Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2020 IPPS/LTCH PPS Final Rule
Overview for Hospital Quality Programs

Questions and Answers

Speakers

Grace H. Snyder, JD, MPH
Program Lead, Hospital Inpatient Quality Reporting (IQR) Program and
Hospital Value-Based Purchasing (VBP) Program
Quality Measurement and Value-Based Incentives Group (QMVIG),
Center for Clinical Standards and Quality (CCSQ), CMS

Michael Brea, MBA
Program Lead, Hospital-Acquired Condition (HAC) Reduction Program, QMVIG, CCSQ, CMS

Erin Patton, MPH, CHES
Program Lead, Hospital Readmissions Reduction Program (HRRP), QMVIG, CCSQ, CMS

Moderator

Candace Jackson, RN
Project Lead, Hospital IQR Program
Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

September 11, 2019
2 p.m. ET

DISCLAIMER: This presentation question-and-answer summary document was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated.

The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Webinar attendees submitted the following questions and subject-matter experts provided the responses. The questions and answers have been edited for grammar.

Hospital Inpatient Quality Reporting (IQR) Program/
Electronic Clinical Quality Measures (eCQMs)

Question 1: **For the chart-abstracted measures, what discharge periods are abstracted for FY 2021?**

For the chart-abstracted measures, CY 2019 discharges are used for the FY 2021 payment determinations.

Question 2: **Has the Influenza Immunization (IMM-2) measure been removed from the Hospital IQR Program for FY 2020?**

The IMM-2 measure was removed from the Hospital IQR Program beginning with CY 2019 discharges, FY 2021 payment determination. Data from discharges that occurred on or before December 31, 2018 are the last data submitted for the IMM-2 measure. For further information regarding the removal of this measure from the Hospital IQR Program, refer to the FY 2019 IPPS/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule (83 FR 41562 through 41567) at https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf.

Question 3: **Slide 61: Will ED-2 no longer be included as a chart-abstracted measure at the end of CY 2019?**

The ED-2 measure, Admit Decision Time to ED Departure Time for Admitted Patients, is removed from the Hospital IQR Program beginning with CY 2020 discharges, FY 2022 payment determination. Data from discharges that occur on or before December 31, 2019 are the last data submitted for the ED-2 measure. For further information regarding the removal of this measure from the Hospital IQR Program, refer to the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41562 through 41567).

Question 4: **Is the chart-abstracted Venous Thromboembolism (VTE)-6 voluntary or mandatory for FY 2020?**

VTE-6, Incidence of Potentially Preventable Venous Thromboembolism, was removed from the Hospital IQR Program beginning with CY 2019 discharges, FY 2021 payment determination. Data from discharges that occurred on or before December 31, 2018 are the last data submitted for the VTE-6 measure. For further information regarding the removal of this measure from the Hospital IQR Program, refer to the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41562 through 41567).

Question 5: **If an organization currently has an electronic clinical quality measure (eCQM) exemption, when will the exemption no longer be available?**

If you're referring to an Extraordinary Circumstance Exception (ECE) that was granted under the Hospital IQR Program for eCQM reporting, that ECE only applies to the specific reporting period for which the exemption was granted. If you need to request another exemption for the next reporting period, please submit a new ECE request form. Otherwise, our exemption policy in general is still in place and no changes were made to it. Visit the ECE Policy page on *QualityNet* to review the ECE policy specific to eCQM reporting.

Question 6: **Are there any plans for eCQMs to be included in the Hospital VBP Program?**

CMS has not indicated that eCQMs will be included in the Hospital VBP Program. Any intention to include eCQMs in the Hospital VBP Program will be discussed in a future IPPS/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule.

Question 7: **Will eCQM data be publicly reported for the CY 2020 reporting period?**

CMS will not publicly report CY 2020 eCQM data. Any intention to publicly report eCQMs for a future reporting period will be discussed in a future IPPS/LTCH PPS Proposed Rule.

Question 8: **When will CMS release the list of randomly selected hospitals for eCQM validation?**

The list of hospitals selected for inpatient eCQM data validation for FY 2021 was released in August 2019 and was posted on the *QualityNet* website. Please visit the eCQM Data Validation Overview page and locate the list of selected hospitals for eCQM data validation. Generally, hospitals are notified of their selection for eCQM data validation sometime in the spring/summer of each year. If you have specific questions about the current eCQM validation selection, you may reach out to validation@hcqis.org.

Question 9: **Slide 16: For the eCQM submission, if the hospital has less than five stroke cases for a quarter, can hospitals submit those cases for the four stroke eCQMs or must other applicable eCQMs be submitted?**

If a hospital has five or fewer discharges for a specific eCQM which their EHR is certified to report, hospitals have the option to either submit the applicable Quality Reporting Document Architecture (QRDA) Category I patient-level files or to utilize the case threshold exemption for a measure for the relevant EHR reporting quarter.

The eCQM for which there is a valid case threshold exemption will count as submission of one of the required eCQMs for both the Hospital IQR and the Promoting Interoperability Programs. Case threshold exemptions are entered on the Denominator Declaration screen within the *QualityNet Secure Portal*.

Question 10: **For eCQM reporting, can you select different quarters for different eCQMs or do all measures need to be from the same quarter of data?**

You will need to pick one quarter to report your eCQM data; all data must come from the same quarter. It can be the first, second, third, or fourth quarter of the reporting year.

Question 11: **Slide 16: One of the requirements listed for eCQM submission is "EHRs certified to all available eCQMs." Can you clarify the meaning of "certified"?**

EHR certification is in reference to the Office of the National Coordinator for Health Information Technology (ONC). The ONC Health IT Certification Program provides assurance to purchasers and other users that a system meets the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. For CY 2019 eCQM reporting and future reporting years, hospitals are required to use the 2015 Edition of Certified Electronic Health Record Technology (CEHRT); the EHR reporting eCQM data must be certified to report on all measures in the eCQM measure set. The list of EHR-based clinical process of care measures can be found on slide 62 of this webinar presentation.

ONC provides a number of resources on the HealthIT.gov website, including details regarding the 2015 edition test method and a Certified Health IT Product List (CHPL) for Health IT modules that have been tested and certified under the ONC Health IT Certification Program.

Question 12: **Slide 17: Are there only eight eCQM measures available for calendar year (CY) 2020 reporting?**

Yes, that is correct. In a previous Inpatient Prospective Payment System (IPPS) final rule, CMS removed several eCQMs from the program. As such, the 2019 reporting period will be the last year that those measures, such as Emergency Department (ED)-1 and Perinatal Care (PC)-01, will be available for reporting. Beginning with the CY 2020 reporting period, only the eight eCQMs are available. Please review slide 17 of this webinar to view the eCQM measures for the CY 2020 reporting period/fiscal year (FY) 2022 payment determination. Review slide 62 of this webinar to view the status of all electronic health record (EHR)-based clinical process of care measures.

Question 13: **Of the four required eCQMs for CY 2021, is the mandatory opioid measure considered one of the four or is the opioid measure in addition to the other four required measures?**

The Safe Use of Opioids measure will be part of mandatory reporting beginning with the CY 2022 reporting period/FY 2024 payment determination. On slide 15, the modified reporting requirements for the CY 2022 reporting period indicate that hospitals would report one self-selected calendar quarter of data for three self-selected eCQMs and report the Safe Use of Opioids – Concurrent Prescribing eCQM. For the CY 2021 reporting period, it will be one of the four eCQMs that hospitals can choose to report.

Question 14: **For CY 2020 eCQM reporting, some hospitals don't have an emergency and/or a labor and delivery department and may not be able to report on four eCQMs from the available ones. Will they be able to declare a zero-denominator declaration for the ones they can't report?**

Zero denominator declarations are applicable to the Hospital IQR and the Promoting Interoperability Programs. To use the zero-denominator declaration, a hospital's EHR system must be certified to report the eCQM and the hospital does not have patients that meet the denominator criteria of that eCQM.

The eCQM for which there is a valid zero denominator will count as submission of one of the required eCQMs for both the Hospital IQR and the Promoting Interoperability Programs. Zero denominators must be entered on the Denominator Declaration screen within the *QualityNet Secure Portal*.

Question 15: **Slide 21: For the Hybrid HWR measure, why did the measure developers choose those labs? Are you expecting those labs on all patients?**

The Hybrid HWR measure contains a set of core clinical data elements (CCDE). The thirteen CCDE include six vital signs (heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, and weight) and seven laboratory test results (sodium, potassium, hematocrit, white blood cell count, bicarbonate, creatinine, and glucose). The CCDE were selected because they meet the following feasibility criteria: obtained consistently under clinical practice; captured with a standard definition across providers and care settings; and entered in a structured field in the EHR to reduce the burden of extraction and ensure consistent reporting.

The intent of the approach to risk adjustment is to include factors related to a patient's severity of illness prior to and at the start of the hospitalization. CMS chose the previously mentioned risk-adjustment variables such that they only capture a patient's clinical status before treatment is provided and the effects of that treatment are realized.

Please visit the voluntary Hybrid HWR measure overview page on the *QualityNet* website to locate resources which include the measure methodology details and specifications. Additional questions regarding the Hybrid HWR measure methodology can be submitted to CMShybridmeasures@yale.edu.

Question 16: **Slide 23: Will the Hybrid HWR measure replace the claims HWR measure in the Merit-based Incentive Payment System (MIPS) calculation of final score?**

The mandatory reporting of the Hybrid HWR measure in CY 2024/FY 2026 payment determination and for subsequent years is specific to the Hospital IQR Program. MIPS is specific to Eligible Clinicians quality reporting; please contact the Quality Payment Program (QPP) support team at QPP@cms.hhs.gov or 1 (866) 288-8292.

Question 17: **When should our facilities start validating the Hybrid HWR measure and the new opioid eCQM?**

Slide 21 of this webinar clarifies that voluntary reporting periods for the Hybrid HWR measure will be available July 1, 2021 through June 30, 2022 and July 1, 2022 through June 30, 2023. Updates will be made available on the *QualityNet* Hybrid Measure Resources webpage regarding resources for test and production QRDA Category I file submissions in preparation for voluntary and eventual mandatory data submissions.

The Safe Use of Opioids – Concurrent Prescribing eCQM measure specifications are posted on the eCQI Resource Center. Hospitals and vendors will be notified as resources are posted to support mandatory reporting of this measure for the CY 2022 reporting period/FY 2024 payment determination.

Question 18: **Is the hybrid measure required or voluntary for critical access hospitals (CAHs)?**

The Hybrid Hospital-Wide Readmission (HWR) measure has been adopted for the Hospital IQR Program only. CAHs are not required to submit the Hybrid HWR measure. CAHs can certainly volunteer to submit the EHR data for the measure and CMS will combine it with claims data. For the subsection (d) hospitals, the measure will become mandatory after the voluntary reporting period ends. Visit the *QualityNet* website to review overview information about the Hybrid HWR measure, the measure methodology, and self-directed resources.

Question 19: **How does CMS plan to use the EDAC data in the future?**

CMS's EDAC measures capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions). Utilization of these services, for any reason, is disruptive to patients and caregivers, costly to the healthcare system, and puts patients at additional risk of hospital-acquired infections and complications. Currently, there are no plans to change how CMS is using this data. CMS began publicly reporting the acute myocardial infarction and heart failure EDAC measures on *Hospital* Compare in July 2017 and the pneumonia ECAC measure in July 2018. Information regarding the EDAC measures can be found on the Excess Days in Acute Care (EDAC) Measures Overview page on *QualityNet*.

Question 20: **How are the EDAC measures calculated and are they new?**

The EDAC measures have been required for the Hospital IQR Program since CY 2016 (FY 2018). Information regarding the EDAC measures methodology can be found on the Excess Days in Acute Care (EDAC) Measures Overview page on *QualityNet*.

Hospital Value-Based Purchasing (VBP) Program

Question 21: **In the Hospital VBP Program, which domains are only based on the Medicare patient population?**

The Medicare Spending per Beneficiary (MSPB) measure, 30-day mortality measures, and PSI 90 measure are calculated based on a Medicare beneficiary population. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, PC-01 measure, and NHSN healthcare-associated infection (HAI) measures are not payer specific.

Question 22: **The CMS Patient Safety Indicator (PSI) 90 measure was in the measure set and then taken out. It is now back in the measure set starting with FY 2023. Can you provide rationale and if anything has changed with the measure?**

In a previous Inpatient Prospective Payment System (IPPS) final rule, CMS proposed and finalized the adoption of the updated PSI 90 measure beginning in FY 2023. There have been some changes from when CMS previously used the PSI 90 measure in the Hospital Value Based Purchasing (VBP) Program. Beginning with the FY 2023 program year, CMS will be using the same version of the PSI 90 measure that's currently used in the Hospital-Acquired Condition Reduction Program (HACRP). As such, we will be back in alignment with that program in terms of the PSI 90 measure.

Question 23: **I attended a CMS webinar recently that showed the Safety domain was removed from the Hospital VBP Program in FY 2021. Can you please comment?**

That is not correct. In last year's IPPS rule, CMS proposed removing the Safety domain and its associated measures from the Hospital VBP Program to reduce the burden of tracking the measures in multiple programs. However, CMS received a lot of public comments, which we appreciated, about the importance of keeping these measures and keeping the financial incentives that are available under the Hospital VBP Program, as continuing to incentivize improvements on reducing infections and patient adverse events is a very high priority. Ultimately, CMS did not finalize our proposal to remove the Safety domain, and it is still in the Hospital VBP Program. The Safety domain is weighted at 25 percent of the Total Performance Score. CMS is continuing to use the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) infection measures and will be bringing back the PSI 90 measure to the Safety domain beginning in FY 2023.

Question 24: **Is there any CMS tool available to estimate ahead of time what the Total Performance Score (TPS) will be?**

CMS does not currently provide or endorse any tools or calculators that estimate the Hospital VBP Program TPS. For more information on scoring methodology and scoring examples for the Hospital VBP Program, reference the August 8, 2019 *What's My Payment? Understanding the Hospital VBP Program Calculations Step-By-Step in the Percentage Payment Summary Report* webinar and the Hospital VBP Program FY 2020 Scoring Quick Reference Guide.

Hospital-Acquired Condition (HAC) Reduction Program

Question 25: **Why are the NHSN infection measures used in both the Hospital VBP Program and the HAC Reduction Program?**

For CMS, patient safety is important for both programs. The HAC Reduction Program doesn't provide an opportunity to reward improvement. Placing those measures in the Hospital VBP Program gives facilities the chance to get credit for improving.

Question 26: **How do the IQR validation results impact the HAC payment? Is the HAC payment at risk based on validation results?**

If a hospital fails validation for one of the HAI measures, they will receive the maximum Winsorized z-score for the measures that were validated when calculating the Total HAC Score. Validation will be performed on either the Central Line-associated Bloodstream Infection (CLABSI), Catheter-associated Urinary Tract Infection (CAUTI), and Surgical Site Infection (SSI) measures or the SSI, *Clostridium difficile* Infection (CDI), and Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia measures. This impact will not change when validation of the HAI measures transitions from the Hospital IQR Program to the HAC Reduction Program.

Question 27: **Is validation for the HAC Reduction Program separate from the Hospital IQR Program validation process? If a hospital is selected for the IQR chart-abstracted validation will that hospital also be selected for the HAI (HAC Reduction Program) validation?**

Validation of HAI measures will transition from the Hospital IQR Program to the HAC Reduction Program starting with the FY 2023 HAC Reduction Program performance period (i.e., discharges from Q3 2020). The FY 2020 IPPS/LTCH PPS Final Rule (84 FR 42407–42408) clarifies that the HAC Reduction Program, in conjunction with the Hospital IQR Program, will use an aggregated random sample selection methodology through which the validation team will select one pool of 400 subsection (d) hospitals for validation of chart-abstracted measures in both the Hospital IQR Program and HAC Reduction Program. The pool of 400 hospitals will be selected randomly and validated for both the HAI measures under the HAC Reduction Program and the chart-abstracted measures within the Hospital IQR Program.

Question 28: **When will CMS release the list of hospitals randomly selected for HAC Reduction Program validation?**

Validation of the HAI measures will transition from the Hospital IQR Program to the HAC Reduction Program starting with the FY 2023 HAC Reduction Program performance period (i.e., discharges from Q3 2020). Dates related to the validation period for the FY 2023 HAC Reduction Program are shown in the FY 2020 IPPS/LTCH PPS Final Rule (84 FR 42407). We anticipate the random selection and notification of hospitals for that timeframe around December 2020.

Question 29: **Why are HAIs at zero not given credit in the HAC Reduction program? For example, we have not had a CLABSI, but it is not rewarded for a zero score. Instead, this score is removed from the calculations.**

HAI measures for which hospitals have zero cases during the performance period are not inherently excluded from Total HAC Score calculations. HAI measures can be excluded from Total HAC Score calculations based on a hospital's predicted number of infections, as calculated by the CDC.

Hospitals only receive measure scores for HAI measures with a predicted number of HAIs greater than 1.0. Any measure for which a hospital has less than 1.0 predicted infections are categorized as having "insufficient data" and excluded from Total HAC Score calculations. A hospital's Hospital-Specific Report (HSR) identifies which measures were categorized as having insufficient data.

Question 30: **Now that HAI measures will now only be publicly reported via the HAC Reduction Program, will they still be displayed as rolling 12-month scores as previously reported in the Hospital IQR Program?**

In the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41477), CMS clarified that the HAC Reduction Program will continue to make data available in the same form and manner on the *Hospital Compare* website as the Hospital IQR Program. The Hospital IQR Program will remove the HAI measures starting in FY 2022, when public reporting transitions to the HAC Reduction Program.

Question 31: **For HAI measures in the HAC Reduction Program, is the CLABSI and CAUTI validation step for day 1 or day 2 tests brand new? Is this like a scrub for CDI?**

In the FY 2020 IPPS/LTCH Final Rule, CMS finalized a change to the sample selection process for chart-abstracted validation of CLABSI and CAUTI measures (84 FR 42408 – 42409). The new sample selection process excludes from the validation pool any CLABSI and CAUTI cases whose positive cultures were all taken within the first two days following admission. Events such as this are community onset (i.e., they are non-hospital acquired). Excluding community onset events from the pool of events for validation more appropriately identifies candidate events that are likely to be true events and will help us better understand the over- and under-reporting of such events.

Question 32: **For the HAC pressure ulcer measure, if a deep tissue pressure injury (DTPI) evolves into a pressure ulcer staged as an unstageable ulcer or a stage III or stage IV, is this worse? Currently, the severity level for a stage III or stage IV is major complications or comorbidities (MCC), and the DTPI is a non-complications or comorbidities (CC). If the DTPI before staging is a non-CC, as it naturally**

evolves, it seems the payment penalty is implemented. Can you explain?

The PSI 03 Pressure Ulcer Rate measure counts the number of stays with a secondary diagnosis of stage III, stage IV, or unstageable pressure ulcer per 1,000 discharges among surgical or medical patients aged 18 years and older. The measure excludes stays that are less than three days; stays with a principle diagnosis of stage III, stage IV, or unstageable pressure ulcer; stays with a secondary diagnosis of stage III, stage IV, or unstageable pressure ulcer that is present on admission; obstetric cases; severe burns; and exfoliative skin disorders. Technical specifications for the PSI measures can be found at https://qualityindicators.ahrq.gov/Modules./

In the scenario described (assuming no exclusions), the individual case would appear in the numerator of the PSI 03 Pressure Ulcer Rate measure. This measure is one of ten component measures that make up the PSI 90 Composite measure. The PSI 90 Composite measure is one of six measures that comprise a hospital's Total HAC Score. The HAC Reduction Program payment penalty only applies to hospitals whose Total HAC Score ranks in the worst-performing quartile among subsection (d) hospitals.

Hospital Readmissions Reduction Program (HRRP)

Question 33: **What if your facility is new and will not have three years of data for HRRP?**

Hospitals do not need to be open for the entire three-year performance period to be included in HRRP. Open hospitals with 25 or more eligible discharges for at least one measure during the performance period are eligible for a payment reduction in HRRP. For FY 2020, CMS identifies open IPPS hospitals using the October 2019 public reporting open/closed hospital list (published April 5, 2019).

Question 34: **Are there any plans to move the HWR measure from the Hospital IQR Program to HRRP?**

Section 3025 of the Affordable Care Act requires that HRRP includes condition or procedure-specific measures. The hospital-wide readmission measure does not fulfill this statutory

requirement. Any future program changes to the HRRP will be proposed through rulemaking.

Question 35: **When will we receive our FY 2020 performance reports for HRRP?**

CMS distributes the HRRP Hospital-Specific Reports (HSRs) via *QualityNet Secure Portal* accounts during the 30-day review and corrections period. For FY 2020, the 30-day review and corrections period was August 9, 2019 through September 9, 2019. If you did not receive an HSR during that time, please reach out to the HRRP support contractor at hrrp@mathematica-mpr.com.

Question 36: **How will CMS differentiate between unplanned and planned admissions from the claims data?**

CMS uses an algorithm to identify admissions that are typically planned and may occur within 30 days of discharge from the hospital. Planned re-admissions are defined as a non-acute readmission for a scheduled procedure. Some types of care are always considered planned. These are limited to transplant surgery, maintenance chemotherapy/immunotherapy, and rehabilitation. Admissions for acute illness or complications of care are never considered planned. For FY 2020, CMS identified planned readmissions using version 4.0 of its Planned Readmission Algorithm for HRRP. Details about the Planned Readmission Algorithm can be found in the 2019 measure updates and specifications reports which are posted on the Readmission Measures Methodology page of *QualityNet*.

Question 37: **Will HRRP include Excess Days in Acute Care (EDAC) data in the future?**

Section 3025 of the Affordable Care Act requires the HRRP to reduce payments to IPPS hospitals for excess readmissions. EDAC measures do not fulfill the statutory requirements of the program because they capture other types of adverse acute care outcomes that occur post-discharge, including ED visits and observation stays. Any future program changes to the HRRP will be proposed through rulemaking.

All Program Related Questions

Question 38: **Are these changes applicable to Long-Term Acute Care hospitals only?**

This presentation regarding updates to the Hospital IQR, Hospital VBP, HACRP, and HRRP programs in the FY 2020 IPPS/LTCH PPS Final Rule is not applicable to Long-Term Acute Care Hospitals. The changes presented are only applicable to the subsection (d) acute care hospitals that are paid under the Inpatient Prospective Payment System.

Question 39: **For facilities that have both PPS-eligible and PPS-excluded units, do any or all quality programs include PPS-excluded units?**

HRRP, HAC Reduction, Hospital IQR, and Hospital VBP Programs use measures which are limited to PPS-eligible units.

Question 40: **When a measure (e.g., CLABSI) is dropped from the Hospital IQR Program, does that mean it is no longer publicly reported?**

If a measure is removed from the Hospital IQR Program and is not required for one of the other inpatient programs, then it would no longer be publicly reported. However, if the measure is required for one of the other programs, then it will continue to be publicly reported unless otherwise specified by CMS. The NHSN HAI measures (i.e., CLABSI, CAUTI, SSI, CDI, and MRSA) and the PSI 90 Composite measure that were removed from the Hospital IQR Program in the FY 2019 final rule will be publicly reported under the HAC Reduction Program.

Question 41: **Does changing your EHR vendor qualify for an extraordinary circumstance exemption for these programs?**

An ECE can be requested for any extraordinary circumstance, including a change in your EHR vendor, for any of the Hospital Quality Reporting Programs. CMS evaluates ECE requests on a case-by-case basis and decides based on the ECE and the documentation of the extraordinary circumstance that is submitted by the hospital. For more information regarding ECEs related to eCQMs, please visit the ECE policy page on *QualityNet*.