Inpatient Quality Reporting (IQR) Program

Support Contractor

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Transcript

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Candace Jackson: Hello and welcome to the Hospital Inpatient Quality Reporting Program webinar on the Fiscal Year 2017, Inpatient Prospective Payment System Final Rule. My name is Candace Jackson and I will be your host for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the question-and-answers will be posted to our Inpatient website, www.qualityreportingcenter.com, within 10 business days. If you registered for this event, a reminder email, as well as the slides, was sent to your email about two hours ago. If you did not receive

that email, you can download the slides at our Inpatient website, again, that's www.qualityreportingcenter.com. And now, I would like to introduce our guest speakers for today, Grace Im and Delia Houseal. Grace Im, JD, MPH is the program lead for the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program, CMS, Center for Clinical Standards and Quality, Quality Measurement and Value-Based Incentives Group. Grace is responsible for all aspects of implementing these programs and works in close collaboration with the Centers for Medicare, as well as other hospital quality programs and major developments made for acute care settings. Grace received her JD from the University of Virginia School of Law and MPH in Health Policy from the George Washington, Milken Institute School of Public Health. Dr. Houseal currently serves as the program and policy lead for the Centers for Clinical Standards and Quality, and Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program. Before moving to CCSQ, Dr. Houseal led the Centers for Medicare and Medicare intervention work and pay for success models, and served as a project officer for two health care innovation awards focused on community-based asthma and Hepatitis C prevention and control. Prior to joining CMS, Dr. Houseal served as the program director for the National Institute of Diabetes and Digestive and Kidney Diseases' short-term research education program for under-represented persons. Her research and professional interests include advancing prevention and population health improvement by addressing the social and environmental improvements of health. Both of her advanced degrees are in Public Health with concentration in health promotion, disease prevention and community health. Next slide please.

The purpose of today's presentation will provide participant with the Fiscal year 2017 IPPS hospital quality program finalized proposals, including the Hospital IQR, HVBP, HAC and HRRP programs. Next slide please.

At the end of today's presentation, the participants will be able to identify changes within the Fiscal Year 2017 IPPS Final Rule. Next slide please.

Any questions that are not answered during our question-and-answer session at the end of the webinar will be posted to the qualityreportingcenter.com website within 10 business days, although we hope to get as many questions as we can in the last 10 to 15 minutes of the call. We do ask that if you submit a question through the chat feature, that you be very specific and, if possible, reference the slide number that you are asking about. Please be aware that not all questions submitted to the chat may now be answered during the presentation. Thank you again to everyone for joining. Grace, the floor is yours.

Grace Im: Thanks, Candace, and good afternoon, everyone. Next slide please. Next slide please. OK, here it goes.

So, we have several policies in the Hospital Inpatient Quality Reporting Program or IQR Program that we finalized in this FY 2017 IPPS Final Rule that was just published this past month. To start off, we are finalizing the removal of 15 measures, beginning with the FY 2019 payment determination and future years, and so this would impact the calendar year 2017 reporting period. Next slide please.

First of all, we have finalized the removal of two chart-abstracted measures. The first is STK-4 for Thrombolytic Therapy and also VTE-5 for VTE Discharge Instructions. And, we finalized the removal because both of these measures are topped-out based on the criteria that we have established through prior rule for the IQR Program. Next slide please.

So, this slide shows the remaining chart-abstracted measures in the IQR Program that hospitals will need to report during the calendar 2017 reporting period. And, in the reporting, it would impact FY 2019 payment determination. So, those measures are two emergency department measures, one immunization measure, a perinatal care measure, sepsis measure, and also the one remaining VTE measure. Next slide please.

So, the IQR Program, we have also finalized the removal of two structural measures, and they are participation in a systematic clinical database registry for Nursing Sensitive Care, as well as the participation in a

systematic clinical database registry for General Surgery. And so, again, these measures are being removed beginning with the FY 2019 payment determination. Next slide please.

We have also finalized the removal of 13 electronic Clinical Quality Measures, or eCQMs, for short. And actually, the removal of these eCQMs are in both the IQR Program, as well as the EHR Incentive Program, as related to removing electronic CQM reporting requirements, and I'll go into that a little further later in this presentation. But, because there are 13 measures, I won't read all of them, but we do have them listed out in the slide. Next slide please.

I do want to note that there are two eCQMs, the STK-4 and VTE-5 measures, we have finalized removing them in both the eCQM form and the chart-abstracted form. However, the VTE-6 eCQM has been removed in the electronic form, but the chart-abstracted form of VTE-6 is still in the IQR Program. Next slide please.

We have also finalized, in the IPPS Final Rule, updates to two existing measures in the IQR Program. One is the Pneumonia Payment Measure and the other is the PSI-90 Measure. And, I'll go into a little bit more detail in each of those. Next slide please.

With respect to the Pneumonia Payment Measure, we have finalized expanding the measure's cohorts to include hospitalization for patients with a principal diagnosis of aspiration pneumonia and also patients with a principal diagnosis of sepsis, who also have a secondary diagnosis of pneumonia present on admission. And, these changes will become effective with the FY 2018 payment determination and future years, and the expansion of the measure cohorts for this Pneumonia Measure, it does align with changes − some of the changes we made in last year's rule with respect to the Pneumonia Mortality measure and the Pneumonia Readmission measure. Next slide please.

We have also finalized several updates to the PSI-90 measure. The PSI-90 measure is a composite and the PSI-90 measure that we have been using in

the program included eight component indicators. The measure that − the measure updates we're adopting will add three new component indicators, PSI 09, 10, and 11, while PSI 07 will be removed from this composite measure. In addition, two other component indicators are being re-specified: PSI 12 and PSI 15. Additional changes to this measure include re-weighting of many of the component indicators, so that they are based not only on volume, but also on the harms associated with the events. And, we do want to make a correction here, PSI 12 should refer to pulmonary embolism, so I just want to note that. Next slide please.

Also, with respect to PSI-90, we have finalized the change to the reporting periods for the FY 2018 and FY 2019 payment determinations. Therefore, FY 2018, we are shortening the performance period from 24 months to a 15-month period, that goes from July 1, 2014, through September 30, 2015. And, in this way, we can calculate the measure using only ICD-9 data. And then, for the FY 2019 payment determination, we will be using a 21-month reporting period that goes from October 1 of 2015 through June 30, 2017, and for that reporting period, we'll be able to calculate the measure using only ICD-10 data. Beginning with the FY 2020 payment determination and future years, we will go back to the 24-month reporting periods for that measure. Next slide please.

We have also finalized, in this IPPS Final Rule, four new measures, all claims-based, for the Hospital IQR Program. And, these measures, we will first begin to use them with the FY 2019 payment determination. And, these measures are three new episode-based payment measures. They will have a one year reporting period. And, the payment measures, will look at the payment associated with aortic aneurysm procedure, cholecystectomy and common duct exploration procedure, and spinal fusion. We are also adopting a new measure of excess days in acute care after hospitalization for pneumonia. So, in terms of the measure, it's similar to the excess days in acute care measure that we adopted previously, focused on AMI, and Heart Failure. So, this measure focuses on pneumonia patients. And, it is a claims-based measure with a 36-month reporting period. Next slide please.

We have also finalized several policies related to electronic Clinical Quality Measures, or eCQMs, reporting and certification requirements. First of all, with respect to certification for the calendar year 2017 reporting period, hospitals will be required to report using certified EHR technology that is certified to the 2014 or 2015 Edition of CEHRT. And also, like the reporting requirement with eCQM for calendar 2016, we do have the hospitals submit their data using Quality Reporting Document Architecture, or QRDA Category I, file format. And, we do want to note that hospitals may continue to use a third party − a vendor − EHR vendor to submit their QRDA Category I file on their behalf. And also, hospitals may continue to either use abstraction or pull the data from non-certified sources to input them into CEHRT for capture and reporting into QRDA I files. Also, we want to note that for calendar year 2018 reporting, even though it's a couple years ahead, we do want to note that we have finalized that hospitals would be required to use certified EHR technology that is certified to the 2015 Edition. Next slide please.

So, with respect to the number of eCQMs that we'll require to be reported on, for calendar year 2016, we'll have to − they're working towards right now, is reporting on four eCQMs for either third quarter or fourth quarter discharges of 2016. For calendar year 2017 reporting, we would be moving to reporting a full year of data or four quarters of data, by an annual submission deadline of February 28, 2018. And, hospitals would need to pick 8 of the remaining 15 eCQMs in the IQR Program. Next slide please.

And, this slide shows the remaining eCQMs that are available to report on. So, here, there are a total of 16 eCQMs, but we do want to note that one of them, ED-3, is an Outpatient measure. So, in order to meet the IQR Program requirement, ED-3, the Outpatient measure would not count, although that measure could be used for reporting through the EHR Incentive Program. Next slide please.

We have also finalized, in this year's IPPS Final Rule, an expansion of the data validation process. And, the expansion would provide for the validation of eCQM data, and we would begin in the spring of 2018 to

validate the data that's reported in calendar year 2017. And, we would select up to 200 additional hospitals for eCQM data validation. We currently select each year 600 hospitals for chart-abstracted validation and that process would not change. Also, I want to note that any hospitals that would be selected for chart-abstracted validation would not be included in the 200 hospitals selected for eCQM validation, in order to not have the burden of meeting validation requirements for both chart measures and eCQM in the same year. We do want to note that, if the hospital is selected for eCQM validation, then they would be required to submit medical information from the EHR for at least 75 percent of the sampled records. And, if that requirement is not met, then it would have an impact to FY 2020 payment determination. Next slide please.

So, again, just going into a little bit more detail on this slide, as noted, in terms of the 200 hospitals that are selected for eCQM validation, it would not include any hospital selected for chart-abstracted measure validation or any hospital that were granted an Extraordinary Circumstance Exemption related to eCQM reporting for that reporting year. Next slide please.

In terms of the number of cases for validation, it would be 32 cases that are randomly selected from the QRDA Category I file, and each hospital would then submit the randomly selected cases to a Clinical Data Warehouse within 30 days of the medical records request date. Next slide please.

And, here is a little bit more detail about what would need to be required in terms of sufficient patient level information to be − is not necessary to match the requested medical record to the originally submitted QRDA I file. And so, that documentation would include such information as arrival date and time, inpatient admission date, and also discharge date from the inpatient episode of care. Next slide please.

I do want to note also that in this first year of eCQM data validation, hospitals will not be scored on the accuracy of the file. We do want to use this first year to gain additional information and experience. However, we

do want to note that what will count is making sure to meet the requirements for submitting the medical records to our Clinical Data Warehouse within the deadline, and to be able to send to us at least 75 percent of the sample of eCQM data. Next slide please.

OK, I'm having a little bit trouble with my computer here, but I'll move on. We've also finalized some updates to our Extraordinary Circumstances Extensions Policy or ECE Policy.

So, we are extending the deadline for when ECE requests are made with respect to a non-eCQM related request from 30 days to 90 days following an extraordinary circumstance. And then, for any ECE requests related to eCQM reporting specifically, the deadline for requesting an ECE would be April 1 of the following year. OK. And then, also, I just want to note that in this year's IPPS Rule, we did seek public comment on several policies and measures that we're considering for the future in the IQR Program. And so, there is information in the Final Rule about providing summary of the public comments that we've received and the feedback, so we appreciate that. Next slide please.

And, this slide provides some resources particularly related to eCQM reporting. We do want to make sure that we let you know about the different resources available. Next slide please.

Now, I'll move on to the Hospital Value-Based Purchasing Program or VBP Program. Next slide please.

First of all, I just want to note that for this FY 2017 program year, under the VBP Program, up to two percent of based-operating DRG payments are at risk for and eligible for bonuses and penalties. And, we estimate that the total amount of all of the payments that are made under the VBP Program will be approximately $1.8 billion for FY 2017. Next slide please.

I also want to let you know of the Table 16 information that's available. So, with the publication of the IPPS Final Rule, we also updated Table 16A. So, this table reflects proxy adjustment factors. I do want to note,

however, that in order to be able to calculate these proxy adjustment factors, we do have to use last year's Total Performance Scores, or TPS, from the FY 2016 program. And, we know hospitals are currently reviewing their percent payment summary report, reflecting their Total Performance Scores for the FY 2017 program year. And so, I just want to let you know now that around mid-October, we will be updating Table 16 again. It will be posted at Table 16B, and we'll be using the finalized FY 2017 Total Performance Scores in order to calculate the adjustment factors. So, I'm just letting you know to keep an eye out for that. Next slide please.

So, we've also finalized several changes to the HVBP Program in coming years. One, is that for the PSI-90 measure, we have adopted a shortened performance period, very similar to the IRQ Program. So, for the FY 2018 program year, we will be using a 15-month performance period that goes from July 1, 2014, through September 30, 2015. In this way, we would be able to use all ICD-9 data only. Next slide please.

Also, we have finalized a change to one of the names of our domains. So, what is currently the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain will now be referred to as the Person and Community Engagement domain. And, that's beginning with the FY 2019 program year, to make it more concise and a little bit easily understandable. Next slide please.

So the − we're also updating two measures that are already in the HVBP Program, the CLABSI and CAUTI measures, so both of these measures were expanding the patient cohorts to include patients in selected non-ICU locations. So, this is very similar to updates that we've already made in both the IQR and the HAC Reduction Program, so that it will be aligned. And, these updates will begin with the FY 2019 program year. Next slide please.

This slide I think provides a good summary of all of the measures that are used in the VBP Program for the FY 2019 program year, and is organized

by each of the domains. And this is, I think, a good summary of the various measures that we have in our program. Next slide please.

And then, also this slide provides an overview of the baseline period as well as the performance period for each of the measures that we'll be using in the FY 2019 program year. Next slide please.

Also, for the FY 2019 program year, this slide presents information on the minimum data requirements for the various measures. Next slide please.

And, for future program years, in the VBP Program, so with FY 2021 and subsequent years, we have finalized an update to the Pneumonia Mortality measure to expand the cohort to include patients with a principal discharge diagnosis of aspiration pneumonia, as well as patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission. And so, this measure update will – is the same as the update that we finalized last year in the IQR Program with the Pneumonia Mortality measure. Next slide please.

We have also finalized the adoption of several new measures in the HVBP Program. So beginning with the FY 2021 payment year, we have updated – we have added two new condition specific payment measures that look at the 30-day Episode-of-Care for both AMI as well as for Heart Failure. I do want to note that, like our Medicare Spending per Beneficiary, or MSPB, measure that is currently in the program, in terms of the benchmark and the achievement threshold, they will be calculated based on the performance period information rather than the baseline period. And, we finalized this because we believe that the data from the performance period would be more current in terms of reflecting their payment policies, and so that is a difference compared to the quality measure that is in the program, and so I want to point that out. Next slide please.

And, this slide just provides a little bit more information on the heart failure payment measure. In this measure, we will also begin using it in the FY 2021 program year. Next slide please.

And, this slide just provides a little bit more information on the baseline period and the performance period for measures that are in the FY 2021 program year. Next slide please.

We've also finalized a new measure beginning with the FY 2022 program year, which is a CABG Mortality measure. And, this measure is currently reported in the IQR Program, and so, we've now adopted it for use in the Hospital VBP Program. Next slide please.

And, this slide just provides information on baseline period and performance period for the Clinical Care measures that we'll use during the FY 2022 program year. Next slide please.

And then, finally for the VBP Program, we have adopted several policy changes with respect to the Immediate Jeopardy Exclusion. And so, beginning with this FY 2017 program year, we have increased the number of immediate jeopardies that hospitals must be cited for before this is excluded from the VBP Program, and we have increased that from two to three citations. And then, also we finalized a change to the use of the date with respect to any immediate jeopardy citations related to EMTALA violations; and so, we will be using the survey end date that is generated in our ASPEN system. So, that wraps up the VBP Program, and I will turn it over to Delia Houseal. Thank you.

Delia Houseal: All right. Thanks, Grace, and good afternoon, everyone. As Candace mentioned, my name is Dr. Delia Houseal, and I'm the program lead for the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program. I'll start off with the hospitals, what I'll call the HAC Reduction Program, that's the next slide.

OK. This year we finalized five proposals in the Fiscal Year 2017 IPPS Final Rule. In the first proposal, we finalized – we finalized – we clarified, excuse me, the data requirements for Domain 1, which is comprised of our PSI-90 measure. Here, we indicated that, in addition to having three or more eligible discharges for at least one component indicator, a hospital must have a minimum of 12 months or more of data

in order for us to calculate a reliable score. OK, we can go to the next slide. OK.

And, our second proposal that – the second proposal that was finalized included our data submission requirements for newly-opened hospitals. Here, we indicated that, if a hospital files a Notice of Participation with the IQR Program within six months of opening, that hospital would be required to begin submitting data into NHSN no later than the first day of the quarter following the Notice of Participation. We also indicated that, if a hospital does not file a Notice of Participation with the Hospital IQR Program within six months of opening, that hospital would be required to begin submitting data on the first day of the quarter following the end of the six-month period to file the Notice of Participation. OK, next slide.

We also finalized our plan to adopt the modified PSI 90. I think my colleague, Grace, talked in detail about what some of those changes were, so I won't go in a whole lot of detail here. But, just to be brief, the PSI-90 measure, what's revised to reflect the relative importance and harm associated with each component indicator and to provide a more reliable and valid signal of patient safety event. We also believed that adopting the modified PSI-90 measure would continue to provide strong incentive for hospitals to ensure that patients are not harmed by medical care they received, which is the critical consideration in quality improvement. So, we can go to the next slide there.

So, in alignment with the IQR Program, we also finalized changes to the PSI-90 performance period to minimize the reporting burden and to minimize program disruption. So, for the fiscal year 2018 and the fiscal 2019 HAC Reduction Program, we indicated that for the payment year fiscal year 2018, the new performance period would be from July 1, 2014, through September 30, 2015. And, during this period, we would only use ICD-9 data. And then, for the fiscal year 2019 HAC Reduction Program, the performance period is from October 1, 2015, through June 30, 2017, and this performance period would only include ICD-10 data. We can go to the next slide there. OK.

Last week, we finalized changes to the HAC Scoring Methodology. We moved from our existing decile-based approach to a continuous scoring methodology, in particular, the Winsorized z-score. We made this change to address numerous issues that were uncovered with the decile-based score and approach. These included ties at the penalty threshold. We noticed that we had difficulty distinguishing between hospital performances. We also noted a phenomenon in which hospitals with no adverse events and no Domain 2 score were still eligible for penalty. We can go to the next slide there.

OK, I'm sorry. Actually, you can go to the next one. I kind of went over that one. OK.

So, what is the Winsorized z-score here? An easy way to think about a z-score is that it assesses how well a hospital performs against the mean. So, a hospital that has poor performance would have a positive z-score and a hospital that performs well would have a negative z-score, meaning that hospital would have a value that's below the national mean. We could go to the next slide. OK.

And based off some of our analyses, we found that the Winsorized z-score would significantly improve the program in several ways. For example, we found that it would eliminate the situation in which hospitals with no adverse events and no Domain 2 scores were – are eligible for a penalty. It also made it easier for us to distinguish between hospital performance. It substantially reduced ties and created a more level playing field for those hospitals who had data in one domain. Next slide.

And so, on this page, I listed several resources if you're interested in, or if you have additional questions about the HAC reduction program.

OK. You can – all right. So now, I'll move on to the hospital readmissions reduction program. OK, go to the next slide.

OK, so for the fiscal year 2017 Hospital Readmissions Reduction Program, we finalized three proposals, we updated the applicable period for the program year, and we updated the formula for calculating

aggregate payments and changed the public reporting timeline. OK, go to the next slide.

On this slide, here, we listed all of our different programs. Currently, the Hospital Readmissions Reduction Program has six applicable conditions. We have AMI, Heart Failure, Pneumonia, total hip and knee arthroplasty, and then we also have COPD. In the fiscal year 2015 IPPS rule and effective with the fiscal year 2017 program, we finalized the inclusion of the CABG measure. And so, I think you can go to the next slide here.

OK, yes, great. The addition of the CABG applicable provision – applicable condition, excuse me, will be included in the calculations of the aggregate payments for excess readmission. The exclusions as finalized in the fiscal year 2015 rule, see, are in admissions where patients who are discharged against medical advice, patients who are diagnosed with initial hospitalization, patients with subsequent qualifying CABG procedures during the measurement period and patients with at least 30 days post-discharge enrolment in Medicare fee-for-service. We can go to the next slide. OK, OK.

Here, we are – our biggest proposal here that we finalized was a shift in the public reporting timeline. The public reporting of excess readmission ratios will be posted on an annual basis to the Hospital Compare website as soon as feasible following the preview period. In previous rulings, we had indicated that it would occur sometime in July, so – but here, we wanted to just indicate that, you know, we wanted to allow ourselves a flexibility of reporting here. We felt like this would align with what other quality reporting programs were doing, and that, you know, it also made it, you know, easier for us to address any questions that we might have right after any preview period. OK, next slide.

All right. And so, again, I've listed some resources here for the Hospital Readmissions Reduction Program. If you have any additional questions or concerns, feel free to either visiting any of these pages or reach out to our support contractors. And now, I will turn it over to Candace.

Candace Jackson: Thank you, Delia, and thank you, Grace, for providing all of the information that you have provided for us today. This last slide here is – we, just for your convenience, have listed the different pages of the Final Rule where you can find the different programs. We will now have time to go into a question-and-answer session. Again, please note that if your question did not get answered on today's call that all questions will be answered and responded to and posted to the www.qualityreportingcenter.com website within 10 business days.

So, to start our question-and-answers period, the first question: what is the expectation for eCQM submission for calendar year 2017? In the Final Rule, it mentions that the option will be semi-annual or yearly, I believe. How often will hospitals need to submit it, and would it still be all encounters for one patient consolidated into one QRDA file?

Grace Im: Thanks, Candace, this is Grace. So, for the calendar year 2017 reporting period, I think the most important thing to know is that there is – that the submission deadline for all calendar year 2017 data is February 28 of 2018. However, we plan to have our system ready to accept the data much earlier than that. We are right now planning for late spring of 2017 to have the system ready to be able to start receiving data files that are reported on calendar year 2017 discharges. So, in terms of talking about quarterly or semi-annual submissions, it's really meant to be − to provide flexibility for the hospitals. If it's, you know, feasible for you and you prefer to do it, to be able to report on a quarterly basis, we want to leave that option for you. But, I think the most important thing to keep in mind is that the final submission deadline of February 2018.

Candace Jackson: Thank you, Grace. Our next question: what quarter was the removal for Stroke-4 and VTE-5 begin?

Grace Im: For those two chart-abstracted measures that we're removing from the IQR Program, it will begin with first quarter 2017 discharges.

Candace Jackson: Thank you, Grace.

Grace Im: For discharges starting January 1 of 2017.

Candace Jackson: Please clarify, because we seem to get a lot of questions – there were several questions in regards to this, so maybe we can clarify this. Please clarify what year this pertains to regarding which calendar year beginning, which fiscal year, and which fiscal year payment determination year?

Grace Im: So, that's definitely a good question, this is Grace, and we get it a lot. I know it can be very confusing. So, all of these requirements are tied to, you know, an annual payment update. And, for IPPS hospitals, payments are made and payment rates are based on the fiscal year timeframe. So, you know, for example, fiscal year 2017 payment updates will begin on October 1 of 2016 and go through September 30 of 2017. In terms of reporting periods for our various quality measures, it depends on the measure. Many of them, such as the chart-abstracted measures and the structural measures and the eCQMs, usually are based on a calendar year reporting cycle. So, for example, for the chart-abstracted measures, the reporting periods to the discharges that you're collecting data on the go from January 1 to December 31 for the calendar year. And then, the reporting of that data and meeting the reporting requirements would apply to the fiscal year payment updates for the following year. So, it's – you know, our team is happy to address any more specific questions, such as, you know, we wanted to be able to provide kind of a high level explanation of how we use calendar year and fiscal year.

Candace Jackson: Thank you, Grace. Our next question: in the fiscal year 2019 and forward HAC Reporting Program, are the domain weight still 85 percent for HAI and 15 percent for PSI, or will these be changing?

Delia Houseal: Yes, great question, this is Delia. For now, the weights will remain steady at 85 percent for Domain 2 and 15 percent for Domain 1.

Candace Jackson: Thank you, Delia. Our next chat question: is the HAC z-score score given at the measure level or at the domain level?

Delia Houseal: So, the z-scores will – so everyone will get a z-score at the measure level, and then those levels will roll up to – and then there will also be – so the

answer is both places. There'll be a z-score at the measurement level as well as at the score – at the score level.

Candace Jackson: OK.

Delia Houseal: And, I do have some more of our team on the line that are experts in the z-score methodology. So, if we have any more of those questions, perhaps we can field those now, so that I can let our team chime in.

Candace Jackson: Our next question: for the 13 eCQMs that CMS is removing, if a 2014 edition certified vendor who is certified to those 13 eCQMs removed support for them in calendar year '17, will it affect their certification status?

Lisa Marie Gomez: Hi, this is Lisa Marie. So, as you have eCQMs that were certified and let's say they were removed, then you don't need to worry about those. But, let's say you still have CQMs that you got certified, when it was certified with the other eCQMs in the past. In order to meet our requirements, they need to be certified to any new eCQMs. So if, let's say, you didn't have any other measures that, let's say, were eliminated or removed during this Final Rule, you will have to ensure that those measures will be certified to the 2014 edition for calendar year 2017.

Candace Jackson: Thank you. Our next question: what timeframe will the changes to the pneumonia patient measure evaluate? And, I believe that is in relation to IQR.

Grace Im: So, in the IQR Program, the pneumonia payment measure is already in the program; but, we are – we have just finalized updating this measure to extend the measure cohort. So, that extension of the measure cohort will begin with the FY2018 program year. So, in terms of the performance period, if you go back, so it should be from July 1 of, I believe, 2013 through June 30 of 2015. I can have our team leader check on that.

Candace Jackson: OK, thank you, Grace. Next question: is there somewhere you can point us towards where you do a sample calculation on the new z-score HAC method? I'm not clear on exactly where you normalize things.

Delia Houseal: Yes, great question. Given that this proposed change was just finalized, our team is working aggressively to put together a number of different educational tools. And so, we will – I'm not sure, if we will have an actual link, but, I would say, if you continue to visit the *QualityNet* website for the HAC Reduction Program, we should be posting up some educational tools on that site soon.

Candace Jackson: OK.

Delia Houseal: And then, also feel free to follow us with us via email as I'm sure again, we'll have some information posted soon.

Candace Jackson: Thank you, Delia. Next question: will you please confirm when the modified PSI 90 will go into effect? I understand for a HAC, its program year fiscal year 18, but I am confused on VBP and IQR.

Grace Im: So, this is Grace. For the IQR program, we are adopting the updated PSI 90 measure at the same time as the HAC Reduction Program. So, it will be beginning with the FY 2018 in the determination. For the VBP program, we are definitely considering adopting the measure update for the VBP program, however, the VBP program has a statutory requirement that the updated measure information is publicly reported for at least one year. So, I would just ask the audience to keep an eye out in next year's IPPS rule for more information.

Candace Jackson: OK, thank you. And, our next question: are online Medicare fee-for-service patients included in the Hospital Readmissions Reduction Program?

Delia Houseal: Hi, I had trouble getting off of mute there. Yes, the HRRP only includes Medicare fee-for-service patients in their calculations. And, we do have some other measure experts on the line, so I want to confirm that – Lynn, is that accurate just in terms of confirming that?

Lynn: Yes, Delia, that's correct.

Delia Houseal: OK, thank you.

Candace Jackson: OK, thank you. On slide 20, it states that hospitals must report using CEHRT certified to the 2014 or 2015 edition, but that you can pull data from non-certified sources and input the data into the CEHRT for reporting. Does the hospital need to have a computer – or excuse me, does the hospital need to have a complete EHR-certified to 2014 or can they purchase a certified eCQM product to capture and pulling the data from the non-certified EHR not upgraded for stage two? And, please let me know if you need me to repeat that question.

Lisa Marie Gomez: Hi, this is Lisa Marie. I think there were a lot of elements in that question. So, similar to the other question, I think what's important here is that in order for – like with our data, any new forms of like CQMs like it's required that they meet the 2014 edition, so it would be certified to that edition. And so, I'm just – and the question, I think it sounds like we need clarification on a couple of items of what they're thinking about, but this is something we can definitely follow up on. But, definitely, they can follow up their – they could just clarify more of what they're talking about in terms of what they would be using instead of using from that certified to the 2014 edition when that's actually required. So, I just want to make sure I understand their question.

Candace Jackson: Thank you. And, we can provide additional detail and response when we post the questions to the Quality Reporting Center website. Next question: where is the weighting – so twice for the same question, where is the weighting of measures in the composite located? Are we able to go to slide 17?

Grace Im: This is Grace. More detailed information about the measure specification for PSI 90 and more recent updates to this measure I believe are available on the AHRQ website. And, after this call, we can provide more specific information about the Web page address.

Candace Jackson: OK, thank you, Grace. Our next question: for the IQR program in calendar year 2017, the CEHRT needs to be certified to all 16 available eCQMs or only to those selected for electronic reporting, eight of the 16 available? Slide 20, in reference to slide 20.

Lisa Marie Gomez: Hi, this is Lisa Marie. So, all CQMs, all 16 CQMs are required to be certified to. And, I just want to note that there may have been like some entities that may have in the past certified their measures because some of the measures are continuing through this calendar year. So, for those, you don't need to be certified, but any new measures that you have not certified to – because before, like as last fiscal year, you know, there were – or last calendar year, there were like 32 measures. And so now, it requires that all CQMs are certified to, you know, the 2014 edition, which means that, if you already have them certified, you don't need to re-certify them. It's only for the CQMs that you have not certified to, they need to be certified to the 2014 edition.

Candace Jackson: Thank you. And, our next question: regarding the question you just asked out loud, is only the Medicare fee-for-service used to calculate performances for HRRP? Is that the same thing too – for HACRP?

Delia Houseal: Hi, this is Delia. Yes, that's correct.

Candace Jackson: OK. And our next question: can you please clarify whether the eCQM submission for IQR fulfills the quality reporting requirement for Meaningful Use?

Lisa Marie Gomez: Hi, this is Lisa Marie. So, as Grace noted, like in her presentation, she said that, you know, with the IQR Program and with the EHR Incentive Program, we're wanting to align. So in our rule, we note that in order to – you don't have to report for both programs. You can report for – you can report once and get credit for both programs. So, there are other requirements that are required in terms of meeting – to meet Meaningful Use. So, it's just really critical that you ensure that you're not only meeting the requirements in terms of what's outlined in the IPPS Final Rule, but also ensuring that you're adhering to any requirements under Meaningful Use, which has to do like stage 2 or even stage 3 because I know there is different entities or hospitals that are at different stages. So, it depends on the Meaningful Use under stage 2 or stage 3, but I just want to note that for the IQR Program and the EHR Incentive Program, you can report once for both.

Candace Jackson: Thank you. Our next question: what will the weighting be for the efficiency domain once the episode spend indicators are added? Will MSPB, Heart Failure, and AMI be weighted 33 percent each?

Grace Im: Can I ask you to please repeat the question?

Candace Jackson: OK. What will the weighting be for the efficiency domain once the episode spend indicators are added? Will MSPB, Heart Failure, and AMI be weighted 33 percent each?

Grace Im: OK, thanks, Candace. This is Grace. So, the AMI and Heart Failure payment measures will be used in the VBP Program for the first time with the FY 2021 program year. And so, at that point, we will have three measures in the efficiency and cost reduction domain. And so, they would be weighted equally within that domain. So, the efficiency domain is 25 percent, and then each of those measures would be weighted as one third of that.

Candace Jackson: OK. And, our next question: when is the earliest that quarter one 2017 eCQMs can be submitted to QNet? Can a hospital change the eCQMs that it reports each quarter, or do we have to report the same eight measures for all four quarters?

Grace Im: So, this is Grace. I'll answer that in – from a risk order. So one, the eight eCQMs, it is for – for each of those eight eCQMs that are selected, a hospital would have to submit a full-year of data. So, once you selected those eight, it would not be – you couldn't change which of those eight for any given quarter. So, hopefully that makes sense. And then, I think as I was noting, we are planning for our system to begin receiving data on calendar year 2017 discharges. Beginning – it would be around late spring of 2017 when our system will be back open for calendar year 2017 data. So, all data will need to be submitted by the final submission deadline, February 2018.

Candace Jac**k**son: Thank you, Grace. And, our next question: for calendar year 2017, what is the success criteria for the submission of the eight CQMs?

Artrina Sturges: Hi, Candace, this is Artrina. I'll assist with this one. So, a successful submission for eCQMs can be reported as a combination of QRDA I files with patients meeting initial patient population of the applicable measures, zero-denominator declarations, and case threshold exemptions. So, it can be any combination of those three for successful reporting.

Candace Jackson: Thank you, Artrina. And our next question: for the HACRP for fiscal year 2018, please verify that the timeframe for Domain 2 is January through December 2016?

Female: The timeframe for the – for reporting is – for fiscal year 2017. I'm sorry, I can't see the question, did they say 2017 or 18?

Candace Jackson: It says, for the HAC RP for fiscal year 2018, please verify that the timeframe for Domain 2 is January through December 2016?

Female: No. It's actually January 1, 2014, through December 31, 2015. It's a two-year period.

Candace Jackson: OK, thank you. Our next question: what are the exact dates that the HAC Reduction and HAC Deficit Reduction Program data be pulled?

Female: Well, last year, we had the claim snapshot on September 25 of 2015, we have not done this and that was for fiscal year 2017 data. We have not done the snapshot yet for fiscal year 2018 data.

Candace Jackson: Thank you. And, our next question: in fiscal year 2018, which version of the PSI 90 measure will be the one described on slide 17? Is it AHRQ 5.0 or beyond?

Grace Im: So this is Grace. Right now, we don't know the exact version number of the software it's going to be, but it will reflect all the measure updates that we finalized. And, I don't think it will be – in terms of version number, I don't think it will be less than 6-dot-something. I don't know what the – but at this time, I don't know what the exact version number is going to be.

Candace Jackson: OK, thank you, Grace. Next question: regarding PSI 90, will the modifications be effective for the 15-month reporting period July 2014 to September 30, 2015, effective going forward with calendar year 2017?

Grace Im: So, this is Grace. For both the IQR Program and the HAC Reduction Program, the – we will be using the updated PSI 90 measure beginning with the FY 2018 program year. And so, for that program year, the reporting period or performance period will be the July 1, 2014, through September 30, 2015, timeframe.

Candace Jackson: Next question: if an organization reports on an eCQM for all measures in the group, for example, ED, does the organization still need to report chart-abstracted measures?

Artrina Sturges: Hi, this is Artrina. Just a quick one for that. In terms of the ED measures, those are still required and identified for chart-abstracted. You can choose the ED measures to report, ED-1 and ED-2, you can choose those to report of eCQMs for the IQR Program, but again, that's part of your self-selection. But, in terms of chart-abstracted, those remain required for recording.

Candace Jackson: And, our next question: on page 51 or slide 51, are these performance periods for just PSI 90, or also for the NHSN HAI measures?

Delia Houseal: I'm sorry, can you repeat that…

Candace Jackson: On slide 51, are these performance periods for just PSI 90 or also for the NHSN HAI measures?

Delia Houseal: I can't see the slide, so is it 61 or 51? But, I think just…

Candace Jackson: Fifty one – five-one.

Delia Houseal: OK, yes, can you go to slide – and you go to 51 here before I respond because I have to – OK, yes, great. So, these are just – these time performance periods are just for Domain 1 for the PSI 90. The Performance Period for – Period for Domain 2 will remain the same.

Candace Jackson: Thank you, Delia.

Delia Houseal: That will remain unchanged. That's a better way to say that.

Grace Im: I'm sorry, speaking to that, I did earlier say that fiscal year 2018 would be first quarter 14 through – or January of 2014 through December of 2015, I meant January of 2015 through December 31 of 2016. So, I just wanted to clarify that on the call.

Candace Jackson: Thank you. And, we will make sure that that gets clarified in the Q&A responses that are posted. Our next question: do you know what date in September that the HAC claims snapshot data will be pulled? Is it the same date for both programs?

Delia Houseal: This is Delia. The date – we don't have a specific date. We normally just like to state that it happens – the snapshot can occur any time between mid to late September. And, when I say same programs, I'm assuming they're referencing the IQR Program. And if so, I think that that snapshot – the snapshots occurred at the same time because we use the same data.

Candace Jackson: OK. Thank you. And, our next question − and we've had several questions in relation to slide 20, so I'd like to go to that slide. Slide 20: explain bullet 3, hospitals may continue to use either abstraction or pull the data from non-certified sources in order to then input these data into CEHRT.

Lisa Marie Gomez: I think for this – this is Lisa Marie – I think for this particular question too – this, and also relation to the other question that we got earlier, and I think it would be good if we could have a collective response on our website for both of those, so we can look at both of those questions.

Candace Jackson: OK, thank you. We have time for one last question. And, the last question is: will a CAH hospital be included in selection of the eCQM validation? And, if a CAH is not fully participating in IQR, they can still submit eight eCQMs to our EHR Incentive Program rather than having to attest for all eCQMs, correct? So, it's a two-part question. The first one is CAHs included in validation?

Grace Im: So, this is Grace. With respect to the IQR Program, you know, CAHs are not required to report into the IQR Program, although we do highly encourage it. And so, the extension of our data validation to eCQM data, it would – it is specifically for the IQR Program. So, Critical Access Hospitals, or CAHs, would not be selected among the 200 hospitals for eCQM data validation.

Candace Jackson: And, the last part of the question: if a CAH is not fully participating in the IQR, they can still submit eight eCQMs for EHR Incentive Program rather than having to attest for all eCQMs, correct?

Lisa Marie Gomez: So, if a CAH is participating in EHR Incentive Program, and they're wanting to report via attestation, they are also required to report on all CQMs. And, in terms of – I mean there is like some nuance with regard to, like, attestation in the rule. So, for example, with attestation, if it's your first time demonstrating Meaningful Use, you're reporting period would be any continuous 90-day period, whereas if you're demonstrating Meaningful Use for any year prior to this particular calendar year of 2017, your reporting period would be one full calendar year with regards to attestation. And again, it would be attesting to all CQMs.

Candace Jackson: OK, thank you very much. Again, I'd like to thank Grace and Delia today for presenting the information on the Final Rule. We hope that it's been beneficial to you. We – I will now turn the presentation over to Dr. Debra Price, who will be going over our Continuing Education Approval Process. Deb, the floor is yours.

Debra Price: Well, thank you, Candace, and all of our subject matter experts, as well as our two distinguished speakers. Due to the added time that we have spent today, we are going to adjust the slides to – I mean we are going to adjust our time to 1.5 Continuing Education set up by the board listed on the slide in front of you.

We now have an online CE certificate process where you can receive your certificate two different ways. If you're listening right now, and you wait till the end of all the slides, a survey will pop up. You take the survey and

at the end of the survey, are instructions on how to get your certificate. If, however, you are in a room with a lot of other people and you were not the one that registered, no worries because we will also be sending out a survey within 48 hours. OK, after the completion of the survey, you just click the Done button and then another page pops up that will help you get your certificate. If you do not immediately receive a response, when you register for your certificate, please redo the survey when we send one out in 48 hours.

This is what the survey will look like in a few slides. You notice on the bottom right-hand corner is a Done button. So, when you are fully – when their survey has been fully complete, please click the Done button.

And then, this page pops up. It has two links. The first link is the new user link. And, that is if you have never received a certificate from us, or if you've attended an event but have not had any success receiving a certificate, please use the new user link. If you have had success in the past, use the existing user link.

Here's what the New User page looks like. You put a first name, last name, and we're asking everybody to use their personal email like Yahoo or Gmail, or AT&T, whatever because we have found that hospitals are starting to have firewalls that are blocking our links, and it just makes it easier for us if you use your personal link for your certificate.

This is what the existing user link looks like. You put your user name in the top link, and then user name is your complete email even with what's after the @ sign. So, it would be the first part and then the @ and then the last part and your password. If you don't remember your password, just click on the box and a link will show up where you can upgrade your password, get a new one.

And now, I'd like to thank everybody for attending today's webinar. We hope that you learned something. And, we will get to all of your questions and have them posted within 10 business days. Please enjoy the rest of your day.