Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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May 9, 2017

2 p.m. ET

Artrina Sturges: Thank you, Matt, and good afternoon everyone. My name is Artrina Sturges and I'm your host for today's event. We just have a few announcements for you before we get started. The presentation is being recorded, and the transcript of the presentation along, with the questions and answers, will be posted to the inpatient website, which is the qualityreportingcenter.com website. And, it will also be posted on *QualityNet*. If you've registered for this event, a reminder email, as well as, a link to the slides were distributed yesterday. If you did not receive the email, the slides are available for download on our inpatient website, again, qualityreportingcenter.com. Next slide, please.

I'd like to introduce our speakers for today. Grace Im is the CMS Program Lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program, Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality.

Lisa Marie Gomez is a CMS Health Insurance Specialist for the Division of Electronic and Clinical Quality. Kathleen Johnson and Steven Johnson are CMS Health Insurance Specialists with the Electronic Health Record Incentive Programs Division of Health Information Technology. Next slide, please.

Today's presentation provides an overview of the proposals outlined in the fiscal year 2018 inpatient prospective payment system proposed rule that was issued on April 14. Our focus will be on the electronic clinical quality measure reporting requirements for the IQR, and the Medicare EHR Incentive Programs for hospitals and other meaningful use requirements under the Medicare and Medicaid EHR Incentive Programs. Later in the webinar, we will also review how to submit formal comments

to become a matter of record and receive response in the final rule. Next slide, please.

In terms of objectives, our intent is to ensure you are able to locate the fiscal year 2018 IPPS proposed rule text published on the *Federal Register*, identify changes within the fiscal year 2018 IPPS proposed rule, and also, be aware of the time frame and process for submitting comments. Next slide, please.

Because CMS must comply with the Administrative Procedures Act, we're not able to provide additional information, clarification, or guidance related to the proposed rule. We, however, encourage stakeholders to submit comments or questions through the formal comments submission process as described in this webinar. Next slide, please.

And at this time, Grace Im will join us to present information regarding the Hospital IQR Program.

Grace Im: Great. Thanks so much, Artrina. Good afternoon everyone, and thank you for joining us today. Next slide, please.

I would like to take a moment to note that my presentation today on the rule proposals for the Inpatient Quality Reporting, or IQR, Program will be limited to EHR-related quality reporting proposals. For other proposals related to the Hospital IQR Program, I'd like to refer you to both the text of the IPPS proposed rule, as well as, a webinar that we presented last week on May 4 that focused on proposals for the Hospital IQR Program, the Hospital Value-Based [Purchasing] Program, the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program. There is an archived copy of the webinar available on the qualityreportingcenter.com website and, as Artrina has noted, it will also be later posted to the QualityNet.org website.

So on this slide, I wanted to start off with noting the current electronical clinical quality measures, or eCQMs, that we have available for reporting in the Hospital IQR Program. There are 15 eCQMs available for the IQR Program and I want to note, there is also a sixteenth eCQM, ED-3, which

is also available for reporting in the Medicare EHR Incentive Program only as it's a measure for the outpatient setting, and it's not available to report for the IQR Program. Along with ED-3, there are a couple of other eCQMs related to emergency department throughput. There is an eCQM related to AMI care, AMI-8a, and another one, CAC-3 related to home management plan of care documentation. There is also a hearing screening measure, EHDI-1A, a couple of perinatal care measures, PC measures, several measures related to stroke care, and a couple of measures related to venous thromboembolism-related care. In this FY 2018 IPPS proposed rule, we're not proposing to add any new eCQMs or remove any eCQMs from the program. Next slide, please.

With respect to our proposals related to the eCQM reporting requirements for calendar year 2017 reporting, which for the Hospital IQR Program, would impact the fiscal year 2019 payment determinations, we have proposed to, the hospitals would need to report six of the 15 available eCQMs, and this is a reduction from requiring the reporting of eight eCQMs, as was finalized in last year's IPPS final rule. We are also proposing to require that data be submitted for any two quarters in calendar year 2017, and this is also a reduction from what we finalized last year, which was a full year of eCQM reporting. The submission deadline would stay the same. It would be February 28 of 2018, and in terms of technical specifications, we would require the use of EHR technology that is certified to either the 2014 or 2015 Edition. We would also require the most recent set of eCQM specifications as they are published on the eCQI Resource Center website, as well as, the use of the 2017 implementation guide or Quality Reporting Document Architecture, or QRDA files. And, information and the implementation guide are also available on the eCQI Resource Center website. I do want to note that critical access hospitals, or CAHs, are encouraged to report eCQMs for the Hospital IQR Program but are not required; although there are clinical quality measures, or CQM, requirements for CAHs in the Medicare EHR Incentive Program as Lisa Marie will go into further, later on in this presentation. Next slide, please.

We also have proposals related to calendar year 2018 reporting requirements, and this would impact fiscal year 2020 payment determinations for the Hospital IQR Program. We are proposing that hospitals would be required to report six of the 15 available eCQMs, which would be the same number of eCQMs as we are proposing for calendar year 2017 reporting. And, this is also a reduction from what we had finalized last year, which was a requirement for eight eCQMs. In terms of quarters of reporting that would be required, we are proposing to require that eCQM data be submitted for the first three quarters of calendar year 2018. And, this is a reduction from what we had finalized last year that would require a full year of reporting. The submission deadline would remain February 28 of 2019. In terms of technical specifications, we would require the use of EHR technology that is certified to the 2015 Edition; also, the 2017 eCQM annual updates and any applicable addenda in terms of eCQM specifications, which are available on the eCQI Resource Center. We would also require use of the 2018 Implementation Guide for QRDA, which is, will be available on the eCQI Resource Center. Right now, a draft of this 2018 implementation guide is actually available on JIRA for public comments through May 22. So, I encourage, encourage stakeholders to review the implementation guide and share any feedback with us. Next slide, please.

We also have in this year's IPPS proposed rule, several proposals related to the process for the validation of eCQM data in the Hospital IQR Program. First of all, we have proposals relating to modifying policies that were finalized in last year's rule and this would be for the validation of calendar year 2017 data that would impact fiscal year 2020 payment determinations under the IQR Program. So, these proposals include selecting eight cases per quarter for validation, and adding some additional exclusion criteria for both the process of selecting hospitals for eCQM validation, as well as, the case-selection process. Then also, proposing to continue certain policies that are related to scoring and medical records submission requirements that we finalized in last year's rule. Next slide, please.

So, specifically, in terms of our proposal related to the number of cases, we have proposed that we would select eight cases per quarter for validation. For validating the calendar year 2017 eCQM data, it would be a total of 16 cases, or eight cases times two quarters, and then for validating calendar year 2018 eCQM data, it would be a total of 24 cases, which is eight cases times three quarters. Next slide, please.

In terms of our proposal related to the selection of hospitals that will be randomly selected for eCQM data validation, we would still select up to 200 hospitals for eCQM validation, but we have proposed to add as an exclusion, any hospital that does not have at least five discharges for at least one of the reported eCQMs. And then, in terms of selecting these specific cases for validation, we have proposed to not include any cases for which the episode of care is longer than 120 days, as well as, any cases that have a zero denominator for a measure. Next slide, please.

And, in terms of scoring for eCQM data validation, we have proposed to continue the policy that the accuracy of the eCQM data submitted for validation would not affect the hospital validation score as it relates to fiscal year 2021 payment determination. We have also proposed that, in terms of being able to fiscally meet the eCQM validation requirements, for those hospitals that are selected for eCQM validation, they would still be required to submit at least 75% of the records in order to be able to meet the requirement. So, just to reiterate, while the accuracy of the eCQM data would not impact a hospital's data validation score, the requirement to meet and provide a sufficient number, a sufficient amount of medical records, and that they are provided timely, within the required time limitation that would [inaudible] in order to meet the data validation requirements for the IQR Program. I also want to note that we have some other proposals related to the validation process of chart-abstracted measures. So, again, I encourage you to make sure to review the IPPS proposed rule text, as well as, refer you to the archived webinar as it relates to other hospital program proposals in the IPPS proposed rule. Next slide, please.

We also have in this year's proposed rule, a proposal to add the voluntary reporting of the Hybrid Hospital-Wide Readmission measure, which uses both claims data and data from the EHR. That is why we refer to it as a hybrid measure, because it uses data from two different sources: claims and the EHR. And this measure, it looks at the same patient cohort and same outcome, which is a 30-day readmissions, as our fully claims-based hospital-wide readmission measure that is currently used in the IQR Program. And with this, with the hybrid measure, we would use the EHR data that are submitted to us for the patient-level risk adjustment. This is in contrast to the claims-based version of the measure where we use data from Medicare Part A and Part B claims to be able to calculate and use for the patient's risk-adjustment methodology. So, in terms of voluntary reporting of the hybrid measure, we would ask hospitals to report data for discharges over a six-month period during the first two quarters of calendar year 2018, which is January 1 to January 30 of 2018, and then, our system would be available using the *QualityNet Secure Portal* to submit these data to us later in the fall of 2018. Hospitals would receive confidential hospital-specific reports to be able to review the information that were submitted. And, as a voluntary measure, reporting on this measure would not impact a hospital's annual payment determination nor would the data be publicly reported. Next slide, please.

So in terms of the actual data elements that we are looking for from the EHR, it would include the first captured values for each of the following elements: it would be 13 core clinical data elements that include six vital signs and seven laboratory test results. We would also ask for six linking variables to be able to match the patient's EHR data to their claims data. And we would also ask that the EHR data be submitted to us using QRDA Category I files, which allow for the transport of patient-level information. And then, with the EHR data, we would still use the claims data to identify the patient cohort and whether they were readmitted, as well as, if the readmission was planned, in order to be able to then calculate the hybrid measure readmission rate. Next slide, please.

Then, finally I wanted to also mention that, in the IPPS proposed rule, we have several new eCQMs that we are considering for possible future inclusion in the IQR and EHR Incentive Programs. There's one eCQM related to the safe use of opioids that looks at concurrent prescriptions for opioids, or opioids and benzodiazepines, at discharge. Also, four eCQMs related to malnutrition or nutrition care. Next slide, please.

We are also considering, and would like public comment on, three eCQMs that are related to tobacco screening and treatments, as well as, three eCQMs related to alcohol or drug use screening and treatments. So, again, these are new eCQMs that we are considering for potential future inclusion in the IQR and EHR Incentive Programs. So, we really encourage you to take a, to read about these measures in the IPPS proposed rule and to provide us with any feedback. Next slide, please.

So now, I would like to turn the presentation over to my colleague, Lisa Marie Gomez. Thank you.

Lisa Marie Gomez: Thanks, Grace. So, today I'm just going to go over the proposed requirements that we have for the 2017 requirements and 2018, relating to the Medicare EHR Incentive Program, and also, the Medicare EHR Incentive Program. Next slide, please.

So as Grace noted, our goal as part of the program is to align where possible, the Hospital IQR Program along with the EHR Incentive Program. So, here, you're going to see that we strove to, or actually, we strive to align, where possible, our requirements. So, in regard to the EHR Incentive Programs for calendar 2018, we are proposing to make modifications to a couple of elements that we had originally finalized. So, as Grace noted, we are proposing to make modifications to the number of CQMs that are available that have to be reported on. So, here, we are proposing that at least six CQMs, self-selected, would be required to [inaudible] are reported on. We are also proposing that for the reporting period, it would be at least two self-selected quarters of CQMS. Also, we are continuing to propose the submission deadline, which would be February 28, 2018. For all the other requirements that we outlined in 2017

IPPS rule, we are not making any other modifications. It's only relative that you see outlined on this slide, which relate to the number of CQMs required to be reported on and the number of quarters to be reported on. Also, I just wanted to note that the CQM requirement fulfilment also satisfies the eCQM reporting requirement for the Hospital IQR Program, except, as Grace noted, the outpatient measure, ED-3, which is part of the National Quality Forum. I also just wanted to note that for attestation options for eligible hospitals and CAHs participating in the EHR Incentive Program, they would be required to report four quarters of data and report on all CQMs, and the submission deadline would be February 28, 2018. Next slide, please.

So for calendar 2018, we are proposing for eligible hospitals and CAHs to be reporting electronically for the EHR Incentive Program. And that they would be reporting on the first three quarters of data for calendar 2018 and would report on at least six self-selected of the available eCQMs. So, here again, we are also trying to align the EHR Incentive Program along with the Hospital IQR Program. We are also proposing that the submission deadline would be February 28, 2019. And again, here, it would be relative to similar, to what we've proposed for 2017. I also just want to note that for 2018, attestation will no longer be available. However, attestation would be an option, in the event that for eligible hospitals or CAHs, there are circumstances that would prevent the electronic reporting. So, in those events, where electronic reporting is not available, attestation would be permissible, and requirements for attestation would be, you know, consisting of reporting four quarters of data, and they would also will need to report on at least all available CQMs. We also note that the submission deadline would be similar to all other submission deadlines, which is February 28, 2019. Next slide, please.

So as Grace noted, we also have requirements relative to the form and manner in which the reporting of eCQMs. So, for the Hospital IQR Program and the Medicare EHR Incentive Program, we would require the use of QRDA Category I for CQM electronic submission. We also are requiring that the EHR technology be certified to the 2015 Edition, so, we

would require the EHR technology is certified to all available CQMs. However, we want to note that we will not require recertification each time updated to the most recent version of CQMs, and that it continues to meet the 2015 Edition of certification criteria. We are also requiring the use of eCQM specifications, which are published in 2017 eCQM annual update for calendar year 2018 reporting, and any other applicable addenda. We just want to note that these materials and resources are available on the eCQI Resource Center, at the website you can see here on this slide deck. Also, as Grace noted, the 2018 CQM Implementation QRDA Guide is available, and can be extracted on the eCQI website, and any other materials, or documents, or specifications, or schematrons, or sample files; all these materials are located on the eCQI Resource Center website. So, we encourage you all to go to the website and get the materials and review the materials. Next slide, please.

So in regards to the Medicaid EHR Incentive Program, we just want to continue to note that same Medicaid Programs continue to be responsible for determining whether or how electronic reporting of CQMs would occur or they wish to allow reporting through attestation. All the other requirements we outlined today, would also be relative to the Medicaid EHR Incentive Program, other than attestation, and when and how electronic reporting would occur. Right now, I'm going to turn over to my colleagues, Kathleen Johnson and Steven Johnson. Thank you.

Steven Johnson: Thank you Lisa Marie. Next slide.

Today we're going to be speaking on the items that pertain to the Medicare and Medicaid EHR Incentive Program that we have proposed in the IPPS rule as is relates to the EHR reporting period of 2018, the provisions found in the 21st Century Cures Act, and the 2015 Edition CEHRT in 2018. Next slide.

In 2018, CMS is proposing to modify the EHR reporting period from the full calendar year to a minimum of any continuous 90 days for all participants, new or returning, to the Medicare and Medicaid EHR Incentives Program. Next slide.

As required under Section 4002 of the 21st Century Cures Act, we are proposing to exempt, from Medicare payment adjustment, EPs, [eligible] hospitals, and CAHs that are unable to comply with requirements of being a meaningful user as a result of their certified electronic health record technology being decertified under the Office of the National Coordinator Health IT Certification Program. Next slide, please.

We're proposing that for this exception, for eligible hospitals, will be applicable for only the 2018 payment adjustment. EPs will qualify for this exception if their CEHRT was decertified either before or during the applicable EHR reporting period for the CY 2018 payment-adjustment year. They may qualify if their decertification incurred anytime during a 12-month period preceding the applicable EHR reporting period for the calendar year 2018 payment adjustment, or if decertification occurred during the applicable EHR reporting period or the calendar year 2018 payment-adjustment year. Please note that the application must be submitted in the former manner specified by CMS by October 2017 or later date. Next slide, please.

For eligible hospitals, this is applicable beginning with fiscal year 2019 payment year. Eligible hospitals qualify for this exception if their CEHRTs were decertified either before or during the applicable EHR reporting period for the fiscal year 2019 payment-adjustment year. Again, they may qualify if decertification occurred at any time during the 12-month period preceding applicable EHR reporting period for the 2019 payment-adjustment year, or if the decertification occurred during the applicable EHR reporting period for the fiscal year 2019 payment-adjustment year. Application must be submitted in the form and manner specified by CMS by July of the year before the payment-adjustment year or later date as specified by CMS. Examples are provided in the rule itself. Next slide, please.

For decertification of CEHRTs for critical access hospitals, this is applicable beginning with the fiscal year 2018 payment-adjustment year. Critical access hospitals will qualify for this exception if their CEHRTs were decertified either before or during the applicable EHR reporting

period, may qualify, as well, if the decertification occurred during the applicable EHR reporting period for the 2018 payment-adjustment year, may qualify if the decertification occurred anytime during the 12-month period preceding the applicable EHR reporting period for the fiscal year 2018 payment adjustment. This application must be submitted in the form or manner specified by CMS by November 30, after the end of the applicable payment-adjustment year or a later date as specified by CMS. For example, the fiscal year 2018 payment-adjustment year will be, is, November 30 of 2018. We provide more information, as well, in the 2018 IPPS rule. Now, I would like to turn it over to my colleague, Kathleen Johnson who will provide more information on our next, on our other proposals.

Kathleen Johnson: Thank you, Steven. The 21st Century Cures Act amended Section 1848 A7D of the Social Security Act to provide that no payment adjustment may be made under Section 1848 A7A for 2017 and 2018 in the case of an eligible professional who furnishes substantially all of his or her covered professional services in an ambulatory surgical center. Therefore, we are proposing a policy, based on this provision, applicable for the calendar year 2017 and 2018 Medicare payment-adjustment years. To implement this policy, we need to identify the minimum percentage of an eligible professional's covered professional services that must be furnished in an ASC setting for the EP to be considered as furnishing substantially all of his or her covered professional services in an ASC. We are proposing two alternative definitions of "substantially all" to define an ASC-based EP. The first definition is 75% or more of covered professional services, and the second definition would be 90% or more of covered professional services. Under these proposals, we would use claims for services furnished in calendar year 2015 to determine whether an EP is ASC-based for the CY 2017 payment-adjustment year and we would use claims for services furnished in calendar year 2016 to determine whether an EP is ASC-based for the calendar year 2018 payment-adjustment year. We are requesting public comment to determine the final definition. Can we have the next slide, please?

We are also proposing to use Place of Service code 24 for ambulatory surgical centers to identify services furnished in an ASC. We are also requesting public comment on whether additional Place of Service codes or mechanisms should be used in addition to, or in lieu of, Place of Service Code 24. May we have the next slide, please?

In the 2015 EHR Incentive Program final rule, we finalized that all eligible professionals, eligible hospitals, and critical access hospitals would be required to use technology certified to the 2015 Edition to demonstrate meaningful use for an EHR reporting period, beginning in 2018. Based on our past experience with transitions to new editions of CEHRT, we understand more resources and time may be required than anticipated to effectively deploy the 2015 Edition. We are currently working with our federal partners, at the Office of the National Coordinator for Health Information Technology, to monitor progress on the 2015 Edition upgrade. If we identify change in the current trends, or significant issues are identified with the certification deployment of the 2015 Edition, we will consider flexibility in 2018 for all participants in the Medicare and Medicaid EHR Incentive Programs. One possibility is flexibility to use technology certified to either the 2014 or 2015 Edition for EHR reporting period in 2018, or we may allow combination of EHR technologies certified to the 2014 or 2015 Edition to be used for the EHR reporting period in 2018 for the EPs, eligible hospitals, and critical access hospitals that are not able to fully implement EHR technology certified to the 2015 Edition. May we have the next slide, please?

I'd like to turn it back to our moderator.

Artrina Sturges: Thank you, Kathleen. Just very quickly, the fiscal year 2018 IPPS proposed rule is available on the *Federal Register* website, and can be accessed by clicking on the first link on this slide. CMS will accept comments on the proposed rule, and input on the request for information, until Tuesday, June 13, 2017. If you would like to submit a comment electronically, you may do so by either clicking on the green button at the top of the proposed rule posted in the *Federal Register*, or you can click on www.regulations.gov and can search for "Hospital Inpatient

Prospective Payment Systems," and then by clicking on the Comment Now button next to the rule. Next slide, please.

At this time, Veronica Dunlap will join us to review the questions entered into the chat box.

Veronica Dunlap: Thank you, Artrina. Hello, everyone. We will start, get started with our questions. The first one is, The 2017 eCQM Implementation Guide mentioned QDM version 3. What version of QDM should we be using for 2017 reporting period?

Artrina Sturges: Hi, this is Artrina. I can assist with this one. From the webinar that we had, I believe it was March 28, if you look at slide 20, it clarifies that for a patient-data section in the QDM, it is showing version 3. So, again, that's slide 20 in that webinar that's already posted on the qualityreportingcenter.com website. Thank you, Veronica.

Veronica Dunlap: Next question. Is there one place where we are able to locate everything in order to read and interpret the calendar year 2017 eCQM and QDM elements?

Artrina Sturges: Hi, this is Artrina. If you visit the eCQI Resource Center, there's a great deal of information that's posted there, everything from the schematrons, the sample files, everything is posted there; it will tell you which implementation guides to use and all the associated information. So, again, please go to the eCQI Resource Center, that's going to be your primary location for all information. Thank you.

Veronica Dunlap: Next question. Are these proposed requirements mentioned on today's webinar for the hospital IPPS or is it for the psychiatric program?

Grace Im: Hi, this is Grace. In terms of the Hospital IQR Program and the Medicare EHR Program, we're talking about IPPS hospitals, not hospitals paid under the inpatient psychiatric facility prospective payment system.

Veronica Dunlap: Thank you. Next question. When will we know when the proposed rule has been finalized to submit six eCQMs instead of eight eCQMs?

Grace Im: Hi, this is Grace. The FY 2018 IPPS final rule will be published sometime around August 1; and, please keep an eye out for that. I also encourage you to make sure you sign up for our ListServes, and that's another way that we will be able to send information when the final rule is published.

Veronica Dunlap: Next question. If it is finalized to only report six eCQMs for two quarters, do they have to be consecutive quarters, and which two quarters are we able to select?

Grace Im: So this is Grace. You can pick any two quarters during calendar year 2017. But we do require that you report the same set of six eCQMs for whichever two quarters that you select to report on, and the idea is to allow for flexibility so that you can select which quarters of the data you want to use.

Veronica Dunlap: Next question. If you have zero cases for one of the six eCQMs selected, are we still able to report it as a zero denominator and/or zero case threshold exemption?

Grace Im: Yes, that's correct.

Veronica Dunlap: Next question. For the proposed rule for 2018 reporting period, is there any possibility to select the first three quarters versus the fourth quarter? I think the question is, is there a possibility to be able to elect which three quarters?

Grace Im: So this is Grace. In terms of what we've proposed in the proposed rule, it would be for requiring data for the first three quarters of calendar year 2018, but, you know, I encourage you to also submit a public comment.

Veronica Dunlap: Thank you. Next question. When will we be able to submit our 2017 test and/or production files?

Artrina Sturges: Hi, this is Artrina. So, for the 2017, the receiving system is already available, so, you can go ahead and submit test and production QRDA files at this time. Thank you.

Veronica Dunlap: Thank you. Next question. How will the 16 cases be validated? And it says, to go on with that question, will there be a validation process and what system will be used for validation?

Mihir Patel: Hi, can you repeat the full question again, please?

Veronica Dunlap: Sure. How will the 16 cases be validated? Will there be a validation process and what system will be used?

Mihir Patel: I would encourage, to submit a formal public comment and we will try to answer as best as we can.

Veronica Dunlap: Thank you. Next question. Are Maryland hospitals still excluded from the eCQM validation?

Mihir Patel: Only hospitals that are part of IQR Program will be validated.

Veronica Dunlap: Next question. For eCQM validations, is there any pass-fail determinations? And, if so, what is the impact of failing eCQM validation?

Mihir Patel: So, as per the 2016, calendar year 2016 final rule, the hospitals do submit records within the time frame and at least 75% of the records. If the records are not on time and it's not complete information, or at least 75% of the information, then the hospitals will fail the validation and they will be subject to the IQR penalty for not meeting the IQR requirements.

Veronica Dunlap: Thank you. Next question. For our eCQM validation, how will hospitals be notified if our site has been selected?

Mihir Patel: You will get a notification via ListServes, via email blast, multiple different avenues as we have been doing with the chart-abstracted validation.

Veronica Dunlap: Next question. Will vendors be authorized to submit on behalf of hospitals for the proposed voluntary hybrid readmission measure?

Grace Im: So, this is Grace. We don't, in the proposed rule text, we don't specify about that, so, I ask you to submit a public comment. But as far as eCQM reporting, and even chart-abstracted measures, HCAHPS patient survey, we certainly allow vendors to be able to submit on behalf of hospitals.

Veronica Dunlap: Thank you. Next question. Will the file format for QRDA files in 2018 change?

Grace Im: This is Grace. So, we don't have any proposals related to any changes to the QRDA Category I file format for 2018 reporting. If you have any feedback on that, please feel free to submit a comment.

Veronica Dunlap: Thank you. Next question. I think we've touched on this, but we're getting this frequently. Do the proposed six eCQMs for two quarters in 2017 have to be the same six for both quarters or can hospitals select different measures?

Grace Im: So, this is Grace. It should be the same six eCQMs for whichever two quarters of data that are selected for reporting.

Veronica Dunlap: Okay, next question. So, is CMS proposing to reduce calendar year 2017 and '18 Medicaid meaningful use reporting period to 90 days for eligible professionals and hospitals?

Kathleen Johnson: Hi, for calendar year 2017, it is already 90 days. We are proposing 90 days for all participants, including Medicaid, for 2018.

Veronica Dunlap: Thank you. Next question. Do you foresee any circumstances in removing the patient messaging measure for eligible hospitals?

Kathleen Johnson: Hi, we are not proposing any changes to the objectives and measures in the IPPS rule.

Veronica Dunlap: Okay, it looks like we have time for another question. Where can we find specifications for the QRDA file format required for the new hybrid measures?

Grace Im: We'll have to follow up on that question.

Veronica Dunlap: No problem. That's about it for the questions that we have time for today. I'll go ahead and pass the ball over to Deb Price, who will review the continuing education process. Deb, take it away.

Deb Price: Thank you, Veronica. This event has been approved for one continuing education credit by the California Board and, all, there are other various boards that we have approved. You must report your own credit to your respective boards. Please complete the survey that you will find at the end of our slides and then register for your certificate. Registration is automatic and instantaneous; therefore, if you do not get a response right away, that means there's some firewall blocking the link, the automatic link. You will need to then register as a new user, using your personal email and your personal phone number. You can take care of all that at the end of our slides here.

If you are a new user or if you have had problems in the past getting certificates, please click on the New User link. And, on the left hand side here, this is what's going to pop up when you click on the New User link. Put in your first name, last name, your personal email, any personal phone number, and then, go to that personal email so you can finish the process. However, if you have been getting certificates all along when you listen to our webinars, you can click on the Existing User link. That link will take you to the slide on the right-hand side, here. You will put in your user ID, which is your complete email address, and including what's after the @ sign in your email and the password that you registered with. If you don't remember your password, just click in the box where it says, "Password," and then a "Help" will show up for you to reset your password.

And now we'd like to thank everyone for joining us today. We hope you learned something. If we did not answer your question, in the past ten minutes, please be aware that we will be answering all questions, and they will be posted at a later date. Please enjoy the rest of your day. Goodbye.