Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2017
Inpatient Prospective Payment System (IPPS)
Final Rule

Question and Answers

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Question 1: **Are the HAC domains weighted similarly as in the past?**

The Hospital-Acquired Condition (HAC) Domains for Fiscal Year (FY) 2018 are weighted the same as for FY 2017. The weights fall as 15 percent for Domain 1 and 85 percent for Domain 2.

Question 2: **As related to the notification sent today related to potential changes in your hospital's HAC score, when will hospitals who are affected be notified?**

Hospitals will be notified if their score or payment status changed by the start of the Review and Correction (R&C) period on September 1.

Question 3: **Do the changes to PSI-90 outlined on slide 17 apply to the IQR, VBP, and HAC reduction programs?**

The modifications listed on Slide 17 correspond to the Hospital IQR Program; however, these changes also apply to the Agency for Healthcare Research and Quality (AHRQ) PSI-90 measure included in the HACRP in FY 2018. CMS did not propose to adopt the new version of the AHRQ PSI-90 measure in the Hospital VBP Program; however, CMS signaled the intent to do so in future rulemaking.

Question 4: **Will you be addressing the questions re: QRDA reporting for clients that are transitioning/migrations certified EHR solutions?**

Yes, we will address questions in the written transcript as well as include this information in a future eCQM webinar. We have a call scheduled for September 12 at 2 p.m. ET. Please visit the QualityReportingCenter.com website if you did not receive the invitation from the IQR or Electronic Health Record (EHR) ListServe.

Question 5: **FY 2018 end date should be 9/30/16 not 9/30/15 as stated on slide, correct?**

CMS finalized the proposal to shorten the AHRQ PSI 90 performance period in FY 2018 for the Hospital IQR Program. The shortened end date is September 30, 2015, prior to the ICD-10 transition date. For more

information regarding the shortened performance period, you may reference the FY 2017 IPPS Final Rule (81 FR 57128-57133); the direct link is https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf.

Question 6: **How soon can we request an ECE for 2017 eCQMs. For example, if we know today that we will be changing EHR's in 2017, can we submit an ECE request today?**

Facilities can submit an Extraordinary Circumstances Exemption (ECE) request related to electronic Clinical Quality Measure (eCQM) reporting by April 1 following the end of the calendar year reporting period. If the intent is to submit an ECE request for Calendar Year (CY) 2017 eCQM reporting, the ECE request form is due by April 1, 2018. Please visit the QualityNet.org website and review the ECE information posted under the Hospital Inpatient eCQM tab.

Question 7: **HRRP: could you state which cases are excluded?**

The readmission measures exclude index admissions for patients without at least 30 days post-discharge enrollment in fee-for-service Medicare or those discharged against medical advice (AMA). In addition, some measure-specific exclusions apply; specifically, for the Coronary Artery Bypass Graft (CABG) measure. If a patient has more than one qualifying CABG surgery admission during the measurement period, only the first CABG admission is included in the measure and the subsequent CABG admissions are excluded. Admissions associated with transfers between acute care hospitals are not excluded from the CABG readmission measure. This is given that a transfer to another acute care facility after CABG surgery is most likely due to a complication of the CABG procedure or the perioperative care the patient received. As such, the care provided by the hospital performing the CABG procedure likely dominates readmission risk, even among transferred patients. However, in a series of one or more transfers, the readmission outcome is always assigned to the hospital that performed the first ("index") CABG surgery, even if it is not the discharging hospital. For example, if a patient is admitted to Hospital A and undergoes CABG surgery, and then transfers to Hospital B, an unplanned readmission within 30 days of the hospital B admission would be captured in Hospital A's readmission outcome.

Additional information on measure specifications and inclusion/exclusion

criteria for the readmission measures are available in the 2016 Measures Updates and Specifications Reports located on *QualityNet* > Hospitals-Inpatient > Claims-Based Measures > Readmission Measures > Measure Methodology page. The URL is https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841

It is also important to note that patients who transfer to a HRRP-applicable hospital are not included in the calculation of the HRRP results. HRRP-applicable hospitals include subsection (d) hospitals and Maryland hospitals participating in the All-Payer Model.

Finally, planned readmissions do not count as readmissions in the CMS 30-day readmission measures. Generally speaking, planned readmissions are not a signal of the quality of care. Therefore, CMS worked with experts in the medical community, as well as with other stakeholders, to identify procedures and treatments that should be considered, and thus not counted as readmissions.

Question 8: **I was previewing the slides page 17 PSI 12. Should Pulmonary Edema not be Pulmonary Embolus?**

You are correct, it should state PSI-12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate, same for slide 50, in the HACRP.

Question 9: **If our EHR vendor is unable to successfully produce a QRDA Category I file, will the submission of a flat file still be acceptable in 2017?**

Facilities must utilize Certified Electronic Health Record Technology (CEHRT) to either the 2014 or 2015 Edition of the Office of the National Coordinator (ONC) certification criteria. This is a requirement for generating Quality Reporting Document Architecture (QRDA) Category I files for submission to the IQR Program.

Question 10: **In CY 2016, four eCQMs have to be reported, therefore can these same eCQMs be four of the eight that are reported in CY 2017?**

A hospital can self-select the same measures to be reported in CY 2017 as reported for CY 2016, if they are still available in the measure set and will

not be removed from the IQR Program. Also, a hospital will need to select four additional eCQMs for CY 2017 reporting. The key is to ensure the EHR is certified to report the facility's measures of choice in order to generate the QRDA Category I files.

Question 11: **In the FY 2019 HACRP and forward − are the domain weights still 85% for HAIs and 15% for PSI, or will these be changing?**

For now, the domain weights will remain steady at 85 percent for Domain 2 and 15 percent for Domain 1. Any changes to the domain weights would be proposed through rulemaking.

Question 12: **Slide 37 - Was pain management removed from VBP HCAHPS for CY 2017?**

The removal of the Pain Management dimension from the FY 2018 Hospital VBP Program is currently proposed in the CY 2017 OPPS Proposed Rule. CMS addressed the proposed methodology in that rule (81 FR 45755-45757); the direct link is https://www.gpo.gov/fdsys/pkg/FR-2016-07-14/pdf/2016-16098.pdf.

Question 13: **Slide 18 & 34 - AHRQ PSI-90 FYs 2019 and 2020. Slide 18 states reporting period FY 2019 and 2020 and slide 34 states proposing to remove PSI 90 in 2019 from VBP. Is it proposing to remove it from HAC program? Is this only for 2019 for VBP?**

CMS stated its intent to propose to remove the AHRQ PSI-90 Composite only from the Hospital VBP Program, beginning with the FY 2019 program year, through future rulemaking.

Question 14: **Slide 34 - is CMS expecting to add the PSI-90 back into the VBP score after a risk-adjusted ICD-10 methodology is available for PSI-90 calculation?**

As stated in the FY 2017 IPPS Final Rule (81 FR 56979-56983), "We recognize that the performance period for the current PSI 90 measure cannot be shortened in the FY 2019 program year because ICD-10 AHRQ QI software for the currently adopted measure will not be available. In light of this, we intend to propose to remove the PSI 90 measure from the Hospital

VBP Program beginning with the FY 2019 program year in next year's rulemaking. We also intend to propose to adopt the modified PSI 90 measure for the Hospital VBP Program in future rulemaking as soon as it is feasible, which we discuss further in section IV.H.2.b. of the preamble of this final rule."

Question 15: **Slide 38 − performance period for PSI-90 crosses over both ICD-9 and ICD-10, different from slide 18 dates. Are both correct?**

In the FY 2017 IPPS Final Rule, CMS stated the following regarding the AHRQ PSI-90 Composite (81 FR 56979-56983): "We recognize that the performance period for the current PSI 90 measure cannot be shortened in the FY 2019 program year because ICD-10 AHRQ QI software for the currently adopted measure will not be available. In light of this, we intend to propose to remove the PSI 90 measure from the Hospital VBP Program beginning with the FY 2019 program year in next year's rulemaking. We also intend to propose to adopt the modified PSI 90 measure for the Hospital VBP Program in future rulemaking as soon as it is feasible, which we discuss further in section IV.H.2.b. of the preamble of this final rule."

Slide 18 references the Hospital IQR Program and the performance period is accurate.

Question 16: **Slide 46 - the provided link for the HACRP results provides FY 2016 performance information. When will FY 2017 performance information be available?**

CMS made the FY 2017 HACRP information publicly available for each hospital on *Hospital Compare* in December 2016.

Question 17: **What happens if the available required chart abstracted measures and the majority of the eCQMs do not fit our specialty hospital setting. Currently we do not have an ER or deliver babies. Do we submit zero's or is there an exemption?**

Facilities have the ability to utilize either the zero denominator declaration, and/or the case threshold exemption. Please keep in mind in order to utilize these for eCQM reporting, your certified EHR has to be able to report the measure in question. Information regarding the use of zero denominator declarations and case threshold exemptions is available on the

QualityNet.org website and with the archived presentations on the QualityReportingCenter.com website.

Question 18: **Are these final rules or still proposals needing final decisions?**

These are final rules. The proposed rule was published in May and an open comment period was offered.

Question 19: **Are these measures (eCQMs) removed from Meaningful Use as well?**

The removal of measures is an aligned effort between the IQR Program and the EHR Incentive Program for hospitals, with the exception of Emergency Department, ED-3. The ED-3 measure remains only applicable to the EHR Incentive Program for electronic reporting and will not count towards IQR Program credit.

Question 20: **For eCQM data reported under the IQR quality reporting requirements, will the performance data continue to be withheld from public reporting?**

eCQMs will not be publicly reported at this time on the *Hospital Compare* website. CMS will signal its intention regarding publicly reporting eCQM data in a future rule.

Question 21: **Currently Critical Access Hospitals (CAHs) aren't validated for IQR or OQR due to measure reporting being voluntary. However, MU is mandatory for CAHs, so could a CAH be included in the sample of 200 hospitals for validation?**

The eCQM data validation activity reviewed during this session is specific to the IQR Program. CAHs would not be chosen for validation. Greater details regarding validation criteria are available within the FY 2017 IPPS Final Rule.

Question 22: **If we are submitting ED-1 and ED-2 as eCQMs for FY 2019, do we still need to chart abstract them as well?**

The Emergency Department, ED-1 and ED-2 measures are available as two

of the 15 measures that facilities can self-select for CY 2017 eCQM reporting to the IQR Program. If a facility chooses to report those two measures as eCQMs, it is still required to report them as chart-abstracted measures to the IQR Program. This would be the case for PC-01 as well, given that they are all required for chart-abstraction, but are also able to be selected by a hospital for eCQM reporting.

Question 23: **In reporting eCQMs, the data for eCQMs must be uploaded to the secure QualityNet site. To upload and make sure the QRDA Category I file is correct, a facility needs to download the PSVA program if they are submitting the file, correct?**

You are correct, QRDA Category I files must be submitted through the *QualityNet Secure Portal*. Facilities have found the Pre-Submission Validation Application (PSVA) tool to be very useful when troubleshooting their QRDA Category I files before submitting test files to the *QualityNet Secure Portal*. For more details regarding the PSVA tool, please review the archived presentations on the QualityReportingCenter.com website. To access the PSVA tool, it is available for download within the *QualityNet Secure Portal*. Please contact the *QualityNet* Help Desk for assistance at qnetsupport@hcqis.org or 1-866-288-8912.

Question 24: **One part of my question was still not answered... is the expectation that only one QRDA file will be submitted per patient for the entire CY2017, regardless of how frequently you put in your submissions?**

CMS anticipates one patient per QRDA Category I file per quarter. That file should include all episodes of care and the measures associated with the patient file.

Question 25: **Slide 20 states hospitals may continue to use either abstraction or pull data from non-certified sources in order to put data into the CEHRT files for the QRDA files. How does this work with the validation of the eCQM files?**

The ability to abstract or pull data from non-certified sources is intended to assist facilities as they transition from one EHR to another. It allows facilities to have one EHR, which contains all the data needed for accurate data capture when reporting eCQMs and supports efforts to achieve interoperability. This will assist facilities as they prepare for eCQM data

validation activities slated for spring 2018.

Question 26: **What does PSVA refer to on slide 30?**

PSVA refers to the Pre-Submission Validation Application Tool. The webinar on September 12 at 2 p.m. ET provides more detailed eCQM information. There are also archived webinars on the QualityReportingCenter.com website that provide more information regarding the use and functionality of the PSVA tool; particularly, the ones from March 10 and June 9, 2016.

Question 27: **When is the earliest that Q1 2017 eCQMs can be submitted to QualityNet? Can a hospital change the eCQMs that it reports each quarter, or do we have to report the same 8 measures for all 4 quarters?**

Facilities are required to submit the same eight measures to represent four quarters of data. CMS will announce when the eCQM data receiving system will be available to receive production files for CY 2017 reporting.

Question 28: **When will the new measures (slide 29) be finalized?**

CMS will propose any new measures for its programs in a future IPPS proposed rule.

Question 29: **What is the expectation for eCQM submission for calendar year 2017? In the final rule, it mentions that the option will be semi-annual or yearly, I believe. How often will hospitals need to submit it and would still be all encounters for one patient consolidated into one QRDA file?**

For the CY 2017 eCQM reporting period, the submission deadline for all CY 2017 data is February 28, 2018. However, it is anticipated that the CMS data receiving system will be ready to receive QRDA Category I files in the spring of 2017. The ability for a hospital to choose a quarterly, semi-annual, or annual data submission timeframe is intended to provide flexibility for the hospitals. ListServes will be distributed through various CMS outlets to ensure data submitters are aware of CMS data receiving system readiness to accept production QRDA I files.

Question 30: **What quarter was the removal for Stroke-4 and VTE-5 begin?**

Removal of the two chart-abstracted measures from the IQR Program will begin with the first quarter 2017 discharges.

Question 31: **Please clarify what year this pertains to regarding which calendar year beginning, which fiscal year and which fiscal year payment determination year?**

All of these requirements are tied to an annual payment update. For IPPS hospitals, payments are made and payment rates are based on the fiscal year timeframe. For example, fiscal year 2017 payment updates will begin on October 1 of 2016 and go through September 30 of 2017.

In terms of reporting periods for our various quality measures, it depends on the measure. Many of them, such as the chart-abstracted measures and the structural measures, are based usually on a calendar year reporting cycle. For example, for the chart-abstracted measures, the reporting periods for the discharges, for which you are collecting data, go from January 1 to December 31 for the calendar year. Then, the reporting of that data and meeting the reporting requirements would apply to the fiscal year payment updates for the following year.

Question 32: **Is the HAC Reduction Program z-score given at the measure level or at the domain level?**

Each hospital will get a z-score at the measure level and then those levels will roll up. Therefore, there will be a z-score at the measurement level, as well as at the score level.

Question 33: **For the 13 eCQMs that CMS is removing, if a 2014 edition certified vendor who is certified to those 13 eCQMs removed support for them in calendar year '17, will it affect their certification status?**

In order to meet the CY 2017 reporting requirements, hospitals do not need to worry about eCQMs that were once certified and then removed. But, if you still have CQMs that were certified along with the other eCQMs in the past, they need to be certified to any new eCQMs in order to meet our requirements. So, if you didn't have any other measures that were eliminated or removed during this Final Rule, you will have to ensure that those

measures will be certified to the 2014 edition for calendar year 2017.

Question 34: **What timeframe will the changes to the pneumonia payment measure evaluate? And, I believe that is in relation to IQR.**

In the IQR Program, the pneumonia payment measure is already in the program, but we have just finalized the updating of this measure to expand the measure cohort. That expansion of the measure cohort will begin with the FY 2018 program year, which will use a performance period of July 1, 2013, through June 30, 2016.

Question 35: **Is there somewhere you can point us towards where you do a sample calculation on the new z-score HAC method? I'm not clear on exactly where you normalize things.**

Given that this proposed change was just finalized, our team is working aggressively to put together a number of different educational tools. Please continue to visit the *QualityNet* website for the HACRP. We are posting some educational tools on that site soon.

Question 36: **Will you please confirm when the modified PSI 90 will go into effect? I understand for the HAC Reduction Program, it's program year fiscal year '18, but I am confused on VBP and IQR.**

For the IQR Program, we are adopting the updated PSI-90 measure at the same time as the HACRP. These will go in to effect beginning with the FY 2018 payment determination. For the VBP Program, we are considering adopting the measure update for the VBP Program. However, the VBP Program has a statutory requirement that the updated measure information be publicly reported for at least one year. Please keep an eye out for more information when the next year's IPPS rule comes out.

Question 37: **On slide 20, it states that hospitals must report using CEHRT certified to the 2014 or 2015 edition but that you can pull data from non-certified sources and input the data into the CEHRT for reporting. Does the hospital need to have a complete EHR certified to 2014 or can they purchase a certified eCQM product to capture and pull the data from the non-certified EHR not upgraded for stage 2?**

Please contact the *QualityNet* Help Desk to provide additional feedback for

your specific questions at qnetsupport@hcqis.org or 1-866-288-8912.

Question 38: **What is the weighting of the new (modified) PSI 90 Composite and what software version will be used in FY 2018?**

For more information on the modified PSI 90 measure and component indicators, we refer readers to the Quality Indicator Empirical Methods available online at: www.qualityindicators.ahrq.gov.

CMS has not yet announced the exact software version or whether the software will incorporate a recalibrated reference population for use in the FY 2018 HACRP and Hospital IQR Program. However, CMS has stated that the minimum of v6.0 will be used. Under a recalibrated software version, Medicare fee-for-service (FFS) observed rates would be used to calculate risk-adjusted and smoothed rates. The change in reference population would affect the risk-adjustment coefficients, signal variance, smoothing target, and composite weights. As a result, CMS cannot release the exact weighting that will be used in calculation of the modified PSI 90 measure. However, CMS intends to display the weighting closer to the FY 2018 Hospital-Specific Report (HSR) release date. In the meantime, you can view the general specifications for the modified PSI 90 composite on the National Quality Forum (NQF) website here: http://www.qualityforum.org/QPS/0531. Please note these specifications may not be the final version. CMS announced in a technical update to the FY 2018 AHRQ PSI 90 performance standards that the measure will be calculated using v5.0.1 fully recalibrated for the Hospital VBP Program. The Hospital VBP Program will use the existing (non-updated) AHRQ PSI 90 Composite in FY 2018.

Question 39: **For the IQR Program in calendar year 2017, does the CEHRT need to be certified to all 16 available eCQMs, or only to those selected for electronic reporting, eight of the 16 available, in reference to slide 20?**

For CY 2017, facilities are required to have either the 2014 or 2015 Edition of CEHRT. Whether facilities are using the 2014 or 2015 edition, the EHR must be certified to report all 16 CQMs. If facilities have an EHR certified to a portion of the 16 available CQMs, they will need to have its EHR technology certified to the remainder of the 16 available CQMs.

Question 40: **Are only the Medicare fee-for-service claims used to calculate performances for HRRP? What about for HACRP?**

The HRRP includes only FFS admissions to subsection (d) hospitals and Maryland hospitals participating in the All-Payer Model. For the HACRP, PSI-90 data are also limited to FFS patients only. However, the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) data are not restricted to FFS and include all patients.

Question 41: **Can you please clarify whether the eCQM submission for IQR fulfills the quality reporting requirement for Meaningful Use?**

We are aligning the IQR Program with the EHR Incentive Program for electronic reporting of CQMs. You don't have to separately report eCQM data for each program; you can report once and get credit for both programs. There are, however, other requirements for the IQR Program, as well as other requirements in terms of meeting Meaningful Use for the EHR Incentive Programs. Note that there are different entities or hospitals that are at different stages, so it depends on the Meaningful Use under stage two or stage three.

Question 42: **What will the weighting be for the efficiency domain once the episode spend indicators are added? Will MSPB, heart failure and AMI be weighted 33 percent each?**

The Acute Myocardial Infarction (AMI) and heart failure payment measures will be used in the Hospital VBP Program for the first time with the FY 2021 program year. At that point, we will have three measures in the efficiency and cost reduction domain, and they would be weighted equally within that domain

Question 43: **For calendar year 2017, what is the success criteria for the submission of the eight eCQMs?**

A successful submission for eCQMs can be reported as a combination of QRDA I files with patients meeting initial patient population of the applicable measures, zero-denominator declarations and case threshold exemptions. It can be any combination of those three for successful reporting.

Question 44: **For the HACRP for fiscal year 2018, please verify that the timeframe for Domain 2 is January through December 2016?**

The FY 2018 Domain 2 reporting period is January of 2015 through December 31 of 2016.

Question 45: **What are the exact dates that the HAC Reduction Program and HAC Deficit Reduction Act Program data be pulled?**

For FY 2017, the claims snapshot occurred on September 25, 2015. The snapshot for fiscal year 2018 data has not yet occurred, that date will be announced at a later time.

Question 46: **If we are submitting ED-1 and ED-2 as eCQMs for FY 2019, do we still need to chart abstract them as well?**

ED 1 and ED 2 are available as two of the 16 measures that facilities can self-select for eCQM reporting. If a facility chooses to report those two measures as eCQMs, facilities are still required to report them as chart-abstracted measures.

Question 47: **On slide 51, are these performance periods for just PSI 90 or also for the NHSN HAI measures?**

The FY 2018 PSI-90 Domain 1 performance period was changed to 15 months and the FY 2019 performance period for PSI-90 will be 21 months. Both changes seek to accommodate the ICD-10 transition. The Domain 2 HAI measure performance period will continue to be 24 months.

Question 48: **Will a CAH hospital be included in selection of the eCQM validation. And if a CAH is not fully participating in IQR, they can still submit eight eCQMs to our EHR Incentive Program rather than having to attest for all eCQMs, correct? So, it's a two-part question. The first one is CAHs included in validation.**

With respect to the IQR Program, critical access hospitals (CAHs) are not required to report to the IQR Program, although we do encourage it. So, the extension of our data validation to eCQM data is specifically for the IQR

Program. CAHs would not be selected among the 200 hospitals for eCQM data validation. Visit the EHR Incentive Program page on the CMS.gov website to review the program reporting requirements listed by reporting period.

Question 49: **If a CAH is not fully participating in the IQR Program, they can still submit eight eCQMs for EHR Incentive Program rather than having to attest for all eCQMs, correct?**

If a CAH is participating in the EHR Incentive Program and they wish to report via attestation, they are also required to report on all 29 CQMs. Visit the EHR Incentive Program page on the CMS.gov website to review the program reporting requirements listed by reporting period.

Question 50: **Are NICU CLABSIs counted in the HAC Reduction program--also CAUTIs in the NICU – are they counted?**

Neonatal Intensive Care Units (NICUs) are included in the Central Line-Associated Blood Stream Infection (CLABSI) measure, but not the Catheter-Associated Urinary Tract Infection (CAUTI) measure.

Question 51: **Regarding slide 12- should hospitals continue participating in a Systematic Clinical Database Registry for General Surgery through June 30, 2017, or may they stop at any time?**

The last reporting period for the Systemic Clinical Database Registry for General Surgery will be from January 1, 2016 through December 31, 2016. Beginning with January 1, 2017, hospitals will no longer need to report on this structural measure.

Question 52: **Stroke is not in the HRRP but stroke readmission rates are included in the STAR rating, where would we find the Stroke readmission data that is used in the STAR report?**

The Overall Star Rating is a summary of select measures reported on *Hospital Compare*. The stroke readmission data can be found in the October 2016 Hospital IQR Preview Report that was uploaded to your *QualityNet* account on July 21, 2016. You may also refer to Table 3 of the October 2016 Overall Star Rating HSR that was distributed on August 5, 2016, for

information regarding your hospital's stroke readmission results. Questions regarding the *Hospital Compare* overall rating may be directed to the *Hospital Compare* Overall Hospital Rating Team by email at cmsstarratings@lantanagroup.com.

Question 53: **If CMS intends to propose removing PSI 90 from the VBP Program because a risk adjusted ICD-10 version is not expected to be available until late 2017, how can the HAC program use PSI 90 in FY 19?**

The FY 2018 PSI-90 domain 1 performance period was changed to 15 months and the FY 2019 will be 21 months. Both changes seek to accommodate the ICD-10 transition. The Domain 2 HAI measure performance period will continue to be 24 months. The FY 2019 HACRP will include only ICD-10 codes. The Hospital VBP Program and HACRP are on different timing schedules for reporting periods and calculation deadlines; therefore, the late delivery of an updated PSI-90 ICD-10 version does not affect the HACRP schedule like it will affect the VBP Program. So, no such change to HACRP is necessary.

Question 54: **How is harm associated with the event being accounted for in PSI-12 and PSI-15?**

In the modified PSI 90, the rates of each component PSI are weighted based on statistical and empirical analyses of volume, level of excess clinical harm associated with the PSI, and disutility (the measure of the severity of the adverse events associated with each of the harms, that is, outcome severity, or least preferred states from the patient perspective). The final weight for each component indicator is the product of harm weights and volume weights (numerator weights). Harm weights are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms. Excess harms are estimated using statistical models comparing patients with a safety event to those without a safety event in a Medicare FFS sample. Volume weights are calculated based on the number of safety events for the component indicators in an all-payer reference population. For more information on the modified PSI-90 measure and component indicators, please reference the Quality Indicator Empirical Methods available online at http://www.qualityindicators.ahrq.gov/.

Question 55: **Why haven't we incorporated the inpatient Rehab quality measures included in this presentation?**

This presentation included only the programs under the IPPS. The Inpatient Rehabilitation Facility Quality Reporting Program and measures are not included under the IPPS Final Rule.

Question 56: **When will the HRRP program include socioeconomic factors in the risk adjustment process?**

As stated in the FY 2017 IPPS Final Rule, CMS understands the important role socioeconomic and sociodemographic status (SES/SDS) plays in the care of patients. However, CMS has concerns about holding hospitals to different standards for the outcomes of their patients of diverse sociodemographic status because they do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations.

CMS routinely monitors the impact of sociodemographic status on hospital results on their measures. CMS is collaborating with the NQF on a two-year trial period to determine if risk-adjusting for sociodemographic factors is appropriate for their measures. Furthermore, as directed by the IMPACT Act, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare Program. CMS will examine the findings of the ASPE reports and related Secretarial recommendations and consider how they apply to CMS quality programs once they are available. If CMS decides to make any changes to the program, the changes would occur through rulemaking and would be published annually with the IPPS Final Rule following a public comment period.

Question 57: **When will the NHSN Antimicrobial Use Measure be required?**

The NHSN Antimicrobial Use Measure was listed as a potential measure to be included in future rulemaking and no date was established as to when this measure would be proposed for adoption.

Question 58: **It would be helpful if you could identify the actual DATE that each of these initiatives are effective. It's very confusing. Is there going to be any effort toward having the same reporting period for each initiative?**

Thank you for your comments. CMS seeks to increase alignment of requirements and measurement periods across quality programs to the extent feasible and will take your feedback into consideration.

Question 59: **When exactly do the new 3 PSI measures start?**

The modified PSI 90 measure was finalized for inclusion in the FY 2018 Hospital IQR Program and HACRP. CMS stated in the FY 2017 IPPS Final Rule the intent to adopt the modified PSI 90 measure in the Hospital VBP Program in future rulemaking.

Question 60: **Follow up - the hospital has a modular certified eCQM solution that is certified for all 29 measures in 2016 and will be certified for all 15 in 2017. They do not have a complete EHR certified for 2014 since they are not doing MU Stage 2. Can they use the certified eCQM solution to report IQR even though their Base EHR is not certified?**

To obtain additional details, please contact the EHR Information Center at 1-888-734-6433 Monday – Friday, 7:30 – 6:30 p.m. CT.

Question 61: **If I understood correctly, CVC related bloodstream infections will be removed from PSI 90 but it will still be part of VBP?**

The non-modified version of the PSI-90 measure will be used in the Hospital VBP Program in FY 2018. As stated in the FY 2017 IPPS Final Rule, CMS intends to propose to remove this version of the PSI-90 measure in FY 2019 in future rulemaking. CMS also stated their intent to propose to include the modified version of the measure in future rulemaking.

Question 62: **Can you confirm the Medicare Advantage claims do not apply to the HAC or VBP Programs?**

The Hospital VBP Program uses only Medicare FFS patients for the AHRQ PSI-90 measure and the 30-Day Mortality Measures. The Medicare

Spending per Beneficiary (MSPB) measure utilizes Medicare Part A and B claims. The remaining measures currently within the Hospital VBP Program are not claims-based. The HACRP uses only Medicare FFS patients for the AHRQ PSI-90 Domain 1 measure, and chart-abstracted data, not claims data, are used from all inpatients for the HAI Domain 2 measures.

Question 63: **For PSI-90, will the modifications be effective retroactively for the 15-month reporting period July 2014 to September 30, 2015? or effective going forward with CY 2017?**

The modified PSI-90 measure will be included in the FY 2018 Hospital IQR Program and HACRP. These programs will use a performance period of July 1, 2014, through September 30, 2015.

Question 64: **If we are using a vendor for our eCQM submission, does our EHR need to be certified for the measures?**

Yes, successful submission is defined as reporting a combination of QRDA Category I files with patients meeting the initial patient population (IPP) of the applicable measures, zero denominator declarations, and case threshold exemptions. In all cases, a facility has to use a EHR certified to report the measures.

Question 65: **Are you able to discuss potential measures of behavioral health?**

The Hospital IQR Program does not currently include any measures directly related to behavioral health. Based on MedPAC analyses, over a third of Medicare inpatient psychiatric admissions are treated "in acute care hospital beds not within distinct-part psychiatric units." Thus, there may be a gap in understanding the quality of care given to patients with behavioral health diagnoses paid under IPPS rather than given in inpatient psychiatric facilities (IPFs) paid under the IPF Payment System. To address this gap, CMS invited public comments on potential behavioral health quality measures appropriate to include in the Hospital IQR Program in future years. Any adoption of these measures will be done through the rulemaking process in future years.

Question 66: **Is there a list of certified eCQM vendors I can access? I would like to take a look and make sure my vendor is in fact on that list and is certified.**

CMS does not provide a list of vendors for hospitals to choose from. It is required that the EHR is certified for the specific measures that your hospital or vendor will be electronically submitting. These quality measures have been developed specifically to allow an EHR system certified to the 2014 or 2015 standards to calculate, export and submit the measure data. Please note that not all vendors are certified for all of the measure sets. Please refer to the Certified Health IT Product List. This list provides the authoritative, comprehensive listing of Complete EHR and EHR Modules tested and certified under the Health Information Technology (HIT) Certification Program, maintained by the ONC.

Question 67: **We are strictly an orthopedic surgical hospital and have only one eCQM to report from the 16 available. All others have been eliminated. What do we do to satisfy the "8" eCQM requirement?**

Hospitals may submit zero denominator declarations and/or case threshold exemptions, which count as a "successful submission." A successful submission is defined as reporting a combination of QRDA Category I Files with patients meeting the IPP of the applicable measures, zero denominator declarations, and case threshold exemptions. In all cases, a facility has to use an EHR certified to report the measures. Zero denominator declarations can be used when a hospital does not have patients that meet the denominator criteria for a specific CQM. If a facility has five or fewer discharges occur during a reporting quarter, a facility has the option to utilize the case threshold exemption.

Question 68: **As far as penalties, which will still apply (i.e., HAC, Readmissions for FY 2017, FY 2018, etc.)?**

For the HACRP, by statute, the payment reduction for those in the worst-performing quartile is one percent each fiscal year.

The payment adjustment formula for FY 2017 HRRP was finalized in the FY 2013 IPPS Final Rule and can be found on the CMS website at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html. Payment

adjustment under the FY 2017 HRRP is based on a hospitals excess readmission ratios with a performance period of July 1, 2012, to June 30, 2015. This is based on six readmissions measures: AMI, Heart Failure (HF), Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Total Hip/Total Knee Arthroplasty (THA/TKA), and CABG Surgery. If a hospital has an excess readmission ratio greater than 1.0000 for a measure with at least 25 eligible discharges, then their excess readmission ratio will enter the payment adjustment formula. Measures enter the payment adjustment formula additively; each additional measure with an excess readmission ratio greater than 1.0000 increases the amount of the payment adjustment until the payment adjustment reaches the maximum three percent penalty (adjustment factor of 0.9700). The size of the excess readmission ratio (the amount above 1.0000) also increases the amount of the payment adjustment.

Question 69: **It would be incredibly helpful if CMS would be more clear in giving us tools to know where we are when performance periods are actually happening. FY 2018 (11 months already done) methodologies are not published, weighting is not published and ICD-10 codes are not published. If they are, please show us a table that would show these elements clearly. Your links only go to pages that have FY 2017 methods published.**

Thank you for your comments, we will take them under review and consideration. However, there are resources available on *QualityNet* that may be beneficial to you:

- The measures table (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473)
- The important dates and deadlines document (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1138115987129)
- The updates to the Specifications Manual (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099).

Question 70: **Slide 50 states the modified PSI-90 for the HAC Reduction Program begins with FY 2018 payment determination year. Wouldn't these changes take effect January 2016?**

The HAC Reduction Program will use the modified PSI-90 beginning in the FY 2018 payment year as finalized in the FY 2017 IPPS\LTCH Final Rule (81 FR 57020). In the same rule, there were concerns regarding overlapping ICD-9 and ICD-10 claims data for the previously established two-year data period, July 1, 2014 – June 30, 2016. As a result, we finalized our proposal to shorten the data period for the modified PSI-90 to 15 months (July 1, 2014 to September 30, 2015) in order to account for only those claims that used ICD-9 (81 FR 57020).

Question 71: **PSI-90 for FY 2019 will use only ICD-10 data for the performance period. How will the Hospital Baseline Period be calculated given that those records will have been coded using ICD-10 and the VBP Program uses both Performance and Improvement Scoring?**

The modified PSI-90 performance period for FY 2019 using only ICD-10 data was finalized for the Hospital IQR and HACRPs only. CMS stated in the FY 2017 IPPS Final Rule that they intend to propose the removal of the PSI 90 Composite from the FY 2019 Hospital VBP Program in future rulemaking.

Question 72: **To clarify eCQM submission requirements for CY2017, we need to submit a total of 8 eCQMs in addition to the 4 eCQMs we will be submitting in Q4-CY2016 or does the 8 required include the 4 initial one chosen?**

For CY 2017 reporting, hospitals will be required to submit at least eight eCQMs for a full calendar year by February 28, 2018. CMS has indicated that hospitals self-select measures that are most reflective of their total patient population. Hospitals may decide to select the same four eCQMs from CY 2016 if they are not being removed from the program; they may also select an additional four eCQMs from the remaining available 15 eCQMs to report in CY 2017.

Question 73: **If a CAH wants to submit eCQMs for the EHR incentive program, how many do they need to submit? Is it all of them or is it 8?**

For CY 2017 reporting to the EHR Incentive Program, CAHs have two options: either self-select eight eCQMs to report through the CMS data receiving system in the *QualityNet Secure Portal* or attest to all 16 measures utilizing the CMS Registration and Attestation System.

Question 74: **If a system is changing EHR platforms (due to current EHR sunsetting product) in 2017, is this grounds to qualify for an ECE (during the year of platform migration)?**

According to the FY 2017 IPPS Final Rule, CMS has finalized that hospitals may submit an ECE request by April 1 following the reporting year. Hospitals may utilize the ECE form to request an exemption from the Hospital IQR Program's eCQM reporting requirement for the applicable program year based on hardships preventing hospitals from electronically reporting. Such hardships could include, but are not limited to, infrastructure challenges (a hospital is in an area without sufficient Internet access) or unforeseen circumstances, such as vendor issues outside of the hospital's control (including a vendor product losing certification).

Question 75: **Can you please confirm that FY 2019 equals CY 2017?**

Meeting the CY 2017 reporting period requirements for chart-abstracted, structural, HAI, eCQM, HCAHPS, and Medicare Spending Per Beneficiary measures applies to the Hospital IQR Program FY 2019 payment determination.

Question 76: **Are chart abstracted measures removed from IQR applicable from discharges of January 2017?**

That is correct. The STK-4 and VTE-5 measures will no longer be required for the Hospital IQR Program beginning with January 1, 2017, discharges.

Question 77: **What does topped out mean?**

A measure is ''topped out'' when measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped-out'' measures) (77 FR 53505 through 53506). The two criteria for being topped-out include: statistically indistinguishable performance at the 75th and 90th percentiles; and Truncated coefficient of variation less than or equal to 0.10.

Question 78: **What time period is this for? Not the payment year but actual CY…**

For the Hospital IQR Program this would be effective for CY 2017.

Question 79: **If a system has two different EHR platforms in 2017 (migrating due to current EHR sunsetting product) and we have eCQM data in two different EHRs, can CMS provide guidance on how to submit data? For example, our new vendor will not have the ability to merge two QRDA I files from two different systems, and there are issues with mapping (i.e. if the two platforms have different patient identifiers, etc.). How can we satisfy CMS's eCQM requirements in this instance?**

The FY 2017 IPPS/LTCH PPS Final Rule indicates facilities are permitted to extract data from noncertified sources into CEHRT for capture and reporting through QRDA Category I files. This will assist facilities to work with their vendors to continue making progress to achieve electronic data capture and reporting. Facilities are also offered the flexibility for CY 2017 reporting to determine if they would like to report data on a quarterly, semi-annual, or annual basis. Your facility can work with your vendor to determine your data submission timeframe for QRDA Category I reporting based on several factors, including internal planning for EHR transition activities (system implementation, training, etc.). This supports your facility's effort to fulfill the intent of achieving interoperability and meet program reporting requirements.

Question 80: **Is this FY 2017 (Cover slide, slide 6) or FY 2019 (slide 9)?**

The IPPS Final Rule is for FY 2017, however, for the removal of the 15 measures for the Hospital IQR Program, it is effective beginning with January 1, 2017, discharges, which impact FY 2019 payment determinations.

Question 81: **I understand that this is for FY 2017- when is the effect date for abstraction- Oct 1?**

For the Hospital IQR Program the required chart-abstracted measures for FY 2019 would be abstracted from January 1, 2017, through December 31, 2017 discharges.

Question 82: **How were PSI 12 and PSI 15 re-specified for PSI 90? Any specifics available or where can I find any details?**

In response to stakeholder concerns, highlighted in the NQF 2014 Patient Safety Report, the modified PSI-90 measure re-specified two component

indicators, PSI-12 and PSI-15. Specifically, for PSI-12 Perioperative (PE) or DVT Rate, the NQF received public comments concerning the inclusion of extracorporeal membrane oxygenation (ECMO) procedures in the denominator, as well as, intra-hospital variability in the documentation of calf vein thrombosis, which has uncertain clinical significance. Therefore, the modified PSI-12 component indicator no longer includes ECMO procedures in the denominator or isolated deep vein thrombosis of the calf veins in the numerator. PSI-15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate, was also re-specified to focus on the most serious intraoperative injuries, those that were unrecognized until they required a subsequent reparative procedure. The modified denominator of PSI-15 now is limited to discharges with an abdominal/pelvic operation, rather than including all medical and surgical discharges. In addition, to identify events that are more likely to be clinically significant and preventable, the PSI-15 numerator was modified to require both a diagnosis of an accidental puncture and/or laceration and an abdominal/pelvic reoperation occurring one or more days after the index surgery. Based on these new specifications, the PSI-15 indicator name has been changed as note above. For more information on the modified PSI-90 measure and component indicators, please refer to www.qualityindicators.ahrq.gov.

Question 83: **Slide 18 - by reporting period, are you specifically referencing the performance period?**

That is correct. The Hospital IQR Program refers to "reporting period," which would be the same as the performance period.

Question 84: **Slide 17 question please – AHRQ has re-specified PSI-08 to include in hospital hip fractures; is this revised PSI-08 specification being adopted by CMS? Only PSI-12 and 15 are noted in this presentation.**

In the FY 2017 IPPS Final Rule, CMS finalized the specifications for all component indicators in the modified PSI-90 Composite, including the re-specification of PSI-08. CMS highlighted the changes to PSI-12 and PSI-15 in response to stakeholder concerns.

Question 85: **Will reporting of CLABSIs still be required?**

Yes, the reporting of the CLABSI measure via the CDC NHSN is still required for the Hospital IQR, HAC Reduction, and Hospital VBP Programs.

Question 86: **On Slide # 27 eCQM data validation – accuracy, is the validation matching looking at our internal eCQM reports to the QRDA I report data? What are you validating the QRDA I file data against?**

The randomly selected QRDA Category I file would be compared against a PDF version of the medical records provided by the hospital 30 calendar days following the requested date listed on the Clinical Data Abstraction Center (CDAC) Request from. Please review page 57179 of the FY 2017 IPPS/LTCH PPS Final Rule for additional details regarding the method for submitting the PDF of the medical records, etc.

Question 87: **Does the removal of IMM-2 also apply to Psych Inpatient Population?**

The Immunization, IMM-2 measure has not been removed from the Hospital IQR Program; it is still a required measure.

Question 88: **Do the chole and spinal fusion episode based payment measures apply to inpatient procedures, outpatient procedures, or both?**

Both the Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure and the Spinal Fusion Clinical Episode-Based Payment Measure use Part A and Part B Medicare inpatient administrative claims data.

Question 89: **With regard to reporting eCQMs for the CY 2018 reporting period/FY 2020 payment determination, would CMS allow a hospital to use an EHR that is certified to the 2014 Edition CEHRT instead of the 2015 Edition, if the hospital uses a quality reporting module certified to the 2015 Edition that imports and calculates eCQMs from the hospital EHR and creates the electronic file for submission?**

According to the FY 2017 IPPS Final Rule, hospitals reporting eCQM data for CY 2018 are required to use an EHR that is certified to the 2015 Edition CEHRT.

Question 90: **What specific guidance does CMS offer providers (re: eCQM/QRDA reporting) who are transitioning/migrating EHRs during the 2017 reporting year? There are several challenges, among them accurate**

reporting of patient data and encounters when patients are inpatients during the transition and so have a QRDA from the legacy system as well as the new EHR. Note: often, during the transition, patients who are in house are discharged from the legacy system and readmitted into the new EHR system and so have 2 QRDAs for the same reporting period. Vendors are not at liberty to manipulate data from the legacy system QRDA file. Will there be documented recommendations forthcoming?

The FY 2017 IPPS/LTCH PPS Final Rule indicates facilities are permitted to extract data from noncertified sources into CEHRT for capture and reporting through QRDA Category I files. This will assist facilities to work with their vendors to continue making progress to achieve electronic data capture and reporting. If that option does not address your scenario, facilities are also offered the flexibility to determine if they would like to report data on a quarterly, semi-annual, or annual basis for CY 2017 reporting. Your facility can work with your vendor to determine your data submission timeframe for QRDA Category I reporting based on several factors, including internal planning for EHR transition activities (system implementation, training, etc.). This supports your facility's effort to fulfill the intent of achieving interoperability and meet program reporting requirements. The request for documented recommendations will be presented to CMS for their consideration.

Question 91: **Currently hospitals are required to designate a vendor in the QualityNet portal for their eCQM submission. Will they be required to continue to update this designation of their vendor? Also, will they need to mark down which eCQMs they are intending on sending?**

Hospitals must authorize their vendor(s) in order to submit data on their behalf. Both the hospital and vendor must obtain the EHR Data Upload Role to be able to upload files. CMS is not requiring hospitals or vendors to notify them in advance of which eCQMs they intend to submit. Please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or 1-866-288-8912 for assistance obtaining the EHR Data Upload Role.

Question 92: **With regards to submitting QRDA files by a vendor, can the QRDA file be generated by the hospital from their EHR and then submitted by the vendor to CMS, or, does the vendor have to generate and submit the QRDA file?**

Either the hospital or vendor may submit the QRDA Category I file to CMS as long as the file is generated from EHR Technology certified to the 2014 or 2015 edition for CY 2016 and CY 2017 reporting. In order for the vendor to submit files on the hospital's behalf, the hospital must authorize the vendor. In addition, both the hospital and vendor need to contact the QualityNet Help Desk to request the EHR Data Upload Role at qnetsupport@hcqis.org or 1-866-288-8912.

Question 93: **Are all hospitals now required to file eCQMs or is that by selection process?**

Starting with CY 2016 reporting, all hospitals participating in the Hospital IQR Program are required to submit at least four eCQMs from either quarter three or quarter four of 2016 by February 28, 2017. For CY 2017 reporting, the same hospitals will be required to submit at least eight eCQMs for a full calendar year by February 28, 2018.

Question 94: **What is the recommendation for a hospital that does not have an electronic health record for reporting the IQR eCQMs? Examples: An exception request or abstracting and using a vendor to report the eCQMs or other?**

In order to fulfill the electronic reporting requirement of CQMs to the IQR Program, a facility must have EHR Technology certified to the 2014 or 2015 version. Facilities need to make a determination regarding their options to electronically report data for CY 2016 reporting. Providers are able to review the criteria for the ECE available on the QualityNet.org website.

Question 95: **For PSI 90 and reporting the 15-month period using ICD-9 codes, is this using the modified PSI version or the existing 8 PSI 90 version?**

In the FY 2018 HACRP and Hospital IQR Program, CMS will be using the modified PSI-90 measure with a 15-month period, ending on September 30, 2015. This performance period will utilize ICD-9 codes only. The FY 2018

Hospital VBP Program will utilize the non-modified (eight indicator) PSI-90 measure utilizing ICD-9 codes only.

Question 96: **Is the chart abstracted validation requirement threshold still at 80% for all four quarters?**

CMS calculates a total score for all four quarters reflecting a weighted average of two individual scores for the reliability of the clinical process of care and HAI measure sets. After the scores are combined, CMS computes a confidence interval around the combined score. If the upper bound of this confidence interval is 75 percent or higher, the hospital will pass the Hospital IQR Program validation requirement.

Question 97: **Hospitals may continue to use a 3rd party to submit QRDA data in 2017. Does this imply that use of the 3rd party may not be an option in future years?**

CMS will signal their intent in future proposed and final rulemaking for future reporting years.

Question 98: **What are the ramifications if a hospital is unable to adequately submit eCQMs by the Feb 2017 deadline due to EHR issue?**

Hospitals that fail to successfully submit at least four eCQMs from either quarter three or quarter four 2016 by the February 28, 2017, deadline are at risk for failing their Annual Payment Update. A successful submission for eCQMs can be reported as a combination of QRDA Category I files with patients meeting initial patient population of the applicable measures, zero-denominator declarations, and case threshold exemptions.

Question 99: **Please confirm if the requirement for the CY 2016 reporting period of 4 eCQM measures remains unchanged.**

For CY 2016 reporting, hospitals are still required to submit at least four eCQMs from either quarter three or quarter four 2016 by the February 28, 2017, deadline.

Question 100: **If you have hospitals during the 2017 reporting year that are one EMR and then switch to another EMR during the reporting year and during a specific quarter, how do we submit the data? Or, is there exemption for that quarter?**

Hospitals are expected to submit one file per patient per quarter. If a hospital transitions to new EHR during the middle of a quarter, CMS recommends importing the data from the old EHR into the new EHR in order to submit one file per patient. Hospitals should work with their EHR vendor or data aggregation vendor to combine their data into one file per patient.

Question 101: **Did the total of number of required eCQMs get changed? Slide 21. We have been working on 13 not 8?**

For CY 2017 reporting, hospitals participating in both the IQR and EHR Incentive Programs are required to self-select a minimum of eight of the available eCQMs. They must report all four quarters of data from a certified EHR by February 28, 2018.

Question 102: **Slide 23 requires complete medical record information for at least 75% of sampled records. So, eCQM data submission is for a sampled population only?**

Slide 23 refers to the eCQM data validation process, not the reporting requirements. The reporting of eCQM data is to be representative of the total patient population. If your facility is chosen to provide QRDA Category I files for eCQM data validation, CMS will randomly select 32 cases. Of those 32 cases, hospitals are required to submit timely and complete medical record information where at least 75 percent of the medical record data is complete. Facilities would not be scored on the basis of measure accuracy for FY 2020 payment determination. Please refer to the FY 2017 IPPS/LTCH PPS Final Rule for additional details.

Question 103: **Will we be penalized if cases are rejected in the PSVA tool or from the QualityNet upload?**

CMS expects the reporting of eCQMs to be representative of the entire patient population for the timeframe in question. All applicable patients should be reported on, so if the cases in rejected files meet criteria to be

included in the hospital's selected eCQMs, they should in fact be submitted in an acceptable QRDA Category I file format for evaluation to meet Hospital IQR Program criteria. Utilization of the PSVA tool is strictly for pre-submission testing and is intended to assist data submitters to identify and troubleshoot any validation issues within the file.

Question 104: **How will eCQM validation be made? Whom in particular at our facility will be notified?**

eCQM validation of CY 2017 reported eCQM data begins Spring 2018 for the FY 2020 payment determination. Up to 200 hospitals will be randomly selected. Those hospitals selected for chart-abstracted measure validation and/or that have been granted an ECE will be excluded from the eCQM validation. Submit validation questions to validation@hcqis.org. Questions on medical record submission should be directed to CDACHelpDesk@hcqis.org.

Question 105: **Will the eCQM be publically reported on *Hospital Compare*?**

eCQM data will not be publically reported on *Hospital Compare* at this time. CMS will signal their intent in future rule making.

Question 106: **We are transitioning EHR vendors in 2017. If our legacy (old) EHR cannot produce a QRDA I file for 8 eCQMs without a costly upgrade, would that qualify our organization for an Extraordinary Circumstances Exemption (ECE)?**

On the QualityNet.org website there is information regarding the ECE process specific to the submission of eCQMs for the IQR Program for CY 2016. Hospitals may utilize the ECE form to request an exemption from the Hospital IQR Program's eCQM reporting requirement for the applicable program year based on the hardships preventing hospitals from electronically reporting. Such hardships could include but are not limited to: infrastructure challenges (a hospital is in an area without sufficient Internet access) or unforeseen circumstances, such as vendor issues outside of the hospital's control (including a vendor product losing certification).

Question 107: **For the eCQM measures that are also part of CMS 5 star, at what point the manually chart abstracted data is replaced with the eCQMs?**

No eCQM data are currently publicly reported on *Hospital Compare* or used as part of overall ratings calculations. If CMS intends to remove any additional chart-abstracted measures from the Hospital IQR Program, it will do so through a future IPPS proposed rule.

Question 108: **For eCQM validation, hospitals need to submit a medical record the same as how medical records are now submitted for abstracted cases? or submit another electronic feed?**

As stated in the FY 2017 IPPS Final Rule (81 FR 57179), the eCQM data validation requirements will include the following: (1) require eCQM validation submission by 30 calendar days following the medical records request date listed on the CDAC request form; (2) require sufficient patient level information necessary to match the requested medical record to the original Hospital IQR Program submitted eCQM measure data record; and (3) require hospitals selected as part of the random sample for eCQM validation to submit records in PDF file format through *QualityNet* using the Secure File Transfer (SFT).

Question 109: **Slide 20 references (CY) 2017 reporting period / FY 2019 payment determination - confirming this CY 2017 = Oct 2016-Sept 2017?**

The CY 2017 reporting period is January 1, 2017, through December 31, 2017. The FY 2019 payment determination refers to payments on claims for discharges from October 1, 2018 through September 30, 2019.

Question 110: **What has been the maximum percentage gained by a facility in the HVBP Program?**

CMS publishes the Hospital VBP Program value-based incentive payment adjustment factors for each of the fiscal years in the IPPS Final Rule tables (Table 16B) for the applicable fiscal year. The most recent finalized table available is for FY 2016 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2016-CMS-1632-FR-Table-16.zip

CMS anticipates the FY 2017 value-based incentive payment adjustment factors will be released in October 2016 and will be posted on the FY 2017 IPPS Final Rule Tables page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

In addition, CMS publishes aggregated payment information on the *Hospital Compare* website at https://www.medicare.gov/hospitalcompare/data/payment-adjustments.html.

Currently, FY 2014 payment data is available and CMS anticipates releasing the FY 2015 payment data during the December 2016 refresh.

Question 111: **Can you confirm that meeting the eCQM requirements within IQR fulfills the quality component of MU?**

For CY 2017 reporting, a full calendar year of at least eight eCQMs submitted by February 28, 2018, will be aligned credit. Please note that each program has additional requirements that must be fulfilled.

Question 112: **We will be changing certified EHR's in the middle of the 4th qtr. 2017. We can submit data for 3 qtrs. but not the 4th qtr. Would the application for ECE cover the whole year or just the 4th qtr.?**

If a hospital chooses to submit the ECE Request Form, the submitter has a field in which to indicate the affected submission quarter. Please visit the QualityNet.org website to review the ECE criteria and to review the form.

Question 113: **Will switching certified EHRs be considered a valid cause for a provider seeking and CMS granting an Extraordinary Circumstances Exemptions (ECE)?**

Hospitals may utilize the ECE form to request an exemption from the IQR Program eCQM reporting requirement for the applicable program year. This can include but is not limited to, "infrastructure challenges or unforeseen circumstances, such as vendor issues outside of the hospital's control or hospitals newly participating in the IQR Program." Please refer to the ECE policy for eCQM reporting located on QualityNet.org.

Question 114: **Are the 3 clinical episode based payment measures for Medicare fee for service patients only?**

Yes, the three clinical episode based payment measures use Part A and Part B Medicare administrative claims data.

Question 115: **What is the timeline for removing all current chart abstracted measures and moving to eCQMs in the IQR Program?**

CMS will signal their intent in future rulemaking.

Question 116: **For the Mort-PN-30 measure, where can we find the ICD-10 codes for inclusion and exclusion criteria?**

For questions regarding the 30-Day Mortality measure methodology, please contact cmsmortalitymeasures@yale.edu. Resources for claims-based measures, including the CMS 30-Day Mortality measures may be found on the *QualityNet* website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1163010398556.

Question 117: **What are citations under the immediate jeopardy exclusion?**

In 42 CFR 412.160 of our Hospital VBP Program regulations, we defined the term ‘‘Cited for deficiencies that pose immediate jeopardy’’ to mean that ‘‘during the applicable performance period, the Secretary cited the hospital for immediate jeopardy on at least two surveys using the Form CMS–2567, Statement of Deficiencies and Plan of Correction’’ (Office of Management and Budget, OMB Control Number 0938–0391). In 42 CFR 412.160, we also adopted the definition of ‘‘immediate jeopardy’’ found in 42 CFR 489.3 of our regulations. In the FY 2017 IPPS Final Rule, CMS increased the number of immediate jeopardy citations required for Hospital VBP Program exclusion from two to three and amended the regulations at 42 CFR 412.160 from “two” to “three” surveys.

Question 118: **I am new to this process. Could you refer us to a glossary of definitions? for example, CY 2017 vs FY 2017 or payment year vs program year. Additionally, baseline period vs performance period. Thank you**

We are not aware of any glossaries of definitions inclusive of all programs, but we appreciate the suggestion. We hope the suggestions below will satisfy the immediate need, but please submit a question to the Inpatient Q&A tool on *QualityNet*, if you need assistance with any other definitions that are not listed.

Calendar Year, or CY, generally refers to the time period from January 1 through December 31. FY generally refers to the time period from October 1 through September 30 of the following year.

Payment or Program Year is stated in reference to when the program's requirements will impact hospital payments for a given fiscal year. For example, we covered FY 2018 and FY 2019 in a number of slides during the presentation. These slides reference when the hospitals will receive payment adjustments. For example, the FY 2018 Payment Year runs from October 1, 2017 through September 30, 2018, but may use data from a year to many years prior for evaluation.

Baseline Period and Performance Period are Hospital Value-Based Purchasing Program terms. CMS uses a scoring methodology in the Hospital VBP Program that awards two scores per measure (an improvement and an achievement score). Improvement compares hospital rates from a more current time period (the performance period) to a prior time period known as the baseline period. Achievement compares the hospital's rates from the performance period to all other hospitals through the use of the benchmark and achievement threshold. The Hospital VBP Program uses the higher of the improvement or achievement score on each measure. For more information regarding terms used in the Hospital VBP Program, please refer to Appendix D in the FY 2017 Fact Sheet on *QualityNet* at

https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890603067&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DVBP_FY17_PPSR_FactSheet_073116.pdf&blobcol=urldata&blobtable=MungoBlobs.

Question 119: **Will CMS rerun the PSI 90 baselines before holding us to the new definitions for FY 2018 payment determination (which is on 10/1/17)? (i.e., all of the baselines we have were under the old definitions).**

CMS did not adopt the modified PSI-90 measure in the FY 2018 Hospital VBP Program. The index values listed in the FY 2018 Baseline Measures Reports were calculated using the non-modified version of the measure using software v5.0.1 fully recalibrated. CMS intends to use those same specifications and software for the performance period calculations.

Question 120: **For CY 2017, what is the success criteria for the submission of the 8 eCQMs?**

A successful eCQM submission is defined as a combination of the following: Accepted QRDA I files with patients meeting the Initial Patient Population of the applicable measures, zero denominator declarations, and case threshold exemptions. For CY 2017 reporting, hospitals are required to self-select at least eight eCQMs and report a full calendar year of data by February 28, 2018.

Question 121: **For slides Pg. 59 and 60 Fiscal 2017 and Fiscal 2018 the dates are the same July 1, 2012 – June 30, 2015. Should the period be July 1, 2013 – June 30, 2016?**

Thank you for your question regarding the FY 2017 Applicable Hospital Discharge Period. There was a typo on slide 60 recently presented in the webinar, which should have referred to the FY 2017 Applicable Hospital Discharge period, not FY 2018. The period of July 1, 2012, through June 30, 2015 is correct for FY 2017. This information is located on page 891 of the FY 2017 IPPS Final Rule available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html or you can visit cms.gov and search for FY 2017 Final Rule.

Question 122: **How do we correct previously reported HAC or Readmission case specific data? If we discover an error, what is the process for resubmitting? Is resubmitting a bill adequate?**

Since claims data are generated by the hospital itself, hospitals in general

always have the opportunity to review and correct these data before the specified deadline. When reviewing data, if there is a coding error on a claim, we suggest the hospital correct the claim using CMS standard processes and follow up with the coding and/or billing department to ensure this type of error does not occur in the future. Correcting administrative claims data errors within the allotted time will also help prevent errors impacting the calculation of other hospital scores associated with the HRRP, HAC, and HAC Deficit Reduction Act (DRA) Program.

In regards to program calculations within the Hospital-Specific Report, hospitals are encouraged to review and correct the accuracy of the calculations during the applicable review and corrections period. Hospitals are not allowed to submit corrections related to the underlying claims data, or to add new claims to the data extract used to calculate the rates. If a hospital wishes to make edits to a claim for purposes other than DRG assignment, that type of edit can occur for up to one year after the date of discharge from an inpatient stay. The Medicare Claims Processing Manual Provisions for Claims Adjustments outlines these provisions and is located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf. We would also suggest you contact your Medicare Administrative Contractor for additional claims adjustment questions.

Question 123: **How can I access the Federal Register referenced on slide 63?**

Access the CMS FY 2017 Inpatient Prospective Payment System (IPPS) / Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Final Rule in the Federal Register (81 FR 56761) at https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf.

Question 124: **On slide 60, it states date range is July 2012 – June 2015 for FFY18. This is the same date range used for FFY17 results. Is this a mistake?**

We apologize for this error. The slide should read FY 2017 not FY 2018. The FY 2017 applicable hospital discharge period dates for the HRRP are July 1, 2012, through June 30, 2015.

Question 125: **The mock report for PSI-90 that you can download on QualityNet doesn't include the new PSI's being included so we can't know the new weights of the measures.**

The mock HSRs that are currently on *QualityNet* are for the FY 2017 Hospital IQR Program, HACRP, and Hospital VBP Program. The mock HSRs for the FY 2018 Programs will be posted to *QualityNet* closer to when HSRs are delivered to hospitals.

Question 126: **There are parts of our EHR that are not certified and cannot be pulled from to report eCQM data. When records are submitted for validation, how will the validators be aware of what portions of the record are certified and can be used for eCQMs versus those that are not?**

Hospitals are required to utilize certified EHR technology in order to generate QRDA Category I files for eCQM reporting. The expectation is that when a provider participates in the validation process in the spring of 2018, the files submitted will be patient-level files or QRDA Category I files that contain the entire medical record and sufficiently document the eCQM measure data elements.

Question 127: **Slide 60: HRRP - Are the Discharge Periods (7/1/12-6/30/15) listed for the FY 2017 or FY 2018 Readmission Reduction Program?**

We apologize for this error. The slide should read FY 2017 not FY 2018. The FY 2017 applicable hospital discharge period dates for the HRRP are July 1, 2012, through June 30, 2015.

Question 128: **Please clarify the data period that eCQM submission (due by Feb, 2017) should include. Q3 or Q4 of 2016 admissions?**

For CY 2016 reporting, hospitals are required to submit at least four eCQMs from either quarter three or quarter four by February 28, 2017.

Question 129: **For CY 2017 eCQM submission, does the CEHRT have to be certified to 2015 criteria or can it still be 2014 Certification?**

For CY 2017 reporting, EHR technology must be certified to either the 2014 or 2015 edition.

Question 130: **Will the retirement of the CMS chart abstracted measures for VTE-5 and STK-4 also be retired for The Joint Commission?**

At this time, we do not know if The Joint Commission will also be removing VTE-6 and STK-4 from their program. Please submit your question to The Joint Commission.

Question 131: **For the eCQM removed measures, the criteria listed states the reason is 'no longer feasible to implement the measures specifications', what does that mean?**

eCQM measures are removed due to the measure steward no longer supporting a specific measure or that there are a number of data capture requirements that cannot be represented adequately in the eCQM form due to conceptual complexity. CMS recognizes the difficulty implementing measure specifications; therefore, they are removed because the burden of retaining those measures outweighs the benefits.

Question 132: **Once an ECE exemption form is submitted, what is the usual turnaround time on a determination?**

Determination timeframe is relative to each individual hospital's scenario; therefore, a specific timeframe to receive feedback from CMS regarding the status of a submitted ECE is not readily available. Submitters of an ECE will receive an email notification when the ECE is received, along with periodic status update emails.

Question 133: **Do you have a tip sheet on how to explain winsorizing to healthcare providers?**

Given that this proposed change was just finalized, our team is working aggressively to put together a number of different educational tools. Please continue to visit the *QualityNet* website for the HACRP, we should be posting up some educational tools on that site soon.

Question 134: **We are implementing a new EHR at the end of January 2017. How would you suggest us meeting the 12-month requirement for eCQM submission? We will not be able to create those 8 eCQMs with legacy**

systems between 1/1 and the implementation of our EHR at the end of January 2017; is there any type of exception that could be granted for facilities who are implementing EHR's mid-year? Only 1 QRDA file will be accepted correct?

CMS recommends that hospitals import the data from the old EHR into the new EHR and submit one file per patient per quarter. Hospitals may manually extract the data from non-certified sources and input this data to CEHRT in order to capture and successfully report QRDA I files to the 2014 or 2015 CEHRT edition. Hospitals are encouraged to work with their EHR vendor or a data aggregation vendor to combine their data into one file per patient. For questions regarding the applicability of the ECE, please refer to the ECE policy for eCQM reporting located in the eCQM section under the IQR Program on www.qualitynet.org.

Question 135: **Can you explain the three new clinical episode-based payment measures and what will be required for abstraction?**

The three new episode of care payment measures include Aortic Aneurysm Procedure Clinical Episode-Based Payment, Cholecystectomy and Common Bile Duct Exploration Clinical Episode-Based Payment, and Spinal Fusion Clinical Episode-Based Payment. Please refer to the FY 2017 IPPS Final Rule for further information regarding these measures. These are claims-based measures that use both Part A and Part B administrative claims, and there is no required chart-abstraction.

Question 136: **For eCQM measures ED 1 and ED 2- should the measure be stratified to ED 1a or 1b and for ED 2, 2a, or 2b?**

eCQM questions on measure specifications are submitted and tracked in the ONC JIRA Tracking System. The Jira Tracking System is where all questions are submitted and tracked regarding eCQMs, their specifications, logic, code sets, measure intent, etc. In addition, you may search for a response to a question that is similar to yours that may have already been posted by the team.

Question 137: **How can you fairly compare HAC scores with facilities with both domains with only one domain?**

CMS acknowledges your concern and is striving to be fair and equitable across reporting hospitals, while using the measures per the guidance of the measure stewards. With this in mind, the HACRP has incrementally added HAI measures and will be incorporating the expansion of patient care locations and the revised NHSN risk-adjusted SIR baselines. This should all help reduce the number of hospitals with no Domain 2 score. Additionally, the PSI-90 composite is being updated, with the inclusion of new indicators and revised definitions for some existing indicators. This would also likely reduce the number of hospitals with no Domain 1 score.

Question 138: **Are online Medicare fee-for-service patients included in the Hospital Readmissions Reduction Program?**

The HRRP includes only Medicare FFS admissions to subsection (d) hospitals and Maryland hospitals participating in the All-Payer Model. We are unclear about your reference to online patients.

For questions about the calculation and reporting of Excess Readmission Ratios for the HRRP, or about the Hospital-Specific Reports, please contact the *QualityNet* Help Desk at: qnetsupport@hcqis.org (with the subject line: Hospital Readmissions Reduction Program).

CMS has contracted with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) to develop and maintain the readmission measures. Send questions about the readmission measure methodology to YNHHSC/CORE at cmsreadmissionmeasures@yale.edu.

Question 139: **Slide 20, explain bullet 3, hospitals may continue to use either abstraction or pull the data from non-certified sources in order to then input these data into CEHRT.**

Hospitals may manually extract the data from non-certified sources and input this data to CEHRT in order to capture and successfully report QRDA I files to the 2014 or 2015 CEHRT edition.