Hospital Outpatient Quality Reporting Program

Support Contractor

CY 2016 OPPS/ASC Proposed Rule: Hospital Outpatient Quality Reporting (OQR) Program

Presentation

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Karen VanBourgondien: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Karen VanBourgondien. I'm the education coordinator for the Hospital OQR Program. If you have not yet downloaded today's handouts, you can get them from our website, qualityreportingcenter.com. Go to the **Events** banner on the right side of the page, then click on today's event. This will direct you to the link that will allow you to access and print the handouts for today's webinar. As you can see, we have a slightly different platform we are using this time, and we are streaming in lieu of using only phone lines. However, phone lines are available should you need them.

Before we begin today's program, I would like to highlight some important dates and announcements. July 1st through November 1st is the submission period for entering the web-based measures into QualityNet. We cannot stress enough how important it is not to wait until the last minute for data submission of your web-based measures. The QualityNet website gets very busy and slows down considerably during the submission times. We do not

want to see anyone not be able to have a timely submission due to technical difficulties. Again, do not wait until the last minute. CMS provides a lengthy submission period. Please take advantage of that.

On July 22nd, there will be a webinar for the ASC portion of the Proposed Rule. August 1st is the next deadline for Quarter 1 Population and Sampling and Clinical Data Submission. This would include encounter dates of January 1st through March 31st, 2015. Remember, this is the first quarter that you will not be submitting data for OP-6 and -7. Additional information and webinars for this program will be issued through the ListServe.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box and the audio portion of today's program, will be posted on qualityreportingcenter.com at a later date. During the presentation, as stated earlier, if you have a question, please put the question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having live chat, we hope to accommodate your questions timely and have real-time feedback. Some of the questions will be shared at the end of the presentation.

I'm pleased to announce our speakers for today's presentation. First, Elizabeth Bainger. Elizabeth joined CMS in June 2014 to become the program lead for the Hospital Outpatient Quality Reporting Program. She is currently pursuing her doctorate of nursing practice at the University of Maryland with an administrative focus on quality improvement. She has a broad clinical background including behavioral health, ambulatory surgery, cardiac care, critical care, and nursing education. Elizabeth also served as a flight nurse instructor in the Air Force Reserves for 10 years. Elizabeth's quality improvement background includes positions as a performance improvement

coordinator and a senior abstraction specialist. She is a Certified Professional in Healthcare Quality and a member of the National Association of Healthcare Quality.

Our second speaker is Dr. Vinitha Meyyur. Dr. Meyyur is a healthcare researcher specializing in research, program evaluation, quantitative data analysis, survey and measure development, contract management, and outcomes research with more than 14 years of experience working on U.S. Department of Health and Human Resources projects. She joined CMS in 2013 and is the measures lead for the Hospital OQR Program. Dr. Meyyur received her PhD in health services research from Old Dominion University.

Without further ado, I will turn the presentation to our first speaker. Elizabeth, the floor is yours.

Elizabeth Bainger: Hi, everyone. This is Elizabeth Bainger, and I want to thank you for joining us today. I also want to extend a warm welcome to Dr. Vinitha Meyyur for joining us today.

I do want to say again that Vinitha and I have pre-recorded this webinar so if we have any difficulties during the day of the presentation, you'll still be able to receive this important information. However, both of us do plan to be live on the phone, and we plan to answer the questions that we can using the chat box. We'll also look for questions that are trending, and we'll answer those at the end of the presentation.

I want to emphasize a few things. First, and it seems to have become my standard disclaimer, that this slide deck and the transcripts are not stand-alone resources. If you have any questions, please refer to the Proposed Rule. The Proposed Rule should be your primary resource until the Final Rule is published later this year. Second, I want to point out that today's webinar

focuses on the Hospital OQR portion of the Proposed Rule. If you are hoping to learn about the ASC portion, then I invite you to join the webinar that will be held on July 22nd. And finally, I want to share with you that when I was an abstractor, I truly hated it when I asked a question only to have the Specs Manual quoted back to me. And yet, today, if you ask a question about the Proposed Rule, by statute, Vinitha and I may only respond with information that can already be found in that Proposed Rule.

Since the Proposed Rule has only recently become available, I hope this will be useful to you. And maybe you've only had a chance to skim it so far, and perhaps we'll be able to direct you to part of the Proposed Rule that you'd overlooked previously. By law, Vinitha and I must ensure that responses to comments and questions are available to all interested parties, not just those participating in this webinar. So, in some cases, we'll direct you to submit your question or comment using one of the public comment submission methods that I'll describe later. That's this third learning objective for today's webinar.

But let's start with the first objective, and that's to learn how to find the Calendar Year 2016 OPPS/ASC Proposed Rule text. Slide 8 provides some historical perspective. You could see that from Calendar Year 2008 through Calendar Year 2015, the rule has been finalized. For Calendar Year 2016, we have published a Proposed Rule.

I want to draw your attention to the far right column. At the top, you can see the link to the *Federal Register*. Let's look at the first light blue row in the far right column. That first number, 80, 8-0, that represents the volume of the *Federal Register*. "FR" stands for *Federal Register*, and 39325 is the first page of the Hospital OQR portion of the Proposed Rule. So remember, volume, FR, for *Federal Register* and then the page number. You can use the

link to the Federal Register and then copy and paste the reference numbers found in the third column, and that will take you to the rule for that particular calendar year. Let's see how that works for the Proposed Rule.

This slide shows the homepage for the *Federal Register*. On this screenshot, you can see that we've copied and pasted the volume number, 8-0, FR for *Federal Register*, and then the page number. Next, click the magnifying glass in the search box to start the search, and this is what you will see. It takes you directly to the Proposed Rule. I've highlighted a box that starts with the words "jump directly to." But before we discuss that feature, I'd like you to look just to the left of that box. Do you see the page numbers there? That's telling you that the Proposed Rule begins on page 39199 and ends on page 39375. It's a really long document. It contains payment rules for End-Stage Renal Disease, Home Health, Hospital Outpatient, Ambulatory Surgery, and Physician fee schedules, payments for biological products, coding changes, and much more. The Hospital OQR portion is just one part of this Proposed Rule.

Now let's look at the highlighted box that reads "jump directly to page 39325." When you click the page number, it will take you directly to that page. Scroll down a bit and you'll see the start of the Hospital OQR portion. It starts with the Roman numeral 13. That's XIII. Now this view of the Proposed Rule is one long column of text. Some people like to view the rule this way, but many others prefer to view the rule as a PDF.

Let's go back to the previous slide. This time, I've highlighted the PDF link. And when you click it, it takes you to the PDF version of volume 80 of the *Federal Register*. You can use your "find" feature to look for page 39325, the first page of the Hospital OQR portion of the Proposed Rule, and there you go. You can see that we're in volume 80 of the *Federal Register*, page 39325. And the Hospital OQR portion of the rule starts with Roman numeral 13.

I didn't include it in the screenshot. Before we move on, I want you to note that if you download the PDF document itself, you'll find it contains 177 pages. The Hospital OQR portion begins on page 127 of the PDF. So now, we've accomplished our first learning objective.

Let's move on to our second learning objective: identifying proposed changes to the Hospital OQR program. We'll start with the proposed measure changes. In the Hospital OQR portion of the Calendar Year 2016 OPPS/ASC Proposed Rule, CMS recommends the adoption of two new measures. We also proposed to remove OP-15, and we are signaling that we intend to allow submission of OP-18 either as an eCQM or chart-abstracted measure beginning with the Calendar Year 2019 APU Determination.

And now, I'm passing the presentation to Vinitha so that she can discuss these measure proposals in greater detail.

Vinitha Meyyur: Thank you, Elizabeth. I'd like to talk by discussing OP-33. Bone metastases are a common manifestation of malignancy. Some cancer types have a bone metastases prevalence rate of 70 to 95 percent. EBRT is a widely used modality to provide pain relief in 50 to 80 percent of patients with painful bone metastases. In October 2009, ASTRO, which is the American society for Radiation Oncology, organized a task force to perform an assessment of existing recommendations in order to address a lack of palliative radiotherapy guidelines. Based on the review of the literature, the task force recommended dosing schedules for patients with previously unradiated painful bone metastases. However, the actual doses continue to be quite high.

To address concerns associated with unnecessary exposure to radiation and a desire for shorter and less painful treatment options, they are proposing to adopt one new web-based quality measure for the Calendar Year 2018

Payment Determination and subsequent years–OP-33: External Beam Radiotherapy for Bone Metastases.

We believe that this measure addresses the performance gap in treatment variation, ensures appropriate use of EBRT, and prevents the overuse of radiation therapy. The measure addresses the NQS [National Quality Strategy] priority of making care safer, and it was supported by the MAP, which is the Measure Applications Partnership. Detailed specifications can be found using the link on this slide. The link may also be found on page 39328 of the *Federal Register*.

Elizabeth Bainger: Vinitha, before you move on to the next measure, I'd like to jump in and describe some of the policies associated with the proposed EBRT measure. First, CMS is proposing this measure for the Calendar Year 2018 Payment Determination and subsequent years, so it would begin with services furnished on or after January 1st, 2016.

Second, I'd like to point out that the PCHQR Program – that's the Cancer Hospital Quality Reporting Program – that program adopted the EBRT measure in the Fiscal Year 2015 IPPS Final Rule. If you'd like to refer to that, it can be found at 79 FR 50278 through 502789. In keeping with the PCHQR Program, we're proposing two methods of submission. First, facilities can report aggregate data using the CMS web-based tool found on the QualityNet website; and second – and this only applies to facilities submitting data via a vendor – aggregate data can be submitted using a flat file such as a file in comma-separated value format. Data submission requirements will be specified on QualityNet. And the last thing I'd like to point out is the data submission deadline for either method would be May 15th. I'll explain more about that May 15th deadline when we discuss policy proposals.

Thanks for allowing me to jump in, Vinitha. And now let me toss the presentation back to you.

Vinitha Meyyur: Communication problems significantly contribute to adverse events in hospitals, accounting for 65 percent of sentinel events tracked by The Joint Commission. Establishment of an effective transition from one treatment setting to another is enhanced by providing the receiving providers and facilities with sufficient information regarding treatment during hospitalization.

To address concerns associated with care when patients are transferred from the emergency department to other facilities, we are proposing to adopt OP-34, the Emergency Department Transfer Communication measure. That EDTC measure captures the percentage of patients transferred to another healthcare facility whose medical record documentations indicated that administrative and clinical information was communicated to the receiving facility in an appropriate time frame. The measure consists of seven subcomponents, which I discussed more on slide 21. Detailed specifications can be found using the link on the slide. The link may also be found on page 39333 of the *Federal Register*. On that same page, you can also find the link to qualityforum.org which provides additional information.

The proposed measure has been rigorously peer reviewed and extensively tested with field tests from 2004 to 2014 across 16 states in 249 hospitals. The proposed measure addresses the NQS priority of Communication and Care Coordination, and it was supported by the MAP.

This slide presents an example of how to score the proposed measure. As I mentioned before, the measure consists of seven subcomponents -- A, administrative data; B, patient information; C, vital signs; D, medication; E, physician information; F, nursing information; and G, procedure and test results. The subcomponents are further comprised of a total of 27 elements,

as illustrated on this slide. The EDTC measure does not require hospitals to submit patient data on each of these elements; but rather, hospitals would be required to answer "yes" or "no" as to whether these clinical indicators were recorded and communicated to the receiving facility within the specified time frame.

We are proposing to use the core methodology by which the facility's score is reported as the percentage, which is zero percent to 100 percent of all cases, with a perfect score of seven. To calculate this score, hospitals assign a value of zero or one to each of the seven subcomponents of each case.

In order to achieve a value of one for each subcomponent, the hospital must have recorded and transferred patient data pertaining to all of the elements that comprise that particular subcomponent. If any data or any element failed to be recorded or transferred, then the value assigned to that subcomponent would be zero.

Next, subcomponent scores are added together for a total ranging from zero to seven for a case. Finally, the facility's score is calculated by adding all of the cases that achieved a perfect score of seven, and dividing that number by the total number of cases to reflect the percentage of cases that receive a perfect score. This slide illustrates a case in which some patient data elements failed to be recorded and/or transferred to the receiving facility. The missed elements are the Glasgow Coma Score and Home Medication.

Elizabeth Bainger: Thanks, Vinitha. I'd like to jump in again and describe some policies associated with this proposed measure. First, we recognize this is a complex measure with seven components, so we're proposing this measure for the Calendar Year 2019 Payment Determination and subsequent years. It will begin with patient encounters on or after January 1st, 2017; the data submission methods align with the proposed EBRT measure. It is proposed that facilities can report aggregate data using the CMS web-based tool found

on the QualityNet website, or facilities that submit data via a vendor can submit aggregate data using a flat file. Again, data submission requirements will be specified on QualityNet.

And the last thing I'd like to point out is that the proposed data submission deadline for either method would be May 15th. Again, I'll explain more about that May 15th deadline when we discuss policy proposals.

Thanks, again, Vinitha, for allowing me to jump in. Back to you.

Vinitha Meyyur: We proposed to remove OP-15, Use of Brain CT in the Emergency Department for Atraumatic Headache, because this measure does not align with the most updated clinical guidelines or practice. Public reporting has been deferred since its adoption in 2012.

Finally, as you are likely aware, CMS is exploring electronic clinical quality measures in this Proposed Rule. We are signaling that we intend to allow submission of OP-18 either as an eCQM or a chart-abstracted measure beginning with Calendar Year 29 APU Determinations. OP-18 is Median Time from ED Arrival to ED Departure for Discharged ED Patients. CMS wants comment on all of these measure proposals.

Before I pass the presentation back to Elizabeth, I would like to mention that OP-4 was inadvertently excluded from the tables that listed the proposed Hospital OQR Program measure set for both the Calendar Year 2018 and Calendar Year 2019 Payment Determination and subsequent years. CMS will clarify this in the Final Rule.

Elizabeth Bainger: Thank you, Vinitha. Now, let's move on to proposed policy changes. CMS is proposing several policy changes. We would like to align the Hospital OQR APU Determination and associate a deadline with ASCs. The current time frame is quite compressed, making it difficult both for the facilities and for CMS to review the decision. To ease this burden, we propose moving the

Hospital OQR timeline up by one quarter. This policy requires a one-time change in the APU determination time frame to cover three quarters instead of four quarters. It also requires us to align other associated deadlines in accordance with ASC policies, namely, the web-based measure submission deadline, the date hospitals can withdraw from the program, and the request for reconsideration deadline.

We also have a few housekeeping tasks that we are addressing in this Proposed Rule. We're proposing a typographical and an editing correction. I'll discuss these more on slide 30. I'll go into more depth with regard to each of these proposed policy changes.

CMS is trying to align its quality reporting programs. Since both Hospital OQR and ASCQR are in the same rule, we want to align these two programs to the extent possible. We have started with aligning the payment determinations for these two programs.

This slide shows the tables found on page 39337 of the *Federal Register*. To be honest, I was a little disappointed in how these were formatted in the PDF version of the Proposed Rule. I tend to be a visual person, and the layout in the PDF is a little confusing to me. So I recommend that you look at the tables on that long column electronic view that I told you about way back in slide 11, and I also want to refer to you to the QualityNet link found on page 39336. There, you'll find the most current detailed information about data validation requirements and deadlines. If this proposed rule is finalized, that page will be updated to reflect these new time frames.

Okay. So let me get into this – when you look at these tables, I want you to keep in mind that we're addressing clinical data submission deadlines for validation. Take a look at the top of this slide. This shows the current state. As you can see, currently the last validation data submission deadline is November. Then, CMS must notify facilities of their findings by the end of

the year. This is a very compressed time frame. It makes it difficult both for facilities and for CMS to review the decision.

Now, skip down to the bottom table. That shows where we hope to be, and it aligns with ASCQR. In our proposed future state, we will still have four quarters of validation data, but the last validation data submission deadline will be in August.

So, to recap, we want to move from the four quarter cycle that we now have, which had its final validation deadline submission in November, to a four quarter cycle that aligns with ASCQR and ends in August. But how do we get there? How do we make that transition? Well, you could see our proposal in the middle table. We propose that for the Calendar Year 2017 Payment Determination, we utilize a three quarter validation cycle. This is a one-time event. It is the only time that we will use only three quarters of data for validation. So for the Calendar Year 2017 Payment Determination, we propose using patient encounters from July 1st, 2015 through March 31st of 2016. Can you see where I'm at? I'm in the middle table in the first column under "Patient Encounter Quarters."

Now, let's look at the second column of that table, the "Clinical Data Submission Deadlines." These deadlines don't change in relation to the patient encounter quarters. You won't need to do anything different on your end. The deadlines will be February 1st, May 1st, and August 1st; same as always. But for that transition cycle, we propose to use only three quarters of data for validation.

Okay, so that's the first of our date-related policy proposal. Again, we're trying to the extent possible to align with ASCQR.

These are pretty straightforward. To align with the Ambulatory Surgical Center Quality Reporting Program, we're proposing to change the deadline for submitting a reconsideration request from the first business day of the month

of February of the affected payment year to the first business day on or after March 17th of the affected payment year. And we are proposing to change the deadline from withdrawing from the program from November 1st to August 31st.

Finally, we're proposing to change the data submission time frame for measures submitted via the CMS web-based tool from July 1st through November 1st, to January 1st through May 15th. But wait, some of you are probably scratching your heads and noticing that ASCQR does not currently have a May 15th deadline. In this case, both the Hospital OQR and ASCQR Programs are proposing to change our deadlines for web-based measures in order to align with the CDC.

The OP-27 measure looks at Influenza Vaccination Coverage among Healthcare Personnel. That's an NHSN measure, and it has a deadline of May 15th. So that all web-based measures are due at the same time, we are proposing to change our deadline to May 15th.

These are a couple of housekeeping policy changes. Last year, you might recall that we renamed our waiver process to the Extraordinary Circumstances Extensions or Exemptions process. Unfortunately, there was a typographical error in the Final Rule. And instead of "exemption," it went out as "exception." We would like to fix that in this year's Final Rule.

And finally, in the *Code of Federal Regulations*, we noticed that the Hospital OQR Program was referred to in terms of fiscal year instead of calendar year. Now, there are some programs like the Inpatient Quality Reporting Program that do run on fiscal years, but not the Outpatient Quality Reporting Program. We run on calendar years, so we want to correct that mistake. CMS welcomes your comments on these policy proposals. And that does wrap up our second learning objective, which is to identify proposed changes to the hospital OQR program.

Let's address our last objective, how to comment on the Proposed Rule. I apologize, I had to make a last minute change to this slide, and now it's a little bit repetitive. But I really want to emphasize, and I can't say this enough, CMS wants your comments. This is your opportunity to impact the measure development process and policy proposals.

But first, I want to refer you to the Proposed Rule, page 39200, about how to submit your comments. Comments can be submitted using various methods including regular mail, express or overnight mail, and by hand or courier. For these methods, the deadline is 5:00 p.m. Eastern Time on August 31st, 2015. Please refer to the Proposed Rule for the necessary addresses, and keep in mind that you must send in your comments so that it's received by the deadline. However, CMS encourages the electronic submission of comments using regulations.gov. The deadline for that method of comment submission is 11:59 p.m. Eastern Time on August 31st, 2015. Responses will be published in the Final Rule which should be issued in November 2015.

On this slide, you see a screenshot of just what you'll see when you go to regulations.gov. In the search box, enter **CMS** and then select the **Search** button. This will take you to this next screenshot. On here, I want you to set your filters. Make sure your comment period is set for **Open** and the document type is **Proposed Rule**. Scroll down until you find the rule. For me, it was the very first rule, but there could be more proposed rules, so you may have to scroll down a little further. Then you can select the **Comment Now** button. Notice that the deadline is August 31st at 11:59 p.m. Eastern Time. This is different than the paper methods of submission.

Now, when you get to this page when you're submitting comments, the system will guide you through a three-step process. For step one, you'll enter your comment, which is limited to 5,000 characters. In addition to entering the comment for step one, you'll also need to enter your contact information. Once that's completed, select the **Continue** button.

Step two allows you to preview your comment and edit if needed. Once completed, select the **Submit Comment** button. You will then be assigned to a tracking number. It's recommended that you take a screenshot of this page or save your tracking number. The tracking number will allow you to follow the status of your comment.

That concludes our third learning objective and the pre-recorded portion of this presentation. Thanks so much for your time.

Karen VanBourgondien: Thank you, Elizabeth and Vinitha. Thanks for all the information you provided. Now, we would like to share some questions that have been coming in during the presentation. This will give you both an opportunity to respond and perhaps provide some clarity for those that have questions. If you are also seeing questions you'd like to read out loud and respond to, by all means, go right ahead.

I do have a question here. "Can you elaborate on OP-15 as it relates to being removed and to public reporting?"

Elizabeth Bainger: Ah, yes. This is Elizabeth. Ever since OP-15 has been included in the Hospital OQR Program, it's generated concerns from stakeholders, and that's been ever since the Calendar Year 2011 Final Rule.

In the 2012 Final Rule, we deferred the public reporting of OP-15, and we extended that postponement of public reporting for this measure in both the Calendar Year 2013 and 2014 Final Rules. Public reporting for OP-15 does continue to be deferred, and this deferral will have no effect on any payment determinations.

Karen VanBourgondien: Thank you, Elizabeth. The next question is, "Did I understand that OP-18, this measure is being voluntary? It's just being considered at this point. In other words, it's nothing immediate. And when will the hospitals have the ability to report this measure as an eCQM?"

Elizabeth Bainger: Yes. As you know, CMS is exploring electronic clinical quality measures, and we want to see if, in future rule making, we can propose that hospitals have the option to voluntarily submit OP-18 electronically beginning with the Calendar Year 2019 Payment Determination. Now – right now, we're just looking at things. We're signaling it. This is the direction we'd like to move. We'd like to hear from hospitals. Do you think you'll be ready? Even if we do opt for this in the Calendar Year 2019 Payment Determination, hospitals would still be able to submit this data for this measure through chart abstraction, so we would have a transition period. It's not going to just automatically convert right over to an eCQM.

Karen VanBourgondien: Thank you, Elizabeth. The next series of questions we've kind of collected relate to OP-33. I think I'll clump those all together in the interest of making the most sense. So, the first question with regard to OP-33 is, "What does OP-33 measure?"

Vinitha Meyyur: Sure. OP-33 is the percentage of patients with painful bone metastasis and no history of previous radiation and who receive EBRT with an acceptable dosing schedule.

Karen VanBourgondien: Thank you, Vinitha. Also as it that relates to OP-33, the next question with regard to that measure is, "Can you explain the exclusions for OP-33?"

Vinitha Meyyur: Yes, the following patients are excluded from the denominator -- patients who have had previous radiation to the same site, patients with femoral access cortical involvement greater than three centimeters in length, patients who have undergone a surgical stabilization procedure, and patients with spinal cord compression or radicular pain.

Karen VanBourgondien: Vinitha, I notice a few people asking about whether OP-33 was an inpatient measure. Can you address that?

Vinitha Meyyur: OP-33 is a measure that's been finalized in the PCHQR Program, which is the cancer hospitals. However, it's not an inpatient measure, is our understanding, and we think it's appropriate in the outpatient setting. So we have proposed this measure with that understanding that this would be a very useful measure for the outpatient setting.

Karen VanBourgondien: Thank you, Vinitha. Also, with regard to OP-33, can you explain what the submission methods would be for OP-33?

Elizabeth Bainger: Sure. Just to note, we're doing this one a little bit differently because we want to align with the PCHQR Program, and they offered two submission methods. And so, we're going to propose the same. We're proposing that the facilities can submit data via the CMS web-based tool, or for facilities using a vendor, you can submit a flat data file, for example, a comma-separated value format file through QualityNet, through their vendor. For both methods, the aggregate data file will combine all the patient information rather than reporting individual patient-level data. And if finalized, we will provide detailed information about the format and submission requirements on QualityNet.

Karen VanBourgondien: Thank you very much, Elizabeth. The last question for OP-33 for right now is, "Can you clarify the effective dates for this measure, OP-33?"

Elizabeth Bainger: Sure. As it's proposed, hospitals will report OP-33 beginning with services furnished on January 1st, 2016, and that would be for the Calendar Year 2018 Payment Determination and subsequent years.

Karen VanBourgondien: Thank you, Elizabeth. As with OP-33, we got quite a few questions about OP-34, which we've kind of clumped together for ease in understanding as well. One of the first questions was, again, "What's the purpose of OP-34? What is this measure? What does it measure?"

Vinitha Meyyur: Okay. OP-34, it captures the percentage of patients who transfer to another healthcare facility whose medical record documentation indicated that

administrative and clinical information was communicated to the receiving facility in an appropriate time frame.

Elizabeth Bainger: Now people are probably wondering what an appropriate time frame is. Administrative communications have to be completed prior to patient departure, and that would include nurse-to-nurse communications and provider-to-provider communication. The other six subcomponents have to be completed within 60 minutes of the transfer.

Karen VanBourgondien: Thank you very much, both Elizabeth and Vinitha. And another question as it relates to OP-34 is, "What are the time frames for OP-34?"

Elizabeth Bainger: Do you mean the effective dates? Is that what you're looking at? Because I just – it's the time frame when we talk about the appropriate time frame for the administrative communications, that's prior to the departure for the other six components; it's 60 minutes of transfer. But if you're looking for the effective dates, hospitals would report OP-34 beginning with January 1st, 2017, outpatient encounters for the Calendar Year 2019 Payment Determination and subsequent years.

And we did this because we realize this is a complex measure, and we wanted to give hospitals adequate time to implement the proposed measure, and we were told by the steward, the measure steward, that most hospitals would require three to six months in order to familiarize themselves with the implementation protocol and the tools related to this measure.

Karen VanBourgondien: Thank you, Elizabeth.

Marty Ball: Elizabeth, I have another question here. "For OP-34, does each subcategory require 100 percent compliance to pass? For example, if a patient has a KUB followed by a CAT scan of the abdomen, would both exams have to be communicated to pass the procedure subsections?"

Vinitha Meyyur: Yes, that is correct. They have to pass both subsections.

Karen VanBourgondien: Okay. Great, thank you. Another question is, "Can you explain the subcomponents associated with the measure OP-34?"

Vinitha Meyyur: And you say "explain," just like, the different subcomponents?

Karen VanBourgondien: I'm getting the feeling they just want an elaboration, or if you could repeat it because you did cover that in your presentation. I think they just want to basically repeat; that's what it looks like.

Vinitha Meyyur: Sure. Those seven subcomponents are administrative data, patient information, vital signs, medication, physician information, nursing information, and procedure and test results. So if you're looking for, like, details within a subcomponent, it's in the manual or

Vinitha Meyyur: Yes …

Elizabeth Bainger: If you look on page 39333 of the *Federal Register* Volume 80, we have a couple of links there for you. There's a link to the University of Minnesota, who is the measure steward, and there's also a link to the National Quality Forum. So that will give you a lot more information about those measures. It'll tell you about the numerator, the denominators, the exclusions. It will go into a lot more detail.

Karen VanBourgondien: Thank you very much to both of you for clarifying that. And here's a question, and again, we get this with every webinar, "Can you explain what version of the Specifications Manual we use when abstracting for OP-26?"

Marty Ball: This is Marty. We use version 8.0a. The reason that we use that is because the codes come in later in the year, and we need to be able to use the most up-to-date information. So we produce that list in the Specifications Manual that would be most current that the facilities have available at that time to be able to gather that information and report it.

Karen VanBourgondien: Thank you, Marty. Another question is, "Will PPS-exempt cancer hospitals be included in the proposed OP-33 EBRT measure?"

Vinitha Meyyur: So, the way the measure is defined is that it's any transfer to a PCH hospital or an acute care facility or a nursing home, yes, would be included. But it's not a – I mean a transfer to a PCH is included. It's not – PCH is not included as part of the cohort.

Elizabeth Bainger: And again, we want to really emphasize, please go to the Specifications Manual provided by the University of Minnesota. And we have that link on page 39333.

Karen VanBourgondien: Okay. Thank you very much. There is some question about – somebody is asking for clarification that there is no change in OP-4. It was just left off in the Proposed Rule, but that is carrying forward?

Vinitha Meyyur: Yes. That's correct. There's no change in OP-4. It was inadvertently left off the table. And CMS will clarify that in the Final Rule.

Karen VanBourgondien: And another question is, "What is required for Critical Access Hospitals?"

Elizabeth Bainger: We – actually in this rule, we haven't proposed to make any changes to our policies regarding Critical Access Hospitals. Critical Access Hospitals are not subject to the hospital Outpatient Prospective Payment System. They must indicate their public reporting designation when they complete their Notice of Participation, and they can change that at any time. So we're not proposing any changes at all with regard to Critical Access Hospitals.

Karen VanBourgondien: Thank you once again, Elizabeth. And here is another question about OP-33. They are wanting an explanation again of the numerator and denominator aspects of this measure.

Vinitha Meyyur: Did you say 33?

Karen VanBourgondien: Yes, ma'am.

Vinitha Meyyur: Okay. The measure numerator includes all patients with painful bone metastases and no previous radiation to the same site who received EBRT with any of the following recommendation fractionation scheme. So those fractionation schemes could be a 30Gy, 24Gy, 20Gy, or 8Gy. So those are the four. And the measure denominator includes all patients with painful bone metastases and no previous radiation to the same site who received EBRT.

Marty Ball: We have a question for a little more clarification on how OP-34 will be scored.

Karen VanBourgondien: The question is, "Can you please explain further about OP-34 and how you would score that?"

Vinitha Meyyur: To calculate the EDTC proposed measure score, hospitals will find a value of zero or one to each of the seven subcomponents for each case. And then in order to achieve a value of one for each subcomponent, the hospital must have recorded and transferred patient data pertaining to all of the elements that comprise that particular subcomponent. If data for any element fails to be recorded or transferred, then the value assigned to that subcomponent would be zero. Next, each subcomponent's scores are then added together for a total ranging from zero to seven per case. And finally, the facility score is calculated by adding all of the cases that achieved a perfect score of seven, and dividing that number by the total number of cases to reflect that percentage of all cases that received the perfect score.

Elizabeth Bainger: And just to let you know – I want to let you know that we put a couple of scoring examples into the *Federal Register*, and you can see them on pages 39331 all the way through 39333. This is complicated, so that's why we wanted to provide a couple of examples. There's one where you get a perfect score and another where there's a couple of missed items. And we really encourage folks to review the *Federal Register* and take a look at those. And

if you're still confused, please submit your comments and questions via the regulations.gov method.

Marty Ball: I just wanted to make one more comment that if you're unable to find the slide pack, where you can find that. If you go to www.qualityreportingcenter.com and look to the right side of the screen, you'll see today's webinar, and the slides are posted there.

Elizabeth Bainger: And I also – this is Elizabeth. I just want to make a quick comment. When we were going through the slides, I noticed slide 29 had a mistake. That's dealing with the change in the deadline for withdrawing from the Hospital OQR Program. We are changing – we are proposing to change that from November 1st to August 31st. I think slide 29 said August 1st; it's actually August 31st. And I want to refer you again to the Proposed Rule. You can find this information on page 39336.

Karen VanBourgondien: Thank you, Elizabeth. I think that's all the time we have today for the questions. We're going to – I'd really like to thank both Elizabeth and Vinitha for all their time and effort, and being available to answer all these questions. We really hope that this has been very helpful to you.

We would like to go ahead and take the time to explain the continuing education process. We would like to remind you that today's webinar has been approved for one continuing education credit by the boards listed on this slide. Please stay on the line until the conclusion of this presentation so that you can complete this process. Also, we'd like to mention that if your question did not get answered in the chat box, it will be answered and posted along with the presentation transcript on our website at qualityreportingcenter.com.

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This is what the new user link looks like. Please register a personal email like Yahoo or Gmail. And the reason for that is those types of accounts are typically not blocked by your hospitals' firewalls. And we'll ask you to please remember your password because you will be using that for all future events.

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This concludes our program for today. And again, a special thank you to our speakers. We hope you've heard some useful information that will help you. Thank you and enjoy the rest of your day.

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