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Speaker: Brian Willis

Hello, everyone, and thank you for attending today's webinar. Before we begin, we'd like to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets you can use. You can expand each widget by clicking on the Maximum icon at the top right of the widget or by dragging the bottom right corner of the widget panel.

This webinar is being recorded, and the recording will be available one day after the webcast using the same audience link used to join today's event. If you have any questions for our presenters during the webcast, click on the Q&A bottom – button at the bottom and submit your question. We will try to address as many questions as possible during the event. If a fuller answer is required or we run out of time, your question will be answered later via email. We do all capture all questions. If you have any technical difficulties, please click on the Help widget. It is the question mark icon and covers common technical issues. You can also submit technical issues via the Q&A widget.

Now I'd like to pass it off to Susan Arday. Susan, you now have the floor.

Speaker: Susan Arday

Thanks, Brian. I would like to welcome everyone to today's webinar. This particular webinar is on Electronic Clinical Quality Measures, and it's entitled Eligible Clinician New eCQMs Finalized for 2019. This is the fifth and final in our eCQM series of webinars for eligible clinicians.

As Brian mentioned, my name is Susan Arday. I am the CMS Contracting Officer's Representative, COR is what we call, for the CMS contract tasked with maintaining the Electronic Clinical Quality Measures, or eCQMs, used in the CMS Merit-based Incentive Payment System, abbreviated MIPS. I will be presenting today along with Dr. Elizabeth DiNenno from the Centers for Disease Control and Prevention, CDC, and Jenna Williams-Bader from the National Committee for Quality Assurance, NCQA.

And today we're going to present two measures. The first will be Quality ID472/CMS249, which is Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Profile for Osteoporotic Fractures. The second will be Quality ID475/CMS349, HIV Screening. Since these are new MIPS quality measures that are – there are many potential questions you may have about these. And today our speakers will review these measure specifications and address your questions.

So, at the end of today's session, you will become familiar with the top-reported new eCQMs finalized for 2019. You will understand the intent of each of these new measures. And you will be able to address and understand the anticipated questions and the answers for each of these eCQMs as you're using them and how to follow ongoing information about each of these measures.

I'd like to make note that the staff and speakers in this presentation have no financial arrangements or affiliations with a corporate organization that either provide educational grants to this program or may be referenced in this activity.

And at this time, I would like to hand this presentation over to Jenna Williams-Bader from the NCQA to discuss CMS249, Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture. Jenna, you have the floor.

QUALITY ID 472 / CMS249: APPROPRIATE USE OF DXA SCANS IN WOMEN UNDER 65 YEARS WHO DO NOT MEET THE RISK PROFILE FOR OSTEOPOROTIC FRACTURES

Speaker: Jenna Williams-Bader

Thank you so much, Susan. Hi, everyone. As Susan said, my name is Jenna Williams-Bader, and I am Director of Performance Government at NCQA. Our – this particular measure has a very long title, so I won't repeat it, but I will be talking to you today about the appropriate use of DXA scans.

This measure assesses the percentage of female patients 50 to 64 years of age without select factors for osteoporotic fracture who received an order for a DXA scan during the measurement period. I'll cover the risk factors in more detail later in the presentation. This is a high-priority process measure that addresses efficiency, cost reduction, and appropriate use. The measure aligns with the 2018 osteoporosis screening recommendation from the U.S. Preventative Services Task Force. Before using bone measurement testing, like DXA, to screen for osteoporosis in post-menopausal women younger than 65 years, the U.S. PSTF recommends assessing women using a formal clinical risk assessment tool and only performing bone measurement testing on those women at increased risk for osteoporosis.

There are several clinical risk assessment tools that assess risk for osteoporotic fracture. This measure focuses on the FRAX, which is a validated assessment from the University of Sheffield that assesses the ten-year risk of major osteoporotic (inaudible) fracture. Clinicians have the option to input bone mineral density results into the FRAX, but those results are not required to produce a FRAX score. Women fall into the denominator if they are 50 to 64 years of age and have an encounter during the measurement period. Since this measure assesses the use of DXA scans in women who are at lower risk for fracture, a lower score equals better quality. The exclusions, therefore, remove women from the measure who may be appropriately screened for osteoporosis because they are at higher risk for fractures.

There are two ways to meet the exclusion criteria, a combination of risk factors based on patient characteristics, diagnoses, and other patient data, or independent risk factors. The combination risk factors are meant to approximate a patient's risk for osteoporotic fractures based on the FRAX. The independent risk factors are conditions that are associated with a higher risk for fractures. Here is a list of combination risk factors. They are a mix of patient characteristics, patient behaviors, conditions, and patient history that put a patient at higher risk for osteoporotic fracture. I won't read the list, but I'll pause here so you have a second to look at it.

And here is the list of independent risk factors. As you'll note, one of these exclusions is a FRAX score, therefore, if clinicians are using the FRAX, they can exclude patients whose risk for major osteoporotic fracture is above the threshold. There are also procedures, medications, and conditions on this list that increase a patient's risk for osteoporotic fracture. Again, I won't read the list out loud, but please take a second to review.

The numerator for this measure is female patients with an order for at least one DXA scan during the measurement period. There are no denominator exceptions. The intent of this measure is twofold. One is to reduce the number of inappropriate DXA scans and the potential harm associated with those scans. And to encourage clinicians to assess and document patients' risk factors for osteoporotic fractures.

Looking now to questions that we might get about the measure, some of you may be wondering why we focus on women age 50 to 64 years and why we don't include women younger than age 50. During testing, we did assess the measure in women 18 to 64. However, we found that few women under age 50 had DXAs, and that the rate of inappropriate DXAs in women age 18 to 49 was lower than women 50 to 64.

As I mentioned earlier, one of the independent risk factors used as an exclusion is a FRAX score indicating higher risk for osteoporotic fractures. When we first developed this measure, we aligned it with the 2011 osteoporosis screening recommendation from the U.S. PSTF. They recommended osteoporosis screening in women under age 65 only if their fracture risk was equal to or greater than that of a 65-year-old white woman who has no additional risk factors. We specifically mention the FRAX as a way to determine this risk, and then set the threshold risk of major osteoporotic fracture at equal to or greater than 9.3%.

In 2018, the U.S. PSTF modified this part of the recommendation. According to the Clinical Considerations section of the recommendation, a 65-year-old white woman of mean height and weight without major risk factors had a ten-year FRAX risk of major osteoporotic fracture of 8.4%. We're hoping to update this threshold during the current annual update process to keep the measures aligned with the U.S. PSTF recommendations.

Moving on to the last question, as I mentioned previously there are two types of exclusions in this measure, the independent risk factors and the age-dependent combination risk factors. The independent risk factors are conditions that significantly raise a patient's risk for osteoporotic fracture. We also exclude patients with combination risk factors in order to approximate a FRAX result for those clinicians not using the FRAX. The number of risk factors decreases as a patient's age increases because osteoporosis risk increases with age.

Q & A

Thank you very much. I'll turn it over to Susan Arday for questions.

Thank you, Jenna. At this time I would like to see if Anita has any questions or comments that came through the Chat. Anita, you have the floor.

Thank you, Susan. Jenna, there are no questions that have come in for you with this measure, so you must have done a great job that making sure that everything got covered.

Susan, back to you.

Thank you, Anita.

Next, I would like to introduce Dr. Elizabeth DiNenno from the CDC, who is going to present on CMS349, HIV Screening. Dr. DiNenno, you have the floor.

QUALITY ID 475 / CMS349: HIV SCREENING

Speaker: Dr. Elizabeth DiNenno

Thank you, Susan, and good afternoon, everybody. As Susan mentioned, I'm Elizabeth DiNenno. I am the Associate Deputy Director for Surveillance, Epidemiology, and Laboratory Sciences here in the Division of HIV Prevention, and I'm happy to present our measure to you today.

The description of this measure is the percentage of patients 15 to 65 years of age who have been tested for Human Immunodeficiency Virus, or HIV, within that age range. I just want to mention that this measure aligns with the 2014 United States Public Services Task Force recommendations. So it basically aligns with that. This is a process measure type. The measure area is community and population health. And this is not a high-priority measure.

The denominator for the measure is patients who are between the ages of 15 and 65 at the start of the measure period and who had at least one outpatient visit during the measurement period. The denominator exclusions are patients diagnosed with HIV prior to the start of the measurement period. There are no other exclusions for the denominator.

The numerator for this measure is patients with documentation of an HIV test between the ages of 15 and 65 and before the end of the measurement period. So, here it's important to note that self-reported testing is not an acceptable report. Providers must request documentation of test results. In cases where the HIV test was performed elsewhere, providers cannot rely on patient self-reports to meet the measure requirements as previous research, that I'll talk about in a bit, has shown that patient self-report is an unreliable indicator of previous HIV testing history. Rather, the provider must request documentation of these test results. If documentation is not available, the patient should be considered still eligible for HIV testing. And if documentation is available but cannot be provided in a standardized format, providers should enter the information into their EHR as a laboratory test in a manner consistent with the EHR in use.

So now I just want to talk about the background for this HIV Screening measure.

The good news is we're at an exciting time because we finally have the tools we need to end HIV – the HIV epidemic in the United States. And I'm sure you may have heard last month that

the White House announced a bold elimination plan for the United States. Today the budget is also released, so we're pleased to see there are funds available currently.

So, if anything, the information I'm going to share has really own grown in importance. So I want to thank you for your consideration, and I hope to show you why HIV screening is so critical. As you likely know, HIV is a communicable infection that leads to a progressive disease with a long asymptomatic period. And though progress is being made, there were still almost 39 - 40,000 new HIV diagnoses in the United States in 2017.

In addition, many people are not aware of their HIV infection. CDC estimates that almost 15% of the 1.1 million adults and adolescents living with HIV infection in the U.S. are unaware of their infection, so screening is an essential first step because it identifies persons who were previously unaware of their infection, enable them to seek medical care, and improve the quality and length of their lives.

Without treatment, most persons develop Acquired Immunodeficiency Syndrome, or AIDS, within ten years of infection. Antiretroviral Therapy, or ART, delays the disease progress and increases the length of survival. And additionally, using ART with high levels of medication adherence has been shown to substantially reduce risk for HIV transmission. So persons living with HIV who use ART and achieve viral suppression can have nearly normal life expectancy.

However, I want to note that diagnosis delays are certainly not equal across all demographic groups. We know that compared to white persons with HIV, black, Asian, Hispanic or Latino, and other races had higher diagnosis delays. So from white – white HIV-diagnosed persons about two years versus three or four years or more for other populations.

So, CDC's 2006 recommendations stated that screening for HIV infection should be performed routinely for all patients age 13 to 64 years. And in those recommendations, CDC noted that healthcare providers should initiate the screening. And the U.S. PSTF essentially concurred with these recommendations by giving the screening recommendations a Grade A in 2014. They have a slightly different age range, so the U.S. PSTF is 15 to 65, and this is what we're using for this measure.

However, the uptake of the recommendations has been uneven, as I mentioned, and there are still many – many disparities. For example, in 2017, one in two people had been living with HIV for three years. And seven in ten people at high risk who didn't get a test for HIV in the past year actually saw a healthcare provider during that time but they were not offered a test.

So we know many of these barriers continue. And one of the largest is not getting screened in a clinical setting. Because systems often don't encourage opt-out testing. To make this point in another way, you can see the data in this slide are taken from published analysis – analysis from last year. It showed another example of missed opportunities for HIV screening. And this is in physicians' offices.

It shows that HIV testing at visits at physician offices are extremely low, and that, in this case, 98.5% of visits where a venipuncture was performed, an HIV test was not ordered. So this just represents the large number of missed opportunities that we see across the system.

So, our intent with this screening measure is to increase the proportion of U.S. adults and adolescents who have ever been screened for HIV. So it turns out there's much room to grow. Using different data sets, we know that screening rates have remained relatively stable, increasing slightly since our 2006 guidelines. So rates of screening have increased a little more for men – I'm sorry – for women than men. But for men, the rates have been stable or even declining.

In 2016, using the Behavioral Risk Factor Surveillance System, we found that only about 44% of persons 18 to 64 were screened, ever. The National Survey of Family Growth found that 46% of men and 51% of women age 15 to 44 were screened. So the immediate intent for us is to increase the proportion of people screened. And the long-term intent, which I just want to emphasize briefly, is to get persons diagnosed into care because we can suppress their viral load, which ultimately will reduce transmission. So, it's more than just getting persons diagnosed because of benefit to them. It also has important downstream impacts.

So with that, I will turn to a couple questions we anticipate. One of the first is, why doesn't the measure include an exception for patient refusal? Now first, we know that when physicians present HIV testing as part of routine care, acceptance rates are likely to be relatively high. But without physicians promoting it, some people will assume they don't need a test and refuse. Partly this is because there is HIV exceptionalism, meaning HIV is seen as different and stigmatized. The idea that some people should be screened and other shouldn't basically reinforces the sense of stigmatization that we believe likely underlies refusals. This also leads to late diagnoses.

We also want to emphasize the personal and public health importance of screening. Another reason to allow for patient refusal would be if the risks of detection would outweigh the benefits. However, we know that not only is late testing related to poor patient outcomes due to not getting medications, and not, therefore, being virally suppressed, but also HIV is a highly transmissible infection. And we estimate that at least 40% of new infections are transmitted by people who are unaware of their infections and so they weren't tested, so they can't on medication. So it could be argued that the imperative to screen most people for HIV exceeds that for conditions that only adversely affect an individual if it's not detected.

The second question is, what happens if a patient reports having been previously tested elsewhere? We noted that documentation is required to rule out a previous HIV test.

So, in cases where the HIV test was performed elsewhere, providers can't rely on patient attestation or self-report to meet the measurement requirements. And I mentioned that previous research has shown that previous research has shown that patient self-report is an unreliable indicator for the variety of reasons I mentioned, stigma, other reasons to get previous HIV testing history.

So the provider must request documentation of the results. And if the documentation is not available, the patient should be considered still eligible for HIV screening. If the documentation is available, but, as I said, if it couldn't be provided in a standardized way, we're asking the providers enter the information into their EHR in a manner consistent with the EHR in use.

Another question is, could this measure lead to repeat testing for low-risk individuals? And if so, what led CDC to decide, or others to decide, that the benefits outweigh overutilization risks?

So, first, I think we would agree that repeat screening for some low-risk individuals is likely. And drivers include the fact that documentation for previous testing may not be available in a structured format. And so this retrieving and manually entering those results may just be too burdensome and a provider would just retest this person. Also, the requirement to ever look back makes this problem a bit worse as negative results from a test performed in like the early 2000s are unlikely to have ever migrated to an EHR. And patients are unlikely to retain results from community-based testing programs, especially if those are not recent.

However, CDC internal calculations suggest that the value of early diagnosis, both for the individual patient and the health system, exceeds the costs of repeat testing this measure that its underlying recommendation might lead to. And also note that when the NQF panel previously reviewed this measure, weighed the economic and quality-of-life costs associated with over-testing compared to those associated with under-testing, it, too, felt it was reasonable to require retesting of previously-screened persons without documentation. And finally, we expect the ongoing process in interoperability and data sharing solutions will improve all measures like this over time.

And lastly, the question might be raised, are clinicians actually expected to receive 100 – achieve 100% on this measure? Now, striving to reach 100% achievement for any performance measure is, of course, a laudable goal, but it may not be realistic. For example, we understand how health system dynamics and patient mobility would render 100% untenable. And CDC did not develop this measure with the objective of it being used, you know, punitively. We really see this measure as an important quality improvement tool that providers can use to enhance delivery and quality of care. And so providers currently have the option to select which MIPS measures they report, and payment under MIPS programs are driven more by reporting than achieving a preset performance threshold.

So, you know, in the future, if we need to set a performance threshold in the future, we will make sure it's consistent with current standards of care and real-world evidence. And we hope that the early adoption of this measure will help us make some headway there.

So now I will turn it back to Susan for questions.

Q & A

Thank you, Dr. DiNenno. At this time, I would like to turn this over to Anita Somplasky to see if there are questions that have come in through the chat. Anita, you have the floor.

Thanks, Susan. Dr. DiNenno, we do have a few questions. So the first is, is the HIV screening part of an OB panel – if, I should say, the HIV screening is part of an OB panel, will this meet the intent of the measure?

Thanks for that question. There actually are other pieces of our recommendation for pregnant women. But in terms of an OB – just talking about a normal clinical visit, I would say yes. But I just wanted to make that distinction. But, yes, I think that would probably be, you know, that would be part of this – fall under this recommendation. As a matter of fact, that’s why we think that many women are probably screened more because they’re actually coming to a clinical setting where it’s more likely to be – where they’re more likely to get screened.

Thank you. The next question is regarding HIV testing. Do you know what the confirmatory test is once a patient has a positive screening test?

Yeah, and – and instead of going through the kind of complicated algorithm that we recommend, there is a – I can send out the link later – but there is a CDC laboratory algorithm that we recommend following. And I think over time we found that, you know, large percentages of clinical – clinical settings are following those recommendations. But I can certainly send it because it – it really – it really depends on what you are using as a screening tool or a screening test as well as whether you are following the algorithm that we recommend. So, again, I can certainly send that out, and that’s worth a good read, I think, for your – for the attendees.

Thank you. The next question is, should automatic screening be suggested depending upon a patient’s lifestyle or past medical history?

So should automatic screening – I think – I mean, what we’re trying to do with this – this recommendation is to basically not make assumptions about what people are doing as a way to screen people at least once in their lives for HIV. And so, of course, you know, a clinician is going to take into consideration people’s, you know, behaviors or what they – they self-report. And actually, although this is not part of the screening recommendation, CDC does also have more frequent recommendations – more frequent testing recommendations for persons at high risk. So I haven’t addressed that, but, again, I can – we can send the link out, but for the gay, bisexual, and other men who have sex with men, for persons who are using drugs, and other heterosexuals at risk, we recommend more frequent screening. So you may consider that, as well, as a clinician in your – in your review. But for this ever-screening measure, I think we’re trying to do away with the idea that behavior has something to do with getting screened at least once.

Thank you for that answer. The next question, and you may not be able to answer this one but there were a few questions related to it. There was a question about documenting – is there a place in the EHR to document the screening and results? And that may be EHR-vendor specific but related to the sensitivity of the testing. Have you had these questions come in before?

You know, that is one I probably will need to follow up with, and – and I’d be happy to send out information later because I’m not quite as familiar about how the EHR – and I agree, it’s going

to depend on the vendor and different, yeah, different fields. So, I apologize. I probably will have to take that one offline.

And – and just to let all attendees know, we will be getting out the full list of questions and responses because there are some that are a little difficult to answer on the spot.

The next question for you is, what is the testing frequency recommended?

To clarify, there are no exclusions regardless of how recent the previous negative test was resulted. If there is documentation of a previous test, then you would not – again, if there is documentation, you would not be rescreening for this measure. Does that – does that answer the question? I think that was the question.

Yes. Okay, the next question is, is this measure to be used in the clinic setting? My providers are in the hospital and urgent care settings. So, do the codes included in your value set include things outside of an outpatient or clinic setting?

We can check, but that is our intent, for sure. We are very interested in increasing the uptake of this screening measure which is being used in other settings, for instance ER and other settings. So we should make sure that the codes reflect that, but I believe they do. We will, again, follow up.

I think you've addressed this one a few different ways, but how often do you recommend retesting for low-risk patients?

Sure, I can address that. Again, we – I would refer you to our guidelines to – that describe what high-risk behaviors and other recommendations are. But, again, if you are, let's just say, a low-risk individual, you would not need to be retested for this measure. Now, again, if there's no documentation, there is no harm in retesting. In fact, the CDC and others are working on sort of revising our recommendations, and perhaps in the future we might identify the need to not just make this a once-in-a-lifetime kind of screening for low-risk individuals, but perhaps, you know, a – maybe multiple times in one's lifetime depending on your, you know, where you are in your lifecycle. But for now, low-risk individuals would not be recommended to test again.

Thank you.

There are several different questions related to coverage for the HIV measure, and I'm not sure if it – you have uncovered that as any part of doing the measure development process, whether or not the insurance companies are paying. Folks are worried that it will not be a covered service.

Umm hmm. Well, again, I just reiterate the fact that the U.S. PSTF recommendation does, you know, is the – is the reason we chose this particular definition because that should – this will definitely cover, you know, those persons who are in that age range and are ever screened are certainly going to be, you know, that – that test will be compensated or reimbursed for. Now, it

does get a little tricky with the retesting as we described. But if you have doc – you know, if you don't have documentation of a previous test result, then this should be covered.

Again, we know that there's many reasons for which it might be hard to get that kind of documentation. And we can – we certainly are, you know, interested to see where this, you know, where there's problems, so we would want to know about that in the future.

Great. The next question is, why is the age limited to 65?

Right. You know, this is based on available data. And the U.S. PSTF, when they did their literature review, again, it's a different age range than what CDC recommended, it's a little bit higher, but it's just based on available literature. Again, that could change over time as, you know, as the epidemic sort of continues to mature. But, surely, so that's – that's just kind of an artifact of the research that's been done and the announcement was done to make the final determination. It's also true in the reverse, the younger age groups, you know, again, this is what the U.S. PSTF has found evidence for, but certainly, you know, we believe that there's – there is still reason for younger ages to be screened as well. But, this is what our recommendation is based on the available evidence.

Great. Okay, the next question. Should a patient be asked while having any bloodwork done if they would like to have the HIV test? Is that the goal to ask all patients to obtain as many patients as possible?

Yeah, thanks. That – that's a really good question. I mean, when I mentioned about when providers present information to a patient, basically – and also – so there's two things. One, when providers present this as a routine, standardized type of activity, patients are much more likely to accept the test than they would be if they are said – if they are asked something like, well, do you want to do this? Because, again, the stigma for HIV screening is – is, you know, different than other diseases. So, we encourage providers to kind of present this as part of, you know, other tests that are being done. You know, standardized, you know, STD, other preventative tests. So whenever you can, we would recommend that. I do want to mention, though, that there are different laws and different regulations and things, by – by state and by even clinics, so you want – you really do have to kind of check to see, you know, make sure that the way you're presenting it is – is appropriate in your setting. Again, opt-out screening means in many cases we find that if we – if a provider says, we're going to screen you for these things unless you do not want them, that's the – what we've found is the most beneficial and appropriate way to screen everybody, which, yes, is our intent, to get everybody screened. As I said, there is a lot of room to improve. Low numbers of persons in the United States are screened compared to other – other countries. So, that's our intent.

Wonderful. The next question is, if the patient declines the screening, is that a denominator exclusion?

So, the – sorry, I'm just looking through the notes. It is not an exclusion. Let's see here. I'm sorry. We just went back and forth with this one. Let me check on that, how it's written in here.

I'm pretty – I mean, obviously, if someone declines, I mean if they say no, you know, that we know that – that there's reasons for that. But you can't, obviously, you know, force someone to have an – an HIV screen, so this is just – it's about, really, the way we present it, which we think is most important. But we don't – I'm sorry, the measure does not include an exception for patient refusal, and so – but, of course, again, you have to check with how this is being presented in your – in your clinical facility.

I'll follow up more on that. We can provide some more –

(Inaudible).

Um hmm?

Okay. There was a follow-on question that's saying, then there are no exclusions regardless of how recent the previous negative test? So, again, if they've had a negative test, they wouldn't need to be rescreened again?

Right. And just to –

(Inaudible)

That's correct. That's correct. But, yes, I'm sorry, I just want to clarify there is no exclusion for refusals in this screen. And, right, if there is documentation of a prev – of a previous test, they do not need to be rescreened.

Wonderful. That – that wraps up – oh, one more. No, they're asking for reimbursement, which we – we know we can't do.

Jenna, I will tell you one other question has come in for you. It – so if the patient is referred to an orthopedic – orthoped – by a PCP, and that orthoped refers the DXA and the PCP fails to get the FRAX, how would that scenario be reported? Is that still numerator-eligible for the PCP? And if so, what if the PCP has a different appointment – if the patient has an appointment with the PCP after the FRAX – after the FRAX?

Thanks, Anita. I think I might have to see that question in writing, so maybe we can take it offline so I can answer because it sounds like there are a few different components and I just want to make sure I'm understanding the question correctly. So if we could take that one offline that would be great.

Sure. We can absolutely do that.

So that wraps up the end of the questions, and Susan, I will turn it back to you to let folks know about follow up.

CONCLUSION

Speaker: Susan Arday

Oh, thank you Anita. This is Susan Arday again. And I would like to thank all of our presenters today. The slide deck and all of the Q&As from today's webinar will be made accessible through the Electronic Clinical Quality Improvement Resource Center. The Resource Center contains information of the new eCQMs finalized for 2019, as well as the measure specifications for 2019 reporting.

Additional questions or issues may be submitted to the eCQM Issue Tracker in JIRA, in the ONC Project Tracking System. So how do you do that? Well, if you're going to submit a question through JIRA to the ONC Project Tracking System, please follow the instructions outlined on this slide to create an account. Once you have that account, follow it up with an issue ticket in the system.

Again, I would like to thank everyone and all of our presenters today. Thank you for attending this webinar.

This concludes our EC eCQM webinar series. Please visit the eCQI Resource Center for more information.

Thank you all for attending this, and goodbye. Have a great day.