



# Inpatient Quality Reporting (IQR) Program

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## Support Contractor

### 2016 CMS QRDA Implementation Guide Changes for Eligible Hospitals/Critical Access Hospitals

#### Presentation Transcript

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**December 17, 2015**

**1 p.m. ET**

**Matt McDonough:** Good afternoon, everybody, and welcome to our webinar this afternoon. My name is Matt McDonough. I am going to be your virtual host for today's event. And before we kick things off and turn things over to our presenters, we do like to cover some housekeeping items with you so that you understand how today's event is going to work and, also, as importantly, how you can submit your questions to our presenters at any time throughout today's event. First and foremost, as you can see on this slide, we are streaming our audio feed over the Internet using ReadyTalk®'s Internet streaming feature, and what this means to you is that you do not need a telephone line to connect to today's event. However, you've got to have those computer speakers or headphones connected and turned on and turned up to hear our streaming audio feed. Now, we'll cover some audio troubleshooting here in a moment. But, if at any time, you do encounter trouble with audio streaming or you just like to dial in and hear the telephone feed instead, we do have a number of dial-in lines – a limited number of dial-in lines available. Please send us a chat message if you need those – that dial-in number and one of our hosts will

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get it out to you immediately. Also, as one of our standard practices, this event is being recorded to be archived and available for playback at a later time.

So, let's talk a little bit about troubleshooting some of those audio issues you might encounter. If you are streaming audio, you might experience your computer speakers breaking up or maybe your audio will suddenly stop. This typically happens if you are on a slower Internet connection. But, there is something that you can do to try to resolve that scenario. Simply either click the *Refresh* icon, which is illustrated on the bottom graphic here, or click the *F5* key on your keyboard. Either of those actions will cause your browser to refresh. You will be temporarily disconnected and reconnected to the event again and your audio feed should resume. And it also [has to] be in sync with the current presenter. So, if you find that your slides might be lagging slightly behind, you also can do this trick to try to reset your audio feed. Again, if neither of these items works for you, we do have the limited number of dial-in lines available if you need one.

So, if you are hearing my voice right now and you might hear me more than once like a bad echo on the call, it's usually caused because you are connected more than once. You can see on this graphic here what it looks like if you are connected to the same event more than once. This is a very easy problem to fix. You will simply close all but one of the browsers or tabs that are connected, and that will reduce the number of audio feeds you are hearing down to one, and that will clear your echo up. Again, make sure you are connected only once to our event today.

And last but not least, let's talk about submitting questions. We do encourage you to submit your questions to our presenters at any time during today's event. And to do so, you can use the Chat feature at the bottom left corner of your screen, as illustrated here with this yellow arrow. It's the Chat with Presenter feature. Simply type your question into that box and click the Send button. Once you click that Send button, your question will be visible to all of our presenters, and as time and as resources, and, of course, the availability of answers allows, we'll answer as many questions as we can today. Please do keep in mind, however, that all your questions are being archived to be addressed in a future Q&A document.

And that's going to do it for my brief introduction. So, without further ado, I'd like to hand things over to our first speaker.

**Stephanie Wilson:** Hi, everyone. Thank you, Matt, and thank you to everyone for joining us today. We are excited to provide this educational session to all of you to

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provide information on the standards necessary for 2016 eCQM data submission.

Just a couple of quick reminders... This presentation is being recorded. It will be posted out to the *QualityNet* website so that you can have it to listen to again or to have more information that you just want to follow-up and hear a section again. And, then, the other thing, as Matt said, we will be taking questions at the end of this call and try to answer as many of those as we can in the time that's allowed. So, please, at any point during the presentation, please put your questions into that Chat box and, then, at the end of the call, we'll answer as many as we can. For any of those that we are not able to answer during this session, we will answer those in writing and we'll post those along with the recording of the presentation.

So, our presenters today are Debbie Krauss, and Yan Heras. Debbie is from CMS and will be providing program information related to eCQM data submission for calendar year 2016, and Yan Heras is one of our technical experts and will be covering the standards and those changes that are necessary for 2016 data submission, as well.

And I'll turn the call over to Debbie Krauss.

**Debbie Krauss:** Thank you, Stephanie.

Hi, everybody, and, again, thanks for joining today during this busy holiday time. But, I – We all appreciate your attendance and hope we can help you as [we] look forward to the submissions for eCQM reporting for next year, for 2016.

Next slide.

So, the purpose of today's discussion is to go over the CMS Quality Reporting Document Architecture (QRDA) Implementation Guide and what changes were made in the CMS Implementation Guide between last year, 2015, and for next year. So, this will be the presentation of the delta of the change that you all can review as you prepare for reporting next year.

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So, today's objectives include looking at the 2016 eCQM submissions of requirements, reviewing the CMS QRDA Implementation Guide, explaining those changes, as I said, and identifying the HL7 QRDA Release 1 changes – Release 3 changes from HL7 QRDA Category 1 Release 2 overview.

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So, the HQR, the Hospital Quality Reporting alignment has always been one of the goals that CMS has been working on for eCQM reporting between the EHR Incentive Program and Hospital Quality Reporting. You know, as we are firm believers in the reporting of data through health information technology, but we realize the challenges and the complexities and certainly want to greatly simplify and streamline your reporting to CMS as much as we can. So, as we continue with our goal, we are aligning and harmonizing measures across quality reporting programs to try to reduce reporting burden on hospitals. So, right now, the programs that we are focused on aligning is the IQR Program and the EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. We will continue to align quality reporting programs in the future across-care settings as the reporting becomes – reporting grows and more programs [report] eCQMs.

Next slide, please.

So, for 2016, the eCQM reporting requirements specify that a hospital must report a minimum of four eCQMs for calendar year 2016 for one quarter, either quarter three or quarter (four) of calendar year 2016, in order to have a 2018 payment determination made. The submission deadline for reporting these four eCQMs is February 28 of 2017. The National Quality Strategy domain distribution will not be required next year. So, if you recall, in the past, we required reporting of the clinical quality measures across three domains. But, we will not have that distribution required next year and we just – [the] minimum requirement is the four eCQMs for one quarter. And, again, the submission period deadline will be February 28 of 2017.

Okay, next slide, please.

So, right now, you can see our program list, our slide list of programs, eCQMs sets, that are available. And there are – for the IQR and EHR Incentive Program, there's 28 eCQMs available. You can see ED-3 has an asterisk, and that is just to remind you that this is an outpatient measure that is applicable to EHR Incentive Program but is not applicable to [the] IQR Program.

Okay, next slide, please.

So, when we talk about successful eCQM submissions, as you all are familiar with, we define it as a submission of at least four eCQMs for next

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year that can be reported as any combination of accepted QRDA Category One files with the patient meeting the initial patient population of that measure. We still accept zero denominator declarations and case threshold exemptions.

Next slide, please.

So, eCQM reporting for 2016 – Eligible hospitals and CAHs that seek to report the CQMs electronically under the Medicare EHR Incentive Program or the Hospital IQR Program must use these specific standards: the first is that the hospital must use an EHR system that is certified to either the 2014 or the 2015 ONC edition certification; the second is that the most recent electronic specifications for the eCQMs must be used. So, for 2016, the annual updates were published in this year earlier for – and they are called the 2015 Annual Updates, and that’s for reporting period 2016, the specifications are on the eCQM Library page and they are also on the eCQI Resource Center. Next, the final Implementation Guide for 2016 was posted in July of this year, and this is the Implementation Guide, the QRDA – CMS QRDA Implementation Guide for Eligible Professionals and Hospital Quality Reporting. That guide is also located on the CMS Library page, and there is a link to it on the eCQI Resource Center page. Hospitals can work with their vendors to confirm that they are certified to these required standards and the measures that their EHR was originally certified so that they can report these measures with at least the 2014 edition of certification. All right, that’s all that I have for the reporting requirements for 2016, and I will turn the presentation over to Yan, who will be speaking to you on the technical details of the changes that you will need to be aware of for reporting using the QRDA Category One. Thank you.

**Yan Heras:**

Thank you. Yes, thank you, Debbie, and thank you, everyone, for attending today’s call.

On to the next slide, please.

Olay, yes, so, I’ll first go – I’ll first give an overview about the 2016 CMS QRDA IG then go over changes made in the 2016 IG for the HQR programs.

Next slide, please.

So, the 2016 CMS QRDA Implementation Guide was published on July 8, 2015. It can be downloaded using the link that is displayed on the slide, and like the 2015 CMS QRDA IG, the 2016 IG also contains Part A, Part B, and also a list of appendices. So, Part A is the QRDA Category One

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Implementation Guide for EPs and for hospital quality reporting programs, which is a focus of this presentation, and Part B is the QRDA Category Three IG for EPs only. The appendices include several change logs that summarize the changes made in the CMS QRDA IG in comparison to the base HL7 QRDA standards and the changes made between the 2016 CMS QRDA IG and the previous year's IG. So, the 2016 IG added two new appendices: additional QRDA-I validation rules for HQR programs and also null flavor rules for data types so – which will be covered in later slides.

Next slide.

For the 2016 CMS QRDA IG, the accompanying QRDA-I and QRDA-III schematron files for each CMS program are also made available to the public on the eCQM Library page. So, in addition to the rules for the base HL7 QRDA standards, these schematron files also include rules for the CMS-specific constraints that are specified in the 2016 CMS QRDA IG, and the link on the slide will download a zip. So, as you unzip the file which you can find the HQR program specific schematron file and a sample file for your reference.

Next slide, please.

So, in the next few slides, I'll walk through the QRDA Category I changes made in the – made in the 2015 CMS QRDA IG that are applicable to the HQR programs.

Next slide.

The most significant change made in the 2016 CMS QRDA IG is the change of the use of Base HL7 QRDA-I standard. So, the 2016 IG is no longer based on the HL7 QRDA-I Release 2 and its errata updates. The 2016 IG now uses the QRDA-I Draft Standard for Trial Use Release 3 that was published in June 2015. And we will go over some of the high-level changes made between the QRDA-I Release 3 and the QRDA-I Release 2 in later slides. Here is – the link of the slide is where you can download the HL7 QRDA-I Release 3 package. The 2016 IG is to be used for the 2016 reporting period. The eCQM specifications to be used with the 2016 IG, as Debbie mentioned, is the June 2015 Annual Update. A new CMS program name is added to the CMS program name code table under CDAC\_HQR\_EHR as an internal code to be used by the CDAC users only.

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So, conventions that are used to name conformance statements are updated in the 2016 CMS QRDA IG. The CMS\_ prefix, for example, CMS\_0021, is now used to indicate new CMS-specific constraints that are added in the IG. So, if a conformance statement from the Base HL7 QRDA-I Release 3 standard is further constrained in the CMS IG, an \_C01 postfix is used – is added to the original conformance statement number from the Base standard. So, this will help to trace back to the Base standard for that conformance statement if needed, and both [the] CMS prefix and the \_C01 postfix are used to indicate a CMS-specific constraint. In the 2015 CMS IG, all conformance statements included in Part A apply to all CMS programs, and in the 2016 IG, however, some conformance statements may only be applicable to one CMS program. And this is indicated by square brackets at the beginning of the constraint with the applicable CMS program names written inside of the bracket. For example, the SHALL constraint for CMS certification number is applicable to HQR programs only and only the HQR program-specific schematron file will contain validations rules for this constraint. So, if a rule does not – does not exist in – this rule does not exist in program-specific schematron file for other CMS programs. So, if a rule is not specifically labeled by default, the constraint applies to all programs.

Next slide.

And template versioning – so, the 2016 CMS QRDA IG followed the template versioning conventions used in the Base HL7 QRDA-I Release 3 standard and the template versioning did not exist in the HL7 QRDA-I Release 2. So, this will be something new when handing template IDs. If a template is updated, which then becomes a new version – and for the new version of the template, template (OID) that is a root attribute remains the same from the previous version and an extension is added to the template identifier supposed to hold an extension attribute together to make up the unique template ID. So, in this example shown on the screen, the extension must be a value 2015-07-01 and both the root and extension attribute must be present. And in some of the later slides, we can see more examples of this.

Next slide, please.

So, in this and the next few slides, I'll go through the changes made to the document header, then move on to the changes made to the section templates. So, first, administrativeGenderCode – In the 2015 CMS QRDA IG, the specification is to allow either ONC Administrative Sex Value Set or HL7 Administrative Gender Value Set. And during the 2016 eCQM Annual Update, the ONC Administrative Sex Value Set was updated to contain only two codes: F for female and M for male, and the

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code U for unknown was removed from the value set. But, the value set always remained the same. So, in the 2016 CMS QRDA IG, the constraint for Administrative Gender Code is updated to allow only the ONC Administrative Sex Value Set to align with the eCQM specification. So, the HL7 V3 Administrative Gender Value Set is no longer allowed by the IG in 2016, and, also, because the code for unknown is removed from the value set, so if a patient's sex is unknown, then this needs to be reported by using nullFlavor="UNK" to indicate unknown.

Next slide, please.

So, for raceCode, these are now changed between the 2016 CMS QRDA IG and the 2015 IG for the raceCode requirement, and the CMS IG continues to require the Race Value Set that is specified in the eCQM specification to be used in the QRDA report. There is a change, however, between the base HL7 QRDA-I Release 3 standard and the HL7 QRDA-I Release 2. As part of the QRDA-I Release 3 update, the templates were updated to align with the consolidated CDA Release 2. So, as a result of this alignment, you will notice that in the base QRDA-I Release 3 standard, the raceCode requires a new race category excluding Nulls value set. But, again, the CMS IG for 2016 continues to require the use of a Race Value Set that is specified, as in the eCQMs.

Next slide.

The requirement for the patient identification number, PID, and the Medicare HIC number are the same for the 2015. So, PID is required for HQR programs. Both the root and extension attributes must be submitted and the actual patient identification number is the value of the extension attribute. And the Medicare HIC number is not required for HQR programs, but it should be submitted if the payer is Medicare and the patient has a HIC number assigned. The 2016 IG did add a narrative text right above the conformance statement to help add clarification about these requirements, and you will notice the conformance statement above the Medicare HIC number in the 2016 IG are labeled with HQR and PQRS in the square bracket in the beginning of the constraint. So, this means that this constraint is applicable to HQR and PQRS only.

Next slide, please.

The CMS certification number is specified under the Custodian document header element. The CCM number is required for HQR programs. So, nullFlavor is not allowed, and you must provide a CCM number in the extension attribute. The length requirement for CCM was six characters in

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the 2015 CMS QRDA IG, and this is changed in the 2016 IG. So, the length is now between six and ten characters in length.

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So, as mentioned in the high-level overview slide, a new CMS Program Name code is added in the 2016 IG and all the other CMS program names remain the same. We wanted to point out an error in this – for this new code. So, in Table Five, QRDA-I CMS Program Name [Code] on page 18 of the CMS QRDA IG, this code was misspelled. The correct code should be CDAC\_HQR\_EHR, and this code is an internal code used for eCQM validation by CDAC users only, so [it] shall not appear in any of the hospital-submitted QRDA files.

Next slide.

The NPI and the TIN requirements for HQR programs in the 2016 IG are the same as the 2015 IG, but the 2016 IG has added more narrative descriptions to help make the requirements more clear. So, because the ID field for NPI and the ID field for TIN are required by the IG, so even though NPI and a TIN number may not be applicable to hospitals, these two fields must still be submitted in QRDA reports. So, if a hospital does not have an NPI or a TIN, the NPI and the TIN ID fields must be sent as shown in this example. So, where you can see the ID, it must have the correct root void for the NPI or for the TIN and the nullFlavor is set to be NA to indicate not applicable. If an NPI number is submitted, then the NPI number must be in the valid format, which is 10 numeric digits where the 10th digit is a check digit computed using the Luhn algorithm. If a TIN is submitted, then the TIN must be nine decimal digits.

Next slide.

So, moving on to the Section templates, there is no change to the major Section templates as acknowledged in this presentation. A new section template called the Reporting Parameters Section – CMS EP & HQR was added, and this template conforms to the Reporting Parameters Section template, an index QRDA-I XML. So both for the template IDs, one for the parent reporting parameter section and also one for this new template itself, have to be present as shown in the XML snippets on the screen. So, as you can see, for the second template ID on the screen showing the example, it must contain both the root attribute and the extension attribute. And this template contains exactly one Reporting Parameters Act – CMS EP & HQR template, which is also new.

So, next slide, please.

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And this new template conforms to the Reporting Parameters Act template. And, again, in the QRDA-I XML, so both template IDs must be present as shown in the example. And the second template in the snippet must contain both the root and extension attributes.

Next slide.

So, the Reporting Parameter Act template is what you use to specify the reporting period. So, within this template, the effective time date range must [be] set to align with one of the program's allowable calendar year discharge quarters – so, either Q3 or Q4 of 2016. And this XML example on the slide shows the date range for Q3 2016. And both the low and the high have to be present, and the date – the value is precise to today.

Next slide, please.

So, [the] 2016 CMS QRDA IG also has a new Patient Data Section, CMS EP & HQR template, which conforms to the parent Patient Data Section QDM template. As this slide [indicates] in the base standard, the Patient Data Section QDM also has a parent template that is Patient Data Section. So, in the XML, all three template IDs must be present. And, as you can see, the bottom two template IDs both have a root and extension. So, similar to the 2015 IG, the 2016 IG does not repeat the entry template that could be contained in the patient data section and the specifications for entry templates would be referred to the base HL7 QRDA-I Release 3 Standard. To make it clear, the 2016 IG did add constraints in the new patient data section. So, once you submit a QRDA-I report, the patient data section must contain at least [a] patient characteristic pair template. And in addition to that, it must contain an entry template that is other than the patient characteristic pair template. So, together, there are – you must – so, you must have at least two entry templates contained in the patient data section.

The next slide, please.

So, Appendix 10 is Additional QRDA-I Validation Rules for HQR Programs. This is a new appendix added to the 2016 IG. It contains validation rules that the HQR receiving systems perform in addition to what are specified in the 2016 IG Part A. So, for example, for Encounter Performed, validations are checking to make sure encounter performed discharge data cannot be null, discharge date must not be after the QRDA-I file upload date, and the encounter performed admission date must be before the encounter performed discharge date and, also, at least one of the encounter performed discharge dates must be within the program's

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allowable calendar year discharge quarter. So, please review the appendix for other details for additional validation rules being added.

Next slide, please.

And this one is for – about reporting Not Done with a Reason. So, Not Done is – so, as part of the HL7 QRDA-I Release Three update, guidance was given on how to report Not Done, such as Medication Order, Not Done: for Medical Reasons. So, in that – in that eCQM CMC launch, it does say something about Medication Order, Not Done: for Medical Reasons or for Patient Reasons, and this is how it is to be reported. And the 2016 CMS QRDA-I follows the footsteps for reporting out, as specified in the QRDA-I R3 standard. So, the first step is to set a patient indicator to be “true” for that – for that template. Then, you do not populate the code attribute with a code from the value set, but, is that – you set the nullFlavor attribute of that code element and set it to be “NA” for not application. Then set the value set attribute to be [VSAC value set OID] that is specified in that logic eQMs. And the last step is to use the text description pattern on – as shown on this slide. So, “None of value set,” then you put in the value set after the code as the original text of the code element. So please refer to this section 3.4, Asserting an Act Did Not Occur with a Reason, in Volume 1 of the HL7 QRDA-I Release 3 for more details.

Next slide, please.

There is another appendix being added for Null Flavor rules for Data Types. It provides clarification to proper nullFlavor attribute use for the list of common data types using QRDA-I. So, for example, the code attribute and a nullFlavor attribute are mutually exclusive, so, you cannot have both together in the instance. And also, for example, for *Instance Identifier*, the (II) data type, the root attribute is allowed to be present with either the extension attribute or the nullFlavor attribute, but, the root attribute is not allowed with both extension and a nullFlavor attributes at the same time. And these rules are included in the HQR program-specific schematron file.

Next slide, please.

So, in the next section, I’ll walk through, at a high level, the changes made between the HL7 QRDA-I Release 2 and the Release 3 standards.

Next slide.

The QRDA-I DSTU Release 3 was published in June 2015. It is a draft standard for trial use. So, comments, issues or errors found about the

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QRDA-I Release 3 during the implementation can be submitted to the HL7 DSTU comments site. And the link to this particular standard – the DSTU comments site, is provided on this screen. So, all changes made in the HL7 QRDA-I Release 3 fall in three major categories. And the first is the QRDA templates are updated to align with the quality data model version 4.1.2. And the June 2015 eCQM specifications, as you know are based on the QDM Version 4.1.2. So, these QRDA template updates made in QRDA-I makes QRDA-I specifications better aligned with the current eCQM specification that will be used for 2016 reporting. And the second change is the four C-CDA templates that were reused in QRDA-I standard. So, those were updated to align with the C-CDA Release 2. So, QRDA-I Release 3 also includes updates made to address those approved errata to the QRDA-I Release 2.

Next slide.

So, QRDA-I Release 3 has retired the templates that correspond to the QDM data types and attributes that were removed from QDM 4.1.2. For example, in QRDA-I Release 3, [the] Diagnostic Study Result template is now retired. And, so, they are – they are now removed from the – they are marked as retired in the – in the (space standard).

The Diagnostic Study Performed template should be used instead. So, this is because *Diagnostic Study Result* data type was removed from QDM 4.1.2 and a new result attribute is added to *Diagnostic Study Performed* data type, which should be used to represent *Diagnostic Study Result*. And all [of] the eCQM specifications have been updated to be based on QDM 4.1.2. So, those are going to be used for 2016 reporting. And, similarly, *Intervention Result* and *Procedure Result* and all the other results, kind of the QDM data types, are all now retired and the corresponding Performed Template should be used instead. And, also, *Patient Characteristic Estimated Date of Conception* and the *Patient Characteristic Gestational Age* are also retired, same for *Physical Exam Finding*, and that is replaced by *Physical Exam Performed*. So, for other changes that were made to align with the QDM 4.1.2, such as some of the QDM attributes, so, please see Appendix B, High-Level Change Log for – in Volume 1 of the Base HL7 QRDA-I Release 3 standard for more details.

Next slide.

There are also changes made to align with the C-CDA Release 2 because the majority of C-CDA templates implied by QRDA-I templates have been updated during the C-CDA Release 2. So, these QRDA-I templates have all been updated in QRDA-I Release 3, as well, to imply the new

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versions of the C-CDA templates, which means that QRDA-I templates are updated to conform to the new version of the – to those C-CDA templates. Three examples of these types of changes include: change from SNOMED codes to LOINC codes where necessary. So, for example, C-CDA Release 2 problem observation now uses a LOINC code for code element rather than a SNOMED code, and this change affects all QRDA-I diagnoses and symptom templates; for QRDA-I order and recommended templates, for example, Intervention Order and Intervention Recommended, the status code is now *Active* instead of *New*. So, those are also a change applied to all these templates.

So, next slide, please.

I also [would] like to highlight how the diagnosis template was modeled in C-CDA R2. It has changed quite a bit. So, this change is reflected in the QRDA-I Release 3, and it affects all diagnoses and the symptom templates. In QRDA-I Release 2, problem status *Active*, *Inactive* and *Resolved* templates were used to indicate a diagnosis and a symptom status, but, these problem status templates are deprecated in C-CDA Release 2. And C-CDA R2 now has a new of indicating status, which is to wrap the problem observation template in the Problem Concern Act template and to use a combination of both templates' status code, the effective time and the time element to indicate a status. So, the table on the slide below shows high-level structural differences of how diagnoses are modeled in Release 3 versus Release 2. So, as you can see, in Release 3, Diagnosis *Active* template now has two parents, Problem Concern Act and the Diagnosis *Active* Concern Act. So, when you build the reports for the diagnosis, please remember to take a closer look of how the XML should now be constructed in R3.

Next slide.

And in QRDA-I Release Two, there is only one general constraint that states it must contain the *sdct:valueSet* attribute to reference the value set OID from VSAC, and this general constraint is removed in QRDA-I R3 and, instead, specific constraints are added throughout the IG for entry templates where Quality Data Elements value set binding occurs. So, for example, in *Encounter Performed*, there is a specific constraint to require the *sdct:valueSet* attribute for the code element. And you are going to see more in other entry templates.

Next slide, please.

Another change made in QRDA-I Release 3 as a result of aligning with the C-CDA R2 is a reference of Author Participation in the Order QDM

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data type. So, in QRDA-I Release 2, for example, Intervention Order, what you have seen is the constraint shall contain exactly one author and this author shall contain exactly one time. And in QRDA-I Release 3, instead of calling out the author element directly, this constraint is now referenced to Author Participation template. And this is because of the C-CDA template updates. So, what this means is in XML, that you will now have a template ID under the author element and it also has to include the assigned Author element, as specified in the Author Participation template. So, please review this in the base standard for the exact details when you construct these templates. Yes, I think I have walked through all the changes made in the 2016 CMD QRDA IG and the highlights to the changes made in the base HL7 QRDA-I Release 3 standard. And, Stephanie, I'll pass the webinar back to you. And thank you, everyone.

**Stephanie Wilson:** Thank you, Yan and Debbie both. We appreciate your sharing that information with us today.

If you can go ahead and skip to the next slide, we just wanted to provide some little information just to remind people to get involved with eCQM data submission. CMS does strongly encourage vendors and hospitals to get started with that process in working through technical requirements that are needed to submit your files. So, we'll be talking in January about a tool that you can use to test your files prior to submitting those. So, we will be providing a webinar on that in January and some more details will be coming out to our ListServe. Also, when you get the opportunity, you can submit test files to the hospital eCQM receiving system, the *QualityNet Secure Portal*. And then, as always, please sign up for our ListServe because that's where we send out all our training notifications and any FAQs or answers to any questions that may come up for the submissions or things like that. So, just to always remind all of you to get involved and let you know that we are here to support you and help you through this process.

Next slide, please.

And, then, we have just listed some resources here, the different Final Rules, so that you can reference those if you have any questions about the program requirements or different things like that.

And that concludes the actual presentation piece. So, we'll go ahead and start answering some of our questions.

Debbie, it seems like the first couple that came through are kind of program-related questions. The first one is, "Would a new hospital in

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stage one of attestation need to submit eCQMs in 2016?” Would you like to take that one?

**Debbie Krauss:** Sure. So, attestation – well, in 2016, everybody should be in. For the EHR Incentive Program, you can still have the option of attesting or electronically reporting your eCQMs. So, both options are available to all hospitals in 2016. The difference is, if you attest, you have to attest to all 16 – to your choice of 16 Clinical Quality Measures. But, if you electronically report, then you only need to electronically report four of the Clinical Quality Measures. However, both options are available to the hospitals in 2016.

Does that answer your question?

**Stephanie Wilson:** Yes, thank you.

**Debbie Krauss:** Yes.

**Stephanie Wilson:** The next question asks, “When will the *QualityNet Secure Portal* be open for submission of eCQMs from quarter three in 2016?”

I can actually answer that question. Currently, the *QualityNet Secure Portal* is scheduled to be opened to begin accepting test data submissions in May of 2016, and, then, you will actually or should be able to submit your production data into the system starting at the beginning of October of 2016, so right at the end of that third quarter, which is the first quarter that you could elect to report data for. So, those are the dates currently that the *QualityNet Secure Portal* should be available for data submission.

Debbie, the next question, “If a hospital submits four eCQMs in 2016, will this meet the Meaningful Use requirement?”

**Debbie Krauss:** It will meet the Meaningful Use requirement for Clinical Quality Measures. So, remember, Meaningful Use is composed of – I always like to bucket it as three main requirements: one, your EHR must be certified; two, you must report on the Meaningful Use objectives; and then, three, you must report on the clinical quality measures. So, for the EHR Incentive Program, you really have to make sure that you meet all three – all of those three main types of requirements. But, if you submit the four eCQMs electronically for Meaningful Use, you would also satisfy that portion of the IQR requirement for those Clinical Quality Measures.

**Stephanie Wilson:** Thanks, Debbie.

**Debbie Krauss:** Yes.

# Inpatient Quality Reporting (IQR) Program

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**Stephanie Wilson:** The next question, again, kind of goes back to program. “Can you expand on what you mean as required? Is this requirement for all hospitals/IQR to submit eCQM measures?”

And I can speak a little bit to the IQR side of that. For 2016, any hospitals – or for Calendar Year 2016, Fiscal Year 2018, any hospital that participates in the IQR program will be required to submit data for at least four of the 28 available eCQMs. And, again, as Debbie stated earlier, that’s for either third quarter or fourth quarter. And that reporting deadline is February 28 of 2017. So, that is a new requirement that goes into place in 2016 for the IQR program. And as Debbie just stated, hospitals that submit those four eCQMs successfully will also meet the meaningful use or the Medicare EHR Incentive Program Clinical Quality Measure requirement. So, you can do both of those with one submission.

Yan, the next question is for you. It’s a more technical question. It says, “Are we absolutely required to report negation, such as the denominator exception for stroke 2, or are we only required to report the data elements that are essential to create the numerator’s denominator?”

**Yan Heras:** I don’t have this (still to you. And I think you’d pardon me). But, it’s in the exclusions that has the Not Done as Part of the Exclusion Criteria, and that you have the data on your data – in your system that you need to submit that information. So, I think the basic requirement for QRDA-I is to submit the data that are required by the – that are specified by the measure.

**Stephanie Wilson:** Okay, thank you.

And, then, the next question is a little more technical, as well, Yan, but it kind of goes maybe more to the measures. So, if you are not able to answer it, we can get an answer to this one in writing and post it, but, the question says, “The 2015 June update for the e-measure specification does not comply with part of the CMS Implementation Guide that new measure specifications are requiring the ingredient-specific medication when the guide clearly states it should be the value set OID as pointed out in the presentation on slide 32. Will there be a fix for this??”

**Yan Heras:** I think this is – it’s at slide 32 about the Not Done issue as well. Yes, so, I think, if we can collect more information about exactly what the measure is and the ingredient – what is that, that this question was referring to, we can look into this because this is now done. It does contradict with what’s specified in the eCQM.

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**Stephanie Wilson:** Okay, so, if the person that submitted that question would like to provide more information in the Chat box, we will look into that and get back to you with an answer.

And, then, another question came in. “Just to confirm, the 28 eCQMs will satisfy both Meaningful Use and IQR?”

And Debbie has said earlier that the 28 – well, those 29 available measures for the EHR Incentive Program, (ED-3 is an outpatient measure, so it is not applicable to IQR), so, if you are able to submit data for any four of those 28, you will meet program requirements for both Hospital Inpatient Quality Reporting and the Medicare EHR Incentive Program.

Debbie, maybe you can – you can take this one. It asks, “Is there an alignment requirement for hospital reporting for the EHR Incentive Program in PQRS?”

**Debbie Krauss:** So, for PQRS and the EHR Incentive Program, they also have the ability to report eCQM, and the reporting would satisfy both programs for that quality measure reporting. That number that needs to be reported is a little different, and I would just refer to the PRQS program page or the EHR Incentive Program page to get the specifics. I know it’s nine measures across three domains for the Clinical Quality Measures, but, the PQRS program is so complex and divided when you talk about quality measure reporting through QCDRs and registries and GPROs, and all those requirements are a little different. So, I would certainly refer you to those program pages in case you have more detailed questions about those types of requirements.

**Stephanie Wilson:** Thanks, Debbie.

Yan, the next number or the next question says, “Can we go back to the HIC number? Is this required in the QRDA file?”

**Yan Heras:** Yes, so, the HIC number – can we go back on the slide on – I didn’t see which slide number – okay, so, slide number 23 – So, the HIC number is required if the – if the payer is Medicare and the patient has a HIC number assigned. So, that is not – so, the HIC number itself is not required for HQR programs, but, it should be submitted if the payer is Medicare and if the patient has a HIC number assigned. The PID is absolutely required, okay?

**Debbie Krauss:** So, Yan, this is Debbie. Just to add a little bit of clarification, so, are you saying that in that field, CMS requires a number? First, it would be the HIC number if it’s a Medicare patient, but, if it’s not a Medicare patient, since the EHR Incentive Program is reporting on all payers, if it’s not a

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Medicare patient with HIC number, then we would require some type of patient identification number?

**Yan Heras:** Yes, so, if the – so, this constraint actually says for the HIC number, it's a *should*. So, if you don't submit – so, you always have to have a PID in your QRDA report. You always have to have the ID field. Then, if the patient is a Medicare patient and has a HIC number, then you will have a second ID field for the HIC number itself. So, the second ID field is not a *must* in the XML file, and if you don't submit, it's just a warning. It's not considered as an error.

Does that help, Debbie?

**Debbie Krauss:** Yes, thank you. I just want to ...

**Yan Heras:** Okay.

**Debbie Krauss:** ... get that clarification.

**Stephanie Wilson:** Okay, it looks like we have one more – time for one more question. So, Yan, "Will the category I file pass validation if the admission encounter start date is prior to the program quarter? For instance, if the patient is admitted 9/30 and discharged 10/3 of the calendar year, will the file pass validation or be rejected?"

**Yan Heras:** Can you repeat that question one more time so I can get the exact date?

**Stephanie Wilson:** Yes, It's – I think, about the QRDA Category I file...

**Yan Heras:** Okay.

**Stephanie Wilson:** And if it will pass validation if the admission or encounter start date is prior to the program quarter. So, let's say they are submitting for fourth quarter, which would start October 1. So, if the patient was admitted on September 30 and discharged on October 3, will that file pass through validation or will it be rejected?

**Yan Heras:** Yes, I think this one goes back to the additional HQR program validation for encounter. So, if we can go back to that slide, maybe it's going to be helpful to look at exact validation. Slide 31. Slide 31. Okay, so, the question asked if the admission date is prior to the discharge quarter, is that right, Debbie?

**Debbie Krauss:** Yes, that's correct.

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**Yan Heras:** Okay, yes, I think I have to go back – you know get back to this question to review with the HQR teams exactly because the rules here only state these four. So, we'll have to get back to you to see exactly if they do any checking for admission time.

**Stephanie Wilson:** Okay, and that brings us up to the top of the hour. So, again, thank you, Yan and Debbie for your presentations today and for leading us through this information.

Again, like I said, we will get answers to all of the questions that we weren't able to answer, and we will get that in writing and post that with the recorded version of the presentation on the *QualityNet* website.

Thank you, all, for taking time out of your schedule today to join us, and we look forward to providing more sessions as we move into next year. Have a great day. Thank you.

**END**