Hospital Inpatient Quality Reporting Program Changes: FY 2019 Payment Determination (CY 2017 Reporting Period)

Clinical Process Measures

Chart-Abstracted Measure Submission

Beginning with January 1, 2017 discharges and forward, eligible facilities participating in the Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program will no longer be required to submit data for two previously required chart-abstracted measures because the measures have been removed (see Table 1).

Table 1: Removal of Two Chart-Abstracted Measures

Short Name	Measure Name	Criteria
STK-4	Thrombolytic Therapy	Topped Out
VTE-5	Venous Thromboembolism Discharge Instructions	Topped Out

For a complete list of Hospital IQR measures for Fiscal Year (FY) 2019, please reference the Measures for Fiscal Year 2019 Payment Update (direct link).

Note: Hospitals will be required to submit population and sample size data **only for those measures submitted as chart-abstracted** under the Hospital IQR Program.

Electronic Clinical Quality Measure Submission

CMS finalized the removal of 13 electronic Clinical Quality Measures (eCQMs) for the FY 2019 payment determination and subsequent years for the Hospital IQR Program (see Table 2).

Table 2: Removal of 13 eCQMs

Short Name	Measure Name	Criteria
AMI-2	Aspirin Prescribed at Discharge for AMI	Topped Out
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Performance or improvement does not result in better patient outcomes
AMI-10	Statin Prescribed at Discharge	Topped Out
HTN	Healthy Term Newborn	No longer feasible to implement the measure specifications
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	No longer feasible to implement the measure specifications
SCIP-Inf-1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Topped Out
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients	Topped Out
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero	No longer feasible to implement the measure specifications

Short Name	Measure Name	Criteria
STK-4	Thrombolytic Therapy	Topped Out
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	No longer feasible to implement the measure specifications
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)	No longer feasible to implement the measure specifications
VTE-5	Venous Thromboembolism Discharge Instructions	No longer feasible to implement the measure specifications
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	No longer feasible to implement the measure specifications

Mandatory eCQM Reporting Requirements

For the FY 2019 payment determination/calendar year (CY) 2017 reporting period, hospitals must submit data for at least eight of the 15 Hospital IQR Program eCQMs that align with the Medicare Electronic Health Record (EHR) Incentive Program. For the FY 2019 payment determination/CY 2017 reporting period only, hospitals must:

- Self-select a minimum of **eight** of the **15** available eCQMs
  - Hospitals must also chart-abstract required measures (ED-1, ED-2, IMM-2, PC-01, SEP-1, and VTE-6) even if those measures are self-selected and submitted as eCQMs.
- Report **one calendar year** of data for the self-selected eight eCQMs on a quarterly, biannual, or annual basis from a certified EHR
- Submit through the *QualityNet Secure Portal* by **February 28, 2018, at 11:59 p.m. PT**
  - The IQR eCQM requirement fulfillment also satisfies the CQM reporting option requirement for the Medicare EHR Incentive Program.
  - CY 2017 reporting will apply to FY 2019 payment determination for IPPS hospitals.
- Report using EHR technology certified to either the 2014 or 2015 Edition (for FY 2019 payment determination/CY 2017 reporting period only)

For the FY 2019 payment determination/CY 2017 reporting period and subsequent years:

- Hospitals must submit eCQM data via **Quality Reporting Document Architecture (QRDA) Category I** files.
- Hospitals may continue to use a third party to submit QRDA Category I files on their behalf.
- Hospitals may continue to either use abstraction or pull the data from noncertified sources in order to then input these data into **Certified Electronic Health Record Technology** (**CEHRT**) for capture and reporting QRDA Category I files.

Note: Beginning with the FY 2020 payment determination/CY 2018 reporting period and subsequent years, hospitals must report using EHR technology certified to the 2015 Edition.

Public Reporting for eCQMs

For FY 2019/CY 2017 reporting, any data submitted as an eCQM **will not be posted** on the *Hospital Compare* website immediately following the submission deadline. Public reporting of eCQM data will be addressed in future rulemaking.

Structural Measures

Removal of Structural Measures

Beginning with FY 2019/CY 2017, hospitals will no longer be required to submit data for the following structural measures listed below (see Table 3).

Table 3: Removal of Two Structural Measures

Measure Name	Criteria
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Performance does not result in better patient outcomes
Participation in a Systematic Clinical Database Registry for General Surgery	Performance does not result in better patient outcomes

Claims-Based Measures

New Claims-Based Measures

There are seven new claims-based measures effective with the FY 2019 payment determination, three of which were finalized in the FY 2016 IPPS/LTCH PPS final rule (see Table 4).

Table 4: Addition of Seven Claims-Based Measures

Short Name	Measure Name	Measure Type
Cellulitis Payment*	Cellulitis Clinical Episode-Based Payment	Payment
GI Payment*	Gastrointestinal Hemorrhage Clinical Episode-Based Payment	Payment
Kidney/UTI Payment*	Kidney/Urinary Tract Infection Clinical Episode-Based Payment	Payment
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment	Payment
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment	Payment
SFusion Payment	Spinal Fusion Clinical Episode-Based Payment	Payment
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	Outcome

*Finalized in FY 2016 IPPS/LTCH PPS final rule

Refinements to Claims-Based Measures

Measure refinements were made to the following existing measures:

- Pneumonia (PN) Payment: Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia
- Patient Safety Indicator, PSI 90: Patient Safety and Adverse Events Composite

PN Payment measure refinements will:

- Expand the measure cohort to include hospitalizations for patients with a:
  - Principal discharge diagnosis of pneumonia, including not only viral or bacterial pneumonia, but also aspiration pneumonia
  - Principal discharge diagnosis of sepsis (but not severe sepsis) with a secondary diagnosis of pneumonia (including viral or bacterial pneumonia and aspiration pneumonia) coded as present on admission (POA)
- Be effective for FY 2018 payment determination and subsequent years

- Align with the measure cohorts for PN Mortality and PN Readmission measures finalized in last year's rule

PSI 90 measure adjustments include the following:

- Changed name to "Patient Safety and Adverse Events Composite"
- Added three indicators:
  - PSI 09: Perioperative Hemorrhage or Hematoma Rate
  - PSI 10: Postoperative Acute Kidney Injury Requiring Dialysis Rate
  - PSI 11: Postoperative Respiratory Failure Rate
- Re-specified two indicators:
  - PSI 12: Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
  - PSI 15: Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
- Removed PSI 07: Central Venous Catheter-Related Blood Stream Infection Rate
- Re-weighted the component indicators in the modified PSI 90 measure to be based on not only the volume of each of the patient safety and adverse events, but also the harms associated with the events
- Be effective for FY 2018 payment determination and subsequent years

CMS finalized the modification to the **PSI 90 reporting periods** for FY 2018 and FY 2019 payment determinations.

- FY 2018
  - Fifteen-month reporting period spanning July 1, 2014 through September 30, 2015
  - Would only use ICD-9 data
- FY 2019
  - Twenty-one-month reporting period spanning October 1, 2015 through June 30, 2017
  - Would only use ICD-10 data
- FY 2020 and subsequent years
  - Return to standard 24-month reporting period, utilizing only ICD-10 data

eCQM Data Validation

eCQM validation of CY 2017 reported eCQM data begins spring 2018 for FY 2020 payment determination.

- CMS will continue to include up to 600 hospitals for chart-abstracted validation for the IQR Program.
- Up to **200** hospitals will be selected for eCQM validation via random sample. The following hospitals will be excluded:
  - Any hospital selected for chart-abstracted measure validation
  - Any hospital that has been granted a Hospital IQR Program Extraordinary Circumstances Exemption (ECE) for the applicable eCQM reporting period
- **Thirty-two** cases (individual patient-level reports) will be randomly selected from the QRDA Category I file submitted per hospital selected for validation.

- Selected hospitals must submit at least 75 percent of sampled eCQM medical records within **30** days of the date listed on the Clinical Data Abstracting Center (CDAC) medical records request. Timely and complete submission of medical record information will impact FY 2020 payment updates for IPPS hospitals.
- Hospitals are required to submit sufficient patient-level information necessary to match the requested medical record to the original submitted eCQM measure data.
  - Sufficient patient-level information is defined as the entire medical record that sufficiently documents the eCQM measure data elements, including, but not limited to:
    - ✓ Arrival date and time
    - ✓ Inpatient admission date
    - ✓ Discharge date from inpatient episode of care
- The accuracy of eCQM data, i.e., the extent to which data abstracted for validation matches the data submitted in the QRDA Category I files that are submitted for validation, will not affect a hospital's validation score for the FY 2020 payment determination.

  Note: This applies for FY 2020 payment determination only.

Extraordinary Circumstances Exemptions/Exceptions Policy

CMS finalized the proposal to update the Extraordinary Circumstance Extensions/Exemptions (ECE) policy by:

- Extending the request deadline for non-eCQM circumstances from 30 to 90 calendar days following an extraordinary circumstance
  - The deadline for ECE requests would apply for extraordinary circumstances events that occur on or after October 1, 2016.
- Establishing a separate submission deadline for ECE requests related to eCQM reporting circumstances to be April 1, following the end of the reporting calendar year
  - As an example, for data collected for the CY 2017 reporting period (through December 31, 2017), hospitals would have until April 1, 2018, to submit an ECE request.