



**CHANGES PROPOSED UNDER THE CMS IPPS RULE AFFECTING
QUALITY REPORTING AND MEANINGFUL USE
April 2017**

Top Level Takeaways:

Meaningful Use	
Reporting Period	90-day reporting has been proposed for 2018 reporting year.
Decertified EHRs	Providers can file for a hardship if their EHR gets decertified anytime during the 12-months prior to or during the reporting period. Starts for payment year 2018 for EPs and CAHs; 2019 for hospitals.
Status of Stage 3 / 2015 Edition CEHRT	Stage 3 and 2015 Edition CEHRT still required for use starting in 2018, however, CMS seeks comments on this issue leaving the strong possibility that the timeline for 2015 CERT may still change.
Practitioners in Ambulatory Surgical Centers (ASCs)	Practitioners working primarily in an ASC will no longer be subject to possible penalties since the 21 st Century Cures Act changed the way these clinicians are treated under Meaningful Use.
Electronic Clinical Quality Measures (eQMs)	
Reporting period	2017: Any two calendar quarters; 2018: First three calendar quarters
Number of Measures	2017: Six measures; 2018: Six measures
New, hybrid measure	CMS has proposed a voluntary hybrid hospital-wide re-admission measure using claims and EHR data that could be voluntarily reported on discharges over a 6-month period in the first two quarters of 2018.
Data validation process	CMS has proposed to change the eQCM validation process by reducing the number of cases required for eQCM data validation for 2017 and 2018.
Data validation education	If an educational review demonstrates that the abstraction score calculated by CMS is incorrect, CMS would use the corrected quarterly score to compute the final confidence interval.
Medicaid EPs	CMS has proposed a shorter reporting period and fewer quality measures for Medicaid EPs.
Long-term Care Hospitals	LTCH's must report quality measures or face a penalty.
Regulatory Relief RFI	CMS is seeking feedback on ideas to reduce burden on healthcare providers.



I. IPPS PROPOSED RULE

This fact sheet will focus on changes proposed by the Centers for Medicare and Medicaid Services under their [2018 Proposed Inpatient Prospective Payment Rule](#). All proposals are draft until CMS issues a final rule which is expected in August. This fact sheet focuses on the areas of most interest to Chief Information Officers (CIOs) which center largely around electronic clinical quality measures and Meaningful Use.

II. QUALITY REPORTING: Hospital Inpatient Quality Reporting (IQR) Program (see starting page 973)

Bottom line: The number of eQMs that hospitals must meet in 2017 has been reduced from eight to six and the reporting period has been shortened from a full year to any two quarters of data under CMS' proposal. For 2018, under the new proposal providers would report six eQMs and the reporting period would be the first three calendar quarters.

CMS previously finalized for the Hospital IQR Program 62 measures for the FY 2019 payment and subsequent years as outlined on the table starting on page 982 of the rule.

A. Common Core Data Set & New Hybrid Measures (page 1022)

Bottom line: CMS is proposing a new hybrid measure which would be voluntary for use.

CMS has previously expressed interest in having hospitals use a core set of clinical data elements extracted from their EHRs for each hospitalized Medicare fee-for-service (FFS) beneficiary over 65 years of age. CMS says the core clinical data elements are data which are routinely collected on hospitalized adults, extraction from hospital EHRs is feasible, and can be utilized as part of specific quality outcome measures. One way they envision using core clinical data elements in conjunction with other sources of data, such as administrative claims, is to calculate "hybrid" outcome measures, which are quality measures that utilize more than one source of data.

CMS has called for creating a voluntary hybrid hospital-wide re-admission measure with claims and EHR Data (NQF #2879) which would consist of data gathered from multiple sources (EHR data, claims data and Medicare enrollment data) which would consist of data reported on discharges over a 6-month period in the first two quarters of CY 2018 (January 1, 2018 through June 30, 2018). A hospital's annual payment determination would not be affected by this voluntary measure. Hospitals that voluntarily submit data for this measure would receive confidential hospital-specific reports that detail submission results from the performance reporting period. CMS has proposed that hospitals that submit data for the hybrid measure must use 2015 Edition CEHRT (page 1110). And, they are proposing 13 core clinical data elements and six



linking variables for the hybrid readmission measure be submitted using the QRDA I file format. The 13 core clinical data elements are listed on page 1033 of the rule. CMS further notes that participating hospitals are expected to successfully submit data values for vital signs and six linking variables required to merge with the CMS claims data on more than 95 percent of all Medicare FFS patients who are 65 years and older discharged from the hospital during the voluntary data collection period. Additionally, participating hospitals are expected to successfully submit values for laboratory test results on more than 50 percent of these patients discharged over the same time period.

B. Proposed Changes to the eQIM Reporting for the Hospital IQR Program for 2017 Reporting / 2019 Payment (page 1042)

Bottom line: CMS is proposing shorter reporting periods and fewer measures for 2017 and 2018.

- ***Measure for 2018 Reporting (2020 payment) (page 1042)***

CMS has proposed numerous changes to hospital quality reporting. A complete list of measures with some proposed modifications (discussed on pages 973-1016) can be found on pages 1016-1022. CMS also discusses possible new quality topics starting on page 1046.

- ***Shorter Reporting Periods (pages 1042 and 1100)***

- **For 2017 reporting (2019 payment):** Provide two, self-selected, calendar year quarters of data.
- **For 2018 reporting (2020 payment):** Provide data for the first three calendar quarters (Q1-Q3).

- ***Fewer Measures (pages 1042 and 1100)***

- **For 2017 reporting (2019 payment):** Reducing the number of measures from eight to six eQIMs.
- **For 2018 reporting (2020 payment):** Reducing the number of measures from eight to six eQIMs; may be the same or a different set of six eQIMs reported on in 2017 as determined by the provider.



C. Measures Under Consideration for Future Inclusion (page 1046)

Bottom line: CMS is considering new measures including new eQMs.

CMS is also considering adding new eQMs on opioid prescribing, malnutrition, tobacco use, and substance use among the adult, inpatient population (starting page 1079). CMS also says they are considering including a measure on informed consent (page 1060), four on end-of-life for cancer patients (page 1064), two staffing nursing (page 1067), skilled nursing (page 1070), nursing hours per patient day (page 1075), and other additional eQM measures (page 1079). A list of the eQMs under consideration can be found below.

Electronic Clinical Quality Measures (eQMs) for Future Consideration in the Hospital IQR and Medicare and Medicaid EHR Incentive Programs	
Measure Name	NQF #
Safe Use of Opioids – Concurrent Prescribing	N/A
Completion of a Malnutrition Screening within 24 Hours of Admission	N/A
Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 Hours of a Malnutrition Screening	N/A
Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment	N/A
Appropriate Documentation of a Malnutrition Diagnosis	N/A
Tobacco Use Screening (TOB-1)	N/A
Tobacco Use Treatment Provided or Offered (TOB-2)/Tobacco Use Treatment (TOB-2a)	N/A
Tobacco Use Treatment Provided or Offered at Discharge (TOB-3)/Tobacco Use Treatment at Discharge (TOB-3a)	N/A
Alcohol Use Screening (SUB-1)	N/A
Alcohol Use Brief Intervention Provided or Offered (SUB-2)/Alcohol Use Brief Intervention (SUB-2a)	N/A
Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)/Alcohol & Other Drug Use Disorder Treatment at Discharge (SUB-3a)	N/A



D. Form, Manner, and Timing of Quality Data Submission (page 1099)

Bottom line: QRDA 1 is still the file format required for use.

Hospitals must submit data using a method specified by CMS. CMS requires hospitals to submit eCQM data via the Quality Reporting Document Architecture Category I (QRDA I). They are permitted to use third parties to submit QRDA I files on their behalf and can either use abstraction or pull the data from non-certified sources and input these data into CEHRT for capture and reporting. CMS is not making changes to the way chart-abstracted data is submitted or the electronic file format. CMS is also not proposing changes to submission deadlines. CMS is proposing other changes, however, concerning eCQMs detailed below.

E. Proposed Changes to the Reporting and Submission Requirements for eCQMs for the FY 2019 Payment Determination and Subsequent Years

Bottom line: CMS has acknowledged concerns around required use of 2015 Edition CEHRT but is not changing their policy for 2018 reporting at this time. CMS is proposing several changes associated with measure validation.

- ***Certification Requirements for eCQM Reporting (page 1103)***

CMS is not proposing any changes to the current requirement which calls for the use of 2015 Edition CEHRT for reporting quality measures beginning in 2018. However, they acknowledge concerns raised by stakeholders on this topic and are monitoring the readiness of vendors and are seeking comments on whether the required use of 2015 Edition CEHRT should be delayed.

CMS did, however, propose two changes concerning certification requirements for eCQM reporting. Current policy requires providers use the most recent version of electronic specifications for each eCQM for which the technology is certified. CMS requires that hospitals using 2014 Edition CEHRT must have software updated to the most recent version of each eCQM specification (Spring 2016 version).

- **2017:** CMS has proposed expanding this to apply to not only hospitals using 2014 Edition CEHRT but also to those using 2015 Edition CEHRT and that they must be using the most recent version of eCQM specifications for all fifteen measures (spring 2016 version).



- **2018:** Would require the use of the most recent version of eCQM specifications (Spring 2017) plus have its EHR certified to all 15 eCQMs to meet the reporting requirements. EHRs certified to 2015 Edition CEHRT would not need to be recertified each time it updates its eCQMs.
- **Validation of Hospital IQR Program Data (page 1116)**

CMS has previously finalized requirements around the process of validation of chart-abstracted measures. They have proposed changes to this process.

Finalized in last year's rule for 2018 reporting	Proposed changes
Number of Selected Hospitals: Up to 200 randomly selected hospitals as a sample	Remains unchanged.
Excluded from validation efforts: <ul style="list-style-type: none"> - Any hospital that was selected for chart-selected validation - Hospitals granted an Extraordinary Circumstances Exception 	Proposing to also add to existing exclusions: <ul style="list-style-type: none"> - Exclude any hospital that does not have at least five discharges for at least one reported eCQM. - Hospitals meeting either of the two exclusions detailed to the left.
Number of cases: 32 randomly-selected cases (8 per quarter) from the QRDA I files submitted by each hospital	<ul style="list-style-type: none"> - 8 per quarter for a total of 16 for 2017 - 8 cases per quarter for a total of 24 in 2018 16 cases per quarter for 2018 reporting -
Selection of cases: No specific process	For the CY 2017 reporting period/FY 2020 payment and subsequent years, CMS proposed excluding the following cases from validation for hospitals selected to participate in eCQM validation: <ul style="list-style-type: none"> - Episodes of care that are longer than 120 days; and - Cases with a zero denominator for each measure.
Start date for validation: Spring 2018 for 2017 reporting	Remains unchanged.



- ***Medical Record Submission Requirements and Scoring (page 1119)***

Hospitals participating in eCQM validation for the 2020 payment year and beyond are required to:

- Submit data by 30 calendar days following the medical records request date;
- Provide sufficient patient level information necessary to match the requested medical record to the original Hospital IQR Program submitted eCQM measure data record; and
- Submit records in PDF file format through QualityNet using the Secure File Transfer (SFT).
- For the FY 2020 payment only for hospitals selected for eCQM validation, CMS requires:
 - At least 75 percent of sampled eCQM measure medical records in a timely and complete manner; and
 - The accuracy of eCQM data submitted for validation would not affect a hospital's validation score (81 FR 57180).

CMS plans to continue the above policies for the FY 2021 payment determination and subsequent years.

- ***Scoring (page 1121)***

The accuracy of eCQM data submitted for validation will not affect a hospital's validation score for 2020 payment. CMS proposes to continue this policy for 2021 payment.

F. Proposed Modifications to the Educational Review Process for Chart-Abstracted Measures Validation (page 1122)

Bottom line: CMS is formalizing its existing process used when hospitals request an educational review or locate errors made by CMS during scoring.

For 2017 reporting (2019 payment) hospitals may request an educational review or appeal cases to identify any potential Clinical Data Abstraction Center (CDAC) or CMS errors. Hospitals that fail to meet Hospital IQR Program validation requirements have 30 days to appeal after this determination. If the results of an educational review indicate that CDAC or CMS has incorrectly scored a hospital, those scores are not changed unless and until the hospital submits a reconsideration request. CMS is proposing to formalize this process; a corrected score would be used to compute the hospital's final validation score whether the hospital submits a reconsideration request or not. CMS' goal is to reduce the number of reconsideration requests. *CMS has proposed a similar process for 2018 reporting (2020 payment).*

G. Proposed Change to the Hospital IQR Program Extraordinary Circumstances Exceptions (ECE) Policy (page 1144 and 1497)



Bottom line: CMS has proposed changes to align the multiple ECE sets of policies under different quality reporting programs.

CMS may grant an exception to hospital quality data reporting requirements in the event of extraordinary circumstances beyond the control of the hospital. CMS considers granting exceptions in the following cases:

- For circumstances not relating to the reporting of electronic clinical quality measure data, a hospital participating in the Hospital IQR Program that wishes to request an exception with respect to quality data reporting requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred.
- For circumstances relating to the reporting of electronic clinical quality measures, a hospital participating in the Hospital IQR Program that wishes to request an exception must submit its request to CMS by April 1 following the end of the reporting calendar year in which the extraordinary circumstances occurred. Specific requirements for submission of a request for an exception are available on QualityNet.org.
- If CMS determines a systemic problem with CMS data collection systems directly affected the ability of the hospital to submit data or has affected an entire region or locale.

The Hospital IQR Program, Hospital Outpatient Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, Ambulatory Surgical Center Quality Reporting (ASCQR) Program, PPS-Exempt Cancer Hospital Quality Reporting Program, the Hospital Value-based Program, Hospital Acquired Infection Reduction Program, and the Hospital Readmissions Reduction Program, share common processes for ECE requests. CMS has also proposed changes to better align the processes for exceptions under these programs including aligning nomenclature and aiming to respond to ECE requests within 90 days.

III. Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (pages 76, 930, 1188, 1234, 1308, 1467, 1507)

Bottom line: LTCH's must report quality measures or face a penalty.

Long-term care providers are required to submit quality data to avoid a financial penalty. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) was enacted on October 6, 2014, and it made several changes that affect the Long-Term Care Quality Reporting Program (LTCH QRP). CMS has proposed continue to implement portions of the law that require LTCHs, among other post-acute care providers, to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. LTCH are required to participate in the LTCH QRP and begin submitting data no later than the first day of the calendar quarter ~~subsequent to~~after 30 days after the date on its CMS Certification Number notification letter. Data must be submitted in the form and manner dictated by CMS. Exceptions and extensions may be granted by CMS for one or more quarters, in the event of certain extraordinary circumstances beyond the control of the



long-term care hospital. Data completion standards for LTCH's are set at 80 percent for completion of measures data and standardized patient assessment data collected using the LTCH CARE Data Set submitted through the Quality Improvement and Evaluation Assessment Submission and Processing System (QIES ASAP); and a second threshold set at 100 percent for measures data collected and submitted using the Center for Disease Control's National Healthcare Safety Network (CDC NHSN). Failure to meet these requirements results in a two percent financial penalty.

IV. Proposed Modifications to the CQM Reporting Requirements for the Medicare and Medicaid EHR Incentive Programs for CY 2017 (page 1365)

CMS is proposing similar quality reporting policies for the Medicare EHR Incentive Program for EHS and CAHs, as they have under their proposal for IQR to better align the programs.

A. *Number of Measures and Reporting Period*

Bottom line: CMS is proposing fewer measures and shorter reporting periods.

Like the changes proposed under the IQR program, CMS is proposing shorter reporting periods and fewer measures for eCQM reporting. See page 1372 for a complete list of all 16 measures for which hospitals may report. For CQMs reported by attestation, 2018 is the last year to do so. Measures reported by attestation must be done for the full year except if a hospital is a first-time reporter in which case its 90 days. CMS maintains the flexibility for states to have submitters send data in manner they deem appropriate. CMS proposes for those submitting via attestation for 2018 that hospitals report all 16 measures for a full year.

- **Shorter Reporting Period**
 - **2017:** Reducing from full year reporting to two self-selected quarters
 - **2018:** First three quarters.

- **Fewer Measures**
 - **2017:** eCQMs reduced from eight measures to six.
 - **2018:** eCQMs reduced from eight measures to six.

- **Reporting Format for 2018 (page 1377)**



CMS proposes data be submitted only electronically and via QualityNet. They also plan on requiring the use of the most recent version of the CQM electronic specification for each CQM to which the EHR is certified. For 2018, this means Spring 2017 version of the CQM electronic specifications. Also, starting in 2018 CMS plans to require the use of EHR technology certified to the 2015 Edition for CQM reporting.

B. CQM Requirements for Medicaid EPs in Meaningful Use for 2017 (page 1380)

Bottom line: CMS has proposed a shorter reporting period and fewer quality measures for Medicaid EPs.

CMS has proposed changes for Medicaid EPs. In previous rules CMS finalized policies for Medicaid EPs which are much for burdensome compared to other providers. CMS has proposed to make the following changes:

- **Shorter reporting period for electronic quality reporting:** Would match what is in the Medicare-based Incentive Program (MIPS); proposing 90 days for 2017. CMS has proposed retaining the full reporting year for eCQMs for Medicaid EPs for 2018, however, if they change this under MIPS they may change it for Medicaid EPs.
- **Measure alignment:** CMS proposes to align the specific CQMs available to EPs participating in the Medicaid Meaningful Use Program with those available to clinicians participating in MIPS who submit CQMs through their EHR. The set of 53 CQMs available to MIPS participants is a subset of the 64 CQMs currently available under the Medicaid EHR Incentive Program.
- **Number of Measures and Type:** CMS is proposing Medicaid EPs report on any six measures that are relevant to the EP's scope of practice. They also call for removing the requirement to report on CQMs across three of the six National Quality Forum domains.

V. MEANINGFUL USE: Changes to the Medicare and Medicaid EHR Incentive Programs (pages 1387 and 1520)

A. Reporting Period (pages 1387 and 1392)

Bottom line: 90-day reporting has been proposed for 2018 reporting year.

CMS has proposed shortening the reporting period for all participating in Meaningful Use (including those reporting through their state Medicaid) from a full-year reporting period to a 90-day reporting period. Factoring into their decision to shorten the time frame was feedback they received from several stakeholders that more time is needed for testing and implementing the technology associated with Application Programming Interfaces (API) (which is required under Stage 3 and the functionality for which is included in 2015 Edition CEHRT) and meeting care coordination measures. HHS estimates more than 85% of hospitals will have 2015 Edition CEHRT whereas 74% of EPs will have it by that time, also factoring into their decision to change the reporting period for 2018.



B. Decertified EHRs (pages 1392, 1491, and 1513)

Bottom line: Providers can file for a hardship if their EHR gets decertified. Starts for payment year 2018 for EPs and CAHs; 2019 for hospitals. Providers qualify if products are decertified anytime during the 12-months prior to the reporting period or during the reporting period.

The 21st Century Cures Act allows the U.S. Department of Health & Human Services (HHS) to exempt providers from a payment cut under Meaningful Use (or affect performance under MIPS) if the reason is due to their EHR becoming decertified. Providers can request an exemption annually but by law the exemption cannot exceed five years. Specifically, CMS proposed:

- **For EPs:**
 - **2017 payment year:** CMS has proposed not to allow use of the exception to avoid a penalty in 2017 because it would be costly and burdensome for them to reprocess claims.
 - **Beginning with the 2018 payment year:** Allowing for use of the decertified exception to avoid payment penalty. 2018 is the final year of financial penalties for EPs under Meaningful Use since the program sunsets and has been replaced by MIPS. EPs would qualify for the exception if their certified EHR was decertified anytime during the 12 months prior to the reporting period or during the reporting period.
- **For EHRs:**
 - **2018 payment year:** CMS is not proposing the exception for the 2018 payment year because their earlier guidance at [FAQ 12657](#) said providers could apply for a hardship if their product was decertified prior to the end reporting period, therefore, CMS believes EHRs would have already received a hardship.
 - **Beginning with the 2019 payment year:** Hospitals can qualify for this hardship if their EHR gets decertified before or during the applicable reporting period. Hospitals will qualify for the exception if their products get decertified anytime during the 12 months prior to the reporting period or during the reporting period. Applications for the hardship would be due by July 1 of the year before the payment adjustment.

EXAMPLE: If an eligible EH intended to attest to Meaningful Use for a 90-day EHR reporting period beginning on April 1, 2017, the EH could apply for this exception if their certified EHR technology was decertified at any time during the 12-month period beginning on April 1, 2016 and ending on March 31, 2017, or if their certified EHR technology was decertified at any time during their 90-day EHR reporting period beginning on April 1, 2017.
- **For CAHs:**
 - **Beginning with the 2018 payment year:** Hardship is available if the EHR was decertified at any time during the 12-month period preceding the applicable EHR reporting period or during the applicable EHR reporting period for the penalty year.



Applications would need to be filed by November 30th after the end of the applicable payment year. **EXAMPLE:** If a CAH intended to attest to Meaningful Use for a 90-day EHR reporting period beginning on April 1, 2018, the CAH could apply for this exception if their EHR was decertified at any time during the 12-month period beginning on April 1, 2017 and ending on March 31, 2018, or if their EHR was decertified at any time during their 90-day EHR reporting period beginning on April 1, 2018.

C. Certification Requirements for 2018 / Stage 3 (page 1402)

Bottom line: Stage 3 and 2015 Edition CEHRT are still required for use starting in 2018, however, CMS seeks comments on this issue leaving the strong possibility that the timeline for use of 2015 CEHRT could still change.

Despite acknowledging concerns from several stakeholders, CMS is not proposing to change the required timeframe for use of 2015 Edition CEHRT which remains a requirement beginning in 2018. They believe the analysis of data shows that sufficient progress is being made toward upgrading to the new software and that pushing back the date by which providers are required to begin using 2015 Edition CEHRT is not warranted now. However, they state, “We will work with ONC to monitor the deployment and implementation status of EHR technology certified to the 2015 Edition. If we identify a change in the current trends and significant issues with the certification and deployment of the 2015 Edition, we will consider flexibility in 2018, for those EPs that attest directly to a State for the State’s Medicaid EHR Incentive Program and eligible hospitals and CAHs attesting to CMS or the State’s Medicaid EHR Incentive Program that are not able to implement 2015 Edition CEHRT to attest for an EHR reporting period in 2018.” CMS invites comments around the possible permitted use of either 2014 or 2015 Edition CEHRT or a combination of both for 2018.

D. Ambulatory Surgical Center (ASC)-based Eligible Professionals (EPs) (page 1399)

Bottom line: Practitioners working primarily in an ASC will no longer be subject to possible penalties under Meaningful Use (and subsequently MIPS) since the 21st Century Cures Act changed the way these clinicians are treated under Meaningful Use.

In order for EPs to avoid a penalty under Meaningful Use (and subsequently MIPS), they must see a certain number of patients using a certified EHRs. For EPs who work primarily in ASCs this has been a challenge since ASCs are not included in the Meaningful Use program, yet these professionals can still be subjected to penalties. The 21st Century Cures Act thus amended the way EPs who work in ASCs are treated for the purposes of Meaningful Use and subsequently under MIPS. Under the new law, these EPs for furnish most of their care under an ASC will no longer be subject to a financial penalty in 2017 or 2018. CMS is proposing to define an ASC-based EP as someone who provides 75% or more of their care in an ASC as identified by their place of service billing code (POS 24) placed on the claim to CMS in the calendar year that is two years



before the payment adjustment year. This is similar to the way CMS defines hospital-based clinicians under MIPS. Alternately, they proposed defining an ASC-based EP as one that provides 90% or more of their care in an ASC.

CMS estimates – based on 2016 data – that working off this definition that relies on a threshold of 75% this would affect 0.8% of EPs. Working off the 90% definition this would affect 0.4% of EPs. CMS invites comments on these proposals.

VI. Burden Estimates for Compliance (pages 1449 and 1795)

Bottom line: CMS says it will take less time and save hospitals money reporting fewer measures.

CMS estimates:

- In assessing the burden on hospitals which CMS is required to do for major rulemaking, previously CMS has estimated that the time it takes for a hospital to report one eCQM per record per quarter.
- The proposed reduction in the required number of eCQMs for 2017 will result in a reduction of 200 minutes per hospital per year, or 3 hours and 20 minutes per hospital per year, for 2019 payment.
- For 2018 reporting, they conclude the reduced measure set would reduce the burden on hospital reporting by 2 hours and 20 minutes (140 minutes) per hospital.

VII. Financial Penalties for Failure to Meet Meaningful Use and Quality Reporting– see 1534

Bottom line: Failure to meet quality reporting and Meaningful Use will result in a substantial financial penalty.

CMS forecasts various reimbursement rates based upon, among other things, a provider's successful compliance with quality reporting and Meaningful Use. The table below depicts the possible different payment scenarios. CMS stated in the rule that on average 100 hospitals do not receive the full annual percentage increase for IQR.



FY 2018	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.725	-0.725
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.175	0.0	-2.175
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Proposed Applicable Percentage Increase Applied to Standardized Amount	1.75	-0.425	1.025	-1.15

VIII. Regulatory Reform (page 1481)

Bottom line: CMS is seeking feedback on ideas to reduce burden on healthcare providers.

CMS has included a Request for Information (RFI) on what the agency is referring to as “CMS Flexibilities and Efficiencies.” They state, “As we work to maintain flexibility and efficiency throughout the Medicare program, we would like to start a national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. We aim to increase quality of care, lower costs improve program integrity, and make the health care system more effective, simple and accessible.” To that end CMS is requesting feedback and ideas from the public on ways to achieve these goals. CMS is particularly interested in ways to incent organizations and clinicians treating patients with opioid addictions. A list of additional items for which they are seeking input is found below:



- 42 CFR Part 405: Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping, Rural areas, X-rays.
- 42 CFR Part 412: Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.
- 42 CFR Part 413: Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.
- 42 CFR Part 414: Administrative practice and procedures, Biologics, Drugs, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.
- 42 CFR Part 416: Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.
- 42 CFR Part 486: Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-ray.
- 42 CFR Part 488: Administrative practice and procedure, Health facilities, Medicare, Reporting and recordkeeping requirements.
- 42 CFR Part 489: Health facilities, Medicare, Reporting and recordkeeping requirements.
- 42 CFR Part 495: Administrative practice and procedure, Electronic health records, Health facilities, Health professions, Health maintenance organizations (HMO), Medicaid, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.