Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2018 IPPS Final Rule
Overview of the Hospital IQR Program and
Medicare and Medicaid EHR Incentive Programs
Specific to eCQMs and MU Requirements

Presentation Transcript

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Artrina Sturges: So what I'd like to do at this time is introduce our speakers for today. Grace Snyder is the CMS Program Lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Programs, Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality. Shanna Hartman will be joining us today to present on behalf of Lisa Marie Gomez. Shanna is the Nurse Consultant for the Division of Electronic and Clinical Quality Centers for CMS. Kathleen Johnson and Steven Johnson are CMS Health Insurance Specialists with the Electronic Health Record Incentive Programs Division of Health Information Technology. Today's presentation is intended to provide an overview of the fiscal year 2018 inpatient prospective payment system final rule published on August fourteenth of this year. During this webinar, we will review the electronic clinical quality measure reporting requirements for the Hospital Inpatient Quality Reporting and Medicare Electronic Health Record Incentive Programs, as well as other meaningful use requirements under the Medicare and Medicaid EHR Incentive Programs.

By the end of this webinar, we are hopeful that you will more quickly, be able to locate the fiscal year 2018 IPPS final rule text and identify the changes within the fiscal year 2018 IPPS final rule. So at this time, I'm going to turn the webinar over to Grace Snyder and Mihir Patel to provide an overview of the Hospital IQR Program.

Grace Snyder: Thanks, Artrina. Good afternoon, everyone, thank you for joining us today. So for the hospital inpatient quality reporting program, I'd actually like to jump over to the next slide, please. Slide 11.

So before we dive into the electronic clinical quality measure or eCQM reporting requirements, I did want to take a moment here to talk about a new voluntary hybrid measure that we have adopted for the Inpatient Quality Reporting, or IQR, Program. This measure, the Hybrid Hospital-Wide Readmission measure, is, in terms of the intent of the quality measure, the same as our fully claims-based, hospital-wide readmission measure that we're already using in the program. The real difference is the use of clinical patient data that's from the, derived from the EHR to use in the calculation of the risk adjustments. So, as a voluntary measure. I just want to make very clear that we're not requiring hospitals to send us any data for this measure. The data, any data, would not be publicly reported, and also the voluntary measure—it wouldn't be counted towards or against any IQR Program requirements. However, we do encourage as many hospitals as are able to voluntarily participate in reporting EHR data for this measure. We think it will be, you know, a really good opportunity to start collecting these data elements so that, you know, for being able to calculate a hospital-wide 30-day readmission measure, we can really start to use our real-time clinical patient data for the risk adjustment, whereas right now, with the fully claims-based version of the measure, we are relying on claims, other claims data, and administrative data to be able to do the risk adjustment. So to dive in a little bit more into the details of, you know, what may be the first question is, what is a hybrid measure? When we talk about a hybrid measure, we're talking about really hybrid in the sense of using data from different sources, so I mentioned collecting patient-level clinical data from the EHR. And those data would be combined with claims data that we already have available to be able to then calculate the readmission rate. And also, because, as a voluntary reporting effort, we are at this time only asking for data to be submitted for at least 50 percent of the applicable patients, which are Medicare, pay-for-service patients age 65 or older, and like, eCQMs, reporting on eCQMs, electronic clinical quality measures, we're asking that the EHR

data be sent to us using QRDA Category I files that are submitted through the *QualityNet Secure Portal*. So for many of you who already have experienced reporting eCQM data to us, it would be using the same QRDA file format, and also using the same *QualityNet Secure Portal* system to be able to securely send the data to us. In terms of, you know, what exactly, what data elements we're asking from the EHR, they consist of 13 core clinical data elements. There are six vital signs that were interested in and seven types of laboratory test results. We'll also be asking for six linking variables that will allow us to match the EHR data that we receive with the claims data to, and then, we will merge the two sources of data to be able to calculate the readmission rate. Next slide, please.

And so, for this voluntary reporting effort, the measurement period we're looking at will be from January 1 through June 30, 2018, which is the equivalent of two calendar quarters of data. And, in terms of when our *QualityNet Secure Portal* will be ready to receive the data files, we're looking at a submission period in the fall of 2018. And then, we'll have more information forthcoming about specifically what that time period will be. But we are looking at a three-month submission period in the fall of next year to be able to submit the data to us. And also, I want to note, as this is a voluntary measure we don't necessarily need to know in advance which hospitals would like to participate or not; you don't have to let us know in advance. And, we will just see, you know, we'll just be ready to collect your data. So it really is an opportunity that's open to all hospitals to submit the data to us. And as I mentioned, we'll have more information coming throughout this fall, and into next year, to provide more details, and, as well as to be available to help answer any questions that you may have. And then, as I mentioned before, the measure cohort that we're interested in is Medicare fee-for-service patients who were aged 65 or older, and discharged from hospitals that are paid under the inpatient prospective payment system or IPPS. And, for submitting the data to us, for those hospitals that participate in this voluntary reporting effort, we will provide confidential hospital specific reports, and these reports will provide more feedback on the data that were submitted to us, including,

you know, the accuracy of the core clinical data elements that I had mentioned, as well as measure results. Next slide, please.

And, as I mentioned earlier as a voluntary measure, this will not impact any meeting of IQR Program requirements or your annual payment update determination. There will be no data related to this measure that are, that's going to be publicly reported. So, you know, really I think, you know, hopefully you can see it is a good opportunity to start practice collecting this data, start thinking about what processes might need to be implemented to be able to more easily collect these data. And, as well as to, an opportunity to ask us any questions related to this measure and to the collection of the data. Please keep an eye out for upcoming ListServe messages about webinars and more technical information, as well as information on ways to reach back out to us for any questions that may come up on the process. And then, I also want to let you know the eMeasure specifications are available on our CMS.gov website, and will also be available very soon on the eCQI Resource Center. Okay, so, now if we could please get back to slide ten with the electronic clinical quality measures.

Okay, great. So in the Hospital Inpatient Quality Reporting Program, we currently have 15 eCQMs that are available to report on. There is a sixteenth eCQM, ED-3, that's available to report to the Medicare EHR Incentive Program. However, as that measure really focuses on the outpatient setting, not inpatient, it's not available to use in the Hospital IQR Program. I think that's an important distinction. And then if we could please go to slide 14.

So just providing a little bit of background and context, as many of you may know, a little over a year ago, we had set eCQM reporting requirements for this calendar year 2017 reporting period, eight eCQMs for a full calendar year of data. However, since then, based on great feedback that we received, that we've been receiving from the hospital community, the health IT vendor community, and all the stakeholders, we've been hearing about many of the challenges that some hospitals and vendors are going through in implementing the processes and the EHR

system upgrades that have been needed to be able successfully report eCQM data to us. So earlier this year we proposed, through rulemaking, to reduce the number of eCQMs to report from eight to six eCQMs, and from a full year of data to report to just two quarters of data. And, this past month, as we published our final rule, and based on the additional feedback that we got through the public-comment process, we have finalized that hospitals will only need to report on four of the 15 available eCQMs, and to pick one calendar quarter of data in 2017 to report. So that can be quarter one, quarter two, quarter three, or quarter four. And also, hospitals do not need to let us know in advance which quarter of data they're picking or which eCQMs that they plan to report on. You know, we ask that you send us the data by the submission deadline of February 28, 2018. Also we want to make sure to clarify that for purposes of the Hospital Inpatient Quality Reporting Program, for critical access hospitals, they're not, they're not required to participate in the IQR Program, however, we certainly encourage reporting of eCQMS. It is different though for the Medicare EHR Incentive Program, which my colleagues will go into a little bit further in detail later in this presentation, where both eligible hospitals and critical access hospitals do need to participate in that program. Next slide, please.

And, in terms of the technical requirements for eCQM reporting, with respect to using certified EHR technology, you can use 2014 Edition, 2015 Edition, or a combination of both, in terms of using certified EHR technology to report eCQMs. Also, the most recent set of eCQM specifications should be used, and eCQI Resource Center is the location for all of the most updated electronic specifications. The applicable implementation guide for creating the QRDA Category I files, all of that information is also available on the eCQI Resource Center. Also, please note that for purposes of calendar year 2017 eCQM reporting—and we know many of you have already actually started submitting eCQM data to us, which we really appreciate—I think it's always great to have earlier reporting rather than waiting closer to the submission deadline. And so, I wanted to make sure to mention that we sent out a communication back on August 18 through a ListServe message to note that, in terms of the

QualityNet Secure Portal and our data receiving system, we do plan to implement an update to it to make sure that all of the various reports that you can run are updated to reflect these finalized eCQM reporting requirements. So, we just ask for a little bit of patience as we implement those updates. However, the *QualityNet Secure Portal* is open and accepting QRDA files now. So there's no need to wait in terms of submitting data to us. But just want to note that, in terms of the various feedback reports you can run through the system, they're not all updated yet to reflect the finalized requirements. Next slide, please.

For calendar year 2018 reporting we had, last year, also finalized requiring eight eCQMs for a full year of data. And again, based on a lot of the feedback that we've heard from the hospital and health IT vendor community, we, earlier this year, proposed the rulemaking to reduce the requirement to use six eCQMs for three quarters of data. And, last month in our final rule, what we finalized was actually only needing to require, only needing to report four eCQMs of the 15 that are available, and to only select one calendar quarter of data. So, like calendar year 2017 reporting, calendar year 2018 reporting will be the same in terms of the number of eCQMs to report, and the number of quarters to report. And, we finalized this, you may know it is similar to what we required in calendar year 2016 reporting of four eCQMs for either third or fourth quarter 2016 data to offer that consistency in terms of the requirements so that, you know, hospitals and their health IT vendors can continue to work on refining the eCQM reporting process, and being more comfortable with it, and continuing to gain more experience. Next slide, please.

So for technical requirements like calendar year 2017 reporting, for calendar year 2018 reporting, we ask that the certified EHR technology that's used is certified to the 2014 Edition, the 2015 Edition, or a combination of both editions. And updated eCQM specifications for calendar year 2018 reporting are available on the eCQI Resource Center, as well as the 2018 implementation guide. Next slide, please.

And then, also wanted to make sure to note that we will not yet be publicly reporting any of the eCQM data. We will in a future IPPS rule make any

information available about the future public display of eCQM data. But in the meantime, we are also looking to begin our eCQM data validation process; and so, at this point, I'd like to turn it over to my colleague, Mihir Patel, to go into further detail about eCQM data validation. Thank you.

Mihir Patel: Thanks, Grace. Good afternoon, everyone. Thank you for joining us today. Next slide, please.

I will be going over the eCQM data validation requirements. CMS will require hospitals selected for eCQM validation to submit eight records; that is, eight cases per quarter or one quarter for the fiscal year 2020 payment determination and subsequent years. And there's no exclusion criteria for the fiscal year 2020 payment determination, and subsequent years will be covered in the upcoming slide. We are continuing previously finalized medical records submission requirements for the fiscal year 2021 payment determination and subsequent years. Next slide, please.

Hospitals selected for participation in the eCQM data validation will be required to submit eight cases for one quarter, the quarter that they selected to submit data on, from the calendar year 2017 and 2018 payment determination, for the fiscal year 2020 and 2021 payment determination, respectively. Next slide, please.

This slide provides additional criteria on the types of hospitals excluded from eCQM validation. And these criteria are as follows:

- Any hospital that does not have at least five discharges for at least one reported eCQM will not be part of the eCQM validation,
- Any hospital's episodes of care that are longer than 120 days will not be part of the eCQM validation, as well as
- Any cases with a zero denominator for each measure will not be part of the eCQM validation.

Please note, criteria will be applied before the random selection of 200 hospitals for eCQM data validation; meaning, hospitals meeting any one of the criteria are not eligible for selection. Next slide, please.

CMS will continue the policy that the accuracy of eCQM data submitted for validation will not affect a hospital's validation score for fiscal year 2021 payment determination. Next slide, please.

So thank you, everyone. Now, I will turn it over to Shanna Hartman, who will go over the Medicare EHR Incentive Program requirements. Thank you.

Shanna Hartman: Thank you. This is Shanna Hartman. So I'm going to be presenting on the final policies regarding the clinical quality measure electronic reporting to the Medicare Medicaid EHR Incentive Programs for the calendar year 2017 for eligible hospitals and critical access hospitals reporting electronically, and either only in participating in the EHR Incentive Program or participating in both the Hospital IQR Program and EHR Incentive Program. They must report on at least four self-selected of the available CQMs. Report one self-selected quarter of CQM data calendar year 2017; and, the Medicare EHR Incentive Program submission deadline also remains February 28, 2018. And, just to note, the CQM requirement fulfillment for the EHR Incentive Program also satisfies the eCQM reporting requirement for the Hospital IQR Program for all measures except the outpatient measure, ED-3 (NQF number 0496). Next slide, please.

And, for the attestation option for eligible hospitals and critical access hospitals participating in the Medicare EHR Incentive Program only, any continuous 90-day period within calendar year 2017 if they are demonstrating meaningful use for the first time in 2017, a full calendar year 2017 consisting of four quarterly data-reporting periods if demonstrating meaningful use in any year prior to 2017. They must report on all 16 available CQMs and the submission deadline remains February 28, 2018. Next slide, please.

For calendar year 2018, for eligible hospitals and critical access hospitals reporting electronically for the Electronic Health Record Incentive Program in calendar year 2018, the reporting period is one self-selected quarter if demonstrating for meaningful use in the first time or demonstrating meaningful use any year prior to 2018. They must report on at least four self-selected of the available CQMs, and the submission deadline is February 28, 2019, two months following the close of the calendar year. Next slide, please.

For calendar year 2018, Medicare and Medicaid EHR Incentive Program CQM reporting requirements, attestation is only an option available for eligible hospitals and critical access hospitals in specific circumstances when electronic reporting is not feasible under the Medicare EHR Incentive Program. A full calendar year 2018 consisting of four quarterly data-reporting periods, they report on all 16 available CQMs, and the submission deadline is February 28, 2019. For eligible hospitals and critical access hospitals demonstrating meaningful use for the first time under their state's Medicaid EHR Incentive Program, the reporting period is any continuous 90-day period within calendar year 2018. Next slide, please.

The CQM reporting form and manner for Hospital IQR and Medicare EHR Incentive Programs for calendar year 2018 requires the following: the use of QRDA Category I for CQM electronic submissions, EHR technology certified to the 2014 or 2015 Edition, they are required to have EHR technology certified to all 16 available CQMs, and we would not require recertification each time updated to most recent version of CQMs and continues to meet the 2015 Edition certification criteria. The technical requirements require the use of eCQM specifications published in the 2017 eCQM annual update for calendar year 2018 reporting and any applicable addenda, which are available on the eCQI Resource Center website at eCQI.healthIT.gov/EH. And the *2018 CMS Implementation Guide for QRDA I for Hospital Quality Reporting*, which is also available on the eCQI Resource Center website. Notice that the QRDA Category I

file specifications, schematrons, sample files, and other helpful materials are located on the eCQI Resource Center website. Next slide, please.

For calendar year 2017 and 2018, state Medicaid programs continue to be responsible for determining whether or how electronic reporting of CQMs would occur or if they wish to allow reporting through attestation. Next slide, please.

And I will pass this presentation over to Steven Johnson.

Steven Johnson: Thanks, Shanna. Next slide.

So just to go over what we're going to discuss regarding the Medicare and Medicaid EHR Incentive Program, we're going to go over the EHR reporting period for 2018. We're going to discuss the two proposals that were finalized in the IPPS rule as a result of the 21st Century Cures Act, and we're also going to discuss the CEHRT—the 2015 CEHRT moving forward in 2018. Next slide.

So, as proposed in the 2018 IPPS final rule, we finalized a 90-day, a minimum of a continuous 90-day EHR reporting period for new and returning participants attested to CMS or their state Medicaid agency. As a result of feedback received from providers, in order for those who will be going to 2015 Edition of CEHRT in 2018, allowing them to be able to fully implement and adjust workflows for upgraded technology in the API, we are aligned for this 90-day EHR reporting period, in addition to allowing for more flexibility. Next slide.

Section 4002 of the 21st Century Cures Act requires that CMS exempt from the payment adjustment eligible providers, eligible hospitals, and CAHs who are unable to comply with the requirement for being a meaningful user because their certified EHR technology has been decertified under ONC's Health IT Certification Program. Next slide.

So for eligible professionals, this goes into effect this CY 2018, and it's only for the CY 2018 payment adjustment year only, given the fact that this is the last year that EPs participate in the Medicare EHR Incentive

Program. In order to qualify for this decertification hardship, or sorry, decertification exception, the EP's CEHRT has to have occurred at any time during the 12-month period preceding the applicable EHR reporting period for the CY 2018 payment adjustment year. That would be for the 2016 or 2017 payment-adjustment year, depending if it was a new participant or a returning EP. Or, the decertification had to have occurred during the applicable EHR reporting period for the CY 2018 payment adjustment year. Again, that would be for the 2017, sorry 2016 or 2017 program year, depending on if it's a new or returning participant. The application must be submitted in the former manner specified by October 1, 2017. Please note that this application is currently posted on our website for more information. Next slide.

For eligible hospitals, this payment adjustment goes into effect beginning with the fiscal year 2019 payment adjustment year. For example, and again, the eligible hospitals qualify for this exception if the decertification occurred at any time during the 12-month period preceding the applicable EHR reporting period for the fiscal year 2019 payment adjustment. Again, or if a decertification occurred during the applicable EHR reporting period for the fiscal year 2019 payment adjustment year. The applications must be submitted in the form and manner specified by CMS by July of the year before the payment adjustment year or a later date, as specified by CMS. An example for the 2019 payment adjustment year, the application must be submitted by July 1, 2018. Next slide.

For critical access hospitals, the applicable, applicable decertification exception begins with the fiscal year 2018 payment adjustment year. Again, as with the EPs and eligible hospitals, decertification had to occur at any time during the 12-month period preceding the applicable EHR reporting period for the fiscal year 2018 payment adjustment year. Again, similar to the EPs and eligible hospitals, decertification only occurred during the applicable EHR reporting period for the fiscal 2018 payment adjustment year. It has to be one of those two qualifications. For a critical access hospital, the application must be submitted in the form and manner specified by CMS by November 30, after the end of the applicable

payment adjustment year or a later date specified by CMS. An example for the critical access hospitals using the November 30 deadline would be for the fiscal 2018 payment year, the application would be submitted by November 30, 2018. And that would be applicable for the 2018 payment adjustment year. Next slide.

So at this point I would like to turn it over to my colleague, Kathleen Johnson. Kathleen?

Kathleen Johnson: Thank you, Steven. As mandated by Section 16003 of the 21st Century Cures Act, we finalized implementation of policy in which no payment adjustments would be made under section 1848A7A of the act for 2017 and 2018 for eligible professionals who furnish substantially all other covered professional services in an ambulatory surgical center. So the definition that we finalized of an ASC-based EP is an EP that furnishes 75 percent or more of their covered professional services and sites of service identified by POS code 24. This policy is applicable only for the calendar year 2017 and calendar year 2018 payment adjustment years. Could we have the next slide, please?

We also finalized CEHRT flexibility for calendar year 2018 only, for all healthcare providers in the Medicare and Medicaid EHR Incentive Programs. So under this final policy for an EHR incentive or for a EHR reporting period in calendar year 2018, healthcare providers have the option to attest to either modified stage two objectives and measures using the 2014 Edition, 2015 Edition, or combination of the 2014 and 2015 Edition CEHRT, as long as the EHR technology they possess supports the objectives and measures to which they plan to attest. In the same vein, healthcare providers also have the option to attest to the stage three objectives and measures using the 2015 Edition CEHRT, or a combination of the 2014 and 2015 Edition CEHRT, as long as their EHR technology can support the functionalities, objectives, and measures that are required for stage three. For attestation for an EHR reporting period in calendar year 2018, healthcare providers will be prompted to select whether they are going to attest to modified stage two or stage three, and they will then attest to the applicable objectives and measures, based on whatever edition

of CEHRT they would be utilizing. To clear up some confusion, in regard to the use of the combination of 2014 and 2015 Edition CEHRT, we want to clarify that a healthcare provider, using a combination of 2014 and 2015 Edition CEHRT, could attest to the stage three or the modified stage two objectives and measures. Healthcare providers who choose to attest to modified stage two will attest to only the modified stage two objectives and measures; and, healthcare providers who choose to attest to stage three will only attest to stage three objectives and measures. Providers who are seeking to attest to stage three in 2018 using the combination cannot do so without support of certain functions that are only available for certification as part of the 2015 Edition certification criteria, which would include the API functionalities. Next slide, please.

At this time, I like to turn it back over to our moderator.

Artrina Sturges: Thank you, all. Thank you, Kathleen. This slide here is just the last one that provides the location of the final rule on the *Federal Register*. It outlines the pages for specific quality programs. So thank you all very much, and what we would like to do now is we would like to go ahead with our question-and-answer session. You have given us a really good volume of questions, so we want to go ahead and get started with that. So it looks like right now we have quite a few questions, looks like, regarding attestation and related items. So Kathleen and Steven, I'll start with you. They're asking, Can we attest to modified stage two if we are on the CEHRT for 2015 EHR?

Kathleen Johnson: This is Kathleen. Yes, they can.

Artrina Sturges: Thank you, Kathleen.

Artrina Sturges: Question for critical access hospitals participating in the Meaningful Use EHR Incentive Program. Let's see, here. They are planning to report four measures electronically for one quarter. Is there a zero denominator exclusion for eCQM reporting for 2017 and 2018, like the IPPS hospitals have for the IQR Program?

Grace Snyder: This is Grace. For both eligible hospitals and critical access hospitals electronically reporting eCQMs, yes, there is available zero denominator declarations, as well as case threshold exemptions, like the calendar year 2016 reporting. So those options are still available.

Artrina Sturges: Thank you, Grace. Next question. Is EHR attestation still done through the previous CMS web-based portal for 2017 and 2018?

Steven Johnson: Hi, this is Steven Johnson. Attestation will occur, I believe there has been some communication, will now occur in *QualityNet* for the 2017 reporting in 2018. More information will be on the CMS home page for the EHR Incentive Program regarding registering in *QualityNet* for the Medicare EHR Incentive Program.

Artrina Sturges: Thank you, Steven. Next question. Regarding the 2017 EHR Incentive Program reporting year for eligible hospitals, will a hardship exemption option be available for switching EHRs mid-year as it has in past program years?

Steven Johnson: Hi, this is Steven Johnson again. If it's for eligible hospitals, I believe that, all being equal, if you previously would apply for the hardship for vendor issues, I believe that time has passed for 2017. That application was due in July. However, beginning in 2018, if you're having vendor issues, you would still apply under that particular category. And that would again open it up sometime next year. But it is to be closed by July or a later date, as specified by CMS.

Artrina Sturges: Thank you, Steven. Next question. The section 4002 of the 21st Century Cures Act have any provision for a provider who only attests to the Medicaid EHR Incentive Program at a state—it looks it must be at a state level—but is prevented by decertified CEHRT? Let me know if that question is not clear enough, Kathleen and Steven.

Steven Johnson: Kathleen, do you want me take this one?

Kathleen Johnson: Sure, go ahead, Steven.

Steven Johnson: Yes, thank you. So we do understand the question. It appears that they're asking if the requirement is provided in Section 4002 extends to the Medicaid EHR Incentive Program, however it does not. The authority was just for the Medicare EHR Incentive Program regarding certification—CEHRTS that have been decertified. If we're hearing the question correctly, it appears that the hospital is a Medicaid-only hospital and they would have to follow the guidance as provided by their state Medicaid agencies. But as it relates to the exception that has been finalized in the 21st Century Cures Act, it is only relevant to the Medicare EHR Incentive Program.

Artrina Sturges: Thank you. Next question. If the hospital is selected for eCQM validation, who will receive the notification email at the hospital? Is it the person who submitted the files to *QualityNet* or the legal authenticator? Or is it another person in the facility?

Mihir Patel: Hi, this is Mihir. The request will come from the Clinical Data Abstraction Center, and it should be addressed to the medical records contact that we have in PRS.

Artrina Sturges: Thank you, Mihir. And, Grace, this is a question about the hybrid measure. Would there be any outcome data that would be available if the hospital participates in the HWR?

Grace Snyder: Thanks, Artrina. This is Grace. So, you know, to be honest, it really depends on how much data we're able to receive through the voluntary reporting effort. But our intention is to make available through those confidential hospital-reports as much feedback information as we can offer. So I think, you know, there will be more information to come. We are planning upcoming webinars that will go into more specific detailed information about the hybrid measure, about the specifications, QRDA file formats, and so forth. So I know the information I provided on this presentation was still fairly high-level and went through it fairly quickly. So please keep eyes and ears open for upcoming information and communications from us.

Artrina Sturges: Thank you, Grace. And just one other follow question for that. Folks are asking, Are critical access hospitals able to participate in the voluntary reporting?

Grace Snyder: So great question. I actually will have to double check on that; not completely positive and I don't want to give the wrong answer. So I will follow up on that.

Artrina Sturges: Very good, thank you, Grace. We did receive a question. Will 2017 or 2018 eCQM submissions from hospitals be published and placed on *Hospital Compare*?

Grace, I'll take this one. As it was mentioned in the webinar, that is not the plan at this time. If there are any, if there's any future intent for any of the eCQM submissions to be published on *Hospital Compare*, it will be initially signaled in a future proposed rule. Okay? And, I'm sorry, we have quite a few voluntary hybrid measure questions, so we will move through those. So my apologies. Okay. Okay. Let's see, oh, Grace, I know we may have to address this later, too, but there is one question about hybrid measures up for consideration as future mandatory measures.

Grace Snyder: Thanks, Artrina. This is Grace. So at this time, we're just doing the voluntary collection of the hybrid measure data. We are considering it as a potential feature measure, mandatory, future mandatory measure for the Inpatient Quality Reporting Program. However, you know, if we intend to do that, we would propose it through rulemaking. So at this time we are, we'd like to do, conduct the voluntary reporting, and to gain experience for that and to have more data to be able to analyze and inform future policies.

Artrina Sturges: Thank you, Grace. Next question. Do you know when the eCQM submission status report will be updated to reflect the changes of four eCQMs for one quarter instead of the current setting of six eCQMs in two quarters.

Grace, I can take that question, as well. In terms of the updates regarding the status report, as Grace mentioned earlier in the presentation, those

changes will be made in the near future. Assume that that information is available. You'll see some updates in multiple places. ListServes will be distributed. There will also be updates that are made to *QualityNet*. And also there will probably be a revision on the Known Issues document that is posted on the *QualityNet* website.

We just have time for a few more questions. What if we've already submitted more than four eCQMs in quarter one and quarter two for 2017 data? Do we need to let you know which quarter we want to use? And Grace, I can take this one, as well. It's great if you've already submitted your data; quite a few hospitals already have. You don't have to signal to us. Basically, what will happen is that the first set of data that's received is the data that's processed, and so that's the data that will be reflected on the reports. So the only way that you would be able to make changes to that information is if you resubmitted. And, let's say it's quarter one that you submitted first, you'd have to resubmit that modified quarter-one data for it to show on the report. Other than that the first one in is the first one that is processed.

Artrina Sturges: Let me try to find one more. I'm not sure that we may be able to respond to this one, but I want to put this one out here because we have had this in a couple of times. Does your reporting period for eCQMs have to match the reporting period chosen for meaningful use attestation, or can you choose a different 90-day period within calendar year 2017?

We may not have anyone on the call that may be able to address that. So what we will do is, we'll take this one back, come up with a revised response to this, and make sure that it's posted in the question-and-answer document here in the near future. Okay, so since we have just a few minutes, we'll go ahead, and we'll go forward with the webinar.

First of all, I want to thank everyone for coming, and thank our presenters for being here today. I think we were able to share some very good information, and receiving great questions. So thank you, all, for your input today.

In terms of continuing education, this event has been approved for one CE. You must report your own credit to your respective boards. Complete your survey, and then register for your certificate. Registration is automatic and instantaneous; so therefore, [if] you do not receive a response, if you don't receive one, there's a firewall blocking the link. You'll need to register as a new user, using your personal email and phone number. If you are a new user or had any problems receiving your credits, use the New User link. If you've not had any issues receiving your credits, use the Existing User link.

And again, at this time we just want to thank all of you very much for your time and attention today, and we want to wish that you all have a very great rest of the afternoon. Thank you.