Hospital Inpatient Quality Reporting (IQR) Program Requirements for Fiscal Year (FY) 2019 Payment Determination

Questions & Answers

Moderator/Speaker

Candace Jackson, RN
Project Lead, Hospital IQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

February 22, 2017

2 p.m. ET

DISCLAIMER: This presentation question-and-answer transcript was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated.

The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

General IQR Questions

Question 1: **For the submission of the clinical chart-abstracted measures to CMS, is there a review and correction period? Can we correct data after the submission deadline?**

Corrections to the data cannot be made after the submission deadline. Data cannot be corrected after that May 15, 2017 deadline. There is approximately a 4.5 month submission period after the end of each reporting quarter that is considered the time period for hospitals to review and correct their data for the chart-abstracted measures. For example, we have fourth quarter 2016 discharges coming up, representing the reporting period from October 1, 2016, through December 31, of 2016. The submission deadline for those measures is not until May 15, of 2017. Hospitals should use that time to review their submitted data to ensure accuracy of the data and make any necessary corrections before the submission deadline. This is why CMS encourages hospitals to submit their data early and not wait until the end of the submission period.

Question 2: **Will any changes made to the HAI data in the National Healthcare Safety Network (NHSN) after the submission deadline be reflected in the CMS report?**

Healthcare-associated infection (HAI) data submitted to NHSN cannot be modified after the submission deadline for use in CMS programs. Immediately following the submission deadline, the CDC creates a file of the data for CMS to use in quality reporting and pay-for-performance programs. This effectively creates a snapshot of the data at the time of the submission deadline.

We understand hospitals have the capability to update data in the NHSN system after the deadline; however, CMS does not receive or use data that were entered in NHSN after the submission deadline. It is CMS' expectation that hospitals review and correct their data prior to the submission deadline. We seek to ensure both accuracy and timeliness of quality measure data used in our value-based payment programs and publicly reported information. Any changes made after the submission deadline will not be reflected in any of the CMS reports, the information displayed on *Hospital Compare*, or used for the Hospital Value-Based Purchasing (VBP) and Hospital-Acquired Condition (HAC) Reduction Programs.

Question 3: **If a number is entered for PC-01, can it be changed later? What is the actual impact of PC-01 ($)? Is the impact of PC-01 zero if less than ten (10) cases are entered?**

If you are entering PC-01 data, you have to enter that or correct any of that data prior to the submission deadline. So for fourth quarter 2016, if you entered PC-01 data prior to the May 15 submission deadline and it was incorrect, you would have until May 15 of 2017 to correct that data and reenter it. After May 15, hospitals will no longer be able to correct the data.

Question 4: **Can you give more details on the Patient Safety Culture structural measure? How is this information gathered?**

This measure will allow CMS to collect data on whether a hospital conducts a patient safety culture survey; and if so, which tool they use, how frequently it is administered, and the response rate. This structural measure will help inform CMS on the feasibility of a measure targeting the culture of patient safety using a specific survey. Data collection for this structural measure for hospitals occur from January 1 through December 31 of each calendar year, with data submission occurring the following year. For the first year, data collection would be from January 1, 2016, through December 31, 2016, with a submission deadline of May 15, 2017. These data will be collected via a Web-based tool available on the QualityNet website.

The adoption of this structural measure is not mandating the use of any specific patient safety culture survey, or one at all. The purpose is to obtain comprehensive information on which, if any, surveys are being utilized from all hospitals eligible to report under the Hospital IQR Program. For hospitals that do not currently have a survey in place, they would simply respond that they do not administer a detailed assessment of patient safety culture using a standardized collection protocol or structured instrument, and leave the rest of the questionnaire blank. Please refer to the FY 2016 Inpatient Prospective Payment System (IPPS) Final Rule for more information (80 FR 49662 – 49664).

Question 5: Critical access hospitals historically have had IQR reporting as voluntary. Does IQR still remain voluntary for CAHs?

Yes, reporting remains voluntary for critical access hospitals (CAHs). We highly encourage the CAHs to submit data for both chart-abstracted and electronic clinical quality measures (eCQMs).

Question 6: Please elaborate on the eCQM validation process on slide 18.

CMS will randomly select up to 200 hospitals for eCQM validation. Hospitals selected for chart-abstracted measure validation or hospitals who have been granted an Extraordinary Circumstances Exemption (ECE), are excluded from being selected for eCQM validation. CMS will randomly select 32 cases (individual patient-level reports) from the Quality Reporting Document Architecture (QRDA) Category I file submitted by hospitals selected for eCQM validation. Each randomly selected case (individual patient-level report) contains eCQM data elements for one patient for one or more eCQMs available in the Hospital IQR Program eCQM measure set. The Clinical Data Abstraction Center (CDAC) would then request that each of the selected hospitals submit patient medical record data (at least 75 percent complete) for each of their 32 randomly selected cases (transmitted by the hospital to the CMS data receiving system) within 30 days of the medical record request date. Please refer to the FY 2017 IPPS Final Rule for further guidance (81 FR 57173 – 57181).

Question 7: We are still abstracting and collecting data on stroke measures. If stroke is not on the IQR program list of measures, does that mean we will no longer submit this data for *Hospital Compare* or CMS?

Yes, beginning with 2017 discharges, stroke is no longer a required IQR measure. So, you will not need to submit that data to the CMS data receiving system.

Question 8: For structural measures on slide 14, are they put into *QNet*?

Yes, structural measures are entered through the *QualityNet Secure Portal*.

Question 9: **Is the Patient Safety Culture Survey a requirement or just a "yes" or "no" question?**

Submitting the structural measure information for the Patient Safety Culture Survey is an IQR requirement. However, the adoption of this structural measure is not mandating the use of a specific patient safety culture survey, or one at all.

The purpose is to obtain comprehensive information on which, if any, surveys are being utilized from all hospitals eligible to report under the Hospital IQR Program. The first question in the structural measure asks, Does your facility administer a detailed assessment of patient safety culture using a standardized collection protocol and structured instrument? This is a yes or no question.

For hospitals that do not currently have a survey in place, they would simply respond that they do not administer a detailed assessment of patient safety culture using a standardized collection protocol or structured instrument, and leave the rest of the questionnaire blank. If you are using a patient safety culture survey, you would answer Yes, then you would be required to answer the additional questions.

Question 10: **Are there any specific patient safety culture surveys that must be used to meet this measure?**

No, there are no specific surveys that must be used. There are multiple surveys that are currently used by the healthcare industry to assess patient safety culture, including but not limited to: the Pascal Metrics Safety Attitudes Questionnaire (SAQ); the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPSC); the Patient Safety Climate in Healthcare Organizations (PSCHO); and the Manchester Patient Safety Framework (MaPSaF).

Question 11: **The questions that were asked today, will they be available to us for review?**

That is correct, the questions and answers from today's webinar will be posted to www.qualityreportingcenter.com, generally within 10 business days of the webinar.

Question 12: **Do you have an idea when CMS will begin publicly reporting SEP-1 data?**

CMS is analyzing the sepsis measure data it has received to determine when the data will be used for public reporting. An announcement will be made when a decision has been made.

Question 13: **For the culture of patient safety structural measure, are we just submitting information that we conducted the survey? Are we required to conduct the survey annually as part of the IQR program?**

You will first answer whether your facility administer a detailed assessment of patient safety culture using a standardized collection protocol and structured instrument. If yes, then you will be asked the following additional questions: What is the name of the survey administered? How frequently is the survey administered? Does your facility report survey results to a centralized location? During the most recent assessment, how many staff members were requested to complete the survey, and how many completed surveys were received? There is no requirement that the survey must be conducted annually.

Question 14: **Per slide 12, what is considered Excess Days in Acute Care after Hospitalization for Pneumonia?**

The Excess Days in Acute Care after Hospitalization for Pneumonia (PN Excess Days) measure is a risk-adjusted outcome measure that incorporates the full range of acute care use that pneumonia patients may experience post discharge, including hospital readmissions, observation stays, and emergency department (ED) visits. The outcome of the PN Excess Days measure is the excess number of days patients spend in acute care (hospital readmissions, observation stays, and ED visits), per 100 discharges during the first 30 days after discharge from the hospital, relative to the number spent by the same patients discharged from an average hospital.

The measure defines days in acute care as days spent: (1) in an ED; (2) admitted to observation status; or (3) admitted as an unplanned readmission for any cause within 30 days from the date of discharge from the index pneumonia hospitalization. For further guidance related to this measure please refer to the FY 2017 IPPS Final Rule (81 FR 57142 – 57148).

Question 15: When will CMS release the new VBP FY 2019 achievement thresholds and benchmarks for the rebaselined HAI measures?

CMS announced a technical update to the FY 2019 Hospital Value-Based Purchasing (VBP) Program performance standards for the HAI measures on February 29, 2017. The announcement came through the Hospital IQR Program and Hospital VBP Program ListServes and through a QualityNet news article.

Question 16: When will SEP-1 validation count towards the overall hospital's confidence interval score for validation? Please take your time.

CMS will provide further guidance on when the measure will be used for the validation confidence interval in future communications. CMS previously announced that for FY 2018 payment determinations, sepsis validation confidence interval scores will not be included.

Question 17: What period of time is the collection period of sepsis data for FY 19?

For FY 2019 payment determinations, the sepsis reporting discharge periods include Calendar Year (CY) 2017 discharges.

Question 18: Is CMS considering a different sampling methodology for SEP-1? It appears that we review a significant number of cases that never meet the definition of Severe Sepsis/Septic Shock for SEP-1. Can we suggest that you sample more cases with diagnoses that are more likely to meet SEP-1?

This has been discussed and a decision was made not to change the population and sampling at this time. Initial data analysis reflects that about 60 percent of the total number of cases in the population are those with uncomplicated sepsis codes.

Of those, about 46 percent actually have severe sepsis or septic shock, but do not correspond to severe sepsis or septic shock under International Classification of Diseases, ICD-10 codes. This represents about 28 percent of the total population that have severe sepsis or septic shock, but do not have ICD-10 codes for severe sepsis or septic shock.

Question 19: **Where do I find the specifications for the claims-based measures?**

Information regarding the expansion of the cohort for the PN Payment measure, the adoption of the modified PSI 90 measure, and the additional Hospital IQR Program measures for FY 2019 payment determination can be found on the www.qualitynet.org website, under the Hospital - Inpatient tab and clicking on Claims-Based Measures. Additional information regarding the claims-based measure specifications can be found in the FY 2017 IPPS Final Rule (81 FR 57123 – 57148).

Question 20: **Are there any changes expected in the electronic algorithms of ED-1 and ED-2, as currently there is a disconnect between the current algorithms and the actual intent of these measures in chart-abstracted measures?**

We are not aware of any changes being made to the algorithms of the electronic clinical quality measure (eCQM) forms of the ED-1 and ED-2 measures.

Question 21: **Are the new payment measures, aortic aneurysm, cholecystectomy, spinal fusion, need to be clinical abstracted? Like core measures are?**

No, the new payment measures are claims-based measures and do not require any chart abstraction or additional data submission.

Question 22: **Since there have been many changes to the sepsis measures and additionally, validation does not seem to always match how we have been instructed to abstract, is there any consideration to have the sepsis validations not be part of the payment determination?**

At this time, although the sepsis measure is being validated, it is not being scored, and is not included in the confidence interval calculation. CMS will provide further guidance on when the measure will be used for the validation confidence interval in future communications.

Question 23: **Are CAHs going to be included in validation of chart-abstracted measures or eCQMs?**

Given that CAHs submit Hospital IQR Program measure data on a voluntary basis, they are not included in the validation process.

Question 24: **We administered the national patient safety culture survey in 2016; usually it is done biannually. Will that count for the 2017 structural measure?**

For the FY 2018 payment determination, the reporting period for the patient safety culture survey would be from January 1, 2016, through December 31, 2016. If you completed the survey during this reporting period, you would be able to answer Yes to the structural measure.

Question 25: **Are the two structural measures just a yes or no?**

For the FY 2019 payment determination, two structural measures will need to be completed: Safe Surgery Checklist and Patient Safety Culture. The Safe Surgery Checklist measure is just a yes or no response. Once you answer Yes or No, you are done with that measure. The Patient Safety Culture measure is also a yes or no response; however, if you answer Yes, then there will be additional questions that you will need to respond to.

Question 26: **Is there a minimum case load that must be submitted for each IQR measure? If zero can be reported, must it be reported for successful participation?**

For the chart-abstracted measures, there is a minimum case load that must be submitted dependent upon the population size for that measure set. Refer to the Sample Size Requirement tables provided in each measure set's Measure Information section (in the *Specifications Manual for National Hospital Inpatient Quality Measures*), to determine the minimum number of cases that need to be sampled for each population. If you have zero cases for the chart-abstracted ED and/or PC-01, you may file an exception using the IPPS Measure Exception Form located on QualityNet. If you have no cases for a chart-abstracted measure set, enter zeros into the Population and Sampling application.

For the electronic clinical quality measures (eCQMs), there is no sampling, and 100 percent of the population is expected to be submitted. To successfully report, hospitals can report any combination of accepted QRDA Category I Release 3 files with patients meeting the Initial Patient Population (IPP) for the corresponding measures, zero denominator declarations, and/or case threshold exemptions.

Question 27: Can you repeat what the voluntary measures are?

For the FY 2019 payment determination, there are no voluntary measures in the Hospital IQR Program.

Question 28: Where can I find details about the population included in the clinical episode-based payment measures?

Information regarding the three new clinical episode-based payment measures can be found on www.qualitynet.org. Additional information regarding the three new clinical episode-based payment measures can be found in the FY 2017 IPPS Final Rule (81 FR 57133 – 57142). Questions regarding the episode-based payment measures can be directed to CMScebsmeasure@econometricainc.com.

Question 29: Are there any updates on the sepsis measure being publicly reported and validation scores being used in payment determination?

CMS will provide further guidance on when the measure will be used for the validation confidence interval and publicly reported in future communications.

Question 30: Can you please repeat your response on stroke measures? The only stoke measure on the IQR list that was removed was Stroke 4?

Beginning with 2017 discharges, stroke is no longer a required IQR chart-abstracted measure. So, you will not need to submit that data to the CMS data receiving system.

Question 31: We don't do deliveries. Would we still need to include PC-01 as a measure?

Hospitals that do not deliver babies may file an IPPS Measure Exception Form. Otherwise, hospitals that do not deliver babies must enter a zero (0) for each of the data-entry fields for each discharge quarter.

Question 32: **When is the deadline for structural measures?**

The structural measures are submitted annually. The reporting year runs from January 1 through December 31, with a submission deadline of May 15 of the following year. The submission deadline for CY 2016 structural measure information is May 15, 2017, and the one for CY 2017 is May 15, 2018.

Question 33: **PC-01 is one of seven measures in the Safety Domain, which counts for 25% of the 2% total. So is the impact 0.000714* the total $?**

For questions regarding the Hospital VBP Program, please submit your question through the Hospital Inpatient Q&A tool on *QualityNet* at https://cms-ip.custhelp.com/.

Question 34: **When will the CMS proposed rule be released this year?**

The IPPS proposed rule is generally published in April.

Question 35: **When will the waiver be available for hospitals that do not do surgeries or have central lines? We report HAIs, but the above are waived.**

The IPPS Measure Exception Form is available on QualityNet.

Question 36: **Slide 12: will there be any baseline data (dry run) for the three clinical episode-based payment measures available?**

There will not be a dry run for the three clinical episode-based payment measures: Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure, Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure, and Spinal Fusion Clinical Episode-Based Payment Measure. The reporting period for the measures is one year (that is, the measure calculation includes eligible episodes occurring within a one-year time frame). For example, for the FY 2019 payment determination, the reporting period would be CY 2017.

Question 37: **Can claims-based measure data be retrieved through *QNet* or any other?**

Claims-based measure data are distributed through the hospital-specific reports (HSRs). HSRs provide hospitals with their detailed measure results, discharge-level data, and state and national results. The HSRs are available to hospital staff who are registered *QualityNet* users and who are assigned two *QualityNet* roles:

- Hospital Reporting Feedback – Inpatient role (required to receive the report)
- File Exchange & Search role (required to download the report from the QualityNet Secure Portal)

For any questions about accessing your HSR, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org. Please provide your hospital's name and CMS Certification Number (CCN) with your question.

Question 38: **When the chart has been corrected, do I just resubmit that corrected chart, or do I have to resubmit all of the charts in my upload?**

You can either just resubmit the corrected chart or you can resubmit all of the charts. This should be done prior to the submission deadline.

Question 39: **Where can I find the structural measures noted on slide 14?**

The structural measures are entered through the *QualityNet Secure Portal*.

Question 40: **Please clarify slide 9. Why would we only submit population and sampling for SEP and VTE-6? What about the ED measures?**

For the FY 2019 payment determination, hospitals will be required to submit the aggregate Medicare and Non-Medicare population and sampling counts for the Global (ED and IMM), Sepsis (SEP-1), and Other Venous Thromboembolism (VTE-6) Initial Patient Populations.

Question 41: **Will you explain slide 13 when exactly are these due? Is there a time we are to complete these requirements?**

The deadlines for the annual data submissions for the FY 2019 payment determination are as follows:

Requirement	Quarters/Dates Included	Submission Deadline/Period
Active *QualityNet* Security Administrator (SA)	January 1, 2017 – December 31, 2017	May 15, 2018
Data Accuracy and Completeness Acknowledgement (DACA)	January 1, 2017 – December 31, 2017	April 1, 2018 – May 15, 2018
Structural Measures	January 1, 2017 – December 31, 2017	April 1, 2018 – May 15, 2018
Influenza Vaccination Coverage Among Healthcare Personnel (HCP)	October 1, 2016 – March 31, 2017	May 15, 2018
Electronic Clinical Quality Measures (eCQMs)	Q1, Q2, Q3, and Q4 2016	February 28, 2018

eCQM-Related Questions

Question 42: **When will eCQM measures be included on *Hospital Compare*?**

At this time, CMS has not indicated when eCQMs will begin to be reported on *Hospital Compare*. This will be signaled in a future IPPS proposed rule.

Question 43: **There was a release on the CMS blog that made reference to some potential easing of the 2017 eCQM requirements. When will we hear more about these potential changes?**

Any proposed changes would be set forth in the FY 2018 IPPS proposed rule that we anticipate to be published in the late spring of 2017.

Question 44: **If a CAH is voluntarily reporting to IQR, do they need to report eCQMs for the IQR program?**

CAHs are encouraged, but not required, to report eCQMs to the Hospital IQR Program. CAHs are required to either electronically report clinical quality measures (CQMs), i.e., report eCQM data, or submit CQMs via attestation for the EHR Incentive Program.

Question 45: **On slide 17, can you submit "0" declaration if you don't have eight eCQMs with data?**

Yes, for the Hospital IQR Program requirements, successful submission is reporting on at least eight of the same eCQMs as a combination of QRDA Category I files, minimum case threshold, and/or zero denominator declarations.

Question 46: **So, as of right now, we are only required to submit four eCQM measures, correct?**

That is correct. For the FY 2018 payment determination/CY 2016 reporting period, hospitals are required to report on a minimum of four eCQMs from either Q3 or Q4 2016 by the March 13, 2017 deadline.

Question 47: **What are the ramifications for a provider that does not submit a minimum of four eCQMs?**

When referencing the FY 2018 payment determination/CY 2016 reporting period requirements, providers who do not meet the eCQM submission requirements, meaning they have not fulfilled all of the Hospital IQR Program requirements, are at risk of receiving a one-fourth reduction of the percentage increase in their annual payment update (APU) for FY 2018.

Question 48: **If you receive an email that you successfully submitted eCQMs and your status report on *QNet* shows you have been successful, are you expected to fix errors and resubmit?**

CMS expects that any file intended for inclusion in the total patient population that has errors would be addressed to troubleshoot the errors and resubmitted.

Question 49: Will the eCQMs be abstracted just like chart-abstracted measures? The chart will just be sent electronically?

If the question is referring to requirements for eCQM data validation, for the FY 2020 payment determination, using CY 2017 reported eCQM data, the FY 2017 IPPS Final Rule indicates the medical records would be submitted in a PDF file format to *QualityNet* utilizing Secure File Transfer (SFT). More details will be provided later in the year as to eCQM validation requirements.

Question 50: For 2017, how many eCQMs do we have to report and how often do we have to report?

For the FY 2019 payment determination/CY 2017 reporting period, hospitals can self-select eight of the 15 available eCQM measures for the Hospital IQR Program with the option of reporting those measures on a quarterly, biannual, or annual basis by the submission deadline of February 28, 2018.

Question 51: For eCQM validation, is CMS looking at the validity of the data being submitted? Will there be a minimum number of inpatient changes needed for CY 2017 data?

For the FY 2020 payment determination, the eCQM validation score will not affect payment. Hospitals will pass or fail validation based on the timely and complete submission of at least 75 percent of the selected records. For example, if a hospital submits timely and complete information for at least 75 percent of requested records, but comparison of the QRDA Category I file and the abstracted data results in a validation score of 28 percent, the hospital would still pass validation and be eligible to receive their full APU. CMS intends to provide further details about proposed changes to validation performed on CY 2017 data in the upcoming IPPS proposed rule.

Question 52: In a 9/12/16 webinar, "FY 2017 IPPS Final Rule: IQR-EHR Incentive Program Requirements," it stated on slide 21, "eCQM data validation," fourth bullet down, "will not be scored on the basis of measure accuracy (for the first year of eCQM data validation only)." What does that mean?

For the FY 2020 payment determination, the eCQM validation score will not affect payment. Please refer to the upcoming IPPS proposed rule for further information on validation plans beyond CY 2017.

Question 53: **For CY 2016, if our hospital does not have an EHR system, or if a hospital has a vendor who cannot meet the specifications for eCQM reporting, does this meet the qualifications for the Hospital IQR Extraordinary Circumstances Extensions/Exemptions (ECE) process?**

EHR vendor issues may be a basis for considering the grant of an ECE for the eCQM reporting requirement under the Hospital IQR Program. Review the ECE Policy Clarification Questions and Answers posted on the QualityNet.org website for more information. The documentation, ECE overview, and ECE Request Form are available for download. The deadline for submitting an ECE request for CY 2016 eCQM reporting is April 1, 2017.

Question 54: **My healthcare system opened a newly constructed hospital (new CCN) on January 17, 2017. Are we required to submit eCQM data for CY 2017 or wait until we can report for an entire CY in 2018?**

A hospital that has received a new CCN and would like to participate in the Hospital IQR Program must submit a completed Notice of Participation (NOP) to CMS no later than 180 days from the date identified as the open date on the approved CMS Quality Improvement Evaluation System (QIES). For more details, contact the Hospital IQR Program phone support at iqr@hsag.com, (844) 472-4477 or (866) 800-8765.

Question 55: **Could you please restate the eCQM validation requirements again?**

CMS finalized the expansion of the Hospital IQR Program data validation process, beginning with the FY 2020 payment determination. CMS will continue to validate up to 600 hospitals for chart-abstracted validation that will also include up to 200 additional hospitals for eCQM validation.

Those hospitals randomly selected for eCQM validation will be required to submit timely and complete medical record information for the electronic health records (EHRs) for at least 75 percent of sampled records. Any hospital that is selected for the chart-abstracted validation, or that has been granted an ECE, for the applicable eCQM reporting period, will be excluded from eCQM validation. Please review the FY 2017 IPPS Final Rule for additional details prior to the updates that will be distributed later this year.

Question 56: **The IQR and EHR programs are currently not in alignment with regard to eCQMs; IQR requires 12 months and EHR requires 90-day continuous period. We changed EHRs this month. Would we need to report out of two systems for the 12-month IQR requirement? This will require us to upgrade our old EMR no longer in use to get January data.**

Per the FY 2017 IPPS Final Rule, there is a 90-day reporting period for eligible hospitals (EHs) and CAHs reporting by attestation and demonstrating meaningful use for the first time. For EHs and CAHs electronically reporting, the reporting period is one full calendar year for those demonstrating meaningful use for the first time, or have previously demonstrated meaningful use.

CMS has recommended that the hospital import the data from their old EHR into the new EHR and submit one file per patient. The FY 2017 IPPS Final Rule indicates hospitals are permitted to extract data from noncertified sources into Certified EHR Technology (CEHRT) for capture and reporting through QRDA Category I files. This will assist hospitals to work with their vendors to continue making progress to achieve electronic data capture and reporting.

Hospitals are also expected to report the same eight self-selected measures for CY 2017 reporting. If there are issues with the legacy system, some hospitals have worked with a data-aggregation vendor to combine their data into one file per patient. Hospitals are also offered the flexibility for CY 2017 reporting to determine if they would like to report data on a quarterly, semiannual, or annual basis. This also supports the hospital's effort to fulfill the intent of achieving interoperability and meet program reporting requirements.

Question 57: **Can eCQMs be submitted at the same time as the quarterly chart-abstracted measures, or are they all submitted one time a year?**

For CY 2017 eCQM reporting, when the CMS data receiving system becomes available for CY 2017 data, hospitals have the option to report their data on a quarterly, semiannual, or annual basis, but all eCQM data must be submitted by the deadline of February 28, 2018.

Question 58: **When do we need to "declare" the eCQM measures we will be submitting?**

Hospitals are not required to signal to CMS which measures they will be reporting. The intend-to-submit feature/screen (IQR Measure Selection Intention) within the *QualityNet Secure Portal* is grayed out and not accessible.

Question 59: **Is eCQM validation checking only for successful submission of files, or will it be checking accurate capture of each data element from the electronic health record?**

For CY 2017 data, CMS will compare QRDA Category I files with medical record data (PDF file format) from a sample of hospitals selected for validation. The eCQM validation score will not affect FY 2020 payment determination. Rather, hospitals will pass or fail validation, based on the timely and complete submission of at least 75 percent of the selected records.

Question 60: **I would like to know why there are STK measures that can be selected for eCQM submission selection, but there are no measure guidelines or definitions included in the 2017 specifications manual.**

Details regarding the stroke (STK) eCQMs are available under EH Measures, eCQM Electronic Specifications, and sorted by reporting period on the eCQI Resource Center. All of the chart-abstracted versions of the stroke measures have been removed from the Hospital IQR Program.

Question 61: **Is there a document that outlines the specifics for the eCQM validation process so we can prepare in the event we are chosen?**

eCQM data validation begins with CY 2017 eCQM data reporting in the spring of 2018, which will impact the FY 2020 payment determination. Details regarding the eCQM validation process can be located in the FY 2017 IPPS Final Rule. This information will be shared later this year in upcoming Education and Outreach webinars and through ListServes.

Question 62: **For eCQM reporting, the expectation is 100% of patients within the defined time frame for the measures selected, so for 2016 our hospital selected to report Q3 – we need to submit 100% of patients who meet the qualification for the measures we selected, correct?**

Hospitals are expected to report 100 percent of the total inpatient patient population for applicable discharges from the identified reporting period.

Question 63: **Do the eCQMs have the same definitions as the related meaningful use indicators?**

Yes, the eCQM specifications are the same for the Hospital IQR Program and the CQMs that can be electronically reported for the Medicare EHR Incentive Program (often referred to as meaningful use). The eMeasure specifications can be accessed through the eCQI Resource Center.

Question 64: **We self-submitted our eCQM data. Our EHR company is building the QRDA file platform for us to use to pull the data to submit to *QNet* – but there are problems with the file – which they are in the process of correcting, so the QRDA won't be rejected (right now all files are rejected) – with the deadline looming – is there any word that the March 13 deadline might be extended?**

CMS has not indicated another extension beyond the March 13, 2017 deadline. Please review the criteria available regarding ECEs to determine if this will assist your hospital regarding CY 2016 eCQM reporting for the Hospital IQR Program. The information is posted on QualityNet.org with an ECE request deadline of April 1, 2017.

Question 65: **Is there a sampling requirement for CY 2016 reporting of eCQMs as there is for the chart abstracted measures?**

The data reported for eCQMs should represent the entire patient population for the reporting period, so there is no sampling requirement; for CY 2016 reporting, that would be quarter three or quarter four.

Question 66: If your vendor assures you that the eCQM submission was successful for CY 2016, where can you run a confirmation report of this on *QualityNet*?

Hospitals can generate the EHR Hospital Reporting – eCQM Submission Status Report within the *QualityNet Secure Portal* to determine successful submission. Review the report and locate the Successful Meaningful Use (MU) Submission and Successful IQR-EHR Submission fields – if both fields indicate a Y, this signals successful submission for at least four eCQMs for CY 2016 reporting.

Question 67: In the ED measures the departure time is when a person physically leaves the ER. However, in the eCQM, the departure time is mapped to the time the inpatient order is written. Is this correct and why is it different? With the eCQM measures, we have long times due to a patient being admitted as observation at first.

Questions on eCQM measure specifications are addressed on the Office of the National Coordinator for Health Information Technology (ONC) JIRA Issue Tracking System website. Please access the JIRA website to identify if a similar question has been posted or to pose your question.

Question 68: Is there another way to run the eCQM Performance Summary Report when the Security Administrators have continuously received error messages?

If there are issues accessing reports, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or 1 (866) 288-2912.

Question 69: Is it acceptable to submit Q3 and Q4 eCQM data for the CY 2016 reporting year? So, if we submitted Q3, but then decide to submit Q4 data, can we do that? Will Q4 override submission of Q3?

Hospitals are permitted to submit either quarter for reporting, and there is no penalty for submitting both quarters. The CMS data receiving system will assign credit for the first successful submission per the definition of reporting on at least four eCQMs as a combination of QRDA Category I files, case threshold exemptions, and/or zero denominator declarations.

Question 70: **We successfully submitted and validated eCQMs to *QualityNet* and ran reports to verify that we had successfully met requirements for IQR/EHR in November. We attested to meaningful use two weeks ago, but our submission status states "Pending eReporting." We sent a question to *QualityNet*, but the only response is that files will not be sent to the EHR Incentive Program until April 2017. Can you provide more information?**

The *QualityNet Secure Portal* will only receive production files until March 13, 2017. If you selected eReporting in the EHR Incentive Program Registration and Attestation System, your status will be "Pending eReporting." After the submission deadline closes March 13, 2017, the *QualityNet Secure Portal* will process the submitted data and generate a report indicating which EHs and CAHs have successfully reported on at least four eCQMs.

The report outcomes are scheduled to be transmitted around March 20, 2017, to the team that oversees the EHR Incentive Program system. At that time, the outcomes will be processed for aligned electronic CQM EHR Incentive Program credit. Hospitals will see a change in the pending status within the EHR Incentive Program Registration and Attestation System. The prior eCQM status of "Pending eReporting" will be replaced by one of two messages: "Locked for Payment" or "Expired." If the message reads "Locked for Payment," the EHR Incentive Program is indicating that the hospital successfully completed the electronic reporting option for CQMs. If the message reads "Expired," the message is indicating the hospital did not successfully complete the CQM electronic reporting option.

To ensure the electronic portion of the CQM reporting requirements have been met for the IQR and the Medicare EHR Incentive Programs, generate the EHR Hospital Reporting – eCQM Submission Status Report, available within the *QualityNet Secure Portal*. When reviewing the report, the "Successful MU Submission" and "Successful IQR-EHR Submission" are key. If both fields indicate a Y, for Yes, this signals successful submission of QRDA Category I files, zero denominator declarations, and/or case threshold exemptions for at least four eCQMs for CY 2016 reporting.

NOTE: The EHR Hospital Reporting – eCQM Submission Status Report indicates **only** the eCQM submission portion of program requirements have been met. Ensure all other program requirements have been met for each of the Hospital IQR and MU Programs by visiting the QualityNet.org and the CMS.gov websites for additional details.

Question 71: **Do we have to submit the eCQM data through *QualityNet*, or can we submit it through the EHR Incentive Program, i.e., Medicare and Medicaid EHR Incentive Program?**

eCQM reporting can only be submitted through the *QualityNet Secure Portal*.

Question 72: **Are you saying that we must resubmit rejections if we have a Submission Status Feedback indicating that we met the following: Successful MU Submission3: Y Successful IQR-EHR Submission4: Y?**

The expectation is that reporting eCQMs represents the total patient population. If the hospital has files that are rejecting, they have an opportunity to utilize *QualityNet* report outcomes, the *CMS Implementation Guide for Quality Reporting Document Architecture Category I and Category III: Eligible Professional Programs and Hospital Quality Reporting (HQR) Supplementary Implementation Guide for 2016, Version 1.0* (aka 2016 CMS QRDA IG) and Appendix, as well as, the Health Level Seven (HL7) base standard to troubleshoot the issues.