Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2019 IPPS Proposed Rule: Overview of eCQM Reporting and Promoting Interoperability (PI) Program Proposals

Presentation Transcript

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May 16, 2018
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 have a few announcements for you. This presentation is being recorded, and a transcript of the presentation, along with the questions and answers, will be posted to the inpatient website, which is the *QualityReportingCenter.com* website, and also posted to *QualityNet* in the coming weeks. If you've registered for the event, a reminder email, as well as the link to the slide, was distributed on Tuesday. If you did not receive the email, the slides are available for download on our inpatient website, again, *QualityReportingCenter.com*.

I'd like to introduce our speakers for today. Shanna Hartman is a nurse consultant for the CMS Division of Electronic and Clinician Quality, Center for Clinical Standards and Quality, CCSQ. Grace Snyder is the CMS Program Lead for the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs, Division of Value, Incentives, and Quality Reporting, CCSQ. Kathleen and Steven Johnson are CMS Health Insurance Specialists with the Division of Health Information Technology (DHIT), CCSQ.

Today's presentation provides an overview of the proposals outlined in the Fiscal Year (FY) 2019 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Proposed Rule that was published on the *Federal Register*, May 7. Our focus will be on the electronic clinical quality measure (eCQM) reporting requirements for the IQR and the Medicare and Medicaid Promoting Interoperability (PI) Programs, previously known as the Medicare and Medicaid EHR Incentive Programs. Later in the webinar, we will review how to submit formal comments to become a matter of record and receive response in the final rule.

Our intent is to ensure that you are able to locate the Fiscal Year 2019 IPPS Proposed Rule text that was published on the *Federal Register*, identify changes within the Fiscal Year 2019 IPPS Proposed Rule, and are aware of the timeframe and process for submitting comments.

Please note that during this presentation, CMS will not be able to provide additional information, clarification, or guidance related to the proposed rule to comply with the Administrative Procedures Act. CMS strongly encourages stakeholders to submit their comments or questions through the formal comment submission process which will be discussed later in the presentation.

Our first presenter for today is Shanna Hartman.

Shanna Hartman: Hi everyone. My name is Shanna Hartman from CMS and I'm here to discuss with you today the Review of 2019 eCQM Reporting Technical Specifications and Resources.

The eCQI Resource Center is a one-stop shop for the most current resources to support electronic clinical quality improvement. Updated eCQM specifications for the 2019 reporting period are found on the eCQI Resource Center. This site provides the most current information regarding eCQI such as eCQM, eCQI standards and tools, and resources.

The Eligible Hospital (EH) and Critical Access Hospital (CAH) eCQMs are located on the hospital page of the eCQI Resource Center shown here on the screen.

The eCQMs for use in the 2019 reporting period will be found by selecting 2019 in the reporting period and hitting Apply. The page will update with all eCQMs and corresponding materials for 2019 reporting.

Additional eCQM materials include an implementation checklist, eCQM specifications, eCQM measure logic and guidance documents, technical release notes, links to QRDA I implementation guides, and more. On the top of this screen, you can see all of these eCQM materials listed out. The eCQM table on this page is dynamic and can be sorted by various column headers by selecting the up and down arrows at the top of each column shown on the bottom of this screenshot.

Each eCQM has an individual measure detail page. Individual specifications are available for download from these pages. See the arrow above where you can download specifications for individual measure(s).

To access the Eligible Hospital and Critical Access Hospital QRDA [I] implementation guide, implementation guides and Schematrons are available on the QRDA page of the eCQI Resource Center and are also available within the eCQM materials list located on the EH measure page.

The eCQI Resource Center welcomes the sharing of eCQI related news, events, and content. Send the items for posting consideration, as well as questions and suggestions for improvement, to the site to eCQI-resource-center@hhs.gov.

Next, we're going to discuss the use of Clinical Quality Language, or CQL Standard.

What is CQL? Beginning with the 2019 program Calendar Year, eCQMs will begin using Clinical Quality Language, or CQL. eCQMs will still utilize the Quality Data Model, QDM, as the data model, but the logic components have been removed and will instead use CQL to express eCQM logic.

CQL is a Health Level Seven, HL7 [International], standard developing organization that provides framework and standards for exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery, and evaluation of health services. CQL aims to unify the expression of logic for eCQMs, as well as clinical decision support. It provides the ability to better express logic defining measure populations to improve the accuracy and clarity of eCQMs. CQL is a standard language for expressing clinical knowledge that is readable, sharable, and computable.

eCQMs will be transitioned to CQL standard logic for expression beginning with the Calendar Year 2019 reporting period. Measure developers have successfully tested CQL for expressing eCQM. CMS published CQL-based eCQMs on Friday May 4, 2018. CQL is applicable

to Eligible Hospitals, Critical Access Hospitals, Eligible Professionals, and eligible clinician eCQMs for the following programs: the Hospital Inpatient Quality Reporting Program; the Medicare and Medicaid Promoting Interoperability (PI) Programs, previously known as the Medicare and Medicaid EHR Incentive Programs; the Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models; as well as the Comprehensive Primary Care Plus, CPC+. CQL is a language that is used to share precise machine-readable, as well as human-readable, measure definition.

There are several benefits to CQL. CQL allows the definition of exact timing relationships, more care data element start and stop times, that were often vague or ambiguous in the QDM logic, calculation in a format more suitable for computer processing, as well as simple calculation. QDM is the information model that defines relationships between patient and clinical concepts in the standardized format. The logic portion of QDM is what has been replaced by CQL.

CQL more accurately represents clinical performance by allowing the use of more precise methods to define activities. It improves the ability to read, interpret, and understand the measure logic. It enables automation to retrieve data with less data entry on the front-end, as well as allows for prospective evaluation of a patient's records to recommend action as Clinical Decision Support (CDS). Clinical Decision Support and eCQM share many common requirements, data elements, and support healthcare quality improvement. The impact of a CDS intervention may be assessed with an eCQM.

In summary, the transition to Clinical Quality Language begins with the 2019 reporting period. CQL replaces QDM logic and aims to improve usability and accuracy. Measures are available at the eCQI Resource Center Eligible Hospital page, as shown previously, and those published for the 2019 reporting period are using CQL logic. At this time, I will pass the presentation over to Grace Snyder to discuss the Hospital IQR Program.

Grace Snyder: Thank you, Shanna. Good afternoon everyone. I would now like to address the proposed changes related to eCQM reporting for the Hospital Inpatient Quality Reporting Program, or the IQR Program. Next slide, please.

For the Hospital IQR Program, we are proposing that the reporting requirement for the Calendar Year 2019 reporting period remains the same as past years with regard to the number of measures and the number of quarters of data. Specifically, we have proposed that hospitals report one calendar quarter of data on four of the available eCQMs by the submission deadline of February 28, 2020. Hospitals can choose which four measures they want to report from the available set of eCQMs and which calendar quarter of data they want to submit to CMS. We've also proposed that the eCQM data be reported using EHR technology certified to the 2015 Edition of the ONC standards. Please note that, as Shanna just mentioned, we have recently published the annual update with the eCQM specifications for the 2019 reporting period, as well as the 2019 CMS QRDA I Implementation Guide, Schematron, and sample files, all available now on our eCQI Resource Center website. Also, as in past years, by meeting the IQR Program's eCQM reporting requirements, hospitals will also meet the CQM requirement for electronic reporting under the Promoting Interoperability (PI) Program, previously known as the EHR Incentive Program. This means that hospitals only need to send us their eCQM data once for both programs. Next slide, please.

For those of you who had a chance to join us on our webinar last week where we described in more detail our new Meaningful Measures Initiative and all of the measures we're proposing to remove from the IQR Program, we very much appreciate your time and attention, and for those of you who weren't able to join us last week, that webinar is archived at the same location as where a copy of these slides are located on our *QualityReportingCenter.com* website. So, you may recall that we're proposing to remove from the IQR Program a total of 39 measures over a four-year period. Specifically, with regard to the eCQM measure set, we're proposing to remove seven eCQMs from the set beginning with the

Calendar Year 2020 reporting period. This would mean that these seven eCQMs would still be available for hospitals to choose from for reporting Calendar Year 2019 eCQM data but would no longer be available to choose from for reporting Calendar Year 2020 eCQM data. Please note, the Promoting Interoperability (PI) Program is proposing to remove an eighth eCQM, the ED-3 measure, which is not available in the IQR Program. If we finalize removal of these eCQMs, it would mean that both programs would truly be aligned in terms of having the exact same eight remaining eCQMs to use in both the IQR and the Promoting Interoperability (PI) Programs for Calendar Year 2020 reporting. We proposed to delay removal of these eCQMs until Calendar Year 2020 because we know many hospitals and vendors are already planning and preparing for the 2019 reporting period. However, we really encourage your feedback through the public comment process on the timing of the measure removals, such as whether we should remove them earlier like in 2019, as well as the particular eCQMs being proposed for removal. We do read each and every comment letter that we receive. Next slide, please.

On this slide is a list of the seven eCQMs plus the eighth eCQM from the Promoting Interoperability (PI) Program that we are proposing to remove in this IPPS proposed rule: AMI-8a; CAC-3; ED-1, and ED-3, as noted at the bottom of the slide, but we are keeping ED-2; EHDI-1a; PC-01, but please note the chart abstracted version of the PC-01 measure will be maintained in the IQR Program; STK-08; and STK-10, which The Joint Commission has already removed. Next slide, please.

On this slide is a table of the 16 eCQMs we have available today and reflects the proposed changes beginning with the Calendar Year 2020 reporting period, which would impact Fiscal Year 2022 payment determinations. I do want to note this chart, while it goes out to Fiscal Year 2023, it's really only for illustrative purposes. So, in interpreting this slide, Fiscal Year 2019 is – we just completed the eCQM reporting for that, it was reporting Calendar Year 2017 data, which would impact Fiscal Year 2019 payment determinations. Then, I know many of you are working very diligently to begin collection of Calendar Year 2018 data,

which will be reported by February of 2019 and would impact the Fiscal Year 2020 payment determinations. Next slide, please.

In the IPPS proposed rule, we're also seeking public comment on the potential future inclusion of two new measures to the Hospital IQR Program: the Claims-Only Hospital-Wide Mortality Measure and/or the hybrid version of the hospital-wide mortality measure that uses both electronic health record data and claims data, as well as we are seeking comment on a new Hospital Harm – Opioid-Related Adverse Events eCQM. For the [Claims-Only] Hospital-Wide Mortality Measure, we are specifically seeking public comment about the service-line division structure of the measure, inputs on the measure-testing approach, and how the measure results might be presented to the public, as well any preferences between the all-claims version of the measure versus the hybrid version that uses both claims data and Core Clinical Data Elements (CCDEs) derived from the EHR. For the opioid-related adverse events eCQM, we are seeking public comment on the measure for use in the IQR Program, whether to initially introduce this measure as voluntary, whether to adopt the measure into the existing eCQM measure sets, or to adopt the measure as mandatory for all hospitals to report, as well as seeking comment on identifying any potential unintended consequences resulting from the use of this measure and potential ways to address any such unintended consequences. Next slide, please.

Beyond the particular eCQM proposals in this year's IPPS proposed rule, we're very much interested in hearing from our stakeholders on how we can continue to improve the use of eCQMs for quality measurement and improving the quality of care, while better balancing the reporting burden. We've been talking with many of you, either at HIINs [Hospital Improvement Innovation Networks] or through participation in CMS listening sessions, as we move toward [a] much more user-centered design approach, and you have helped us identify areas for improvement in the implementation of eCQMs under a variety of CMS programs including the IQR Program. Some of the feedback that we've been receiving is that some stakeholders would like to see the availability of new eCQMs, for us

to develop eCQMs that focus on patient outcomes rather than processes and that address higher impact measurement areas. You have also helped us explore how eCQMs could, in the long-run, reduce the cost and information-collection burden associated with quality measurement compared to chart-abstracted measures. We also understand there are still a lot of barriers which may contribute to a lack of adequate development of eCQMs and limit their potential. As part of the continuing effort to hear directly from our stakeholders, in this proposed rule, we're seeking your feedback on the following set of questions. So, please don't feel limited in your feedback to just these questions. We want to hear from you especially about anything that we may not have considered or that we should give more consideration or priority to. The questions that we've set forth in the proposed rule that we would love to get your feedback on are the following: What aspects of the use of eCQMs are most costly to hospitals and health IT [information technology] vendors? What program and policy changes do you think would have the greatest impact on addressing eCQM costs? What are the most significant barriers to the availability and use of new eCQMs today? What specifically would stakeholders like to see us do to reduce costs and maximize the benefits of eCQMs? Next slide, please.

How could we encourage hospitals and health IT vendors to engage in improvements to existing eCQMs? Would hospitals and health IT vendors be interested in or willing to participate in pilots or models of alternative approaches to quality measurements? In what ways could we incentivize or reward innovative uses of health IT that could reduce costs for hospitals? Last question: What additional resources or tools would hospitals and health IT vendors like to have publicly available to support testing, implementation, and reporting of eCQMs? Next slide, please.

Now, I will turn it over to my colleagues to describe the Promoting Interoperability proposals. Thank you.

Steven Johnson: Thank you, Grace. Today, Kathleen and I will walk through the proposals for the Medicare and Medicaid Promoting Interoperability (PI) Programs. These proposals all aim to better highlight the direction in which we, here

at CMS, are headed in regard to burden reduction, providing greater access to healthcare data electronically, and a general overview over providing greater interoperability for our patients.

Today, we will talk about, in particular, the name change from the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs, the EHR reporting period in 2019 and 2020, the new proposed scoring methodology, the new proposed objective and measures, the CQM proposals, our codification of the Puerto Rico hospitals into the Promoting Interoperability (PI) Program, as well as a general overview of the Medicaid proposals.

It's been noted through ListServe communications and highlighted in the 2019 IPPS proposed rule, we have changed the name of the Medicare and Medicaid EHR Incentives Programs to the Medicare and Medicaid Promoting Interoperability (PI) Programs. These changes align with the new direction we're going with the overhaul of EHR Incentive Program and signals a change in how we view patient data. We want to highlight the focus of the program to now focus more on the safe transmission of patient data and that each healthcare provider should ensure that patients are able to retrieve their data in an electronic format. We also note that the former name, Medicare and Medicaid EHR Incentive Programs, does not adequately reflect the current status of the programs, as the incentive payments under the Medicare program generally have ended with a few exceptions.

In the 2018 IPPS final rule, we allowed for certain flexibility in 2018 to allow for healthcare providers to use either the 2014, 2015, or a combination of both the 2014 and 2015 Edition of CEHRT [Certified Electronic Health Record Technology]. In this rule, we're reiterating that the Stage 3 objectives and measures are required beginning in CY 2019. We note that a large proportion of the sectors rates solely use the 2015 Edition. We believe that maintaining a requirement to keep both certification editions contributes to market fragmentation, which heightens implementation costs for health IT developers, hospitals, and healthcare providers. We believe that with implementation of a 2015 Edition, Eligible

Hospitals and CAHs will see a reduction in burden through relief from being required to certify to a legacy system and can use this edition to better streamline workflows and utilize more comprehensive functions to meet patient safety goals and improve care coordination across the continuum. This all focuses on achieving our goal of a truly interoperable system.

We continue to receive feedback from EPs, Eligible Hospitals, hospital associations, and other clinical associations, indicating that additional time will be necessary for testing and implementation of the new API [application programming interface] functionality requirement for Stage 3. We also are proposing an updated scoring methodology for all of the hospitals and CAHs that will begin in 2019, as well as two new opioid measures and one new health information exchange measure that we believe Eligible Hospitals and CAHs will want to report on as soon as those measures are available in their CEHRT. We want to provide additional flexibility to healthcare providers, as they're becoming more familiar with the new scoring methodology and measures, and that we're proposing, as well, adequate development time for EHR developers and vendors to test and incorporate the new scoring system and measures for deployment and implementation. Therefore, we're proposing changes to the EHR reporting period in 2019 and 2020 and believe these changes would result in a reduction in burden on healthcare providers, EHR developers, and vendors. We are proposing these changes for 2019 and 2020, as we believe it may take more than one year for Eligible Hospitals and CAHs to adjust to the new scoring methodology as well as the measures.

As we consider the future direction of EHR reporting for the Promoting Interoperability (PI) Program, we considered how to increase the focus of EHR reporting on interoperability and sharing data with patients. We also considered the history of the program stages from Stage 1 to Stage 3, as well as the increased flexibility provided by the Bipartisan Budget Act of 2018, which removed a stringency requirement from the program and a lot of these considerations. We're proposing a new scoring methodology that

reduces burden and provides greater flexibility to hospitals, while focusing on increased interoperability and patient access. We have received feedback from hospitals and hospital associations that the current Meaningful Use (MU) requirements are not always meaningful to them and distracts from their ability to provide care to their patients. They have further suggested through inquires and listening sessions that the requirements to meet all of the measures have been administratively burdensome, particularly those that require patient action. In addition, through the same listening sessions, we found that certain rural hospitals find it more challenging to meet all of the measure thresholds and requirements due to financial limitations. Many of these rural hospitals expressed an interest in fully participating in the Medicare EHR Incentive Program but said that they're only able to meet a subset of the objectives and measures. They stated that a new scoring reporting structure will allow them to focus on their patient population, which will help them successfully participate in the program. We are proposing performance-based scoring methodology would apply to Eligible Hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability (PI) Program beginning with the EHR reporting period in CY 2019. This structure requires the Eligible Hospitals or CAHs to report on all measures and meet thresholds for most of the measures or claim an exclusion as part of demonstrating meaningful use to avoid the payment adjustments or to earn an incentive in the case of subsection (d) Puerto Rico hospitals. This slide provides the current reporting structure with a general summary overview of the current objectives and measures and reporting requirements.

Under the proposed scoring methodology, Eligible Hospitals and CAHs will be required to report certain measures for each of the four objectives with performance-based scoring occurring at the individual-measure level. Each measure will be scored based on Eligible Hospitals and CAHs performance for that measure, except for the public health and clinical data exchange objective, which requires a Yes/No attestation. Each measure will contribute to the Eligible Hospital or CAH total promoting interoperability score. The scores for each of the individual measures will

be added together to calculate the total Promoting Interoperability score of up to a hundred possible points for each Eligible Hospital or CAH. A total score of 50 or more would satisfy the requirement to report on the objective measure of meaningful use codified at 495.24, which is one of the requirements for Eligible Hospitals or CAHs to be considered a meaningful user under CFR 495.4 and thus earn incentive payment and/or avoid a Medicare payment reduction. Eligible Hospitals and CAHs scoring below 50 points would not be considered meaningful EHR users. While we understand this approach maintains some of the same requirements of the EHR Incentive Program, we note that we're proposing to reduce the overall number of required measures from 16 to 6. We also note that measures we're proposing to include contribute to the goal to increase interoperability and patient access and no longer require the burdensome predefined thresholds from the EHR Incentive Program and, thus, allow new flexibility for Eligible Hospitals and CAHs and how they are scored. We believe that this proposal allows Eligible Hospitals and CAHs to receive high performance in areas where they excel in order to offset performance in areas where they may need additional improvement. The Query of the Prescription Drug Monitoring Program, PDMP, and Verify Opioid Treatment Agreement measures would be optional for the EHR reporting period for 2019. These new measures may not be available to all Eligible Hospitals and CAHs for EHR reporting period in 2019, as they may not have been fully developed by the health IT vendor or not fully implemented in time for data capture reporting. Therefore, we're not proposing to require these two new measures in 2019, although Eligible Hospitals and CAHs may choose to report on them and earn up to five bonus points for each measure.

We are proposing, however, to require these measures beginning with the EHR reporting period and CY 2020 and we're seeking public comment on this proposal. We note that due to varying state requirements, not-Eligible Hospitals and CAHs would be able to e-Prescribe control substances and, thus, these measures will not be available to them. For these reasons, we're proposing exclusion for these two measures which Kathleen will talk about in more detail in her section. We believe, as the two new opioid

measures become more broadly available in CEHRT, we're proposing each of these three measures within e-prescribing will be worth five points each beginning in 2020. We note that requiring two measures would add ten points to the maximum total score and these measures would no longer be eligible for optional bonus points. To maintain a maximum total score of 100 points beginning with the EHR reporting period in 2020, we're proposing to rewrite the e-Prescribing measure from ten points down to five and reweight the Provide Patients Electronic Access to Their Health Information measure from 40 points down to 35. We're proposing that, if the Eligible Hospital or CAH qualifies for e-Prescribing exclusion and is excluded from reporting all three of the measures associated with the 15 points for the e-Prescribing objective, [points] will be redistributed evenly among the two measures associated with Health Information Exchange objective and Provide Patients Electronic Access to Their Health Information measure by adding five points to each measure.

Here, we provide an example for the scoring methodology from a fictitious hospital. As you can see, they have the denominator and a numerator and their performance rate which was equal to their score. We'll give you a moment to walk through, to look through, that. For more information about the weights and the scoring, we refer readers to the new scoring methodology section of the 2019 IPPS proposed rule.

Next, I'm going to turn it over to Kathleen Johnson, who's going to go into more detail regarding the objective and measure proposals for the Medicare Promoting Interoperability (PI) Program.

Kathleen Johnson: Thank you, Steven. On this slide, we'd like to show everyone how the objectives and measures will align with the scoring methodology. So, you can see we have various objective proposals including removal, changes, and maintenance of current objectives under Stage 3, as well as proposals of new measures, removal of certain measures, changes to the name of certain measures, and maintenance of measures, as well. In addition, we will go through the exclusion criteria proposals, and, lastly, we will discuss the request for comment for a new HIE [Health Information Exchange] measure.

Under our new measure proposals, as previously mentioned, we are proposing two new opioid measures under the e-Prescribing objective. We are proposing to require that the two new opioid measures of Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement would begin with an EHR reporting period in 2020 and are proposing an exclusion for them, as not all Eligible Hospitals and CAHs would be able to e-Prescribe controlled substances. In addition, we are also proposing a new Health Information Exchange measure, which is the Support Electronic Referral Loop by Receiving and Incorporating Health Information, which includes the actions of the Request/Accept Summary of Care and Clinical Information Reconciliation measures under Stage 3, which are currently included and, therefore, would basically replace them. As previously mentioned, we are proposing an exclusion for any Eligible Hospital or CAH that is unable to implement the measure for an EHR reporting period in 2019 and would, therefore, be excluded from having to report this measure.

We've outlined in the table the changes to the objective including the new measures under e-Prescribing and the Health Information Exchange.

We are proposing to remove the following objectives and measures: the Coordination of Care through Patient Exchange [Engagement] Objective and all of the associated measures; the Patient Electronic Access to Health Information Objective measure, Patient-Specific Education; as well as the Health Information Exchange measures Request/Accept Summary of Care and Clinical Information Reconciliation. Note that we are proposing to replace the HIE measures with Support Electronic Referral Loops by Receiving and Incorporating Health Information as noted on the previous slides. As we previously indicated in rulemaking, if finalized, healthcare providers may still continue to use the standards and functions of measures removed based on their preferences and practice needs. We believe that the proposals will reduce burden and enable healthcare providers to focus on measures that further interoperability, the exchange of healthcare information, and advances of innovation and the use of CEHRT.

On this slide, we have a table that outlines the measures that are proposed for removal and what the current objective for Stage 3 is.

We are proposing the following changes to the objectives and measures for the Public Health Reporting objective. We are changing the name and the requirements. We are changing the name or proposing to change the name of the Patient Electronic Access to Health Information Objective to Provider to Patient Exchange. We are proposing to change the name of Provide Patient Access measure. We're proposing to change the name of Send a Summary of Care measure, and we are maintaining the proposals under the e-Prescribing measure, and we are maintaining the Public Health and Clinical Data Exchange measures. We're only changing the requirements for reporting, as well as the overall name, to Public Health and Clinical Data Exchange.

On this table, we are outlining the several changes that we are making and the revisions to the objective and measures including the names. For example, we are changing the Provide Patient Access measure name to better reflect the emphasis on patient engagement in their healthcare and patient electronic access of their health information through use of APIs. Additionally, we are changing the Send a Summary of Care measure name to better reflect the emphasis on completing the referral loop and improving care coordination.

We are proposing to remove exclusion criteria from all of the measures except for the e-Prescribing objective, which would include the e-Prescribing measure, the new Query of PDMP measure, and Verify Opioid Treatment Agreement measure. We discussed the new measure exclusions in previous slides. In addition, under the Health Information Exchange objective, we are proposing a new exclusion for the Support Electronic Referral Loops by Receiving and Incorporating Health Information, and, lastly, we are maintaining the Public Health and Clinical Data Exchange objective measure exclusions for all of the public reporting options.

We are seeking to introduce additional flexibility to allow providers a wider range of options selecting measures that are most appropriate to

their setting, patient population, and clinical practice improvement goals. Currently, the Stage 3 program requirements for Health Information Exchange primarily focus on the exchange between and among Eligible Hospitals, CAHs, and eligible professionals. However, we do note that the care continuum is much broader and includes a wider range of healthcare providers in settings of care, including long-term care and post-acute care settings, such as skilled nursing facilities and behavioral health settings. In addition, many of these settings have adopted and implemented health IT systems that support patient care and exchange of healthcare information. Due to this, we are seeking comment on two potential new measures which would exchange healthcare information across a broader range of those care settings.

At this time, I would like to turn this over, back to Steven Johnson.

Steven Johnson: Thank you, Kathleen. In future years of the Promoting Interoperability (PI) Program, we will continue to consider changes which support a variety of HHS goals, including reduced administrative burden, supporting in line with the Quality Payment Program, advancing interoperability in exchange of health information, and promoting innovation through the use of health IT. We believe a focus on our ability and simplification will reduce healthcare provider burden while allowing flexibility to pursue innovative applications that improve care delivery. One strategy we're exploring is creating a set of priority health IT activities that will serve as alternatives to traditional EHR Incentive Program measures. To that extent, we seek comment on the following: the PI Program support HHS goals to make sure that we are doing so. We're seeking comment on the Trusted Exchange Framework and Common Agreement (TEFCA) Health IT activity, and we're just asking general ways to reduce burden. Additionally, we're seeking other activities from commenter's that CMS should consider on the next phase of the PI Program.

As we stated previously in rulemaking, we plan to continue to align the CQM reporting requirements for the Promoting Interoperability (PI) Program with Hospital IQR Program. To align with the Hospital IQR Program, we are proposing to reduce the number of eCQMs in the

Medicare and Medicaid Promoting Interoperability (PI) Programs, the eCQM measure set for Eligible Hospitals and CAHs report by proposing to remove eight eCQMs from 16 eCQMs that are currently in the measure set, beginning with the reporting period and CY 2020. For CY 2019, we're posing the same CQM reporting periods and criteria, as established in the 2018 IPPS final rule for the Medicare and Medicaid EHR Incentives Programs. For CY 2019 Eligible Hospitals and CAHs that report CQMs electronically, we're proposing the reporting period for the Medicare and Medicaid Promoting Interoperability (PI) Programs would be one self-selected calendar quarter of CY 2019 data and the submission period for the Medicare Promoting Interoperability (PI) Program would be the two months following the close of the Calendar Year, ending February 29, 2020.

Next, I'd like to turn it over to Kathleen Johnson who will talk about participation in the Medicare Promoting Interoperability (PI) Program for subsection (d) Puerto Rico hospitals. Kathleen?

Kathleen Johnson: Thank you, Steven. We are proposing to codify the program instructions we have issued for subsection (d) Puerto Rico hospitals and to amend our regulations under Parts 412 and 495, as the provisions that apply to Eligible Hospitals would include subsection (d) Puerto Rico hospitals, unless otherwise indicated. This would include our proposal to formalize the Medicare Promoting Interoperability (PI) Program for Eligible Hospitals in Puerto Rico (information previously implemented in 2016 through guidance) and proposal to align the requirements with the requirements for other Eligible Hospitals in the Medicare Promoting Interoperability (PI) Program.

At this time, we would like to turn the discussion over to Artrina Sturges. Thank you.

Artrina Sturges: At this time, we would like to review a brief page directory to assist you to locate program-specific information associated with eCQM reporting and outline the process to submit questions and comments.

This slide provides you with a direct link to the Fiscal Year 2019 IPPS Proposed Rule and outlines the pages for each of the specific programs associated with eCQM reporting.

CMS is accepting comments on the Fiscal Year 2019 IPPS Proposed Rule until June 25, 2018. Comments can be submitted either electronically, by regular mail, by express or overnight mail, or by hand courier. CMS will respond to comments in the final rule, which is scheduled to be issued by August 1, 2018.

Program resources are outlined for the Hospital IQR Program and the Medicare and Medicaid Promoting Interoperability (PI) Programs.

At this time, we would like to begin the question-and-answer (Q&A) session. As stated earlier, CMS will not be able to provide additional information, clarification, or guidance related to the proposed rule to comply with the Administrative Procedures Act. CMS strongly encourages stakeholders to submit their comments or questions through the formal comment submission process. We'd like to go ahead and get started with our questions. We just have a handful, as I said, that can be addressed during this session. So, question number one: Are there any chart-abstracted measures required for Calendar Year 2019 by CMS?

Shanna Hartman: Sorry. Can you repeat that question?

Artrina Sturges: Sure. They're asking what chart-abstracted measures would be required for Calendar Year 2019 reporting.

Grace Snyder: Hi, this is Grace. So, for this presentation today, we're really only focusing on eCQMs for the IQR Program, but, yes, there are some chart-abstracted measures that would also still need to be reported for the IQR Program, such as the sepsis measure. You can find more detailed information on our *QualityNet.org* website where we have available measure tables for the programs as well as information on the reporting periods and which Fiscal Year payment determinations they would impact. So, hopefully, you can find more detailed information there, and, if you still have more questions

on that, I would also direct you to slide 57 from today. It has contact information to our program support contractors.

Artrina Sturges: Thank you, Grace, and, just to add to that, the webinar that you may be seeking, the IQR-specific information, was from May 9. So, that information, as Grace stated, is posted on *QualityNet*. It's also posted on the *QualityReportingCenter.com* website. Okay, thank you. The next question: When will the USHIK [United States Health Information Knowledgebase] links be updated with the 2019 reporting period information?

Shanna Hartman: Hi, this is Shanna, and, as of earlier this week, the USHIK website is updated with the 2019 eCQM value set. So, you can access them as of now and be able to see them for compare features.

Artrina Sturges: Thank you, Shanna. Next question: Does CQL logic mean we are no longer using SNOMED, LOINC, and RxNorm codes?

Shanna Hartman: Hi, this is Shanna again, and, no, that does not mean that. The CQL is the logic that makes up the specification and there are still specific codes and sums used in the value set such as SNOMED and RxNorm, as you mentioned.

Artrina Sturges: Thank you, Shanna. For those who want to go back and look at the CQL-specific information, that should start around slide 20 in the slide deck. Okay? Thank you. Okay, Grace, this one may be for you. For eCQMs that have been developed that meet the needs… Excuse me. Have eCQMs been developed that meet the needs of a specialty hospital, such as an orthopedic specialty hospital without an emergency department?

Grace Snyder: So, I would, in terms of measures we have under development and not just eCQMs, but various kinds of measures that are in development or under consideration for any of CMS's quality programs, I would refer you to our CMS website. We actually have a new measures inventory tool. Sorry, I don't remember the hyperlink off the top of my head, but we can certainly provide it in the questions-and-answers document that we'll be preparing after this webinar. So, that's one place. Also, I would strongly recommend

submitting a public comment if you would like to see more specialty measures available. I think I would definitely encourage you to submit a public comment.

Artrina Sturges: Thank you, Grace, and, if we can go to Slide 56, there was a question regarding the deadline for public comments. So, we just want to reinforce that public comments are being accepted until June 25 of 2018, and then, it provides the listing of the four different methods of how comments could be submitted. Okay? Thank you.

I believe, at this time, we have room for one more question and, of course, if we need to address this offline, we certainly can in terms of the Q&A transcript, but there is a question. If this is a proposed rule, they're questioning the name change of Promoting Interoperability and why that's being made effective immediately.

Grace Snyder: So, this is Grace. We want to clarify that changing the name of what was previously the EHR Incentive Program to the Promoting Interoperability (PI) Program is not a formal proposal; but, you know, understand in this proposed rule is the first time that we've communicated the name change. We will, of course, try to do our best in terms of all of our communications and education outreach materials to, you know, make it clear the name of the program. Obviously, understand it will take a little bit of time for all of us to get used to the new program name. I know I'm certainly still getting used to it. So, but, you know, please don't hesitate to reach out to us through any of our help desks or email inboxes if there are any concerns about that. Of course, always welcome to also submit public comments or any feedback related to any of the proposals that we've presented on this webinar today.

Artrina Sturges: Thank you very much, Grace. At this time, Dr. Deborah Price will join us, and she will review the continuing education credit process.

Deborah Price: Well, hello, and thank you for allowing me time to go over these credits. Today's webinar has been approved for one continuing education (CE) credit by the boards listed on this slide. We are now a nationally

accredited nursing provider and, as such, all nurses report their own credit to the board using the national provider number 16578.

We now have an online CE certificate process. You can receive your certificate two different ways: The first way is, if you registered for the webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate, and, the second way to receive your certificate is, within 48 hours, your host will be sending out another survey link. If there are other people in the room that are listening to this event, this is the time that you can send the link to them.

If you do not immediately receive a response to the email that you signed up with in our Learning Management Center, that means you probably have a firewall that's blocking our automatic link. If that's the case, please go back and use a New User link, and use your personal email, as well as your personal phone number.

This is what the survey will look like at the end of this event. It will pop up and will be sent, again, will be sent to all attendees within 48 hours. In the bottom, you'll notice the Done, the little gray Done box. Click that and this is the page that's going to pop up. You notice that there are two links in this page, the New User link and Existing User link. If you've been having certificates all along and haven't had any problems, please click on the Existing User link. If you have had problems, that's when we'd like you to use the New User link and input your personal email, as well as a personal phone number. This is what the New User slide will look like. You put in your first name, your last name, and your personal email, and personal phone number.

This is what the Existing User slide will look like. Your User Name is your complete email address, including what's after the @ sign. Your Password is whatever you used to sign up. If you forgot your password, it's okay. Just click in that box and you will be prompted what to do next. Now, I thank you for attending the webinar. I hope that you learned something and please enjoy the rest of your day.