



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor (SC)

CMS QRDA Category I Implementation Guide Changes for CY 2019 Hospital Quality Reporting

Questions and Answers

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Question 1: Can you re-review the calendar year (CY) 2019 reporting requirements for eCQM?

For CY 2019 reporting, hospitals participating in the Hospital IQR Program need to self-select and successfully report on a minimum of four of the 15 available eCQMs using the *QualityNet Secure Portal*. That can be any combination of Quality Reporting Document Architecture (QRDA) Category I files, zero denominator declarations, and/or case threshold exemptions.

Hospitals are required to report data for at least one self-selected quarter for CY 2019 (Q1, Q2, Q3 or Q4), using health information technology that is certified to the 2015 edition of the Office of the National Coordinator for Health Information Technology certification standard. Hospitals also want to ensure that the system is certified to report on all 15 eCQMs. The deadline is March 2, 2020, by 11:59 p.m. Pacific Time. The original deadline occurred during a weekend or a holiday, which is why the deadline is now March 2, 2020, for CY 2019 reporting. Visit the [eCQM reporting overview](#) page on the *QualityNet* website for additional information.

Question 2: Where can I locate helpful tools and resources for CY 2019 reporting?

On the [QualityNet website](#), there is a tab where all the [eCQM reporting overview](#) information is posted. There also is a menu on the left side of the page to review different information about eCQMs, including the 15 measures specific to IQR reporting and details for using the Pre-submission Validation Application (PSVA) to test QRDA Category I files. Updates will be provided via ListServe and webinar when the data receiving system on *QualityNet.org* is ready to start receiving CY 2019 data. There is also a tab specifically for resources, including submission checklists and a one-page program overview. In addition to the [eCQI Resource Center](#) as a primary location for information for eCQM reporting, there is also a [technical specifications tab](#) on *QualityNet* that leads to [eCQI Resource Center educational materials](#).



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Question 3: Has CMS announced when the receiving system will be open to start receiving test and/or production files for CY 2019 eCQM reporting?

CMS has not announced this; but, as soon as that information is made available, it will be communicated in multiple ways, including ListServes, *QualityNet* updates, and webinars. Ensure receipt of the most current updates by visiting the [ListServe and Notifications registration page](#) on *QualityNet.org*.

Question 4: Where can I locate the correct template versions for CY 2019?

Visit the [Health Level Seven \(HL7\) website](#) to find the [QRDA Category I product page](#) and the HL7 QRDA Category I Standard for Trial Use (STU) Release 5, which is the base standard that is used by the CMS QRDA Category I implementation guide for the CY 2019 reporting period. Visit the [QRDA page](#) on the [eCQI Resource Center](#) to find the 2019 CMS QRDA Category I Implementation Guide for Hospital Quality Reporting, which specifies HL7 QRDA Category I STU Release 5 as the base standard and identifies the correct template versions for 2019.

Question 5: What format should be used if we are unable to identify a patient's birthday?

Hospitals have identified this as a concern for accurate eCQM data submission when the patient birthdate is unknown. Most hospitals have an internal protocol for capturing patients who lack a birthdate within their electronic health record. Hospitals have the option, when submitting QRDA Category I files to Hospital Quality Reporting (HQR) via the *QualityNet Secure Portal*, to use a default date of "09/09/9999" for an unknown birthdate. Please note, for eCQMs that specify age in their measure criteria (e.g., if an initial population has measure criteria for patients age 18 and older) patients with an unknown birthdate will not be included in the initial population. Please contact the *QualityNet* Help Desk for additional assistance at qnetssupport@hcqis.org or (866) 288-8912.

Question 6: Is the information regarding the CY 2019 changes only applicable to inpatient hospitals or is it related to eligible clinicians or professionals?



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The information presented for this webinar is specific to reporting hospital eCQMs. Eligible professionals and eligible clinicians have a different set of QRDA reporting requirements. Visit the eCQI Resource Center [Eligible Professional/Eligible Clinician eCQMs page](#) to obtain the reporting specifications at <https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms>.

Question 7: **Are we required to print the value set Object Identifier (OID) for CY 2019 eCQM reporting of CMS and HL7-based QRDA Category I files?**

Beginning with the CY 2019 reporting period, if the templates are not negated, there is no need to print value set OIDs. If the templates are negated (e.g., Procedure, Not Performed or Medication, Not Administered), then print the value set OID and use a nullFlavor. However, if the eCQM specification references a direct reference code, instead of a value set (in this scenario, if the templates are negated) then provide the direct reference code. For example, eCQM CMS26v6 specification has [“Communication: From Provider to Patient, Not Done”: “Asthma action plan”]. It uses a direct reference code for “asthma action plan” instead of a value set. In this case, when generating the negated template, set the negation indicator to “true” and use the LOINC code for “asthma action plan” as specified in the eCQM.

Question 8: **Can you better explain the actual XML changes related to “Not Done with a Reason” updates for CY 2019?**

There are no changes in the approach for representing “Not Done with a Reason” in general when compared to 2018. In the XML, the submitter still needs to set the negationInd to “true;” set the code as nullFlavor equals to “NA;” provide the value set OID; and provide reason for Not Done in XML. The only difference is that now Quality Data Model (QDM) 5.3 Annotated allows a direct reference code to be used for defining a QDM data element. If the eCQM specification uses a direct reference code, instead of a value set in the XML, the submitter will set the negationInd to “true” and set the code to be the direct reference code (instead of setting the code as nullFlavor equals “NA;” providing the value set OID; and providing the reason for Not Done). The [HL7 QRDA I Standard for Trial Use \(STU\) Release 5 Volume 1](#) on the HL7 website provides detailed descriptions and examples of reporting “Not Done with a Reason.”



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Question 9: Will the eCQI Resource Center always have the latest Schematron and vocabulary (VOC) files available for download, or is there another place to receive those updates?

The [eCQI Resource Center](#) contains the latest release for Schematrons and VOC files. As those files are updated, along with the CMS QRDA Category I IGs, communication is distributed using a number of different ListServes to notify data submitters and vendors that the updates are available and the eCQI Resource Center is the CMS source of truth.

Question 10: What different validation checks are performed through the PSVA versus direct submission to the data receiving system via *QualityNet*?

The PSVA provides file format validation. So, it does not perform additional checks that are completed by the CMS data receiving system. Additional checks performed by the data receiving system within *QualityNet* include checks of the Clinical Document Architecture schema, submission period dates, measure outcome information, hospital assignment, and vendor authorization for the user to be able to submit on a hospital's behalf. For answers to additional questions about the information presented, please visit the [QualityNet PSVA overview](#) page for clarity or contact the *QualityNet* Help Desk at qnetssupport@hcqis.org or (866) 288-8912.

Question 11: Are there any available tools other than Cypress to test measure outcomes for CY 2019 QRDA Category I files?

There are no other testing tools beyond Cypress Validation Utility (CVU) that are currently available specific to measure outcomes for QRDA Category I files. The CVU will be updated in May 2019 for measure calculation results for CY 2019 QRDA Category I files. Test submissions for QRDA Category I files to evaluate measure outcomes will be available through the *QualityNet* data receiving system and the PSVA when the system and tool become available for CY 2019 data reporting. When the system becomes available, CMS will notify the data submitter community through a number of outlets, which include ListServes, webinars, and the [QualityNet](#) website.



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Question 12: **Is printing the value set OID for the negation template and single code the requirement for HQR (hospital quality reporting) only, or is it true for eligible professional measures as well? Are the criteria based on the HL7 guide or the CMS implementation guide?**

The direct reference code is a change that was made starting with the QDM version 5.3. Previously, a QDM data element could only be defined with a value set. Currently, a QDM data element can be defined by binding it to a value set or a direct reference code, which is a single code. Printing the value set OID for a negated template has been a requirement in the HL7 QRDA Category I standard. QDM version 5.3 allows a direct reference code. HL7 QRDA Category I STU Release 5 Volume 1 not only describes how to report a negated template when a QDM data element binds to a value set, but it also describes how to report a negated template when it is a direct reference code. This information is specified in the HL7 QRDA Category I IG. The 2019 CMS QRDA Category I IG follows what is specified in the HL7 QRDA Category I IG. For positive templates, printing the value set OID is no longer required. This requirement is specified in the HL7 QRDA Category I IG and is not driven by a CMS requirement. If a hospital is producing QRDA Category I files to report eligible professional eCQMs based on the HL7 QRDA Category I IG STU Release 5, the same requirements specified in the HL7 QRDA Category I IG STU Release 5 would be applicable as well. The instructions for how to report for negation and all cases are specified in the HL7 base standard and reflected in the CMS QRDA Category I IG, available on the [eCQI Resource Center](#).

Question 13: **Can we have the same template ID with different extensions within the same XML file for compatibility purposes?**

If including different extensions for the same template in the same XML (e.g., the version specified in the 2019 CMS QRDA Category I IG as well as the version specified in the 2018 CMS QRDA Category I IG), the XML file will not be rejected. Submitters should ensure they are using the correct version of the templates specified in the 2019 CMS QRDA Category I IG for HQR and the HL7 QRDA Category I STU Release 5 base standard.



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Providing the older version and forgetting to include the correct version specified in the 2019 CMS QRDA Category I IG and HL7 QRDA Category I STU Release 5 may potentially cause issues with calculated measure outcomes. If using only an extension for the old version, none of the data will be analyzed by the Schematron for the correct version. The Schematron only looks at the data that coincide with the latest extension as specified in the IG.

Subject-matter experts researched and answered the following question after the live webinar. The questions may have been edited for grammar.

Question 14: **Have you (CMS) or The Joint Commission ever considered sharing files so hospitals only need to submit once?**

CMS and The Joint Commission continue to meet regularly to identify and implement areas of alignment regarding programs, methods, format, and content for reporting. That includes eCQM submission activities. Due to the different receiving systems utilized by each organization for the collection, calculation, and storage of patient-identifiable information, CMS and The Joint Commission remain committed to identifying greater areas of alignment when reporting QRDA Category I patient files but cannot share such files at this time.