Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program CY 2018 (FY 2021 Payment Determination) eCQM Validation Overview for Selected Hospitals

Question and Answer Summary

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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: **When will emails that notify hospitals they were selected for fiscal year (FY) 2021 electronic clinical quality measures (eCQMs) validation be sent?**

The notification of providers selected for FY 2021 eCQM validation should be sent out within the next several weeks.

Question 2: **Can you confirm that eCQM validation is for inpatient prospective payment system (IPPS) hospitals only? The critical access hospitals (CAHs) submit eCQMs for the Medicare Electronic Health Record (EHR) Incentive Program but not for the Hospital IQR Program. Are CAHs included in the validation process?**

CAHs are not affected by the Hospital IQR Program. Therefore, they will not be selected for validation.

Question 3: **Can a hospital be selected for both chart-abstracted and eCQM validation?**

Each year, CMS will only require hospitals to participate in one of the two Hospital IQR Program validation processes (chart-abstracted validation or eCQM validation). If a hospital is currently selected for FY 2021 chart-abstracted validation, that same six-digit CMS Certification Number/ provider identification will not receive a request for eCQM validation in the same validation cycle.

Question 4: **Why would non-discrete data fields be validated when the purpose of eCQMs is to electronically capture structured EHR data?**

The intent of a quality measure is to assess the quality of care provided to a patient. Thus, when validating cases, the CMS Data Abstraction Center (CDAC) will review data in both discrete and non-discrete fields of the records provided and compare the medical record data to the Quality Reporting Document Architecture (QRDA) data based on the eCQM specifications.

Additionally, as the CDAC completes the abstraction, the entire record is reviewed to determine if the quality of care meets the measure's intent. Patterns observed in documented data in structured and unstructured fields may be shared with the measure stewards.

Question 5: **How do we notify CMS of a new health information management director in our facility?**

If you wish to change your hospital contact information, please use the Hospital Contact Change Form on *QualityNet* (*www.QualityNet.org* > Hospitals-Inpatient > Hospital Inpatient Quality Reporting Program > Hospital IQR Program Resources) and on our website *www.QualityReportingCenter.com* (Inpatient > Hospital IQR Program > Resources and Tools > Forms) at this direct link: https://www.qualityreportingcenter.com/globalassets/iqr2019events/hospital-contact-change-form_mar-2018_vfinal5081-ff.pdf

To ensure accurate information is entered, please review form entries for legibility. Illegible forms will be returned for clarification.

Question 6: **Will the validators use information in the chart other than in the designated bills to validate the record?**

The abstractors use the eCQM specifications to determine where in the record they should look for the information.

Question 7: **Does updating the contacts in *QualityNet* work?**

Updating the contacts within the official CMS contact database will ensure that the correct individuals receive notifications related to eCQM validation.

If you wish to change your hospital contact information, please use the Hospital Contact Change Form on *QualityNet* (*www.QualityNet.org* > Hospitals-Inpatient > Hospital Inpatient Quality Reporting Program > Hospital IQR Program Resources) and on our web site *www.QualityReportingCenter.com* (Inpatient > Hospital IQR Program > Resources and Tools > Forms) at this direct link: https://www.qualityreportingcenter.com/globalassets/iqr2019events/hospital-contact-change-form_mar-2018_vfinal5081-ff.pdf

To ensure accurate information is entered, please review form entries for legibility. Illegible forms will be returned for clarification.

Question 8: **After hospitals are notified that they were selected, where I can locate the list of those selected?**

Once the hospitals have been selected and notified for FY 2021 eCQM validation, that list will be posted on the *QualityNet* eCQM Data Validation - Overview page at this direct link: https://www.qualitynet.org/dcs/ContentServer?cid=1228776288801&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page

CMS will directly notify the hospitals of their selection via an email from the validation support contractor (VSC). A news article will appear on the *QualityNet* website and a Listserv will be sent.

Question 9: **Was only one quarter of eCQM data required for submission in calendar year (CY) 2018 (which was FY 2021)? Is that the only quarter of data that will be requested to be sent to the CDAC for validation?**

The cases selected will only be from one quarter of data submitted by the hospitals, not from different quarters.

Question 10: **Regarding the validation of the non-discrete fields, are mismatches identified due to non-discrete documentation, considered true mismatches, or deemed educational comments?**

The intent of validation is to ensure data accuracy based on the measure's intent. If non-discrete fields are used by the CDAC to determine the outcome, it could result in a mismatch. However, mismatches are not being taken into consideration for FY 2021 payment determination. As such, even if a mismatch occurs and you see that mismatch on your eCQM case detail report, that does not mean that the mismatch actually affects your score or payment.

Question 11: **Is CY 2018 considered FY 2020 for validation?**

CY 2018 eCQM data will affect FY 2021 payment determination.

Question 12: **What is meant by this phrase? "As long as hospitals sent in at least 75 percent of the requested medical records within the deadline..." Will this meet the eCQM data validation requirement?**

CMS is going to select eight cases or individual patient-level reports from the QRDA Category I file submitted by the hospital. When the CDAC requests the copy of the medical record for validation, the CDAC will review the records for the measure(s) for which the record was requested.

The hospital must submit the entire medical record for the episode of care. When hospitals submit complete medical records, within the requested timeframe, for at least 75 percent of the requested records, they will receive a passing score for validation. For example, if eight medical records are requested, at least six medical records must be adequately submitted to meet that 75 percent requirement. For FY 2021 payment determination, the accuracy of the data itself will not affect payment.

Question 13: **If our facility is selected for chart abstraction review, where do we find the final report after submitting records to CDAC?**

To adequately respond to your question, please submit your question to the VSC at validation@hcqis.org.

Question 14: **Can the complete medical record be submitted to CDAC in paper form?**

For eCQM data validation, only portable document format (PDF) medical records will be accepted via the *QualityNet Secure Portal* Secure File Transfer application. Paper and/or removable media copies of medical records sent directly to the CDAC will not be accepted for eCQM validation.

Question 15: **In what FY will the mismatched data count against the hospital for payment?**

CMS will inform the hospital community of future changes to policy through rulemaking.

Question 16: **When I Google CY and FY for the Hospital IQR Program, I see CY 2019 is applicable for FY 2021. Can you explain the differences in CY and FY for eCQM data validation versus the chart-abstracted data validation?**

For validation, the FY and the reporting CY may appear differently. For FY 2021 payment determination, we are using CY 2018 eCQM data that were submitted by your hospital in early 2019.

The CYs that are used for eCQM validation may be different than those used for some of the other Hospital IQR Program requirements. For example, the submission of the chart-abstracted measures for CY 2019 discharges would be effective for FY 2021. Please review the *QualityNet* eCQM Data Validation - Overview page for details.

Question 17: **If a hospital submits more than the required eCQMs for CY 2018, how will CMS choose which four measures to validate?**

CMS will randomly select two cases per measure, for a maximum of eight cases across four submitted measures per hospital. If fewer than two cases are available for a given measure, more than two will be selected from another measure, not to exceed a total of eight cases. If a hospital submits multiple quarters, the system will select the most recently submitted quarter by your hospital.

Question 18: **Will all patient measures contained within a single QRDA Category I file be validated, or will only a select measure be validated? For example, within the quarter that was submitted, the patient was admitted twice. If, within that patient file, the patient qualified for the emergency department (ED) measures for both admissions, will both admissions require validation documentation to be sent?**

CMS will randomly select the cases for validation, and not all patient measures contained within a single QRDA Category I file will be validated. Only the selected measures will be validated within the requested record.

Question 19: **If multiple measures (e.g., ED, venous thromboembolism [VTE], and stroke) are included within the file, will all measures or only one measure be validated? For example, would only VTE be validated?**

CMS will select up to eight cases per hospital for a single quarter. From that one quarter, CMS will randomly select one to eight cases per measure, depending on how many measures the hospital reports for no more than eight cases total across all the measures. For example, if a hospital reports four measures, CMS may randomly select two cases from each measure without exceeding eight total cases.

If a case is selected for the ED measures, only ED measures are validated. However, it is possible for the same case to be selected for validation of multiple measures, in which case only one medical record for that episode of care would need to be submitted. Additional information will be provided within the medical records request packet sent by the CDAC.

Question 20: **Will all eCQM validation documentation need to be contained within one document?**

If your hospital is unable to contain everything within one document due to size limitations, the initial request for medical records sent by the CDAC includes details on how to submit multiple files for the same patient record. You will need to make sure you follow those instructions to ensure you are using the correct file naming convention.

Question 21: **If our eCQM vendor did not submit 100 percent of our cases for the ED-2 measure for CY 2018, how will failure of eCQM validation be determined and what will be the impact?**

When hospitals sign the Data Accuracy and Completeness Acknowledgment, which is a Hospital IQR Program requirement, they are attesting that, to the best of their knowledge at the time of submission of the form, all the information that has been reported for the hospital is accurate and complete.

Any time data are inaccurately reported, there is a potential for a mismatch in the data validation process. However, the accuracy of the data does not affect payment, and the ultimate passing or failing the validation is based on the timely submission of at least 75 percent of the records.

Question 22: **Will CY 2018 eCQM validation results be posted on the *Hospital Compare* website?**

CMS has no plans at this time for results of eCQM data validation to be publicly posted.

Question 23: **How will cases be selected if one or more of our eCQMs had zero cases reported?**

To adequately respond to your question, please submit your question to the VSC at validation@hcqis.org.

Question 24: **What is meant by "all information from an EHR"? Could you give some general examples or an example of a piece of information that may be overlooked?**

Ultimately, it is the hospital's responsibility to ensure that all the necessary information is present in the submitted medical record in order for the CDAC to properly complete an abstraction. It is strongly recommended that a trained abstractor at your hospital review each record after it's been converted to PDF and before it is sent to the CDAC. Further direction will be provided in the request for the medical record sent by the CDAC.

Question 25: **Do you anticipate any difficulty submitting a PDF of these records through the Secure File Transfer in *QualityNet* due to each record exceeding 1,000 pages? Are there instructions to submit such large documents as PDFs?**

Hospitals have been successfully delivering large medical records via the *QualityNet Secure Portal* Secure File Transfer system for several years. Last year, in the first year of eCQM validation, all hospitals selected were able to send their records via the Secure File Transfer system. We do not anticipate any issues that will stop hospitals from submitting. Further direction will be provided in the request for the medical record sent by the CDAC.

Question 26: **Even though the records are not being scored for accuracy, will the eCQM Validation Case Detail Report still provide hospitals information regarding the accuracy of the abstracted data elements and measures?**

Yes.

Question 27: **Records are required to be submitted as PDFs through the *QualityNet Secure Portal*, but our medical records department does not have access to the Secure File Transfer application. Do we need to add medical records to this role?**

It would be beneficial for anyone at your hospital deemed responsible for submitting the medical records to have an active *QualityNet* account and access to the *QualityNet Secure Portal* Secure File Transfer application. If you have questions or need assistance obtaining a *QualityNet* account or correcting the reports role assigned to yourself or others at your hospital, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or by phone at (866) 288-8912.

Question 28: **We have a hybrid EHR, with some documentation scanned and/or non-electronic. Should we submit the entire record, including the scanned documentation?**

It is ultimately the hospital's responsibility to ensure all necessary information is present within the record before sending. We strongly recommend a trained abstractor review each record before it sent to the CDAC.

Subject-matter experts researched and answered the following question after the live webinar.

Question 29: **I am still concerned about the use of non-discrete data for the validation of eCQMs. I understand that documentation could support measures criteria, but eCQMs will never be able to capture that information and, therefore, they create a risk for passing validation. Please comment.**

The intent of a quality measure is to assess the quality of care provided to a patient. Thus, when validating cases, the CDAC will review data in both discrete and non-discrete fields of the records provided and compare the medical record data to the QRDA data based on the eCQM specifications.

Additionally, as the CDAC completes the abstraction, abstractors look throughout the entire record to determine if the quality of care meets the measure's intent. Patterns observed with data documented in structured and unstructured fields may be shared with the measure stewards.

At this time, the accuracy of reported eCQM data does not affect payment, and the ultimate passing or failing of validation is based on the timely submission of at least 75 percent of the records requested by CDAC.