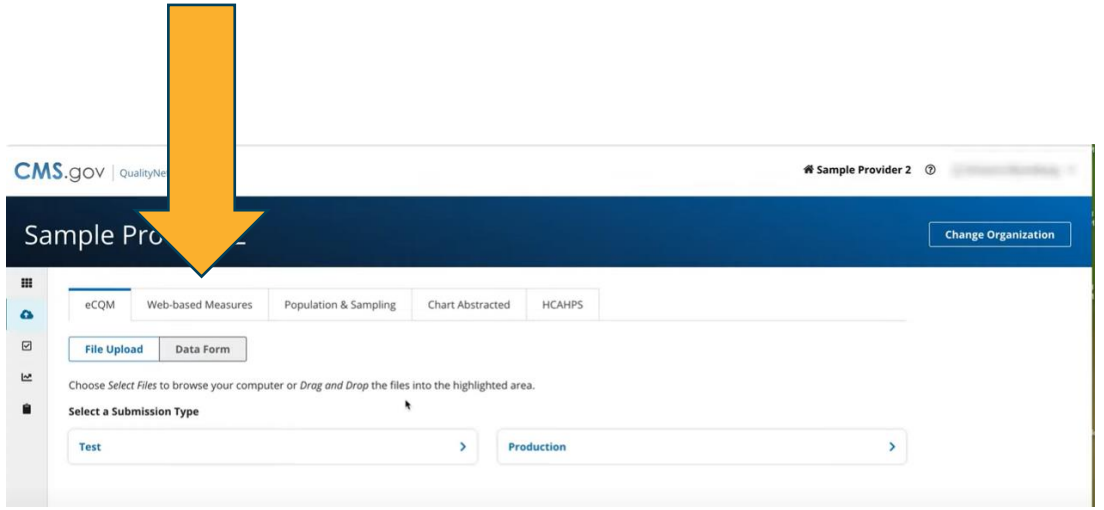
- From the dashboard you'll find data submissions on the left menu



To Submit OP-22 by Data Form

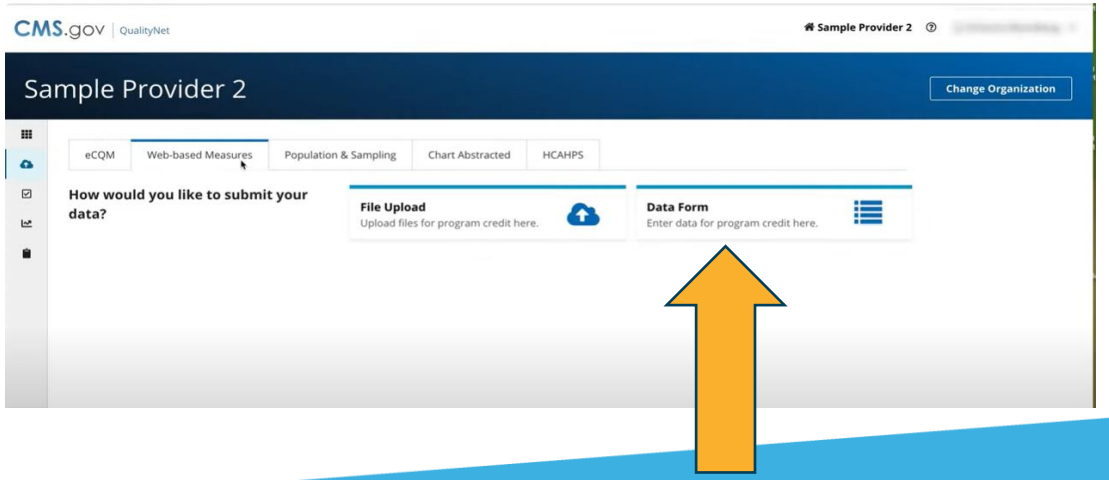
Step 1

- ❑ Select Web-based Measures Tab



Step 2

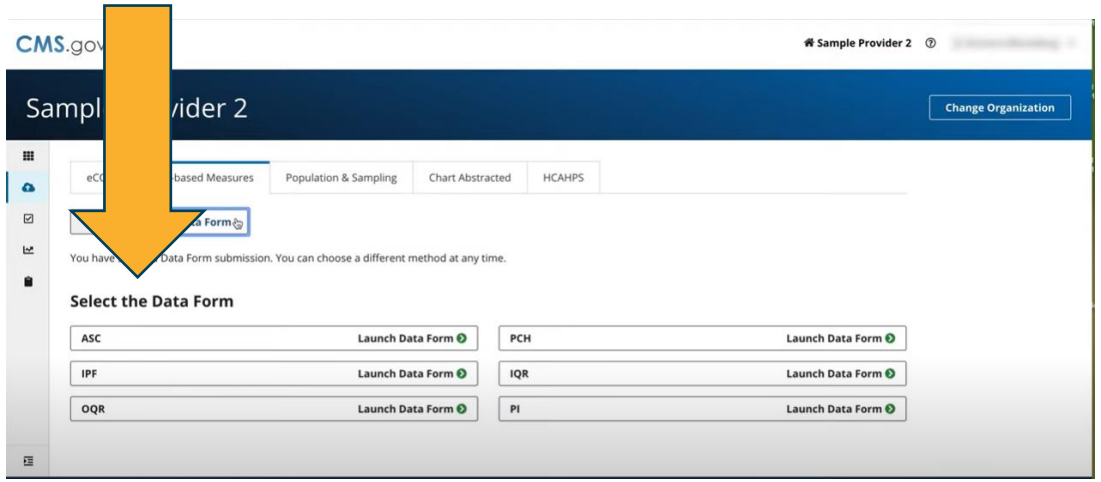
- ❑ Select Data Form

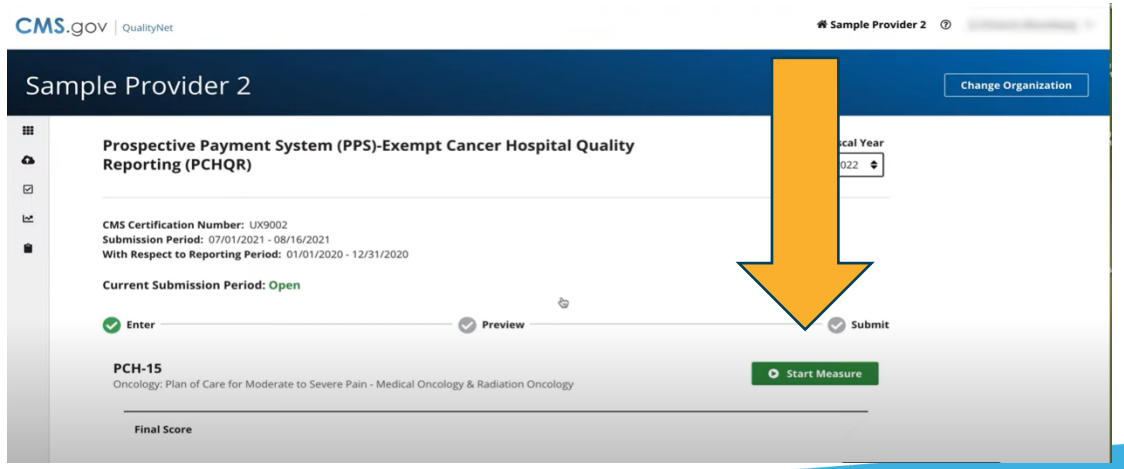


To Submit OP-22 by Data Form

Step 3

- ❑ Select the data form for the program of your choice **(For OP-22, you'll select OQR)**
- ❑ Once you pick a quarter/year you'll be able to select start measure **(For OP-22, you'll select the previous year. If it's the year 2024', you'll select data from January 1st – December 31st, 2023')*





To Submit OP-22 by Data Form

Step 4

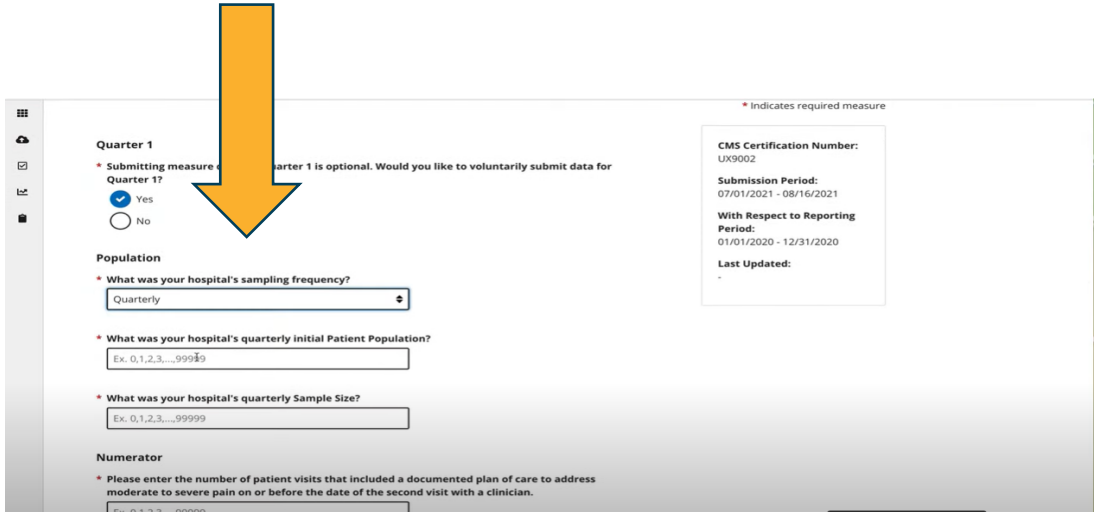
- ❑ Add your data

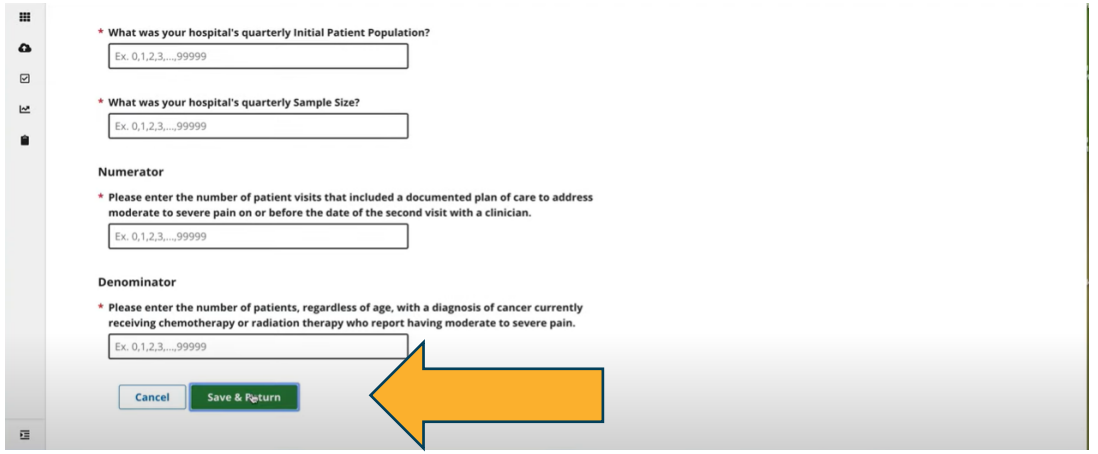
Remember for OP-22 there are two questions:

Numerator – What was the total number of patients who left without being evaluated by a physician/APN/PA?

Denominator – what was the total number of patients who presented to the Emergency Department?

- ❑ Once all your data is entered click 'Save and Return' at the bottom

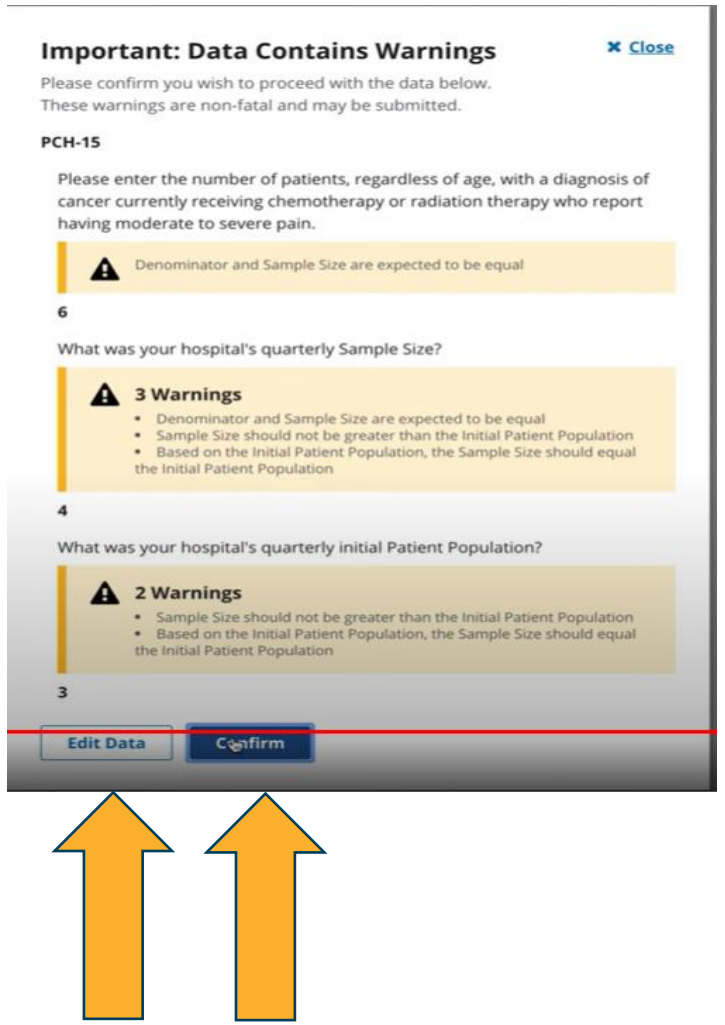




To submit OP-22 by Data Form

Step 5

- ❑ Confirm your choices
  - ○ Edit Data to review what you submitted if there are warnings
  - ○ Confirm what you submitted

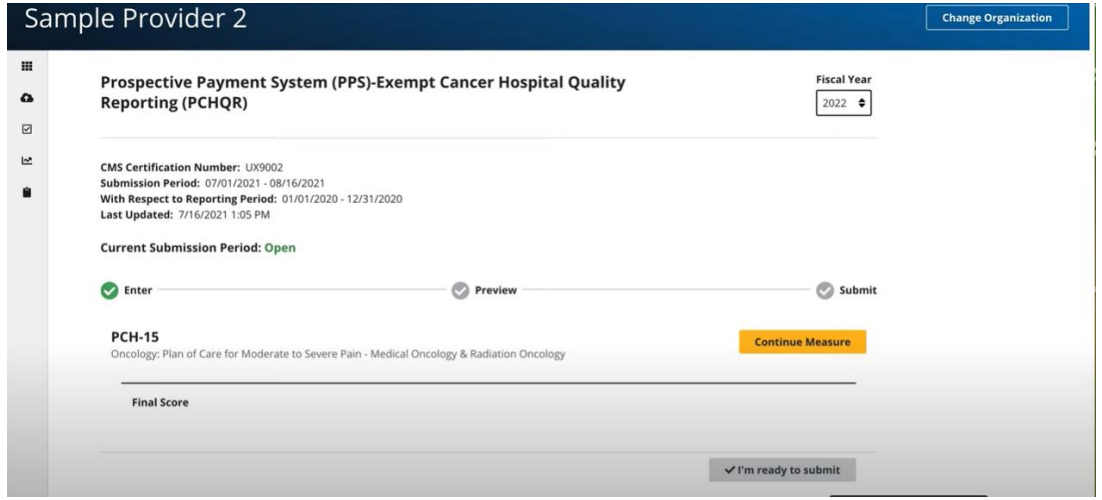


To Submit OP-22 by Data Form

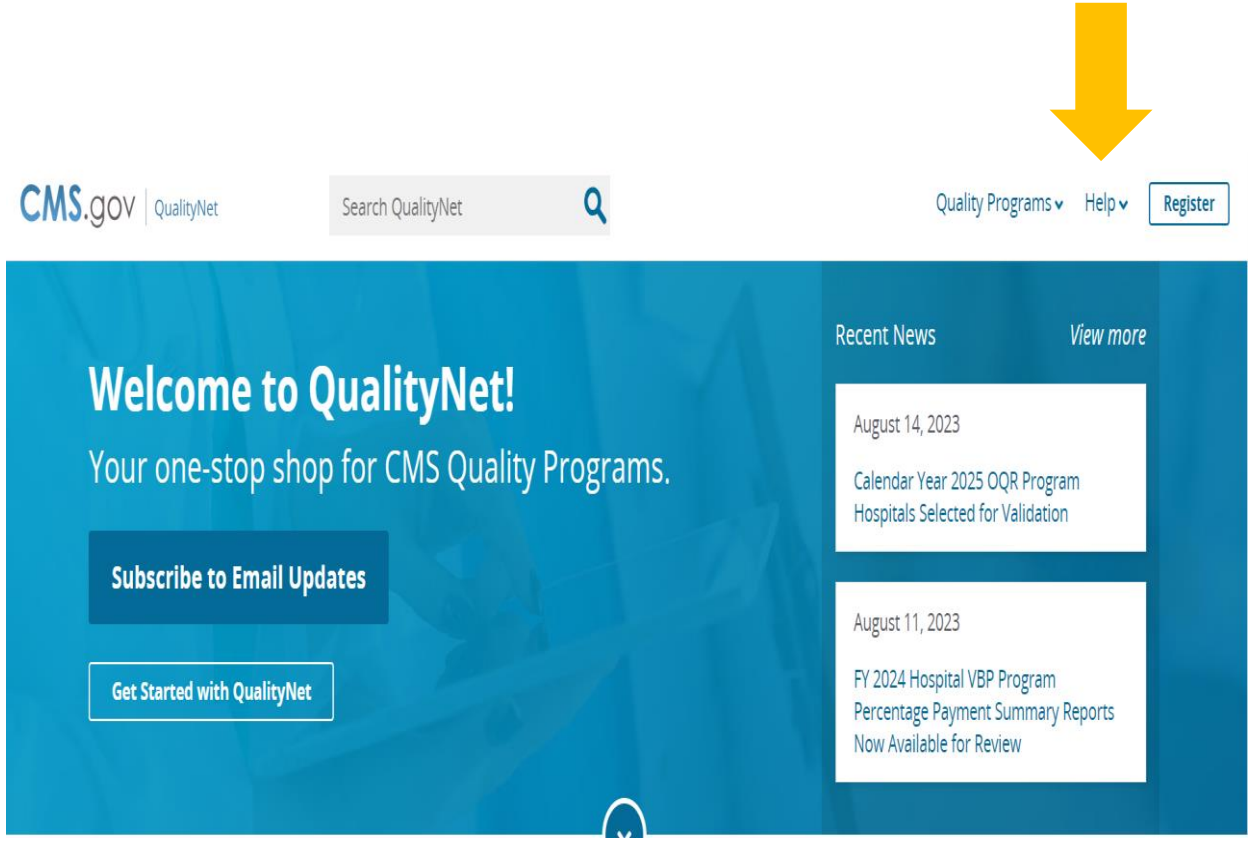
Step 6

- ❑ Finish entering data or editing data by clicking 'Continue Measure'
- ❑ Click 'I'm ready to submit' once you're done

You're all set!



Quality Net Support



CCSQ Support Center

E-mail: qnetsupport@cms.hhs.gov
For ESRD support, e-mail: qnetsupport-esrd@cms.hhs.gov

Phone: (866) 288-8912*
TTY: (877) 715-6222

8 am - 8 pm ET, Monday - Friday

*For more information on available menu options when calling the QualityNet Service Center, reference the CCSQ Support Center Phone Tree.

Question & Answer Tools

Question & Answer Tool	
Hospitals - Inpatient	View
Hospitals - Outpatient	View
Ambulatory Surgical Centers	View
PPS-Exempt Cancer Hospitals	View
End-Stage Renal Disease (ESRD) QIP	View
Inpatient Psychiatric Facilities	View

Note: Registration Required

Questions?

Thank you

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