



News Updates

eCQI Resource Center Now Integrated with U.S. Health Information Knowledgebase (USHIK)

The Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the National Coordinator for Health Information Technology (ONC) have integrated the [eCQI Resource Center](#) with [USHIK](#).

USHIK is a publicly available database with technical measures and specifications for calculating quality metrics established for federal payment reimbursements.

The recent integration allows users to compare different versions and metadata of electronic Clinical Quality Measures (eCQMs). Users can also download measure version details in several file formats for use in different software programs.

Links to this new functionality are found in the measure tables within the [Eligible Hospitals](#) and [Eligible Professionals](#) pages on the eCQI Resource Center website:

<https://ecqi.healthit.gov/>



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News Updates

CMS Publishes Update on Electronic Clinical Quality Measure (eCQM) Value Sets for 2017 Performance Period

The Centers for Medicare & Medicaid Services (CMS) and the National Library of Medicine (NLM) has published an addendum to the 2016 eCQM specifications (published in April 2016). This addendum updates relevant International Classification of Diseases (ICD)-10 Clinical Modification (CM) and Procedure Coding System (PCS) eCQM value sets for the 2017 performance year. These changes affect electronic reporting of eCQMs for the following programs:

- The Hospital Inpatient Quality Reporting Program;
- The Medicare Electronic Health Record (EHR) Incentive Program for eligible hospitals and critical access hospitals (CAHs);
- The Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians.

What Changes are Included in the Addendum?

Changes will only affect the value sets for eCQMs remaining in the programs listed above for 2017 reporting. The Health Quality Measure Format (HQMF) specifications, the value set object identifiers (OIDs), and the measure version numbers for 2017 eCQM reporting will not change.

The changes to the ICD-10 value sets consist of deletion of expired codes and addition of relevant replacement codes. Newly available codes that represent concepts consistent with the intent of the value set and corresponding measure(s) were also added. CMS is prioritizing these ICD-10 updates. Updates for other terminologies will take place during the 2017 Annual Update.

All changes to ICD-10 value sets are detailed in revised technical release notes, including the OIDs affected and information on the codes added or deleted from the value sets.

Where is the Addendum Posted?

The following updated measure information is available on the [eCQM library](#) and the [electronic Clinical Quality Improvement \(eCQI\) Resource Center](#) websites, including:

- eCQM specifications, which include only measures in use for 2017 eCQM reporting
- eCQMs for Eligible Clinicians Table January 2017 and eCQMs for Eligible Hospitals Table January 2017, which include only measures in use for 2017 eCQM reporting
- Revised release notes, which provide an overview of technical changes implemented in the addendum. Two sets of release notes will be available.

-The first set provides information on ICD-10 value set updates for measures affected by this addendum.

-The second set provides information on changes from this addendum and all other updates for the measures included for 2017 eCQM reporting.

All changes to the eCQM value sets are available through the NLM's Value Set Authority Center (<https://vsac.nlm.nih.gov/>). The value sets are available as a complete set, as well as value sets per measure. The Data Element Catalog on the VSAC home page contains the complete list of updated eCQMs and value set names.

What Do I Need to Do?

Measure implementers should review these changes and revise mapping of ICD-10 codes as needed to ensure their submissions comply with the updated requirements included in this addendum for 2017 reporting. Clinicians may also have to revise their workflows to comply with the ICD-10 code additions and removals included in this addendum.

More information on implementing and mapping of ICD-10 codes can be found on the CMS website at: <https://www.cms.gov/Medicare/Coding/ICD10/Frequently-Asked-Questions.html>.

Where Do I Go for Assistance?

Questions regarding the addendum, eCQM value sets, appropriateness of mapping, and non-ICD-10 code system updates should be reported to the [ONC CQM Issue Tracker](#) available at <http://jira.oncprojecttracking.org/browse/CQM/>.



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News Updates

Find Out More about Calculations for Objectives and Measures Requiring Patient Action in the EHR Incentive Programs

CMS recently updated an FAQ to provide information about calculations for [EHR Incentive Programs](#) objectives and measures requiring patient action. We encourage you to stay informed by taking a few minutes to review the updated information below.

Question: In calculating the meaningful use objectives requiring patient action, if a patient sends a message or accesses his/her health information made available by their eligible professional (EP), can the other EPs in the practice get credit for the patient's action in meeting the objectives?

If attribution of the message is impossible (it absolutely cannot be determined who from the group practice sent it), it may be counted in the numerator for any provider within the group sharing the CEHRT who has contributed information to the patient's record, if that provider also has the patient in their denominator for the EHR reporting period. However, if the message is attributed to a specific provider, then it cannot count. The transitive effect applies to the Secure Electronic Messaging objective, the second measure of the Patient Electronic Access (View, Download and Transmit) objective, and the Patient Specific Education objective. (FAQ12825)

For More Information

For more information about the EHR Incentive Programs, visit the [EHR Incentive Programs](#) page on the [CMS website](#).



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News Updates

Visit the Educational Resources Page for New Materials on the Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) recently posted new resources to the Quality Payment Program [website](#) to help eligible clinicians and data submission vendors successfully prepare to participate in the program.

CMS encourages these eligible clinicians, registries, qualified clinical data registries (QCDRs), and electronic health record (EHR) vendors to visit the website to review the new materials and information, including:

For Clinicians:

- [Quality Payment Program: Key Objectives](#)
- [Advancing Care Information Fact Sheet](#)
- [Alternative Payment Models](#) (APMs) in the Quality Payment Program
- [Improvement Activities](#) in MIPS APMs
- [APMs: Medicaid and All-Payer Models Fact Sheet](#)

For registries, QCDRs and EHR vendors:

- [Quality Measures Specifications](#)
- [Quality Measures Supporting Documents](#)
- [2017 Quality Benchmarks](#)
- [Quality Measure Encounter Codes](#)
- [Advancing Care Information Measure Specifications](#)
- [Advancing Care Information Measure Specifications Fact Sheet](#)
- [Advancing Care Information for Vendors](#)
- [Qualified Registry Self-Nomination Fact Sheet](#)
- [QCDR Self-Nomination Fact Sheet](#)

Coming Soon

CMS will continue to update the [Educational Resources](#) webpage of the [Quality Payment Program](#) website to include additional information and resources throughout 2017. Stay tuned for future announcements about the website.



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News Updates

CMS Publishes Updated eCQM Table for Eligible Clinicians and Eligible Professionals for 2017 Performance Period

The Centers for Medicare & Medicaid Services (CMS) has published an updated table accompanying the 2016 electronic clinical quality measure (eCQM) specifications (published in April 2016) for the 2017 performance period. The updated table, titled [Electronic Clinical Quality Measures for Eligible Professionals and Eligible Clinicians](#) can be found on the [eCQM Library Page](#) and the [Electronic Clinical Quality Improvement \(eCQI\) Resource Center](#).

This update removes the previous meaningful use domains and now aligns with the domains listed in the Calendar Year 2016 Medicare Physician Fee Schedule, as well as the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) tracks of the Quality Payment Program.

Questions regarding the measure table or domains should be reported to the [ONC CQM Issue Tracker](#) available at <http://jira.oncprojecttracking.org/browse/CQM/>.



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News Updates

View QPP Webinars and CMS' HIMSS17 Presentations on the CMS Website

The Centers for Medicare & Medicaid Services (CMS) recently posted new resources to the Quality Payment Program [website](#) to help healthcare professionals participate in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

CMS was a very active participant at HIMSS 2017; the HIMSS presentations also provide information on the Quality Payment Program and value-based care. Use the links below to access the presentations on each topic.

Webinar Presentations:

- [MACRA Quality Payment Program Overview](#)
- [APMs in the Quality Payment Program for Shared Savings Programs](#)
- [Medicaid in the Quality Payment Program](#)
- [Quality Payment Program Final Rule MLN Connects® Call](#)
- [MIPS Overview](#)
- [MIPS Performance Categories: Advancing Care Information & Improvement Activities](#)
- [MIPS Overview: Understanding Quality and Cost](#)
- [National Provider Call: Transitioning from Quality Programs to MIPS](#)

- [Virtual Groups in the Quality Payment Program](#)
- [Getting Started with the Quality Payment Program: An Overview of MIPS for Small, Rural, and Underserved Practices](#)
- [MACRA Merit-based Incentive Payment System Annual Call for Measures and Activities](#)

HIMSS17 Presentations:

- [Delivery System Reform](#)
- [Quality Payment Program Overview](#)
- [Advancing Care Information and Improvement Activities](#)
- [MIPS: Quality and Cost](#)
- [Overview of MIPS for Small, Rural, and Underserved Practices](#)

For More Information

If you have questions on other topics related to the Quality Payment Program, please contact the Quality Payment Program Service Center at gpp@cms.hhs.gov or 1-866-288-8292.



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News Updates

Review Important Updates to eCQM Standards, Terminology, and Measures for Quality Reporting in 2018

The [2017 electronic clinical quality measure \(eCQM\) Annual Update Pre-Publication Document](#) describes important standards, terminology, and measure changes in the 2017 eCQM Annual Update, slated for late spring 2017. The changes correspond to the 2018 reporting periods for the Centers for Medicare & Medicaid Services' (CMS) quality reporting programs.

This pre-release of expected changes and requirements is meant to help health information technology developers, eligible professionals, eligible clinicians, and eligible hospitals prepare for the 2018 reporting periods.

For More Information

Please visit the [electronic Clinical Quality Improvement \(eCQI\) Resource Center](#), and sign up for [CMS](#) and the [Office of the National Coordinator for Health Information Technology \(ONC\)](#) listservs to receive live updates and announcements on the eCQM Annual Update publication and related materials.



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News Updates

Learn about the FY 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information

On April 14, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update 2018 Medicare payment and policies when patients are admitted into hospitals.

The agency also released a Request for Information (RFI) to solicit ideas for regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation. This RFI is meant to inform the discussion on future regulatory action related to inpatient and long-term hospitals.

CMS will accept comments on the proposed rule and the RFI until Tuesday, June 13, 2017.

In the rule, CMS proposed an increase of about 1.6 percent in operating payment rates for general acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) that participate successfully in the Hospital Inpatient Quality Reporting (IQR) program and

are meaningful electronic health record users. The agency projects the rate increase—together with other proposed changes to IPPS policies—will increase IPPS operating payments by about 1.7 percent.

In addition, CMS estimates that proposed changes in uncompensated care payments will increase IPPS operating payments by an additional 1.2 percent, for a total increase in IPPS operating payments of 2.9 percent.

Meanwhile, CMS has proposed a one-year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while CMS continues to evaluate long-term care hospital policies. CMS also proposed to reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

For More Information

To find the press release and fact sheet about the proposed rule, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-14.html>

To learn more about the proposed rule (CMS-1677-P) and the Request for Information, please visit: <https://www.federalregister.gov/public-inspection/current>



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News Updates

Visit the EHR Incentive Programs Website to Access the Centralized Repository for Public Health Agency and Clinical Data Registry Reporting

The Centers for Medicare & Medicaid Services (CMS) developed a [Centralized Repository](#) for public health agencies (PHA) and clinical data registries (CDR) to provide a centralized source of information for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) looking for public health, clinical data, or specialized registry electronic reporting options.

[The Medicare and Medicaid EHR Incentive Programs](#) include several public health measures that require EPs, eligible hospitals, and CAHs to engage with a PHA or CDR to submit electronic public health data. The repository will assist providers in finding entities that accept electronic public health data.

Please Note: CMS' Centralized Repository is not the authoritative source of all public health reporting options currently available. For the Medicare or Medicaid EHR Incentive Program, the absence of an entry in the CMS Centralized Repository is not sufficient documentation for claiming an exclusion and should not prevent a provider from reporting

to a registry. Providers must check with the jurisdictional public health agencies or specialty societies to which they belong and document that information to satisfy Medicare or Medicaid reporting.

For More Information

Review [FAQ 13657](#) and [FAQ 14117](#) for steps providers should take to determine if there is a specialized registry available, or if they can claim an exclusion. To learn more about what qualifies as a specialized registry, please review [FAQ 13653](#).



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News Updates

Submit Comments on Proposed Changes to EHR Incentive Programs by June 13

The Centers for Medicare & Medicaid Services (CMS) issued the FY 2018 Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) rule on April 14, 2017, which proposes a number of changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The publication date is scheduled for April 28, 2017.

The proposals include:

- For CY 2018, modifying the EHR reporting period from the full calendar year to a minimum of any continuous 90-day period for new and returning participants in the Medicare and Medicaid EHR Incentive programs.
- Adding a new exception from the Medicare payment adjustments for Eligible Professionals (EPs), Eligible Hospitals, and Critical Access Hospitals (CAHs) that demonstrate through an application process that complying with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.
- Implementing a policy in which no payment adjustments will be made for EPs who furnish "substantially all" of their covered professional services in an ambulatory

surgical center (ASC); applicable for the 2017 and 2018 Medicare payment adjustments.

- Using Place of Service (POS) code 24 to identify services furnished in an ASC as well as requesting public comment on whether other POS codes or mechanisms should be used to identify sites of service in addition to or in lieu of POS code 24.

Submit a Formal Comment by 5:00 p.m. ET on Tuesday, June 13

The public can submit comments in several ways:

- Electronically
- By regular mail
- By express or overnight mail
- By hand or courier

Please review the Proposed Rule for specific instructions for each method and submit by ONLY one method.

For More Information

To learn more, review the [proposed rule](#) and visit the [CMS website](#).



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News Updates

Review 2017 Program Requirements in the 2017 OPPS/ASC Final Rule on the EHR Incentive Programs Website

Providers who have not demonstrated meaningful use successfully in a prior year and are seeking to demonstrate meaningful use for the first time in 2017 to avoid the 2018 payment adjustment must attest to Modified Stage 2 objectives and measures. Providers who have demonstrated meaningful use successfully in a previous year may attest to Stage 3 objectives and measures starting in 2017.

CMS encourages eligible hospitals, CAHs, and dual-eligible hospitals to visit the [EHR Incentive Programs website](#) for more details about the [2017 program requirements](#) outlined below.

OPPS/ASC Final Rule with Comment Period:

- Eliminated the Clinical Decision Support (CDS), and the Computerized Provider Order Entry (CPOE) objectives and measures beginning in 2017;
- Reduced the threshold for the View, Download or Transmit (VDT) measure of the Patient Electronic Access Objective to at least one unique patient (or patient-authorized representative) for Modified Stage 2;

- Reduced the thresholds for a subset of Patient Electronic Access to Health Information, Coordination of Care through Patient Engagement, Health Information Exchange, and Public Health Reporting and Clinical Data Registry measures for Stage 3;
- Added [new naming conventions for measures](#); and
- Requires that actions occur within the EHR reporting period, or the calendar year in which the EHR reporting period occurs, in order to be included in the numerators for specific measures.

For More Information

Visit the EHR Incentive Programs website and review the following materials:

- Modified [Stage 2](#) and [Stage 3](#) Attestation Worksheets for Eligible Hospitals, CAHs, and Dual-Eligible Hospitals.
- [Overview of the OPPS/ASC Final Rule Changes for the EHR Incentive Programs](#)



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News Updates

Updated eCQM Specifications for Calendar Year (CY) 2018 Available on the eCQI Resource Center Website

The Centers for Medicare & Medicaid Services (CMS) posted the 2017 annual update for eCQMs for CY 2018 reporting for Eligible Hospitals and Critical Access Hospitals (CAHs), and CY 2018 performance for Eligible Professionals (EPs) and Eligible Clinicians. These updated eCQMs are fully specified and **may** be used to electronically report 2018 clinical quality measure data for CMS quality reporting programs. Measures will not be eligible for 2018 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for each applicable program.

CMS updates the specifications annually to align with current clinical guidelines and code systems so they remain relevant and actionable within the clinical care setting. All of the updated measure specifications have been re-specified using the Quality Data Model (QDM) 4.3-based Health Quality Measures Format (HQMF) version R 2.1.

CMS has updated eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting (IQR) Program
- The Medicare Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and CAHs

- The Medicaid EHR Incentive Program for EPs, Eligible Hospitals and CAHs
- Quality Payment Program: The Merit-based Incentive Payment System (MIPS) for MIPS Eligible Clinicians and Alternative Payment Models

Where to Find the Updated Measures

The updated measure specifications are available on the Electronic Clinical Quality Improvement (eCQI) Resource Center for [Eligible Hospitals and Critical Access Hospitals](#), and [Eligible Professionals and Eligible Clinicians](#).

Note: The eQMs and supporting materials are no longer available on the [eCQM Library](#) webpage of [cms.gov](#). CMS plans to migrate all information on the library webpage to the eCQI Resource Center later this year.

Provide Feedback on the Update Measures

To report questions and comments regarding the updated measures, visit the [ONC CQM Issue Tracker](#).

For More Information

To find out more about eQMs, visit the [eCQI Resource Center](#).



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News Updates

CMS Releases Lookup Tool to Help Clinicians Determine their MIPS Participation Status

Unsure of your participation status in the Merit-based Incentive Payment System (MIPS)? Clinicians can now use an interactive tool on the CMS Quality Payment Program website to determine if they should participate in the MIPS track of the [Quality Payment Program](#) in 2017.

To determine your status, enter your national provider identifier (NPI) into the entry field on the tool which can be found on the Quality Payment Program website at <https://qpp.cms.gov/>. Information will then be provided on whether or not you should participate in MIPS this year and where to find resources.

Participation Criteria

You will participate in MIPS in 2017 if you:

- Bill Medicare Part B more than \$30,000 a year **AND**
- See more than 100 Medicare patients a year.

You must also be a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse practitioner

If you are new to Medicare in 2017, you do not participate in MIPS. You may also be exempt if you qualify for one of the special rules for certain types of clinicians, or are participating in an Advanced Alternative Payment Model (APM). To learn more, review the [MIPS Participation Fact Sheet](#).

If you are not in the program in 2017, you can participate voluntarily and you will not be subject to payment adjustments.

Participation Notification Letters – CMS recently sent letters in the mail notifying clinicians of their MIPS participation status. See a [sample of the letter](#) (zip) on the [Education page](#) of <https://qpp.cms.gov/>. This tool is another resource for clinicians to use to determine their status.

For More Information

To get the latest information, visit the [Quality Payment Program website](#). The Quality Payment Program Service Center may be reached at 1-866-288-8292 (TTY 1-877-715-6222), available Monday through Friday, 8:00 AM-8:00 PM ET or via email at QPP@cms.hhs.gov.



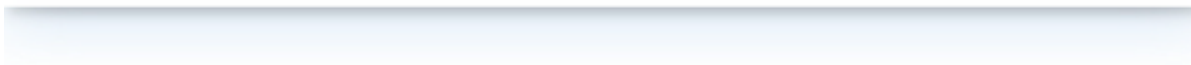
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News Updates

Review 2017 Program Requirements on the EHR Incentive Programs Website

Returning EPs in the Medicare EHR Incentive Program

Eligible professionals (EPs) who demonstrated meaningful use successfully in a prior year for the Medicare EHR Incentive Program can determine their participation status in the Quality Payment Program for 2017 through a look up tool on the [Quality Payment Program](#) website. Information will then be provided on whether or not you should participate in the Merit-based Incentive Payment System (MIPS) this year and where to find resources.

If you are new to Medicare in 2017, you do not participate in MIPS. You may also be exempt if you qualify for one of the special rules for certain types of clinicians, or are participating in an [Advanced Alternative Payment Model \(APM\)](#). To learn more, review the [MIPS Participation Fact Sheet](#).

If you are not in the Quality Payment Program in 2017, you can participate voluntarily and you will not be subject to payment adjustments.

Participation Notification Letters - CMS recently sent letters in the mail notifying clinicians of their MIPS participation status. A sample of the letter can be found on the

[Education page](https://qpp.cms.gov/) of <https://qpp.cms.gov/>. This tool is another resource for clinicians to use to determine their status.

EPs New to the Medicare EHR Incentive Program in 2017

For EPs who are participating in the Medicare EHR Incentive Program for the **first time** in 2017, they must take one of the following actions by **October 1, 2017** to avoid the 2018 payment adjustment:

- 1) Attest to the Modified Stage 2 2017 EHR Incentive Program requirements; **OR**
- 2) Submit a one-time hardship exception application if they are transitioning to the MIPS path of the Quality Payment Program and plan to report on measures specified for the [Advancing Care Information](#) performance category.

- The one-time hardship exception application can be found [here](#).

EPs in the Medicaid EHR Incentive Program in 2017

EPs that attest directly to a state for that state's Medicaid EHR Incentive Program will continue to attest to the measures and objectives finalized in the [2015 EHR Incentive Programs Final Rule](#) (80 FR 62762 through 62955). In 2017, Medicaid EPs have the option to report to the Modified Stage 2 or Stage 3 objectives and measures. As a reminder, EPs who are eligible only for the Medicaid EHR Incentive Program are not subject to payment adjustments.

For More Information

CMS encourages EPs to visit the [EHR Incentive Programs website](#) for more details about the [2017 program requirements](#).



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News Updates

Visit the QualityNet Website for CY2017 eCQM Resources and Tools

In response to provider need, the Centers for Medicare & Medicaid Services (CMS) has developed and posted updated resources to assist with the reporting of calendar year (CY) 2017 electronic clinical quality measure (eCQM) data for the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare Electronic Health Record (EHR) Incentive Program for eligible hospitals and critical access hospitals. These documents include:

- CY 2017 Available eCQMs
- CY 2017 eCQM Overview
- CY 2017 Preparation Checklists for Test and Production Files
- CY 2017 EHR Report Overview

You may view these documents under the eCQM Resources pages on the QualityNet.org and QualityReportingCenter.com websites. We hope that you will find them useful as you outline the steps needed for the submission of eCQM data for CY 2017.

Hospitals and vendors are able to use the Pre-Submission Validation Application (PSVA) tool to submit test and production Quality Reporting Document Architecture (QRDA)

Category I files to the *QualityNet Secure Portal* for the Hospital IQR and the Medicare EHR Incentive Programs.

As a reminder, hospitals are required to submit at least eight eQMs as any combination of QRDA Category I files with patients meeting the initial patient population of the applicable measure(s), zero denominator declarations, and/or case threshold exemptions. Using the zero denominator and case threshold exemption apply only if the hospital has EHR technology certified to report the eQMs. Hospitals will self-select whether to report a calendar year of discharge data on a quarterly, semiannual, or annual basis prior to the February 28, 2018, 11:59 p.m. PT reporting deadline.

For additional information on the CY 2017 eQCM reporting requirements and resources for the Hospital IQR and Medicare EHR Incentive Programs, please read the full article located on the home page of *QualityNet.org* under [QualityNet News](#).

Please do not respond directly to this email. For further assistance regarding the information contained in this message, please contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Team at <https://cms-ip.custhelp.com> or (844) 472-4477.



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News Updates

Now Available: ONC eMeasurement and Quality Improvement Webinar Recording

On Thursday, May 4, the Office of the National Coordinator for Health Information Technology (ONC) hosted a roundtable on **Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement**. [A recording of the event](#) is now available.

More About the Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement Roundtable

ONC summarized research on the current state and future opportunities to promote better health and care, improved communication and transparency, rapid translation of knowledge for all stakeholders, and reduction in the burden of data collection and reporting for providers.

Attendees discussed opportunities to foster innovation in electronic data exchange for eMeasurement and quality improvement and national thought leaders shared their experiences and insights about innovative approaches.

The roundtable was supported by Discern Health.



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News Updates

New Quality Payment Program Resources Available – and New Site Look

The Centers for Medicare & Medicaid Services (CMS) has recently revamped the look of the Quality Payment Program [website](#) and also posted new resources to help clinicians successfully participate in the first year of the Quality Payment Program.

CMS encourages clinicians to visit the website to review the following new resources:

- [MIPS Quick Start Guide](#): Outlines the steps MIPS clinicians need to take between now and March 2018 to prepare for and participate in MIPS, including checking [participation status](#), choosing to participate as an [individual or as part of a group](#), deciding how to submit data, and selecting [measures and activities](#).
- [Medicare Shared Savings Program and Quality Payment Program Fact Sheet](#): Explains how the Shared Savings Program and the Quality Payment Program align reporting requirements for participating Accountable Care Organizations (ACOs) and MIPS clinicians, and how certain tracks in Shared Savings Program ACOs meet Advanced Alternative Payment Model (APM) criteria under the Quality Payment Program.
- [MIPS APM Fact Sheet](#): Provides an overview of a specific type of APM, called a “MIPS APM,” and the special APM scoring standard used for those in MIPS APMs.

For More Information

To get the latest information, visit the [Quality Payment Program website](#). The Quality Payment Program Service Center can also be reached at 1-866-288-8292 (TTY 1-877-715-6222), available Monday through Friday, 8:00 AM-8:00 PM ET or via email at QPP@cms.hhs.gov.



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News Updates

5 Ways for Healthcare Providers to Get Ready for New Medicare Cards

Medicare is taking steps to remove Social Security numbers from Medicare cards. Through this initiative the Centers for Medicare & Medicaid Services (CMS) will prevent fraud, fight identity theft and protect essential program funding and the private healthcare and financial information of our Medicare beneficiaries.

CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI) to replace the existing Social Security-based Health Insurance Claim Number (HICN) both on the cards and in various CMS systems we use now. We'll start mailing new cards to people with Medicare benefits in April 2018. All Medicare cards will be replaced by April 2019.

CMS is committed to helping providers by giving them the tools they need. We want to make this process as easy as possible for you, your patients, and your staff. Based on feedback from healthcare providers, practice managers and other stakeholders, CMS is developing capabilities where doctors and other healthcare providers will be able to look up the new MBI through a secure tool at the point of service. To make this change easier for you and your business operations, there is a 21-month transition period where all healthcare providers will be able to use either the MBI or the HICN for billing purposes.

Therefore, even though **your systems will need to be able to accept the new MBI format by April 2018**, you can continue to bill and file healthcare claims using a patient's HICN during the transition period. We encourage you to work with your billing vendor to make sure that your system will be updated to reflect these changes as well.

Beginning in April 2018, Medicare patients will come to your office with new cards in hand. We're committed to giving you information you need to help your office get ready for new Medicare cards and MBIs.

Here are 5 steps you can take today to help your office or healthcare facility get ready:

1. Go to our provider [website](#) and [sign-up](#) for the weekly MLN Connects® newsletter.
2. Attend our [quarterly calls](#) to get more information. We'll let you know when calls are scheduled in the MLN Connects newsletter.
3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact [Social Security](#) and update their Medicare records.
4. Work with us to help your Medicare patients adjust to their new Medicare card. when available later this fall, you can display helpful information about the new Medicare cards. Hang posters about the change in your offices to help us spread the word.
5. Test your system changes and work with your billing office staff to be sure your office is ready to use the new [MBI format](#).

We'll keep working closely with you to answer your questions and hear your concerns. To learn more, visit: cms.gov/Medicare/SSNRI/Providers/Providers.html.



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News Updates

New Resources on Quality Payment Program Website to Help Clinicians Participate in MIPS

The Centers for Medicare & Medicaid Services (CMS) has posted new resources on the Quality Payment Program [website](#) to help clinicians successfully participate in the first year of the [Merit-based Incentive Payment System \(MIPS\)](#).

CMS encourages MIPS clinicians to visit the [website](#) to review the following resources:

- [**Advancing Care Information Measure Specifications and Transition Measure Specifications - UPDATED**](#): Includes additional details on each objective and measure in the Advancing Care Information performance category.
- [**An Introduction to Group Participation in MIPS in 2017**](#): Offers an in-depth overview of how to participate as a group in MIPS. This user guide is interactive for quick navigation.
- [**CMS-Approved Qualified Clinical Data Registries \(QCDRs\) Vendor List for 2017**](#): Provides contact information for the QCDRs that will be able to report data for the Quality, Advancing Care Information, and Improvement Activities performance categories in 2017.

- [Consumer Assessment of Healthcare Providers & Systems \(CAHPS\) for MIPS – CMS-Approved Survey Vendor List](#): Includes contact information for the survey vendors approved by CMS to administer the CAHPS for MIPS Survey in 2017.
- [MIPS Measures Guide for Cardiologists - UPDATED](#): Highlights a non-exhaustive sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to cardiologists in 2017.
- [MIPS Measures Guide for Primary Care Clinicians](#): Offers a non-exhaustive sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to primary care clinicians in 2017.

Additional resources are available in the [Resource Library](#) section of the Quality Payment Program [website](#).

For More Information

To get the latest information, visit the [Quality Payment Program website](#). The Quality Payment Program Service Center can also be reached at 1-866-288-8292 (TTY 1-877-715- 6222), available Monday through Friday, 8:00 AM-8:00 PM ET or via email at QPP@cms.hhs.gov.



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News Updates

2017 CMS QRDA III Implementation Guide Now Available

The Centers for Medicare & Medicaid Services (CMS) has published the 2017 CMS Quality Reporting Document Architecture Category III (QRDA III) [Implementation Guide](#) (IG) Version 1.0 (7/07/2017) for Eligible Clinicians and Eligible Professionals (EPs) Programs with [Schematron and sample files](#). This version replaces the 2017 CMS QRDA III IG for Eligible Clinicians Reporting v0.1 (12/29/2016).

The 2017 CMS QRDA III IG for Eligible Clinicians and EPs provides technical instructions for QRDA III reporting for the following programs:

- Merit-based Incentive Payment System (MIPS)
- Comprehensive Primary Care Plus (CPC+)

The 2017 CMS QRDA III IG for Eligible Clinicians and EPs contains the following high-level changes compared with the reporting specifications in the 2016 CMS QRDA IG:

- The 2017 IG is based on the Health Level Seven (HL7) QRDA Category III R1, Standard for Trial Use R2.1
- For MIPS, Advancing Care Information (ACI) measures and Improvement Activities (IA) can be reported using the two new section templates: ACI Section and IA Section, respectively

- A performance period must now be specified using the Reporting Parameters Act template that is contained within each section template for Quality (electronic clinical quality measures), ACI, and IA

The 2017 CMS QRDA III Schematron provides rules that enforce the conformance statements of the IG. QRDA III submissions to CMS for the 2017 performance period will be submitted through the new Quality Payment Program submissions API or via file upload on the Quality Payment Program website. CMS will provide immediate, clear, and actionable feedback at the time of submission which will enable submitters to be confident that they successfully submitted their data. If there is a problem with the submission, submitters will get the issue specifics right away – and be able to address them immediately. Exact validation feedback provided by the Quality Payment Program may differ, but this Schematron file will validate that a QRDA III file is properly structured and will help with file submission through the Quality Payment Program submission system.

The new Schematron and sample files for this IG replace the 2017 CMS QRDA III Schematrons and Sample Files for Eligible Clinicians Programs v0.1. For more details regarding the changes, visit the “Change Log” sections of the IG.

Additional QRDA-Related Resources

You can find additional QRDA related resources, as well as current and past implementation guides, on the [eCQI Resource Center](#) and the [CMS eCQM Library](#). For questions related to the QRDA Implementation Guides and/or Schematrons, visit the [ONC QRDA JIRA Issue Tracker](#). For questions related to Quality Payment Program/MIPS submissions, visit the Quality Payment Program [website](#) or call 1-866-288-8292.



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News Updates

Now Available: 2018 CMS QRDA I HQR Implementation Guide, Schematron, and Sample Files

The Centers for Medicare & Medicaid Services (CMS) has published the 2018 Quality Reporting Document Architecture (QRDA) Category I Hospital Quality Reporting (HQR) [Implementation Guide \(IG\)](#), [Schematron](#), and [sample files](#).

The 2018 CMS QRDA HQR IG provides technical instructions for QRDA Category I reporting for Eligible Hospitals and Critical Access Hospitals (CAHs) for the following programs:

- Hospital Inpatient Quality Reporting (IQR) Program
- Medicare Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and CAHs

The 2018 CMS QRDA I HQR IG contains the following high-level changes compared with the reporting specifications for Eligible Hospitals and CAHs in the 2017 CMS QRDA I HQR IG:

- The 2018 HQR IG is based on the HL7 IG for CDA Release 2: QRDA Category I, Release 1, Standard for Trial Use (STU) Release 4, which supports the Quality Data Model (QDM) version 4.3

- The CMS Certification Identification Number is now a required data element
- Medicare Beneficiary Identifier (MBI) should be submitted if the payer is Medicare and the patient has an MBI number assigned

Additional QRDA-Related Resources:

You can find additional QRDA-related resources, as well as current and past implementation guides, on the [eCQI Resource Center](#) and the [CMS eCQM Library](#). For questions related to the QRDA Implementation Guides or Schematrons, visit the [ONC QRDA JIRA Issue Tracker](#).

CMS has also published the 2017 CMS Eligible Clinicians and Eligible Professionals Programs QRDA Category III IG with Schematron and sample files on the [eCQI Resource Center](#).



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News Updates

New Medicare Card (formerly called SSNRI)

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, we said that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, we referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, we will refer to this project as the New Medicare Card.

To help you find information quickly, we designed a new homepage linking you to the latest details, including how to [talk to your Medicare patients](#) about the new Medicare Card. Bookmark the [New Medicare Card](#) homepage and [Provider](#) webpage, and visit often, so you have the information you need to be ready by April 1.



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News Updates

Eligible Hospitals and Critical Access Hospitals: Submit Meaningful Use Data to the Hospital Quality Reporting System (HQR) via the QualityNet Secure Portal in 2018

The Centers for Medicare & Medicaid Services (CMS) is continuing efforts to reduce burden by easing reporting requirements and streamlining data submission methods for eligible hospitals and critical access hospitals participating in the Electronic Health Record (EHR) Incentive Programs.

What Does This Mean For You?

- **Medicare Eligible Hospitals:** Beginning January 2, 2018, eligible hospitals and critical access hospitals participating in the Medicare EHR Incentive Program will submit their 2017 meaningful use data to the [QualityNet Secure Portal](#). The [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#) will not be available for Medicare hospitals after December 31, 2017. The goal of this change is to make it simpler for facilities to report data to CMS. Most hospitals are

already familiar with using the QualityNet Secure Portal for secure communications and healthcare quality data exchange with CMS.

- **Medicaid Eligible Hospitals:** The Medicare & Medicaid Registration and Attestation System will still be available for Medicaid eligible hospitals. Medicaid-only hospitals should contact their [state Medicaid agencies](#) for specific information on how to attest.
- **Medicare and Medicaid Eligible Hospitals:** Hospitals attesting for both the Medicare and Medicaid EHR Incentive Programs as dually eligible hospitals will register and attest for the Medicare program in the HQR system. Dually eligible hospitals should contact their state Medicaid agencies to submit Medicaid attestations. Dually eligible hospitals new to the EHR Incentive Programs must register in the EHR Incentive Program Registration & Attestation system and register to use the QualityNet Secure Portal.

Stay Up To Date

As CMS prepares for this transition, stay up to date by:

- Reviewing relevant information on the [EHR Incentive Programs website](#)
- Following us on [Twitter](#)
- Signing up for the [EHR Incentive Programs listserv](#)

CMS will distribute more information on this transition as it becomes available. In the meantime, don't forget to review the [EHR Incentive Programs requirements](#) to ensure you are ready to attest in 2018.

For questions about this transition, please contact the EHR Inquiries Mailbox at EHRIquiries@cms.hhs.gov.



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News Updates

Final Rule Supports Transparency, Flexibility, Program Simplification and Innovation in the Medicare Program

On August 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

“This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare’s sickest patients,” said CMS Administrator Seema Verma. “Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need.”

In the final rule, CMS is increasing the amount of uncompensated care payments made to acute care hospitals by \$800 million to approximately \$6.8 billion for fiscal year 2018.

Uncompensated care represents healthcare services provided by hospitals or providers for which they don't get reimbursed. Often uncompensated care arises when people don't

have insurance and cannot afford to pay the cost of care. CMS is also providing further clarification about discounts given to uninsured patients who meet the hospital's charity care policy.

In relieving providers of administrative burdens and encouraging patient choice, CMS is finalizing a one-year regulatory moratorium on the payment reduction threshold for patient admissions in long-term care hospitals. CMS continues to evaluate this policy. CMS is also finalizing provisions that reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of \$2.4 billion in fiscal year 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by \$110 million in fiscal year 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

CMS also issued a notice with comment period updating 2018 Medicare payment policies and rates for inpatient psychiatric facilities. CMS estimates that Medicare payments to inpatient psychiatric facilities will increase by \$45 million, or nearly one percent, in fiscal year 2018.

For a fact sheet on the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html>

For a fact sheet on the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment period, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02-2.html>

The fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule (CMS-1677-F) and the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment

period (CMS-1673-NC) can be downloaded from the Federal Register at:

<https://www.federalregister.gov/public-inspection>.



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News Updates

Visit the EHR Incentive Programs Website for Information about 2017 Program Requirements

The Centers for Medicare & Medicaid Services (CMS) would like to remind eligible professionals (EPs) and eligible hospitals that the [Medicaid EHR Incentive Program](#), which is administered voluntarily by states and territories, will continue through 2021.

To participate in the program in 2017, EPs and eligible hospitals must attest to:

- [Modified Stage 2 objectives and measures](#), or
- [Stage 3 objectives and measures](#)

To learn more, visit the [2017 program requirements](#) page on the [EHR Incentive Programs](#) website. For state-specific information and resources, review the [Medicaid State Information](#) page.

Incentive Payment Information

- There are no payment adjustments in the Medicaid EHR Incentive Program.
- EPs and eligible hospitals who meet program requirements can continue to attest to their state Medicaid agencies to receive yearly incentive payments.
- The incentive payment is a fixed amount for each year of participation.

- EPs and eligible hospitals can receive incentive payments for six years nonconsecutively. EPs and eligible hospitals who began the program in 2016 must participate consecutively to receive the full payment amount over six years.
- Eligible hospitals that are eligible to participate in the Medicare and Medicaid EHR Incentive Programs may attest under Medicare to avoid a payment adjustment.

Please note: 2016 was the last year EPs and eligible hospitals could begin participation in the Medicaid EHR Incentive Program.

Medicaid EHR Incentive Program and the Merit-based Incentive Payment System (MIPS)

[MIPS does not](#) replace the Medicaid EHR Incentive Program. If a provider plans to participate in the Medicaid EHR Incentive Program through their state and they are also a Medicare Part B clinician who is eligible for MIPS, they will also need to participate in the MIPS program to avoid a negative MIPS payment adjustment.

For More Information

- Visit the [EHR Incentive Program website](#)
- Email your question to EHRInquiries@cms.hhs.gov
- To learn more about MIPS, visit qpp.cms.gov



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News Updates

Corrected ACI Table in 2017 CMS QRDA III Implementation Guide Now Available

The Centers for Medicare & Medicaid Services (CMS) has corrected an error in the [2017 CMS Quality Reporting Document Architecture Category III \(QRDA III\) Implementation Guide \(IG\) Version 1.0 for Eligible Clinicians and Eligible Professionals Programs](#). The updated version is a republication of the 2017 CMS QRDA III IG for Eligible Clinicians and Eligible Professionals published on 7/7/2017. This announcement is for vendors and data submitters about the correction in Table 49: Advancing Care Information Objectives and Measures Identifiers. The description of the measure identifier ACI_LVITC_1 now includes the word "Exclusion". **There are no other changes in this document.**

- Measure Objective: Health Information Exchange
- Measure Identifier: ACI_LVITC_1
- Measure: *Proposed Request/Accept Summary of Care **Exclusion**
- Reporting Metric: Yes/No

Additional QRDA-Related Resources

You can find additional QRDA related resources, as well as current and past implementation guides, on the [eCQI Resource Center](#) and the [CMS eCQM Library](#). For questions related to the QRDA Implementation Guides and/or Schematrons, visit the [ONC](#)

[QRDA JIRA Issue Tracker](#). For questions related to the Quality Payment Program or MIPS submissions, visit the Quality Payment Program [website](#) or call 1-866-288-8292.



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News Updates

CMS Announces Updates to eCQM Value Sets for Q4 2017 Reporting, and 2018 Reporting and Performance Periods

The Centers for Medicare & Medicaid Services (CMS) and the National Library of Medicine (NLM) will publish updates to the electronic clinical quality measure (eCQM) value sets to align with the most recent releases to terminologies, including, but not limited to, International Classification of Diseases (ICD)-10 Clinical Modification (CM) and Procedure Coding System (PCS), SNOMEDCT, LOINC, RxNorm, and Current Procedural Terminology (CPT). CMS will publish two addenda containing updates to these terminologies for the 4th Quarter (Q4) 2017 reporting period, and 2018 reporting and performance periods.

[When will the addenda be published and what programs are affected by the addenda?](#)

2017 Q4 Reporting Period eCQM Value Set Addendum: In September, CMS will publish an addendum to the eCQM specifications (published in April 2016) to update relevant eCQM value sets for Q4 2017 reporting. This addendum will affect the electronic reporting of eCQMs for the following hospital programs:

- Hospital Inpatient Quality Reporting (IQR) Program; and
- Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for eligible hospitals and critical access hospitals (CAHs).

The 2017 Q4 Reporting Period eCQM Value Set Addendum does not impact eCQM reporting for eligible professionals (EPs) in the Medicaid EHR Incentive Program or eligible clinicians in the Quality Payment Program.

2018 Reporting/Performance Period eCQM Value Set Addendum: By October, CMS will publish an addendum to the eCQM specifications (published in May 2017) to update relevant eCQM value sets for the 2018 reporting year. This addendum will affect the electronic reporting of eCQMs for the following programs:

- Hospital IQR Program;
- Medicare and Medicaid EHR Incentive Program for eligible hospitals, CAHs, and EPs; and
- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

What changes are included in the addenda?

Changes will only affect the value sets for eCQMs. The Health Quality Measure Format (HQMF) specifications, the value set object identifiers (OIDs), and the measure version numbers for Q4 2017 eCQM reporting and 2018 eCQM reporting (Jan 1-Dec 31) will not change.

The changes to the value sets consist of (1) deletion of expired codes, (2) addition of relevant replacement codes, and (3) addition of newly available codes that represent concepts consistent with the intent of the value set and corresponding measure(s).

Where will CMS and the NLM post the addenda?

All changes to the eCQM value sets will be available through the [NLM's Value Set Authority Center download tab](#). The value sets will be available as a complete set, as well as value sets per measure.

Updated measure information, including revised technical release notes, will be available on the [eCQI Resource Center](#) website.

What do I need to do?

Measure implementers should review these changes to ensure their submissions comply with the updated requirements.

Where do I go for assistance?

Measure implementers can report questions regarding the addenda, eCQM value sets, and appropriateness of mapping to the [ONC CQM Issue Tracker](#).



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News Updates

Now Available: Electronic Clinical Quality Measure Value Set Addendum for the 4th Quarter 2017 Reporting Period for Hospital Quality Reporting Programs

The Centers for Medicare & Medicaid Services (CMS) has issued an addendum to the electronic clinical quality measure (eCQM) annual update specifications published in April 2016. The addendum updates the eCQM value sets, technical release notes and the binding parameter specification for the 4th Quarter 2017 reporting period for [Eligible Hospitals and Critical Access Hospitals \(CAHs\)](#).

These changes affect electronic reporting of eCQMs for the Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Eligible Hospitals and CAHs.

All changes to the 2017 4th Quarter Reporting Period eCQM value sets are available through the [National Library of Medicine's Value Set Authority Center \(VSAC\)](#). The value sets are available as a complete set, as well as value sets per measure. Measure implementers

should review these changes to ensure their submissions comply with the updated requirements.

Please note that we have revised the value sets based on updates to the following terminology code systems:

- International Classification of Diseases, 10th Revision – Clinical Modification and Procedure Coding System (ICD-10-CM/PCS)
- Logical Observation Identifiers Names and Codes (LOINC)
- RxNorm
- SNOMED CT

No changes have been made to the measure logic, the Health Quality Measure Format (HQMF) specifications, the value set object identifiers (OIDs), and the measure version numbers for 2017 eCQM reporting.

For More Information

Questions regarding the addendum and eCQM value sets should be submitted to the [ONC CQM Issue Tracker](#). For information about eCQM specifications and supplemental materials, visit the [eCQI Resource Center](#).



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News Updates

Hurricane Irma - Disaster Exceptions/Exemptions for Medicare Certified Providers Affected by Severe Storms and Flooding

The Centers for Medicare & Medicaid Services (CMS) is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, PPS-exempt cancer hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, long-term care hospitals, and ambulatory surgical centers located in areas affected by Hurricane Irma due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an extraordinary circumstances exception request if they are located in one of the Florida counties, Puerto Rico municipios, or U.S. Virgin Islands county- equivalents, all of which have been designated by the [Federal Emergency Management Agency \(FEMA\)](#) as a major disaster county, municipio, or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memo posted on [9-14-17](#), however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

CMS will continue to monitor the situation and adjust exempted reporting periods and submission deadlines accordingly.

Additional details and materials are available on the [Hurricane page](#) webpage. Please check back frequently for updates.



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News Updates

Now Available: 2018 Electronic Clinical Quality Measure Value Set Addendum for Eligible Clinician, Eligible Professional, and Hospital Quality Reporting Programs

The Centers for Medicare & Medicaid Services (CMS) has issued an addendum to the electronic clinical quality measure (eCQM) annual update specifications published in May 2017. The addendum updates the eCQM value sets, technical release notes, and the binding parameter specification for the 2018 Reporting period for [Eligible Hospitals and Critical Access Hospitals \(CAHs\)](#) and the Performance period for [Eligible Professionals \(EPs\) and Eligible Clinicians](#), and is now available on the eCQI Resource Center.

These changes affect electronic reporting of eQMs for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM)
- Hospital Inpatient Quality Reporting (IQR)
- Medicaid Electronic Health Record (EHR) Incentive Program for EPs
- Medicare and Medicaid EHR Incentive Programs for Eligible Hospitals and CAHs

All changes to the 2018 Reporting/Performance Period eCQM value sets are available through the [National Library of Medicine's Value Set Authority Center \(VSAC\)](#). The value sets are available as a complete set, as well as value sets per measure. Measure implementers should review these changes to ensure their submissions comply with the updated requirements.

Please note that we have revised the value sets based on updates to the following terminology code systems:

- International Classification of Diseases, 10th Revision – Clinical Modification and Procedure Coding System (ICD-10-CM/PCS)
- Logical Observation Identifiers Names and Codes (LOINC)
- RxNorm
- SNOMED CT
- Current Procedural Terminology (CPT) and Vaccine Administered (CVX)
- Healthcare Common Procedure Coding System (HCPCS)

No changes have been made to the measure logic, the Health Quality Measure Format (HQMF) specifications, the value set object identifiers (OIDs), and the measure version numbers for 2018 eCQM reporting.

For More Information

Questions regarding the addendum and eCQM value sets should be submitted to the [ONC CQM Issue Tracker](#). For information about eCQM specifications and supplemental materials, visit the [eCQI Resource Center](#).



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News Updates

Transition to New Medicare Numbers and Cards

The Centers for Medicare & Medicaid Services (CMS), through the Medicare Administrative Contractors (MACs), recently mailed letters to all Medicare fee-for-service providers about our work to assign new numbers known as Medicare Beneficiary Identifiers (MBIs) and issue new Medicare cards to Medicare beneficiaries beginning in April 2018.

Our top priorities include:

- Ensuring your Medicare patients have continuous access to care; and
- You have the tools and information you need for a smooth transition. Starting in June 2018, you can look up your patients' new Medicare numbers through your MAC's secure web portal.

Carefully review the letter and accompanying fact sheet and find out how to prepare to accept the new number beginning in April 2018. Your letter will contain specific information for your MAC. You can also view a [sample letter](#) and [print-friendly fact sheet](#).

For More Information

Review the [new Medicare card design](#) and [press release](#) to learn more.



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News Updates

Eligible Hospitals and CAHs: The Meaningful Use Attestation System is Moving in 2018

The Centers for Medicare & Medicaid Services (CMS) is continuing to take steps to make attestation simpler for eligible hospitals and critical access hospitals (CAHs) participating in the Electronic Health Record (EHR) Incentive Program.

What is changing?

- For **Medicare eligible hospitals and CAHs**, we're migrating the 2017 meaningful use submission process from the [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#) to the [QualityNet Secure Portal](#) (QNet). QNet is the same system you currently use for CQM reporting, so beginning January 2, 2018, you can submit both meaningful use and quality attestations in one place. The change applies to 2017 meaningful use data, as well as future reporting periods. CAHs that attest to meaningful use using QNet will also have the option to manually or electronically attest for CQMs using QNet.
- The Registration and Attestation System will still be available for **Medicaid eligible hospitals**. Medicaid-only hospitals should contact their [state Medicaid agencies](#) for specific information on how to attest.

- **Hospitals and CAHs attesting for both Medicare and Medicaid** (as dually eligible hospitals) will register and attest for Medicare on the [QNet](#) portal and update and submit registration information in the Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

What Do You Need to Do?

Starting in October 2017, CMS will open new user enrollment registration on the [QNet](#) portal. Between October and December 2017, you will be able to view your data in the existing CMS EHR Incentive Program's Registration and Attestation system.

As of October 1, 2017, QNet enrollment is open, and you can take one of two actions:

- **If you don't have an account on QNet** already from previous CQM submissions, you'll need to create a new one before you attest.
- **If you—or the person/department at your hospital who usually submits meaningful use data—already has an account**, you'll need to update that existing account by adding the "meaningful use" role before attestation. If your organization's account has several users associated with the account, you may not have permission to make the change. The designated Security Administrators can make the meaningful use role update.

When Can You Attest?

On January 2, 2018, QNet will be open for 2017 meaningful use attestation. CMS will release a user guide in the coming weeks to help you to navigate QNet registration and attestation screens.

If you have authorized a **surrogate** to attest for you, they will need to create their own QNet account to attest using your data.

At this time, **vendors** will not be able to electronically attest on behalf of hospital clients. Measure and objective results files exported by vendors will need to be entered into QNet manually, rather than imported directly. CMS is working toward allowing vendor attestation in the future.

Where Can You Find More Information?

Visit the [CMS EHR Incentive Programs website](#) and follow us on [Twitter](#) for up-to-date information on the transition.

You can also submit questions to the EHR Information Center, available at 1-888-734-6433 (press option 1) from 9:00 a.m. to 5:00 p.m. CT Monday through Friday, except federal holidays.

CMS will distribute more information on this transition as it becomes available. In the meantime, don't forget to review the 2017 [Modified Stage 2](#) and [Stage 3](#) EHR Incentive Program requirements to ensure you are ready to attest in 2018.



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News Updates

CMS QRDA Reference and Guides Now Located on the eCQI Resource Center

Effective October 1, 2017, the Centers for Medicare & Medicaid Services (CMS) has moved the source of truth of the CMS Quality Reporting Document Architecture (QRDA) Reference and Implementation Guides (IGs) from the electronic clinical quality measure (eCQM) Library Page to the [QRDA page of the Electronic Clinical Quality Improvement \(eCQI\) Resource Center](#). The eCQM Library Page will sunset at the end of the year and will be replaced with a redirect link to the eCQI Resource Center.

The CMS QRDA Reference and IGs contain technical implementation guidance for Eligible Hospitals, Critical Access Hospitals (CAHs), Eligible Professionals (EPs), Eligible Clinicians, health information technology vendors, and quality staff to electronically submit quality data to CMS.

CMS publishes QRDA guides for use in eCQM reporting for the following programs:

- [Quality Payment Program: The Merit-based Incentive Payment System \(MIPS\) and Alternative Payment Models](#)
- [Medicaid EHR Incentive Programs for EPs, Eligible Hospitals, and CAHs](#)
- [Hospital Inpatient Quality Reporting](#)
- [Medicare EHR Incentive Program for Eligible Hospitals and CAHs](#)

For More Information

To find out more about QRDA and eCQMs, visit the [eCQI Resource Center](#).



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News Updates

Now Available: 2018 Electronic Clinical Quality Measure Logic Flows for Eligible Clinicians and Eligible Professionals

The Centers for Medicare & Medicaid Services (CMS) published the 2018 performance period electronic Clinical Quality Measure (eCQM) Logic Flows for Eligible Clinicians and Eligible Professionals (EPs) to the [eCQI Resource Center](#). The eCQM Measure Logic Flows are designed to assist in interpreting eCQM logic and calculation methodology for performance rates. The flows begin with identifying the initial population (denominator) for the measure, and then outlines the measure's quality action (numerator) as well as reasons why the measure's numerator was not met.

The eCQM Logic Flows supplement eCQM specifications for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
- Medicaid Electronic Health Record (EHR) Incentive Program for EPs

These flows are intended to be used as an additional resource when implementing eCQMs and should not be used in place of the measure specification.

For More Information

Questions on the measure flows should be directed to the [ONC CQM Issue Tracker](#). For more information about QPP, please visit us online at qpp.cms.gov.



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News Updates

Updated Technical Release Notes for the Electronic Clinical Quality Measure Value Set Addendum for 4th Quarter 2017 and 2018 Reporting are Now Available

The Centers for Medicare & Medicaid Services (CMS) issued revised technical release notes (TRNs) for the addendum to the electronic clinical quality measure (eCQM) annual update specifications for 4th Quarter 2017 reporting and 2018 reporting periods.

Revisions were made to TRNs for the following measures for 4th Quarter 2017 reporting:

- **Eligible Hospital and Critical Access Hospital (CAH) measures:** CMS71v6, CMS72v5, CMS104v5, and CMS108v5

Revisions were made to TRNs for the following measures for 2018 reporting:

- **Eligible Hospital and CAH measure:** CMS108v6
- **Eligible Clinician and Eligible Professional (EP) measures:** CMS90v7, CMS117v6, CMS136v7, CMS137v6, CMS146v6, CMS147v7, CMS156v6, CMS164v6, and CMS166v7

The revised TRN files were updated to reflect:

- The inclusion of additional TRNs to accurately document all applicable coding changes for each measure,
- The removal of TRNs that were irrelevant to a specific measure, and/or
- The numbers of codes indicated in the TRNs.

*Please note: Only the TRNs have been updated. The value set content recently published in September as part of the addenda have **not** changed.*

For More Information

Revised TRN files are now available for download on the [EP/Eligible Clinician eQMs](#) and [Eligible Hospital/CAH eQMs](#) webpages of the eCQI Resource Center.



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News Updates

Eligible Hospitals and Critical Access Hospitals Attesting to CMS: Create Your Account in the QualityNet Secure Portal for Meaningful Use Attestations in 2018

Beginning January 2, 2018, eligible hospitals and critical access hospitals (CAHs) attesting to CMS will submit their 2017 meaningful use (MU) attestations through the [QualityNet Secure Portal \(QNet\)](#).

Eligible hospitals and CAHs attesting to CMS must have an active and updated QNet account before submitting MU attestations.

Enroll and Update Your QNet Account

Beginning in October:

- Eligible hospitals and CAHs attesting to CMS who are **new to the QNet system** need to enroll to create a QNet account and select the MU option.
- Eligible hospitals and CAHs attesting to CMS who are **existing QNet users** need to select the MU option in their QNet accounts.

For a step-by-step guide to enrolling in QNet and adding the MU option to your QNet account, review the [QualityNet Secure Portal Enrollment and Login User Guide](#).

For More Information

- Visit the [QNet](#) webpage
- Visit the [EHR Incentive Programs](#) website
- Follow CMS on [Twitter](#)
- Subscribe to the [EHR Incentive Programs listserv](#)



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News Updates

CMS Announces Transition of Electronic Clinical Quality Measures to Clinical Quality Language for the CY2019 Reporting/Performance Periods

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that following more than one year of testing and input from the vendor and implementer communities, electronic clinical quality measures (eCQMs) in CMS quality programs will be transitioned to use the [Clinical Quality Language \(CQL\) standard \(CQL Release 1, Standard for Trial Use \(STU\) 2\)](#) for logic expression. CQL is a Health Level Seven International standard and aims to unify the expression of logic for eCQMs and Clinical Decision Support (CDS). CQL provides the ability to better express logic defining measure populations to improve the accuracy and clarity of eCQMs.

Measures expressed using CQL logic will continue to use the Quality Data Model (QDM) as the conceptual model to express clinical concepts contained within quality measures. Refer to the [QDM v5.3 Annotated version](#) and current version of the [CQL standard](#) to better understand how they work together to provide eCQMs that are human readable, yet structured for electronic processing.

The transition to reporting CQL-based measures will begin with the calendar year (CY) 2019 reporting period for Eligible Hospitals and Critical Access Hospitals (CAHs), and CY 2019 performance period for Eligible Professionals (EPs) and Eligible Clinicians. To support the transition, CMS will publish CQL-based eCQMs in Spring 2018 for potential inclusion in the following programs:

- Hospital Inpatient Quality Reporting Program
- Medicare Electronic Health Record Incentive Program for Eligible Hospitals and CAHs
- Medicaid EHR Incentive Program for EPs, Eligible Hospitals, and CAHs
- Quality Payment Program: The Merit-based Incentive Payment System (MIPS) and Alternative Payment Models

Draft eQCM specifications using CQL will be available through November 13, 2017 on the [CQM Issue Tracker](#) via the following tickets. Please note, that these draft specifications are for informational review only and are not intended for implementation and/or submission:

- Eligible hospital and critical access hospital measures ([CQM-2858](#))
- Eligible professional and eligible clinician measures ([CQM-2860](#))

Available Resources and Tools:

- [CQL-based Health Quality Measure Format \(HQMF\) Implementation Guide Release 1, STU 2.1](#) - Defines the approach to using the CQL with the QDM and HQMF to define eCQMs. This STU 2.1 includes a Terminology section and vocabulary management guidance.
- [CQL Formatting and Usage Wiki](#) - A collaborative workspace for the development of CQL formatting conventions and usage patterns for the representation of logic within quality measures.
- [CQL GitHub Tools Repository](#) - Provides tooling in support of the standard, including the CQL-to-ELM translator, with a reference implementation for syntactic and semantic validation of CQL and [example measures](#) used by the translator.
- [Measure Authoring Tool](#) - A web-based tool that allows measure developers to author eCQMs using the QDM.
- [Bonnie Testing Tool](#) - A tool designed to support streamlined and efficient pre-testing of eCQMs.

CMS will be offering general and targeted educational sessions to share how CQL is used to support eQMs beginning in November 2017. To learn more about CQL, please check the [eCQI Resource Center Events page](#) for information on upcoming webinars.

For More Information

You can find more CQL and QDM resources on the [eCQI Resource Center](#). Please submit CQL related questions to the [ONC CQL Issue Tracker](#).



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For More Information

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News Updates

Northern California Wildfires - Disaster Exceptions/Exemptions for Medicare Certified Providers

The Centers for Medicare & Medicaid Services (CMS) is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the Northern California wildfires since October 8, 2017, in and around counties in Northern California. These providers will be granted exceptions without having to submit an extraordinary circumstances exception request if they are located in one of the California counties which has been designated by the [Federal Emergency Management Agency \(FEMA\)](#) as a major disaster county.

The scope and duration of the exception under each Medicare quality reporting program is described in the [memo](#) posted on 10-30-17, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

In addition, CMS will continue to monitor the situation and adjust exempted reporting periods and submission deadlines accordingly.

Further details and materials are available on the [CMS 2017 California Wildfires](#) webpage.
Please check back frequently for updates.



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News Updates

Visit the JIRA Website to Submit Official Comments on Draft 2018 CMS QRDA III Implementation Guide by November 17, 2017

The Centers for Medicare & Medicaid Services (CMS) published the draft 2018 CMS Quality Reporting Document Architecture (QRDA) Category III Implementation Guide (IG) for Eligible Professionals (EPs) and Eligible Clinicians (referred to as the Draft 2018 CMS QRDA III IG). The IG is posted in [JIRA](#), ticket number [QRDA-605](#), for public comment. A JIRA account is required to comment. The public comment period begins **November 6, 2017** and ends **November 17, 2017**.

The Draft 2018 CMS QRDA III IG provides implementation guidance for the 2018 performance period for submitting QRDA Category III (QRDA-III) files for the following CMS Programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Comprehensive Primary Care Plus (CPC+)

- Medicaid Electronic Health Record (EHR) Incentive Program for EPs; based on individual state submission acceptant requirements

The Draft 2018 CMS QRDA III IG:

- Is based on the Health Level Seven (HL7) QRDA Category III R1, Standard for Trial Use R2.1. There are no changes to the QRDA templates from the 2017 CMS QRDA III IG.
- Includes updated electronic clinical quality measure (eCQM) specifications for EPs and Eligible Clinicians universally unique identifier (UUID) list for the 2018 performance period.
- Includes updates to the advancing care information measures and improvement activities for the 2018 performance period.

For more detail regarding the changes from previous versions of the CMS QRDA III IG, visit the “Change Log” section of the document. We look forward to receiving your feedback.

Additional QRDA-Related Resources:

- You can find current and past CMS QRDA Implementation Guides, Schematrons, and Sample Files on the [eCQI Resource Center](#).
- For questions related to the QRDA IGs or Schematrons, visit the [ONC QRDA JIRA Issue Tracker](#).
- For questions related to the Quality Payment Program, visit the Quality Payment Program [website](#) or contact the Service Center by phone 1-866-288-8292 (TTY 1-877-715-6222) or email gpp@cms.hhs.gov.



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News Updates

Eligible Hospitals and CAHs: How to View Your Meaningful Use Data

The Centers for Medicare & Medicaid Services (CMS) is streamlining the Medicare attestation process by migrating the meaningful use attestation system from the [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#) to the [QualityNet Secure Portal](#) (QNet).

As part of this transition, **meaningful use data is now in view-only mode on the EHR Incentive Program Registration and Attestation System**. Starting January 2, 2018, eligible hospitals and CAHS will be able to access this meaningful use data on QNet.

Attesting in 2018

Don't forget that starting in January, Medicare eligible hospitals and CAHs must attest to CMS for meaningful use through QNet. The change applies to 2017 meaningful use data, as well as future reporting periods. QNet is the same system Medicare eligible hospitals and CAHs currently use for CQM reporting.

- **Medicaid eligible hospitals** should contact their [state Medicaid agencies](#) for specific information on how to attest. The Registration and Attestation System will still be available to these hospitals.

- **Dually eligible hospitals and CAHs** will register and attest for Medicare on the [QNet](#) portal and update and submit registration information in the Registration and Attestation System.

Create or Update Your QNet Account

QNet enrollment is now open, and you can take one of two actions:

- **If you don't have an account on QNet** already from previous CQM submissions, you'll need to create a new one before you attest.
- **If you—or the person/department at your hospital who usually submits meaningful use data—already has an account**, you'll need to update that existing account by adding the “meaningful use” role before attestation. If your organization's account has several users associated with the account, you may not have permission to make the change. The account's designated Security Administrators can make the meaningful use role update.

Step-by-step instructions for updating your account and enrolling on QNet are available in the [QNet User Guide](#).

Get More Info

Visit the [CMS EHR Incentive Programs website](#) and follow us on [Twitter](#) for up-to-date information on the transition.

You can also submit questions to the EHR Information Center, available at 1-888-734-6433 (press option 1) from 9:00 a.m. to 5:00 p.m. CT Monday through Friday, except federal holidays.

Don't forget to review the 2017 [Modified Stage 2](#) and [Stage 3](#) EHR Incentive Program requirements to ensure you are ready to attest in 2018.



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News Updates

New Medicare Card: Provider Ombudsman Announced

The Provider Ombudsman for the New Medicare Card serves as a CMS resource for the provider community. The Ombudsman will ensure that CMS hears and understands any implementation problems experienced by clinicians, hospitals, suppliers, and other providers. Dr. Eugene Freund will be serving in this position. He will also communicate about the New Medicare Card to providers and collaborate with CMS components to develop solutions to any implementation problems that arise. To reach the Ombudsman, contact: NMCPProviderQuestions@cms.hhs.gov.

The Medicare Beneficiary Ombudsman and CMS staff will address inquiries from Medicare beneficiaries and their representatives through existing inquiry processes. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.



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News Updates

Now Available - QRDA III Implementation Guide for the Calendar Year 2018 Performance Period

The Centers for Medicare & Medicaid Services (CMS) published the [2018 CMS Quality Reporting Document Architecture \(QRDA\) Category III Implementation Guide \(IG\) for Eligible Professionals \(EPs\) and Eligible Clinicians](#) (referred to as the 2018 CMS QRDA III IG) with [Schematrons and Sample Files](#).

The 2018 CMS QRDA III IG provides implementation guidance for the 2018 performance period for submitting QRDA Category III (QRDA III) files for the following CMS Programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Comprehensive Primary Care Plus (CPC+)
- Medicaid Electronic Health Record (EHR) Incentive Program for EPs

About the 2018 CMS QRDA III IG:

- The 2018 CMS QRDA III IG is based on the Health Level Seven (HL7) QRDA Category III R1, Standard for Trial Use R2.1. There are no changes to the QRDA templates from the 2017 CMS QRDA III IG.

- Includes updated eCQM specifications for EPs and Eligible Clinicians universally unique identifier (UUID) list for the 2018 performance period.
- Includes updates to the MIPS advancing care information measures and improvement activities for the 2018 performance period.

For more detail regarding the changes from previous versions of the CMS QRDA III IG, visit the “Change Log” section of the document.

Additional QRDA-Related Resources:

- You can find current and past CMS QRDA IGs, Schematrons, and Sample Files on the [eCQI Resource Center](#).
- For questions related to the QRDA IGs or Schematrons, visit the [ONC QRDA JIRA Issue Tracker](#).
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