Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) Final Rule: Acute Care Hospital Quality Reporting Programs Overview

Questions & Answers

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Electronic Clinical Quality Measures (eCQMs)

Question 1: **Slide 17: Do the same measures chosen for 2018 submission of eCQMs need to continue into 2019 or can different measures be chosen each year?**

Hospitals can self-select at least four eCQMs to successfully submit for calendar year (CY) 2017 and CY 2018 Hospital IQR and the Electronic Health Record (EHR) Incentive Program clinical quality measure (CQM) reporting requirements. CMS does not require hospitals to submit the same measures for the CY 2017 reporting year and for the CY 2018 reporting year.

Question 2: **Slide 17: If our hospital is transitioning to Epic 2017 this year 2017, will we be able to use data from Epic 2017 for eCQM reporting 2018? Will this be updated? I only see EHR certified to 2014–2015 on the slide.**

It is unclear if Epic 2017 is the proper name of the software or references the edition of software available. The Health Information Technology (IT) would need to be certified to the Office of the National Coordinator for Health Information Technology [ONC] 2014 Edition, the 2015 Edition, or a combination of both to be utilized for eCQM reporting in CY 2018. Please refer to the ONC Certified Health IT Product List to ensure your EHR technology is certified to the correct edition per CMS requirements.

Question 3: **Do we have to submit a selection form on the eCQMs we have selected and which quarter for FY 2017 and FY 2018?**

Hospitals are not required to signal to CMS which clinical measures they intend to report electronically for the Hospital IQR Program or the EHR Incentive Program through the *QualityNet Secure Portal*. When the data is reported via the *QualityNet Secure Portal*, CMS will know at that time which measures and quarter of discharge data the hospital intended to report on to fulfill a portion of CMS reporting requirements.

Question 4: **When will national performance benchmarks be made available for the eCQMs?**

CMS will signal in a future IPPS proposed rule when they intend to publicly report eCQM outcomes. As eCQMs are not used in the Hospital VBP Program, performance standards (i.e., benchmark and achievement thresholds) are not calculated or published for these measures.

Question 5: **When is the deadline to select the four electronic measures for 2017 data?**

Hospitals are not required to notify CMS which eCQMs will be submitted. The measure "intent to submit" screen within the *QualityNet Secure Portal* has been grayed out and is not accessible. When the data is reported via the *QualityNet Secure Portal* by the February 28, 2018 deadline, CMS will know which measures and quarter of discharge data the hospital intended to report on to fulfill a portion of CMS reporting requirements.

General

Question 6: **For all measures, can you tell me if the Bill Type 110 and Condition Code W2. These patients are admitted as inpatients; however, they do not qualify under the 2-midnight rules and are reimbursed as an outpatient. In the claims-based measures of the programs discussed, sometimes these patients show up in the measures and other times they do not. Can you please clarify their status as it relates to the HIQR programs? We have asked Noridian, MedPAR, the measure stewards, asked for clarification in the rule (not responded to) and our quality improvement organization (QIO) without success.**

CMS does not use bill type to identify inpatient claims. Inpatient claims are identified as those with a "national claims history (NCH) Claim Type Code" of 60, which is defined in the Research Data Assistance Center (ResDAC) as "Inpatient Claim." The claim must also have a "Claim Facility Type Code" of 1, which is defined in ResDAC as "Hospital." (Claim Facility Type Code is part of Bill Type, but that is the only part that CMS uses.) CMS only selects final claims for use in measure calculations.

There are additional measure-specific inclusion and exclusion criteria that are applied as detailed in the user guide that accompanies the hospital-specific reports for claims-based measures and in the condition-specific measure updates and specifications reports found on *QualityNet*.

The 2017 condition-specific measure updates and specifications reports and supplemental code lists on *QualityNet* include the International Classification of Diseases, Tenth Revision (ICD-10) codes.

For Mortality measures, they can be found here:

QualityNet.org > Hospitals-Inpatient > Claims-Based Measures > Mortality Measures > Measure Methodology

Readmission, Complication, Payment, and Excess Days in Acute Care (EDAC) measure reports can be found in their corresponding Measure Methodology section.

Hospital-Acquired Condition (HAC) Reduction Program

Question 7: **For the FY 2020 annual payment update (APU), is the HAC Reduction Program using July 1, 2016? June 30, 2018 data for the revised PSI 90 now called the Patient Safety and Adverse Events Composite?**

Yes, that is correct.

Question 8: **Will PSIs be used in the HAC Reduction Program?**

Yes, the PSI 90 Composite will still be used in the HAC Reduction Program.

Question 9: **Does any of this [HAC Reduction Program requirements] apply to critical access hospitals?**

No, the HAC Reduction Program only applies to subsection (d) hospitals, as defined in section 1886(d)(1)(B) of the Social Security Act.

Question 10: **Will the new PSI 90 be used in the FY 2018 HAC Reduction Program?**

Yes, the modified version of the recalibrated PSI 90 Patient Safety and Adverse Events Composite is being used in the FY 2018 HAC Reduction Program.

Question 11: **Will rebaselined healthcare-associated infection (HAI) data be used in the FY 2018 HAC Reduction Program?**

Yes, the Centers for Disease Control and Prevention (CDC) used CY 2015 as the baseline data period, with updated risk adjustment in each of the HAI models for FY 2018.

Hospital IQR Program

Question 12: **What will happen with the five-star ratings with the PSI 90?**

The PSI 90, Patient Safety and Adverse Events Composite, measure is still included in the Hospital IQR Program and will remain as one of the measures used in the *Hospital Compare* overall star rating.

Question 13: **Is Patient Safety Indicator (PSI) 4 included in the Hospital IQR Program for FY 2018, given the concerns about transfers to acute care not being excluded and the lack of National Quality Forum (NQF) endorsement?**

Yes, the PSI 4 measure is still included in the Hospital IQR Program for FY 2018 (using a reporting period of July 1, 2014 through September 30, 2015). CMS routinely assesses the appropriateness of measures used in its quality reporting programs such as the Hospital IQR Program, and the status of NQF endorsement is taken into consideration. Any measures that CMS may consider for removal from a program would need to be formally proposed for removal in a proposed rule with the opportunity for the public to comment.

Question 14: **Slide 13: Where can I find more information about the National Institutes of Health (NIH) ICD-10 stroke severity codes?**

The response below assumes your request is for publicly available information on the National Institutes of Health ICD-10 stroke severity codes.

Information on the coding guidelines for the NIH ICD-10 stroke severity codes can be found on page 17 and 69 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, available at https://www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf.

The specific ICD-10-CM codes for the NIH Stroke Severity Scale can be found below and in the icd10cm_order_addenda_2017.txt file, inside the 2017-ICD10-Code-Descriptions.ZIP on the CMS website at https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html.

ICD-10 Code	NIH Stroke Scale Score
R29.700	Score 0
R29.701	Score 1
R29.702	Score 2
R29.703	Score 3
R29.704	Score 4
R29.705	Score 5
R29.706	Score 6
R29.707	Score 7
R29.708	Score 8
R29.709	Score 9
R29.710	Score 10
R29.711	Score 11

R29.712	Score 12
R29.713	Score 13
R29.714	Score 14
R29.715	Score 15
R29.716	Score 16
R29.717	Score 17
R29.718	Score 18
R29.719	Score 19
R29.720	Score 20
R29.721	Score 21
R29.722	Score 22
R29.723	Score 23
R29.724	Score 24
R29.725	Score 25
R29.726	Score 26
R29.727	Score 27
R29.728	Score 28
R29.729	Score 29
R29.730	Score 30
R29.731	Score 31
R29.732	Score 32
R29.733	Score 33
R29.734	Score 34
R29.735	Score 35

R29.736	Score 36
R29.737	Score 37
R29.738	Score 38
R29.739	Score 39
R29.740	Score 40
R29.741	Score 41
R29.742	Score 42

For information on the updated stroke mortality measure, please see the FY 2018 IPPS/LTCH PPS Final Rule and the "Mortality_Stroke_Updated_Report_3.28.16" document found in the "AMI, HF, PN, COPD, and Stroke Mortality Update [ZIP, 7MB]" at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Please note that ICD-10 codes are not included in the methodology report posted on this location.

Question 15: **Could you please let us know what the required chart-abstracted measures are for calendar year (CY) 2018?**

There were no changes to the required chart-abstracted measures for CY 2018. The required chart-abstracted measures are as follows:

- ED-1: Median Time from ED* Arrival to ED Departure for Admitted ED Patients
- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients
- IMM-2: Influenza Immunization
- PC-01: Elective Delivery
- SEP-1: Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)
- VTE-6: Incidence of Potentially Preventable Venous Thromboembolism

Chart-abstracted measure data reported by hospitals for CY 2018 discharges will apply to Hospital IQR Program payment determinations for FY 2020.

*ED = Emergency Department

Hospital Value-Based Purchasing (VBP) Program

Question 16: **FY 2023 program year = data collection in CY 2021, correct?**

The Hospital VBP Program uses two time periods for each fiscal year, the baseline period and the performance period. The following table displays the baseline and performance periods for FY 2023. The finalized baseline and performance periods can also be found in the FY 2018 IPPS/LTCH PPS Final Rule (82 FR 38261).

Domain/Measure	Baseline Period	Performance Period
Clinical Care: Mortality Measures	July 1, 2013 – June 30, 2016	July 1, 2018 – June 30, 2021
Clinical Care: THA/TKA Complication Measures	April 1, 2013 – March 31, 2016	April 1, 2018 – March 31, 2021
Person and Community Engagement: HCAHPS Survey	January 1, 2019 – December 31, 2019	January 1, 2021 – December 31, 2021
Safety: PC-01 and HAI Measures	January 1, 2019 – December 31, 2019	January 1, 2021 – December 31, 2021
Safety: Modified PSI 90	October 1, 2015 – June 30, 2017	July 1, 2019 – June 30, 2021
Efficiency and Cost Reduction: MSPB	January 1, 2019 – December 31, 2019	January 1, 2021 – December 31, 2021
Efficiency and Cost Reduction: AMI and HF Payment	July 1, 2013 – June 30, 2016	July 1, 2018 – June 30, 2021
Efficiency and Cost Reduction: PN Payment	July 1, 2013 – June 30, 2016	August 1, 2018 – June 30, 2021

Question 17: **I know the Maryland Quality-Based Reimbursement (QBR) Program was trying to align with CMS for VBP, do you know if Maryland is following all of these changes?**

CMS recommends contacting the State of Maryland Health Services Cost Review Commission for information about its Quality-Based Reimbursement (QBR) Program and efforts to align with the Hospital VBP Program.

Question 18: **Slide 27 states FY 2019, does this mean it begins in CY 2018?**

The Hospital VBP Program uses two time periods for each fiscal year, the baseline period and the performance period. The following table displays the baseline and performance periods for FY 2019. The finalized baseline and performance periods can also be found in the FY 2018 IPPS/LTCH PPS Final Rule (82 FR 38259–38260).

Domain/Measure	Baseline Period	Performance Period
Clinical Care: Mortality Measures	July 1, 2009 – June 30, 2012	July 1, 2014 – June 30, 2017
Clinical Care: THA/TKA Complication Measures	July 1, 2010 – June 30, 2013	January 1, 2015 – June 30, 2017
Person and Community Engagement: HCAHPS Survey	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Safety: PC-01 and HAI Measures	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Efficiency and Cost Reduction: MSPB	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017

Question 19: **What version of the Patient Safety Indicator (PSI) measure specifications is currently being used for CMS?**

CMS finalized its proposal to remove the old version of the PSI 90 Composite from the Hospital VBP Program effective for FY 2019. CMS also finalized its proposal to add the new version of the PSI 90 Composite to the Hospital VBP Program in FY 2023.

The HAC Reduction Program and Hospital IQR Program started using the new version of the PSI 90 measure in FY 2018.

For more information, please reference the PSI 90 Resources web page on *QualityNet.org*, located at https://www.*QualityNet*.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228695355425 .

Question 20: **Slide 29: Is the performance period correct? It says August 1 instead of July 1. Is that right?**

In the FY 2018 IPPS/LTCH Final Rule (82 FR 38257), CMS explains its rationale for using the August 1 start date to the performance period, "We proposed to adopt a 23-month performance period because we anticipate that the refined measure will not be posted on *Hospital Compare* for one year until July 2017. Therefore, for the FY 2022 program year, we proposed to adopt a 23-month performance period that runs from August 1, 2018 to June 30, 2020 and a baseline period that runs from July 1, 2013 to June 30, 2016."

Question 21: **Are we currently in a performance period for PSI 90?**

CMS finalized its proposal to remove the old version of the PSI 90 Composite from the Hospital VBP Program effective for FY 2019. CMS also finalized its proposal to add the new version of the PSI 90 Composite to the Hospital VBP Program in FY 2023. For the FY 2023 Hospital VBP Program, the baseline period for the PSI 90 Composite is October 1, 2015 through June 30, 2017, and the performance period is July 1, 2019 through June 30, 2021.

Question 22: **When will pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems® Survey (aka CAHPS® Hospital Survey) be reintroduced to Hospital VBP?**

CMS has not proposed the adoption of new pain management questions for use in the Hospital VBP Program. Any new measures for the Hospital VBP Program would be proposed in a proposed rule with the opportunity for the public to comment.

Question 23: **I am new to the PSI 90. Is information for this measure taken from claims or is it something that must be abstracted and inputted?**

The PSI 90 Composite is a claims-based measure. CMS uses the information available in Medicare fee-for-service claims and patient enrollment data to calculate the measure. There is no requirement for hospitals to abstract or submit any additional measure data for PSI 90.

Question 24: **On one of the previous slides named "Removal of PSI 90," is there a difference between the act of "removal" rather than "update" leading to "Adoption of PSI 90 Modifications?" I wasn't sure if this is due to the PSI name change to Patient Safety and Adverse Events Composite. Just wanted some clarification.**

There were a number of changes beginning with modified version of PSI 90 6.0. The following lists a high-level summary of the changes: a name change; the number of component indicators increased from eight to ten; PSI 08, PSI 12, and PSI 15 changes; the reference population updated and only includes data with complete present-on-admission (POA) data; component weighting now incorporates harm; and component weights have changed and are more equally distributed among the component indicators.

For more information on the updates and use of the new version of the PSI 90 Composite, CMS recommends reviewing the questions and answers (Q&A) transcript from the webinar, *Updates on Patient Safety Indicators (PSIs) for Use in CMS Programs*.

For the Hospital VBP Program, PSI 90 will not be used for the FY 2019–FY 2022 program years; the updated version of PSI 90 (as described above) will be used, beginning with the FY 2023 program year.

Question 25: **Is the slide [34] correct that the achievement threshold and benchmark are the same for PC-01?**

The slide is correct. The PC-01 achievement threshold and benchmark for FY 2020 are both 0.000000. These values were calculated, based on the definition of Hospital VBP Program achievement threshold and benchmark set forth in 42 Code of Federal Regulations 412.160.

Question 26: **What is the purpose of the floor measure for HCAHPS Survey domain?**

The floor is the rate of the lowest performing provider during the baseline period for a specific dimension. The floor is used to calculate a hospital's lowest dimension score, which is then used to determine the hospital's consistency score.

Question 27: **Is the Pain Management/Communication About Pain dimension still excluded from the Hospital VBP Program?**

The Pain Management dimension was removed from the Hospital VBP Program in FY 2018. Subsequently, CMS has not proposed to include a Pain Management dimension in the Hospital VBP Program. Any new measures for the Hospital VBP Program would be proposed in a proposed rule with the opportunity for the public to comment.

Question 28: **For the HCAHPS Survey, the floor percent seems high as compared to previous and current floor percent. FY 2019 Comm. w/ RN is 28.10%. Slide 35 shows FY 2020 Comm. w/ RN as 51.80%. Why are the FY 2020 floors so high?**

The floor value is the rate of the lowest performing hospital per dimension. As the floor is based on one hospital per dimension, the floor values can generally fluctuate more than values based on the entire population, such as the benchmark and achievement threshold.

Question 29: **What is the performance time frame for the FY 2021 program for episodes of care? Starts January 19?**

For the FY 2021 Hospital VBP Program, the AMI and HF Payment measures have a baseline period of July 1, 2012 through June 30, 2015 and a performance period of July 1, 2017 through June 30, 2019.

Domain/Measure	Baseline Period	Performance Period
Clinical Care: Mortality Measures MORT-30-PN	July 1, 2011 – June 30, 2014 July 1, 2012 – June 30, 2015	July 1, 2016 – June 30, 2019 September 1, 2017 – June 30, 2019
Clinical Care: THA/TKA Complication Measures	April 1, 2011 – March 31, 2014	April 1, 2016 – March 31, 2019
Person and Community Engagement: HCAHPS Survey	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Safety: PC-01 and HAI Measures	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Efficiency and Cost Reduction: MSPB	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Efficiency and Cost Reduction: AMI and HF Payment	July 1, 2012 – June 30, 2015	July 1, 2017 – June 30, 2019

Question 30: **Please share what *Hospital Compare* files contain the values to estimate the annual base-operating diagnosis-related group (DRG) [classification system] reimbursement to apply the Hospital VBP and Excess Readmissions multipliers against.**

There are no *Hospital Compare* files that contain the estimated base-operating DRG payment amounts at the CMS Certification Number (CCN) level. However, there are aggregate results of the Hospital VBP Program available on *Hospital Compare* for FY 2015. CMS anticipates refreshing the results with FY 2016 data in December 2017.

Question 31: **What are the complications that are recognized for hip and knee patients in the Clinical Care domain of the Hospital VBP Program?**

The THA/TKA complications measure methodology and updates are posted on the *QualityNet* website, on the Measure Methodology Reports web page. The measure methodology report has specific information about the complications measured, as well as inclusion and exclusion criteria for the measure.

Hospital Readmissions Reduction Program (HRRP)

Question 32: **Will this new readmission payment methodology be applied to FY 2018 payment or will the FY 2018 methodology remain the same as FY 2017 methodology?**

The FY 2018 payment adjustment methodology will remain the same as FY 2017. The new stratified methodology will be applied starting with the FY 2019 program.

Question 33: **Does the HRRP apply to CAHs?**

No, HRRP does not apply to CAHs. As defined in section 1886(q)(5)(C) of the Social Security Act, "applicable hospitals" with respect to the HRRP include subsection (d) hospitals, as defined in section 1886(d)(1)(B) of the Social Security Act, and Maryland hospitals participating in the All-Payer Model.

As finalized in the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53397), subsection (d) hospitals applicable for the Hospital Readmissions Reduction Program (HRRP) do **not** include the following:

- Long-term care hospitals
- CAHs
- Rehabilitation hospitals and units
- Psychiatric hospitals and units
- Children's hospitals
- Prospective payment system (PPS)-exempt cancer hospitals

Question 34: **Where can one locate the list of what is considered a total hip arthroplasty (THA) and total knee arthroplasty (TKA) complication?**

The measure specifications are located on *QualityNet* on the Measure Methodology Reports Readmission Measures web page, located at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841.

Question 35: **Where do we learn which peer group our hospitals are assigned to? Is there a table available?**

CMS will be publishing on the HRRP web page of cms.gov, a FY 2018 IPPS/LTCH PPS Final Rule hospital-level dual proportion and peer group file in the fall of 2017 to allow hospitals to see what their peer group assignment would be, using FY 2018 data. This information will also be available in the early-look, hospital-specific report (HSR) using FY 2018 data.

Question 36: **Is this national peer groups or state peer groups for the CURES Act?**

National peer groups composed of HRRP eligible hospitals.

Question 37: **What is the definition of a safety-net hospital?**

For the purposes of the analysis included in the FY 2018 IPPS/LTCH PPS Final Rule, safety-net hospitals were defined as hospitals in the top quintile for disproportionate share hospital (DSH) patient percentage. DSH patient percentage was calculated among all hospitals with a positive DSH value (including hospitals not eligible for DSH payments).

Question 38: **What was your definition of safety-net hospitals vs. non-safety net?**

For the purposes of the analysis included in the FY 2018 IPPS/LTCH PPS Final Rule, safety-net hospitals were defined as hospitals in the top quintile for DSH patient percentage. DSH patient percentage was calculated among all hospitals with a positive DSH value (including hospitals not eligible for DSH payments).

Non-safety net hospitals are defined as hospitals not in the top quintile for DSH patient percentage. DSH patient percentage was calculated among all

hospitals with a positive DSH value (including hospitals not eligible for DSH payments).

Question 39: When will the early look on HRRP hospital-specific report (HSR) become available to us through *QualityNet*?

Early-look HSRs will be released first quarter 2018. Hospitals will be notified via email when the reports are distributed.

Hybrid Hospital-Wide Readmission (HWR) Measure

Question 40: Will the HWR measure be required at any point?

CMS has not made any proposal to require the Hybrid HWR measure. Any proposal to implement a mandatory Hybrid HWR measure in the Hospital IQR Program or any other CMS program would be proposed through a future proposed rule with the opportunity for the public to comment.

In the FY 2018 IPPS/LTCH PPS Final Rule, CMS noted that they are considering proposing the Hybrid HWR measure as a required measure in the future, so information collected during the voluntary reporting effort will be very important to take into consideration. As noted, any requirement for mandatory reporting on this measure would be proposed through future rulemaking. For more information on the FY 2018 IPPS/LTCH PPS Final Rule, please refer to https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

Question 41: Referencing slide 14 and the 13 core clinical data elements from electronic health records (EHRs) and the six linking variables, how are these data to be submitted to CMS?

CMS asks that the core clinical data elements and linking variables be submitted via a Quality Reporting Document Architecture (QRDA) Category I file through the *QualityNet Secure Portal*.

Question 42: **Slide 14: Do we sign up through the *QualityNet Secure Portal* to participate in the voluntary HWR measure?**

Hospitals participating in the voluntary submission of the Hybrid HWR measure are not required to signal their intent to submit. The successful submission of QRDA Category I files uploaded through the *QualityNet Secure Portal* will be sufficient for informing CMS of participation.

Question 43: **Slide 15: Vital signs: multiple values throughout the day. Which are used?**

As stated in the core clinical data elements specification, only the first recorded vital signs within the 24-hour lookback period or two-hour look-forward period from the admission date and time for each inpatient encounter should be extracted from the EHR and submitted to CMS. The electronic specifications for extraction of the core clinical data elements used in the measure are now available on the CMS.gov Measure Methodology web page within the Core Clinical Data Elements and Hybrid Measures ZIP file and the Electronic Clinical Quality Improvement (eCQI) Resource Center website under the 2018 Reporting Period Eligible Hospital (EH)/CAH eCQMs.

Question 44: **When will more details about the Hybrid HWR measure be released, such as file formats, etc.?**

CMS does not plan to release a file format for the voluntary Hybrid HWR measure because they are asking that the data be submitted via a QRDA Category I file through the *QualityNet Secure Portal*. The electronic specifications for extraction of the core clinical data elements used in the measure are now available on the CMS.gov Measure Methodology web page within the Core Clinical Data Elements and Hybrid Measures ZIP file and the eCQI website under the 2018 Reporting Period EH/CAH eCQMs.

Additionally, CMS will provide more information describing the electronic specifications and reporting requirements through the webinar, *Hybrid Hospital-Wide 30-Day Readmission (HWR) Measure Core Clinical Data Elements Data Submission*, in December 2017. Information will be distributed in the near future via ListServe messages. Visit the *QualityNet* website to ensure you are receiving those notifications. For more details about the agendas of upcoming webinars, please visit the Upcoming Events web page on the *Quality Reporting Center* website, located at http://www.qualityreportingcenter.com/inpatient/iqr/upcoming/.

Question 45: **Is this EHR data for the Hybrid HWR measure obtained through abstraction?**

The core clinical data elements and the linking variables should be extracted from the EHR, using the core clinical data elements electronic specification. The electronic specifications for extraction of the core clinical data elements used in the measure are now available on the CMS.gov Measure Methodology web page within the Core Clinical Data Elements and Hybrid Measures ZIP file and the eCQI website under the 2018 Reporting Period EH/CAH eCQMs.

Question 46: **For the hybrid readmission measure, how will these clinical data elements be transmitted? Will this have to be a separate Quality Reporting Document Architecture (QRDA) with just this information, since this data is not included in eCQM QRDAs?**

CMS asks that providers that participate in the voluntary Hybrid HWR measure submit data using **separate** QRDA Category I files than those used for eCQM reporting. The submission deadline will not overlap with the eCQM reporting deadline. CMS has indicated that the submission period for the voluntary Hybrid HWR measure will occur in the fall of CY 2018.

Question 47: **Will the claims-based HWR be measured concurrently with the new Hybrid HWR for those volunteering for that?**

For all providers that choose to participate in the voluntary Hybrid HWR measure, CMS will not publicly report the results of the hybrid measure on *Hospital Compare* or anywhere else. CMS will continue only to publicly report the results of the claims-based HWR measure. However, providers that participate will be able to receive confidential reports with details about the core clinical data elements and linking variables submitted, as well as measure results. If CMS decides to propose making the Hybrid HWR measure mandatory in the future and to replace the claims-based HWR measure, they would propose and seek public comment in a future proposed rule.

Question 48: **On the voluntary hybrid measure, where are the specifications for the vital signs and lab tests. Is this a separate QRDA file from eCQMs?**

Yes, CMS asks that providers that participate in the voluntary Hybrid HWR measure submit a separate QRDA Category I file from the eCQM reporting files. CMS has indicated that the data-submission period for the voluntary Hybrid HWR measure will occur in the fall of calendar year 2018. The electronic specifications for extraction of the core clinical data elements used in the measure are now available on the CMS.gov Measure Methodology web page within the Core Clinical Data Elements and Hybrid Measures ZIP file and the eCQI website under the 2018 Reporting Period EH/CAH eCQMs.

Question 49: **Our hospital is in the process of building a new EHR system. Our go-live date is in May 2018. I am concerned with the Hybrid measure reporting with the change in our EHR during the same period of time. Is there a waiver available, or how do you suggest we report?**

The Hybrid HWR measure is a voluntary measure. Providers are not required to submit the EHR data, therefore, there will be no waiver required if providers choose not to submit the EHR data. If providers want to attempt submission and are unsure of how successful they will be, there will be no penalty for incomplete or inadequate submission of EHR data.

Question 50: **In reference to Slide 14, will there be an upcoming webinar to discuss submission of these EHR data? We participated in the pilot and are aware of the time involved in getting the data put into the right format. Thus, we'd like to get an early jump on this work since this begins in January.**

CMS will provide additional information describing the electronic specifications and reporting requirements through the webinar, *Hybrid Hospital-Wide 30-Day Readmission (HWR) Measure Core Clinical Data Elements Data Submission*, in December 2017. The electronic specifications for extraction of the core clinical data elements used in the measure are now available on the CMS.gov Measure Methodology web page within the Core Clinical Data Elements and Hybrid Measures ZIP file and the eCQI website under the 2018 Reporting Period EH/CAH eCQMs. For more details about the agendas of upcoming webinars, please visit the Upcoming Events web page on the *Quality Reporting Center* website, located at http://www.qualityreportingcenter.com/inpatient/iqr/upcoming/.

Validation

Question 51: **If selected for eCQM validation, who at the hospital or healthcare system will receive the notification of the selection? What format will the notification be received in? Email, postal mail, phone call?**

The hospital will be notified of its selection via an email notification. Additionally, a ListServe will be released, letting the hospital community know that the list of selected eCQM providers is available for viewing. After being selected for validation, subsequent medical record requests will be sent via FedEx, and an email notification will also supplement the medical record request being sent.

Question 52: **When they say episodes of care with a length of stay (LOS) > 120 days is an exclusion, does that mean that hospitals that have patients with a LOS > 120 days are excluded or only the patients with a LOS > 120 days are excluded?**

Patients with a length of stay greater than 120 days will not be selected as a case for eCQM validation.

Question 53: **Since the eCQM measures may not be correct (like chart-abstraction), what will validation entail?**

As stated in the FY 2018 IPPS/LTCH PPS Final Rule on page 38401, "As finalized in the FY 2017 IPPS/LTCH PPS Final Rule (81 FR 57178) for the FY 2020 payment determination only, the accuracy of eCQM data (the extent to which eCQM data reported for validation matches the data previously reported in the QRDA I files for eCQM reporting) submitted for validation will not affect a hospital's validation score.

In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20069), we proposed the continuation of this policy for the FY 2021 payment determination, such that the accuracy of eCQM data submitted for validation would not affect a hospital's validation score. We intend for the accuracy of eCQM data validation to affect validation scores in the future and would propose any changes related to this in future rulemaking. We are finalizing our proposal, as proposed, that the accuracy of eCQM data submitted for validation will not affect a hospital's validation score for the FY 2021 payment determination."

CMS notes that an eCQM embeds measure logic; therefore, there is no expectation for a one-to-one match between a chart-abstracted version and an eCQM version of ED-1 or any other eCQM where there is a similar chart-abstracted measure.

Question 54: **When will hospitals be notified if they have been selected for the eCQM validation?**

CMS will select the hospitals to participate in eCQM data validation after the CMS Clinical Warehouse identifies the chart-abstraction validation sample. The CMS Clinical Warehouse will complete the selection of 600 hospitals (400 random and 200 targeted from the previous validation cycle) for the existing chart-abstraction validation procedures in the April 2018 time frame. The CMS Clinical Warehouse will then select up to 200 random hospitals that were not selected for chart-abstraction validation to validate their eCQM data in the April/May 2018 time frame.

CMS notifies hospitals of its selection with a targeted email. After distributing the initial notification, CMS sends communication via ListServe, and posts a news article, as well as the list of chosen providers on *QualityNet*.

Question 55: **Regarding eCQM validation, what is meant by eight records (eight cases per quarter)? Does this translate into eight patients regardless of the number of eCQMs they qualify for?**

CMS will validate up to eight cases (i.e., patient charts/medical records) per hospital for the quarter selected by the hospital among the eCQM measures reported. CMS will select cases from the hospital-submitted data. No more than eight cases will be selected across all the measures reported.

Question 56: **I'm confused by slide 23. Chart-abstracted data validation will be changed for FY 2020?**

No, the process of chart-abstracted validation is not being changed, except to the extent that beginning with the FY 2020 payment determination, CMS will use the corrected quarterly score, as recalculated during the educational review process for the first three quarters of validation, to compute the final confidence interval (CI).

Question 57: **Would you please elaborate on the chart-abstracted validation "formalizing the educational review process"? What does this mean, and how will it be used in correcting quarterly scores?**

As stated in the FY 2018 IPPS/LTCH PPS Final Rule on page 38402, "For the FY 2020 payment determination and subsequent years, we proposed that if an educational review, that is requested for any of the first 3 quarters of validation, yields incorrect CMS validation results for chart-abstracted measures, we would use the corrected quarterly score, as recalculated during the educational review process, to compute the final confidence interval (CI). These corrected scores would be applicable to the corresponding quarter, within the first 3 quarters of validation, for which a request was submitted. We note that under this proposal, the quarterly validation reports issued to hospitals would not be changed to reflect the updated score due to the burden associated with reissuing corrected reports. Beginning with the FY 2020 payment determination, we proposed to use the revised score identified through an educational review when determining whether or not a hospital failed validation. Further, under this proposal, as with the current educational review process, corrected scores identified through the educational review would only be used if they indicate that the hospital performed more favorably than previously determined."

Also on page 38403, "After consideration of the public comments we received, we are finalizing our proposals, as proposed, for the FY 2020 payment determination and subsequent years, to: (1) Formalize the educational review process for chart-abstracted measures; and (2) use this process to correct quarterly scores for any of the first 3 quarters of validation in order to compute the final confidence interval (CI)."

Question 58: **Will CAHs be included in validation of eCQMs?**

No, CAHs will not be selected for validation of eCQMs under the Hospital IQR Program.

Question 59: **I want to confirm the time periods on slide 20 are correct. CY 2017 eCQM data for FY 2020 payment determination and CY 2018 eCQM data for FY 2021 payment determination?**

Yes, the time periods listed on slide 20 are correct. Hospitals selected for participation in eCQM data validation will be required to submit the following:

- Eight cases (8 cases x 1 quarter) from CY 2017 eCQM data (for the FY 2020 payment determination)
- Eight cases (8 cases x 1 quarter) from CY 2018 eCQM data (for the FY 2021 payment determination)