Hello and thank you for joining us for today's webinar. My name is Matt McDonough and I'm going to be your virtual host for today's event. Before we get started and turn things over to our speakers, I like to cover some event housekeeping items with you, so that you understand how today's event is going to work and also how you can interact with our speakers on today's call. As you can see on this slide, we are streaming our audio for today's call over ReadyTalk®'s internet streaming service. If you're hearing my voice coming out of your speakers or headphones right now, then you're connected. This service means that no telephone line is required to listen to today's event, but you do need to have those speakers or headphones plugged in and turned up to hear the streaming audio feed.

If for some reason you're not able to stream audio today or you
encounter issues with the streaming audio feed, we do have a limited number of dial-in lines available. Please just send us a chat message if you need to dial in, and we’ll get that number out to you as soon as possible. Also as always, we are recording today’s event, so that it can be archived and played back at a later date.

If you are streaming audio today, you may encounter some audio issues that affect the quality of your audio feed. For example you may hear choppy audio at times or your audio feed may stop completely. Fortunately, there are a few things you can do to try and correct this without dialing in on a telephone. One, you can click the F5 key located in the top row of your keyboard. Two, you could click the refresh button in your browser. The image here on this slide is what that button looks like in Internet Explorer. Either of these two actions will do the same thing, refresh your browser, reconnect it to the event, and restart your audio feed. This should clear up any audio issues you may be experiencing. Also if you know that the audio feed is lagging behind the slides, you can perform either of these two actions to refresh your event and catch-up in the presentation. If neither of these two options resolves your audio issue, remember, we do have those dial-in lines available, simply reach out to us in the chat window for a dial-in number and you can listen to the audio feed that way.

If you’re streaming audio today and hear a bad echo on the call – does it sounds like you can hear my voice multiple times? – then you may be connected in our event today in more than one browser window or tab. More than one connection in your browser equals more than one audio stream from your computer. Fortunately, this is something that you can easily fix. Simply close all but one of the browsers or tabs connected to our event today. The graphic here shows what that might look like on your screen. Once you are down to only one connection, you should only be hearing one audio stream, and the echoing issue should clear up.
Again, we do have dial-in lines available if you prefer to hear the audio feed over your telephone.

All of our attendees are in a listen-only mode today but that doesn't mean that you can't interact with our speakers today. We encourage you to submit any questions or comments you may have to our speakers at any time today using the [Chat with Presenter] feature located in the bottom left corner of your screen. Simply type your question or comment into the [Chat with Presenter] box and click the [Send] button. Your feedback will be visible to all of our presenters on today's call. As time, resources, and the availability of answers allows, we will address as many questions as possible either verbally or in the chat window. Please do note, however, that if we don't get to your question today all questions submitted during today's event are being archived to be addressed in a future Q&A document. That's going to do it for my introduction. So, at this point, I’d like to hand things over to our first speaker.

Thanks for your time and enjoy today’s event.

Artrina Sturges:

Thank you very much, Matt. Good afternoon everyone. My name is Artrina Sturges, and I’m your host for today’s event. Before we start, we would like to make a few announcements. This presentation is being recorded and the transcript of the presentation along with the Q&As will be posted to the Inpatient website, www.qualityreportingcenter.com, within 10 business days and posted to QualityNet at a later date. If you registered for the event, a reminder email, as well a link to the slide, was distributed about two hours ago. If you did not receive the email, the slides are available for download at our Inpatient website, which is www.qualityreportingcenter.com. Our speakers for today's event are Dr. Grace Im and Ms. Debbie Krauss. Grace is the program lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program for the Quality Measurement and Value-Based Incentives Group for the Centers for Medicare & Medicaid Services.
Debbie is a nurse consultant for the Division of Electronic and Clinician Quality for the Centers for Medicare and Medicaid Services. Next slide please.

The presentation will provide participants with an overview of the Fiscal Year 2017 IPPS Inpatient Quality Reporting, Electronic Health Record Alignment Proposed Rule, as well as an overview of how to log comments to become a matter of record and receive response in the Final Rule. Please note, CMS cannot respond to comments or answer questions related to the Proposed Rule during this webcast. It is our intent that participants will be able to locate the Fiscal Year 2017 Proposed Rule Text as it relates to IQR/EHR alignment proposals, identify the proposed changes for the IQR and EHR Incentive Programs, and remember the time period for submitting comments regarding the proposed rule. At the end of today’s presentation as time allows, there will be a Q&A session. Any questions that are not answered during the question-and-answer session at the end of this webinar will be posted to the Quality Reporting Center website within 10 business days. And now I would like to introduce Grace, who will speak to us about the Hospital IQR Program.

Grace Im: Hi. Thanks, Artrina, and welcome everybody, and thank you for joining us today. We really appreciate the high level of interest on the topics that we’ll be covering. So, please note that I’ll be focusing on the eCQM-related proposals as it relates to the IQR Program, the Inpatient Quality Reporting Program. We have several other rule proposals related to Hospital IQR Program requirements that we’re not covering today. But I highly encourage you to 1), actually go to the Proposed Rule text, as well as, if you go to qualityreportingcenter.com, we’ve archived a webinar that we did last week focusing more broadly on the requirements for the proposals that we made with respect to requirements for the Hospital IQR Program as well as our Hospital Value-Based Purchasing Program, the Hospital Acquired Condition Reduction Program and the Hospital Readmission Reduction Program.
So to start off, this year we have proposed to remove 13 electronic Clinical Quality Measures, or eCQMs, from the IQR Program that would begin with the calendar year 2017 reporting period which would affect FY 2019 APU payment determination and for future years. We currently have 28 eCQMs. So, if we finalize the proposal to remove 13 eCQMs, then we would have 15 eCQMs still remaining in the Hospital IQR Program. And, we’re also proposing to remove the same eCQMs from both the Medicare and Medicaid EHR Incentive Programs, which Debbie will be discussing further. And we felt that by making this proposal to reduce the total number of eCQMs in the IQR Program that this would allow hospitals to focus on the smaller, more specific set of eCQMs to be able to meet the requirements of these programs.

And here is a list of the specific eCQMs that we have proposed to remove from the programs. And most of these we are proposing to remove because they are either topped out, meaning that hospitals are performing at too high level [so] that there's very little room for improvement or variation in performance, or because the measure specifications are no longer feasible to implement and remain in the program.

And here is the second page of the list of the 13 eCQMs we’re proposing to remove. I would like to note that STK-4 and VTE-5, we have also proposed to remove the chart-abstracted versions of those measures. I do also want to note that for VTE-6, so we are proposing to remove the eCQM version. However, we are – there is a chart-abstracted version of VTE-6 in the IQR Program which we would be keeping.

And here is a list of the 15 eCQMs that would stay in the hospital IQR your program. Note that ED-3 is actually an Outpatient measure, so it – this specific measure is not included in the IQR Program. We are also proposing several changes with respect to the reporting of eCQM data. And to summarize, we’re (proposing) two main changes with respect to eCQM reporting. One is that hospitals would need to submit data for an
increased number of eCQMs. For calendar year 2016 reporting, hospitals are required to select four of the 20 available eCQMs. With our proposal for this year, hospitals would be required to report on all 15 of the remaining eCQMs. This is assuming that our proposal to remove the 13 eCQMs is finalized. And the second change would be, that instead of reporting for one quarter and for calendar year 2016, it’s either third-quarter or fourth-quarter data that hospitals would be required to report, a full – full calendar year of data, and it would be submitted on an annual basis at two months following the end of the reporting calendar year. So for example for calendar year 2017 reporting, the eCQM data would be required to be submitted by February 28 of 2018. And then, also we want to confirm that the eCQM data would need to be submitted using QRDA I file format, and that they would be need to be submitted through the QualityNet Secure Portal. And those – and that – that requirement of using the QRDA-1 file format and submission to QualityNet Secure Portal is an existing requirement.

With respect to certification policies – So, for the calendar year 2017 reporting period, hospitals would need to use either the 2014 or the 2015 edition of CEHRT, and that will be very similar to calendar year 2016 reporting. However, we proposed that beginning with calendar year 2018 reporting periods that hospitals would have to use the 2015 edition of CEHRT only. And then also, we wanted to note that like current requirements, hospitals can choose to use a third-party vendor to submit their QRDA I file on their behalf, and also hospitals may continue to either this abstraction or pull the data from non-certified sources in order to then put those data into CEHRT in order to report the QRDA I file to us.

And – actually before I move on to validation, I did want to note that in last year's IPPS Final Rule, we did signal that we would be moving in the direction of reporting on all eCQMs that are in IQR Program. And so, we felt that, you know, we want to continue to expand on eCQM reporting for the IQR Program and so making this proposal would help to further that
goal. I do also want to note that we have three measures, ED-1, ED-2, and PC-01 that are – that would be in the IQR program in both the eCQM form and in the chart-abstracted form. So, I did want to note that hospitals would be required to report on those measures in – in both eCQM and chart-abstracted forms. The difference being that the eCQM data would be reported on an annual basis for a full calendar year data, whereas the chart-abstracted measures would be reported on a quarterly basis for four quarters, and that's similar to our other chart-based measures.

We also have several proposals related to modifying our validation program for the Hospital IQR Program. So, currently we select up to 600 hospitals for chart-abstracted validation. We have proposed to include up to an additional 200 hospitals for eCQM data validation. And these proposals are for the FY 2020 payment determination and also hospitals will be required to submit on a timely and complete basis their medical record information from the EHR for at least 75 percent of the sample record. However, for this first year of eCQM validation, we’ve proposed that there would be no scoring with respect to the measure accuracy. However, it would be required that – that the medical record information are submitted on a timely basis for at least 75 percent of the sample records.

And so, to dive a little bit more deeply into our proposal, as I noted the eCQM validation piece would begin with respect to FY 2020 payment determination. So, we would actually be beginning to request medical records in the spring of 2018. And, as I had mentioned, we would select up to 200 hospitals for eCQM validation. And this will be by random sample. We would not select from that 200 any hospitals that were selected for chart-abstracted measure validation or any hospitals that were granted an extraordinary circumstance exemption. So, the total number of hospitals for eCQM validation could end up being slightly less than 200.
With respect to the number of cases, we propose that 32 cases of individual patient-level reports be randomly selected from the QRDA I file that is submitted per hospital. And each hospital would then submit the randomly selected cases to our clinical data warehouse within 30-days of the medical record – records request. And that 30-day time period is aligned with our time period for chart-abstracted measure validation.

And we’ve also proposed that hospitals need to – would need to be able to provide sufficient patient-level information that will be necessary to match the requested medical records to the originally submitted eCQM measure data. And with respect to sufficient – what is – sufficient patient level information, we would consider that the entire medical record that sufficiently documents the secured measure data elements and everything, including but not be limited to: arrival date and time, inpatient admission date, and discharge date from the inpatient episode care.

With respect to scoring of the eCQM validation … so as we noted for this first year of eCQM validation, we would not actually be scoring with respect to accuracy of the eCQM data and the maturate to the EHR medical record data. However, in order to still be able to meet all of the eCQM validation requirements, we would require that hospitals submit at least 75 percent of the sample eCQM measure medical records within the 30 days of the medical records request.

We have also proposed a couple of changes to our Extraordinary Circumstance Extensions or Exceptions or ECE policy, and they’re both related to this timeline for submitting an ECE request to us. So, for ECE requests that are related to eCQM reporting circumstances, we’ve proposed to set a deadline of April 1st following the end of the reporting calendar year. And we picked April 1st to -- in order to try to align with the EHR Incentive Program Hardship request deadline, which is typically April 1st, although sometimes that deadline changes in the EHR Incentive Program. But typically it’s April 1st, and so we’ve tried to align that
Support Contractor

deadline in the IQR Program. And then for ECE request that are not related to eCQM circumstances, we would extend the deadline. Currently, it’s 30 days following the extraordinary circumstance event, and we propose to extend that to 90 days.

So, now I’ll turn it over to my colleague, Debbie.

Debbie Krauss: Thanks, Grace. Hi, everyone. I’m going to cover information that is proposed in the 2017 IPPS Rule that aligns or covers the IQR Reporting Program and EHR Incentive Program.

So, as you know, last year in the 2015 EHR Incentive Program’s Final Rule, we signaled that issues related to CQM reporting requirements for the Medicare and Medicaid EHR Incentive Program for 2016 and beyond would be addressed in the IPPS rulemaking. We thought that this was an important step in order to help avoid redundant or to put duplicative reporting among hospital programs and to allow CMS to review and receive public comments for a multiple quality programs together. And it helped to ensure communication and alignment of the CQM reporting among these programs. It also helps to finalize the program requirements simultaneously to improve this alignment, making things easier for you all who are participating in both of these programs, and also added overall value and consistency to the requirements and to the programs. So, as begin -- as we began last year in the 2016 IPPS rule, we addressed and aligned wherever we possibly can and look at the CQM reporting requirements for the EHR Incentive Program. We’re also working to work on the certification alignment so that in the 2015 Edition Final Rule, the Office of the National Coordinator or ONC, proposed to address certification policy for reporting CQMs, and so they also work in conjunction with our Annual IPPS rulemaking.

As Grace mentioned, just wanted to note, again, this is a chart of the proposed CQM measures for electronic reporting, but this includes also
not only the IQR Program but the EHR Incentive Program. As we noted, (ED-3), which is the median time from ED arrival to ED departure for discharge to ED patients, is an Outpatient measure and not applicable for IQR. So, if you are reporting for the IQR and EHR Incentive Programs, you would report on all of these measures except for ED-3, and that is what we have proposed in the 2017 NPRM.

And what we proposed as electronic reporting requirements for the EHR Incentive Program and the IQR Program are basically that participants would report on all 15 available eCQMs beginning with the calendar year 2017. And, as Grace mentioned, as we currently -- you currently use the electronic QualityNet Secure Portal that would also continue as is proposed, and you would submit a full calendar year of data for eCQMs and to be submitted by February 28 of 2018.

If by chance you are only electronically reporting CQMs for the EHR Incentive Program, if you're an eligible hospital or critical access hospital, you would report on 15 of the 16 available CQMs. You would still submit these results through the QRDA files through the QualityNet Secure Portal. You would submit, again, quarterly data reporting periods for one full calendar year, still with the same deadline of February 28, 2018 for the submissions.

If you were going to report CQMs by attestation only for the EHR Incentive Program, right here is a list of the various requirements that are proposed for 2017. So, eligible hospitals and critical access hospitals would be required to report on all 16 of the available CQMs in calendar year 2017 if you're going to attest. You would use the Registration and Attestation System and, again, you would submit one full calendar year of the data, and this would be aggregate results. Again, the same submission deadline would be February 28 of 2018. However, if you're a provider who’s demonstrating meaningful use for the first time, then you are required to only report any 90-day continuous reporting period within
Inpatient Quality Reporting (IQR) Program

Support Contractor

calendar year 2017. The submission deadline is the same, February 28, 2018. And then a recent proposal that was filed -- that was proposed, is that eligible hospitals and critical access hospitals who have demonstrated Meaningful Use in any year prior to 2017 may also attest. However, that attestation would be also the four quarterly data reporting periods for one full calendar year, and you would submit aggregate results for that calendar year. Again, the submission deadline is 27 – February 28 of 2018. Again, remember attestation is only for participants in the EHR Incentive Program. Attestation is not a requirement and does not meet any of the reporting requirements for Inpatient Quality Reporting.

So, just a comment about the Medicaid EHR Incentive Program, the states will continue to be responsible for determining whether or how to report Electronic Clinical Quality Measures, and they will also determine if hospitals are allowed to report through attestation. So, again the state requirements for Medicaid are specific and unique to each of the states.

So, for calendar year 2017, we propose the form and method for reporting that we have currently used, which is the QRDA Category 1 file format. We had accepted and did receive the QRDA Category 1 files for the 2016 reporting period and are proposing to continue that in 2017 and future years. The QRDA Category 3 file format has been removed as an option for reporting.

As far as certification is concerned, we are aligned for EHR Incentive Program exactly in the same way that Grace mentioned is being proposed for IQR. And so for 2017 reporting, eligible hospitals and critical access hospitals that seek to report CQMs must use certification – electronic health records that are certified to either the 2014 or the 2015 Editions. The electronic specifications for CQMs for e-Reporting for the 2017 reporting period are currently posted on the CMS library page and eCQM Resource Center. These are posted as the April 2017 CQM Electronic Specifications for the 2017 Reporting Period. And then later this summer,
we will be publishing the 2017 CMS QRDA Implementation Guide for these measures for Hospital Quality Reporting and EHR Incentive Program CQM reporting. So, look for that implementation guide later this summer.

As far as future considerations that were mentioned in the 2017 IPPS Proposed Rule, we are proposing that as of 2017, I'm sorry -- we are proposing that as of 2018, eligible hospitals and critical access hospitals participating in the Medicare EHR Incentive Program will be required to electronically report using their certified EHR technology. So, attestation to CQMs will no longer be an option except where electronic reporting is not feasible.

And now for the final segment of the information we’re presenting today, I'll turn it over to Artrina.

Artrina Sturges: Okay, thank you, Debbie. As you can see for the fiscal year 2017 IPPS Proposed Rule page directory, we actually have the link here for you to be able to download from the Proposed Rule the Federal Register. And then also, below that, you'll see that there are details outlined regarding the number of quality reporting programs, and then they can be found or identified on the pages listed below. So, as you can see, we have different pieces there: VBP and HAC; IQR is listed there; and a number of the other programs. And then our information is listed towards the very end of the slide. So, we just wanted to make sure to provide that information for you so you can use your time reviewing aspects of the Proposed Rule. Okay, next slide, please.

Artrina Sturges: You know, in terms of feedback for commenting on the fiscal year 2017 IPPS LTCH Proposed Rule, CMS is accepting comments on the Proposed Rule until June 17, 2016. I believe that in the actual Proposed Rule, they’ve extended the time. So, instead of it being 5 p.m. Eastern Time, believe it is midnight – until 11:59. So, you'll see those changes there.
Inpatient Quality Reporting (IQR) Program

Support Contractor

Again, it identifies that comments can be submitted by way of four methods so either electronically, by regular mail, express or overnight mail, or by hand or courier. And they are asking that – that you take a look at the Proposed Rule for specific instructions for each method for commenting and that you only submit the information via one method. And then, CMS will respond to the comments in the Final Rule, and that will be scheduled to be issued by August 1st of 2016. So what we like to do now and – thank you to Grace and to Debbie for all their assistance in presenting the information – what we like to do is just host a brief question and answer session. As we stated earlier, CMS can’t respond to comments or answer questions related to the Proposed Rule during the webcast, but you are encouraged to submit your questions to CMS for further clarifications through the formal comment process. So again, as I just outlined here, these are the steps that we need to take to be able to submit that information. And if you need additional details on that, again the – if you look on page – that’s 24,946 in the Proposed Rule, actually outlines all the information that’s captured here on the slide.

So we’re going to go ahead and start with just a few questions here. This one may be for Grace. It looks like that on Slide 14 we do have a question. They’re asking for elaboration on the last bullet point of Slide 14, specifically the sentence that states “Hospitals may continue to either use abstraction or pull the data from non-certified sources in order to then input these data into certified health records for capture and reporting of QRDA-1 files.”

Grace Im: I’m sorry. So the question is to provide more clarification?

Artrina Sturges: Yes, they’re asking about that – that last bullet point of the slide.

Grace Im: I’m sorry, I guess I’m not quite sure what additional information is being asked for.
Artrina Sturges: Okay. Okay, very good. What we’ll do is, as we stated earlier, anything we’re not able to address immediately on this particular presentation, we’ll provide as much information as we can for the questions and answers that are posted. And again, keeping in mind that this may just be a question that needs to be submitted for clarification in terms of a comment for the Proposed Rule.

Okay, thank you. We’ll go ahead.

Debbie Krauss: This is Debbie and I’m not sure if the information I have will answer or provide more clarification, but we have gotten similar questions in the past about this. And so, there are some measures that require information or a data element to be reported that may appear in a report, maybe a radiology report, but it needs to be inputted into the EHR in a structured field; so they – this is basically stating that hospitals can continue to look at a report that may be part of the patient’s record but not in a structured data element, but then be able to enter it in a structured field in the certified EHR so that then that data element can be captured in the QRDA-1 for reporting on that measure.

Artrina Sturges: Okay, thank you Debbie. We do have a follow-up for that. They are also asking if this allowed for the calendar year 2016 reporting, as well, so the reporting (inaudible) can be done.

Debbie Krauss: Yes.

Artrina Sturges: Okay, thank you. Okay, the next question that we have received is a question of, “Is there anything that we need to do prior to submission for eCQM, such as selecting our vendor or which eCQMs we are reporting on for 2016?”

Okay, so I’m happy to take that question if that’s okay with the group. If you want to take a look at identifying what type of vendor you would like
to use, they do have what they call the CHPL website. What that means is Certified Health IT Product List and it’s, you know, sponsored by the Office of the National Coordinator for Health Information Technology. And what you’re able to do is to use that website to search for a list of certified products. And what that does is that you can go on and take a look and find out what types of systems are available; what they are certified to report; and which measures they are certified to report. You can look at those, and then based on the version of the measures that are available. So that does give you a good tool to be able to use in preparation. And again, that’s called the CHPL website, Certified Health IT Product List. Okay, and in terms of the second part of your question for the eCQMs that you’re reporting for 2016, the Intent to Submit screen for 2016 reporting will not be available. You don’t have to identify which measures you’re going to report. If you just choose your four, then that’s fine.

Okay, the next question we have is there was a question about providing information about the EHDI-1a measure. They’re having trouble finding it on the QualityNet website, and also I’d like to assist with this question, as well.

If you’d like to visit the eCQI Resource Center, under EH measures, they’ll give you a list of all the measures, the eCQMs, that are available based on reporting period. The measure that you’re specifically asking about is the Hearing Screening Prior to Hospital Discharge, and the CMS measure ID for that is CMS31 V4. So that’s version 4 if we’re specifically talking about the 2016 reporting period.

Debbie Krauss: And Artrina, this is Debbie. Also the NQF number ID for the hearing screening prior to discharge is 1354.

Artrina Sturges: Okay, perfect. Thank you, Debbie.
Inpatient Quality Reporting (IQR) Program

Support Contractor

Okay, we do have an additional question. The [Proposed] Rule does not address what would happen for specialty hospitals, such as surgical centers. Has that been addressed or should that be addressed in comments and then go on to say some specialty hospitals have no possible options to submit for eCQMs?

Grace Im: So, we in the FY2017 IPPS rules, and this is Grace, it’s true that we don’t have any proposals this year specifically related to specialty hospitals, so you know I do suggest formally submitting a comment. But also do want to mention that for any hospitals where they might have very small number of cases with respect to a certain eCQM, we suggest reviewing requirements – policies related to zero denominators or case threshold exemptions.

Artrina Sturges: Okay, very good. Thank you.

The next question is, “Will questions or we will submit for” – oh, there it is – “Will measures submitted for calendar year 2017, will any of the scores for those measures be publicly reported per the Proposed Rule?”

Grace Im: So, with respect to calendar year 2017 reporting of eCQM data, currently we do not have any proposals related to Public Reporting. So that is an aspect that we are still considering.

Artrina Sturges: Okay, thank you.

Okay, we do have a question. “What are the benefits for using a third party to submit QRDA-1 files?”

Debbie Krauss: This is Debbie, and I’ll just say that I – it is really site-specific as to and dependent on what your institution or hospital is capable of doing. So you’re using a certified EHR. So all certified EHRs are - have the ability to produce a QRDA Category 1 file, and that’s the purpose – one of the purposes of certification. Now, whether or not your hospital finds it
beneficial and possible for you to produce a QRDA Category 1 [file] on your own, or to elicit the support of a data submission vendor, that's up to you to determine based on your staffing, your experience, your comfort with the EHR. So, it's really quite dependent on each hospital and each hospital staff, and ability, and understanding. And – but every EHR that is certified is certified to be able to produce a QRDA Category 1 file. And we also have pre-submission validation tools such as one found on QualityNet, and pre submission validation application, and the Cypress Validation Utility, which are updated to the current versions of the QRDA 1 files that need to be submitted for the 2016 reporting period. So, there's tools out there to support your submissions. There's data submission vendors to support your submissions, but this is a determination that needs to occur at the hospital level and maybe between the hospital, your team, and possibly investigating other data submission vendors to see what will work best for you.

**Artrina Sturges:** Thank you, Debbie. We do have a validation question. “So, for eCQM validation, you would still have to submit the complete medical record?” They are asking if that's correct.

**Mihir Patel:** Yes, that is correct.

**Artrina Sturges:** Okay, and we do have another question. So, in terms of the medical record information, they’re asking, “Is it PDF files of the actual chart as it's currently requested?”

**Mihir Patel:** Yes.

**Mihir Patel:** Yes, it's a PDF file that you have to submit.

**Artrina Sturges:** Okay, very good. Thank you. The next question is, “Are Maryland Hospitals still exempt from eCQM validation since Maryland operates under the Medicare waiver?”

**Mihir Patel:** Yes, they are. They are exempt from eCQM validation.
Artrina Sturges: Very good, thank you. Another validation question, “Could critical access hospitals will be selected for that validation process of eCQMs?”

Mihir Patel: So, if they’re not required to participate in the IQR program, then they are – they won't be selected for eCQM validation.

Artrina Sturges: Okay, very good. Thank you. We do have one question, and I'm not sure if our group can speak to this, but it says, “Could the organization choose to submit quarterly instead of annually?”

Debbie Krauss: You know, we really cannot comment on that since it's proposed in the Rule. So I would encourage you all to submit your comments as what's outlined earlier.

Artrina Sturges: Very good, thank you. Okay, one other question because we're – we have just a few more minutes. “If we are using a vendor to submit QRDA 1 files to CMS, can they also submit our IQR files, and therefore we wouldn’t need to submit via the QualityNet Portal?”

Debbie Krauss: So, what is proposed then – this is Debbie – in the 2017 Proposed Rule, you – if a hospital is participating in IQR and the EHR incentive program, you only need to report one for the eCQMs by submitting your QRDA Category 1 File through the QualityNet Secure Portal. If you're just participating in the EHR Incentive Program only, or just in the IQR Program only, you would still need to go through the QualityNet Secure Portal site for the QRDA Category 1 Files to be submitted.

Artrina Sturges: Okay, thank you, Debbie. We do have a couple of questions that look similar to the next one that I will ask. So, the question is, “ED-1, ED-2, and PC-01 will be reported as chart-abstracted and eCQM.” So there's some confusion around there. And they said, “I was under the impression that eCQMs were in place. We do not need the manual abstraction process. Please clarify.”
Grace Im: Yes, so we would require hospital to report ED-1, ED-2, and PC-01 in both the eCQM format and the charter extracted form – PC-01 is actually a web-based measure. That’s how the data will be reported to us.

Artrina Sturges: Okay, thank you. One last validation question. “Can you clarify what is meant by submitting 75 percent of medical records if chosen for validation?”

Mihir Patel: Yes, so, for example, if there are 10 cases requested, and this is just an example, we would at least like to have seven or eight cases submitted, in its entirety, to meet that 75 percent requirement.

Artrina Sturges: Okay, thank you. And we’re receiving a number of questions, but they have already been addressed in terms of clarifying questions about quarterly submissions versus yearly for the Proposed Rule. Okay, we addressed that as well.

Alright, and I believe that there will be a number of these that will be addressed during the question and answer information that is posted on QualityNet and also on the Quality Reporting Center at a later date. So, I think we’ll go ahead and we will close this session for that piece for today.

We just do want to say thank you for your questions. And again, anything we haven’t answered will be posted. And at this time, what I’d like to do is go ahead and turn the webinar over to Deb, and she is going to discuss the continuing education process. Thank you.

Deb Price: Well, thank you Artrina. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider and as such, all nurses report their own credits to their board using our national provider number on the last bullet on the slide, it's 16578.
We now have an online CE certificate process. You can receive your certificate two separate ways. If you registered for the event through ReadyTalk®, a survey will automatically popup when the webinar closes. This survey will allow you to get your certificate; however, if you're in a room with other people and you were not able to register, only the one person registered, no worries, because we will be sending around another survey within 48 hours. Please take that survey and send it to the other people in the room so they will be able to get their certificate.

If you do not immediately receive an email after the survey, that means you have some kind of a firewall up on your email address. So we're asking that you go back and register as a new user using a personal email because personal emails will not have the firewalls up that hospital emails have.

Okay, this is what the survey will look like, as soon as the rest of my slides close out, we'll have a survey, and at the bottom right-hand side, we see a little square [Done] button.

When you click the [Done] button, this is the page that opens up. There's two green links; one is the new user link, and if you have had any problems at all getting the certificate for your webinar, please click on the [New User] link and register a personal email on that link. If, however, you've been receiving certificates for all of our events, go ahead and use the [Existing User] link.

This is what the [New User] link page looks like. You put a first name, last name, a personal email, and a phone number that we can reach you at just so, you know, in case we need anything or to associate that email with.

This is what the [Existing User] box looks like. You input your username, which is your entire email address including what is after the “at” sign in your email. So, it would be the beginning, the “at,” and whatever else is
in your email, and of course, your password. If you don't remember your password, just put something there and as soon as you click the [Log In] button, another message will show up saying the incorrect password and please if, you know, if you need help with your password you just click in and it will reset your password.

And now, I'd like to thank everyone for attending today's webinar. We hope that you had a very nice day and we hope that you learned something today. Have a great rest of the day. Goodbye.

END