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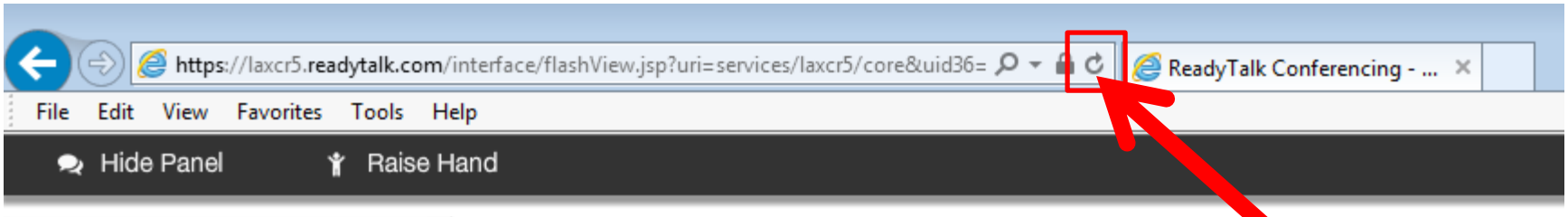
- This event is being recorded.

Troubleshooting Audio

Audio from computer speakers breaking up?
Audio suddenly stops?

- Click **Refresh** icon
  or
- Click F5

F5 Key
Top row of keyboard

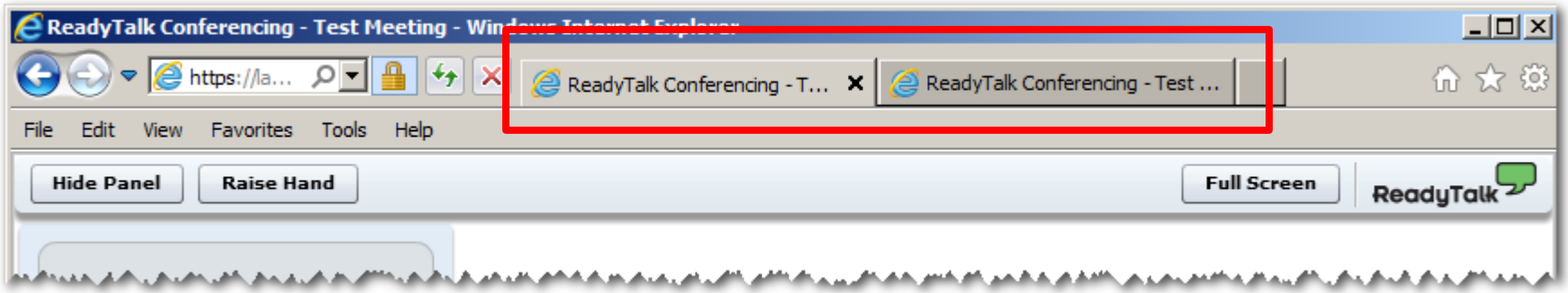


Location of buttons

Refresh

Troubleshooting Echo

- Hear a bad echo on the call?
- Echo is caused by multiple browsers/tabs open to a single event (multiple audio feeds).
- Close all but one browser/tab, and the echo will clear up.



Example of two browsers/tabs open in same event

Submitting Questions

Type questions in the “Chat with Presenter” section located on the bottom-left corner of your screen.

CY 2017 OPPS/ASC Final Rule: Hospital Outpatient Quality Reporting (OQR) Program

Elizabeth Bainger, DNP, RN, CPHQ
Program Lead, Hospital OQR, CMS

Liz Goldstein, PhD
Director, Division of Consumer Assessment and Plan Performance, CMS

Grace H. Im, JD, MPH
Program Lead, Hospital Inpatient Quality Reporting (IQR), CMS

Vinitha Meyyur, PhD
Measures Lead, Hospital OQR, CMS

November 29, 2016

Announcements

- January 1, 2017: Submission period for web-based measures submitted via *QualityNet* begins
- February 1, 2017: Clinical Data and Population and Sampling deadline for Q3 (July 1–September 30, 2016)
- Please be sure to access the National Healthcare Safety Network (NHSN) and QualityNet Secure Portal every 60 days to keep your password active

Save the Date

- Upcoming Hospital OQR Program educational webinars:
  - December 12, 2016: Hospital OQR Specifications Manual Update
  - January 18, 2017: Help I'm New: What Do I Do?
- Notifications of additional educational webinars will be sent via ListServe

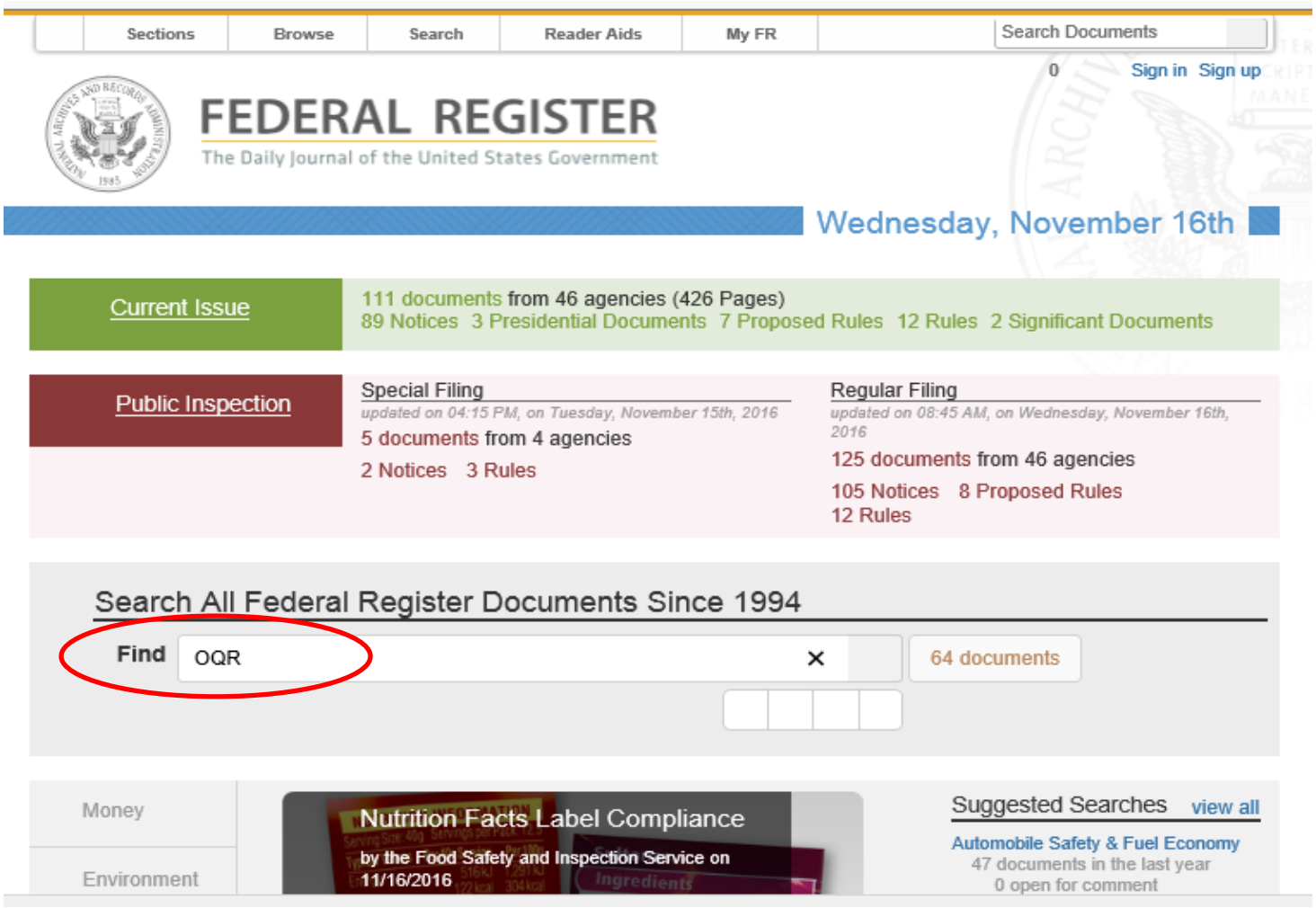
Learning Objectives

At the conclusion of the program, attendees will be able to:

- Locate the CY 2017 OPPS/ASC Final Rule text
- Identify the measure changes to the Hospital OQR Program
- List the policy changes to the Hospital OQR Program
- Identify the change to the Hospital Value-Based Purchasing (VBP) Program

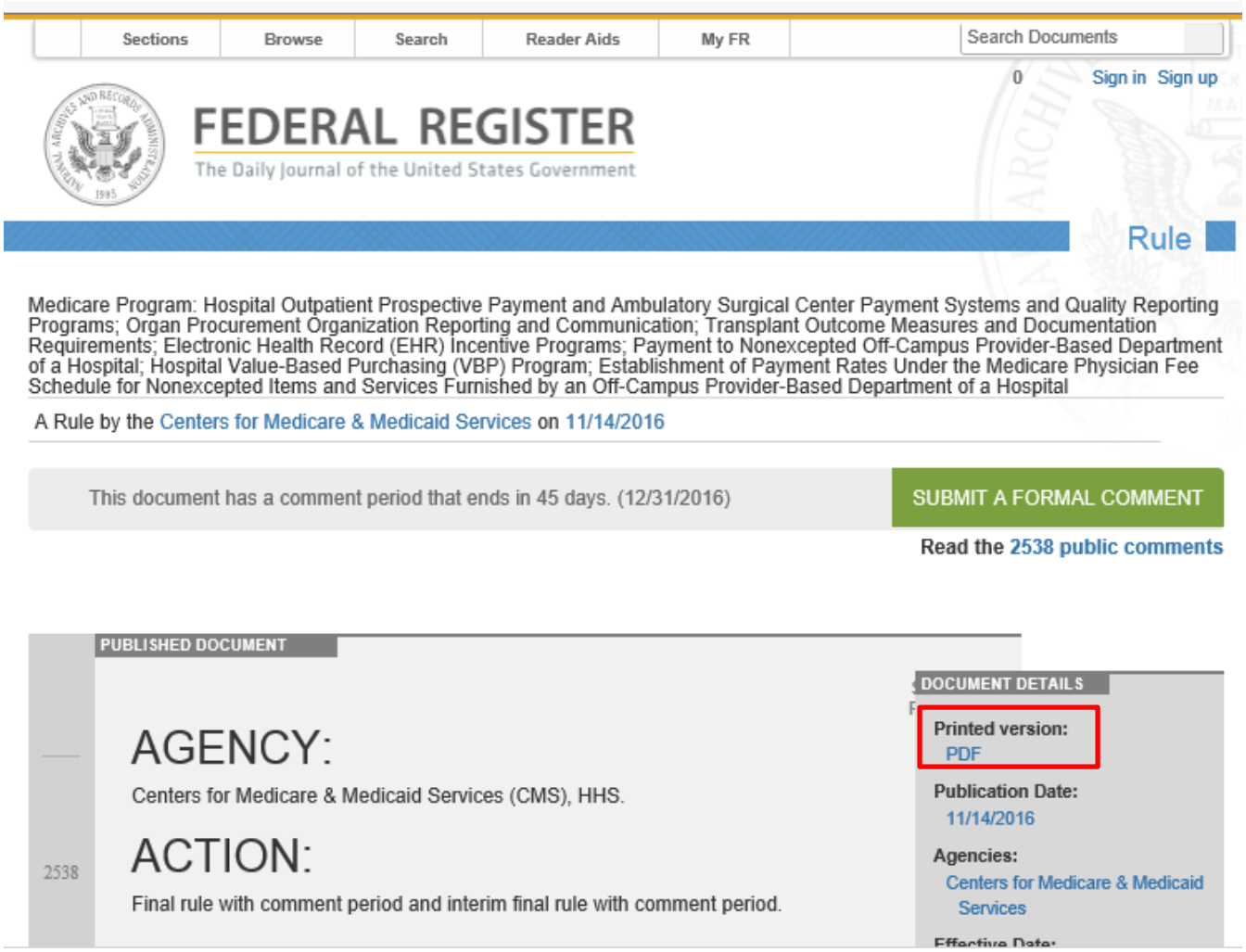
Locating the Rule

Navigating the *Federal Register*



Navigating the *Federal Register*

Navigating the *Federal Register*



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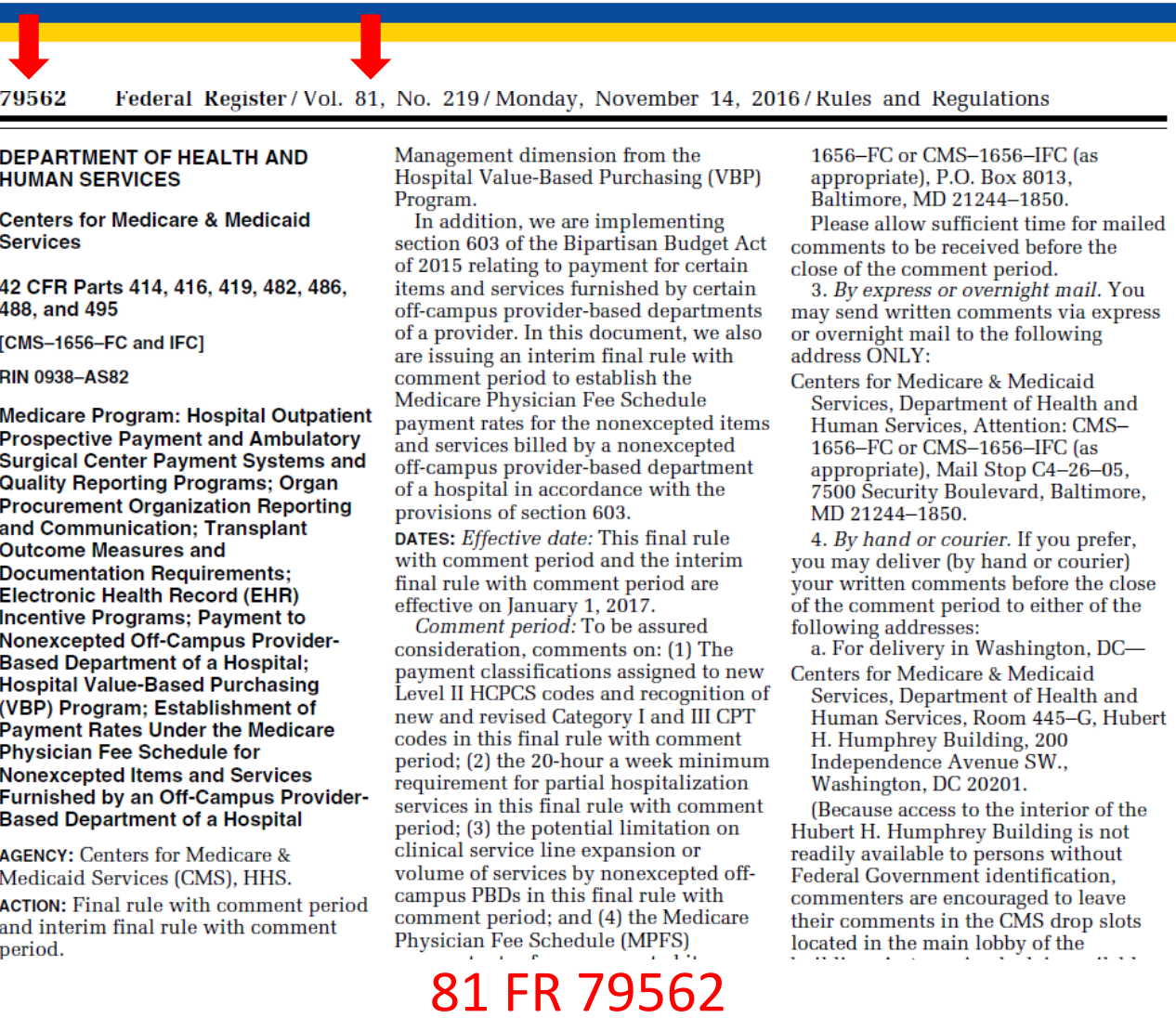


DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 414, 416, 419, 482, 486, 488, and 495

[CMS–1656–FC and IFC]

RIN 0938–AS82

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period and interim final rule with comment period.

Management dimension from the Hospital Value-Based Purchasing (VBP) Program.

In addition, we are implementing section 603 of the Bipartisan Budget Act of 2015 relating to payment for certain items and services furnished by certain off-campus provider-based departments of a provider. In this document, we also are issuing an interim final rule with comment period to establish the Medicare Physician Fee Schedule payment rates for the nonexcepted items and services billed by a nonexcepted off-campus provider-based department of a hospital in accordance with the provisions of section 603.

DATES: *Effective date:* This final rule with comment period and the interim final rule with comment period are effective on January 1, 2017.

Comment period: To be assured consideration, comments on: (1) The payment classifications assigned to new Level II HCPCS codes and recognition of new and revised Category I and III CPT codes in this final rule with comment period; (2) the 20-hour a week minimum requirement for partial hospitalization services in this final rule with comment period; (3) the potential limitation on clinical service line expansion or volume of services by nonexcepted off-campus PBDs in this final rule with comment period; and (4) the Medicare Physician Fee Schedule (MPFS)

1656–FC or CMS–1656–IFC (as appropriate), P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1656–FC or CMS–1656–IFC (as appropriate), Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

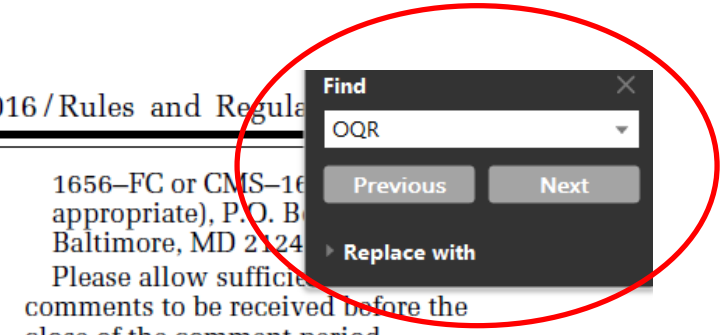
a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the

81 FR 79562

Navigating the *Federal Register*



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 414, 416, 419, 482, 486, 488, and 495

[CMS–1656–FC and IFC]

RIN 0938–AS82

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing

Management dimension from the Hospital Value-Based Purchasing (VBP) Program.

In addition, we are implementing section 603 of the Bipartisan Budget Act of 2015 relating to payment for certain items and services furnished by certain off-campus provider-based departments of a provider. In this document, we also are issuing an interim final rule with comment period to establish the Medicare Physician Fee Schedule payment rates for the nonexcepted items and services billed by a nonexcepted off-campus provider-based department of a hospital in accordance with the provisions of section 603.

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Comment period: To be assured consideration, comments on: (1) The payment classifications assigned to new

1656–FC or CMS–16
appropriate), P.O. B
Baltimore, MD 2124

Please allow sufficie
comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1656–FC or CMS–1656–IFC (as appropriate), Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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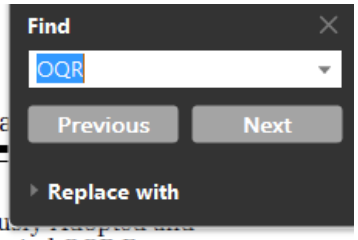
a. For delivery in Washington, DC—

Centers for Medicare & Medicaid

Navigating the *Federal Register*



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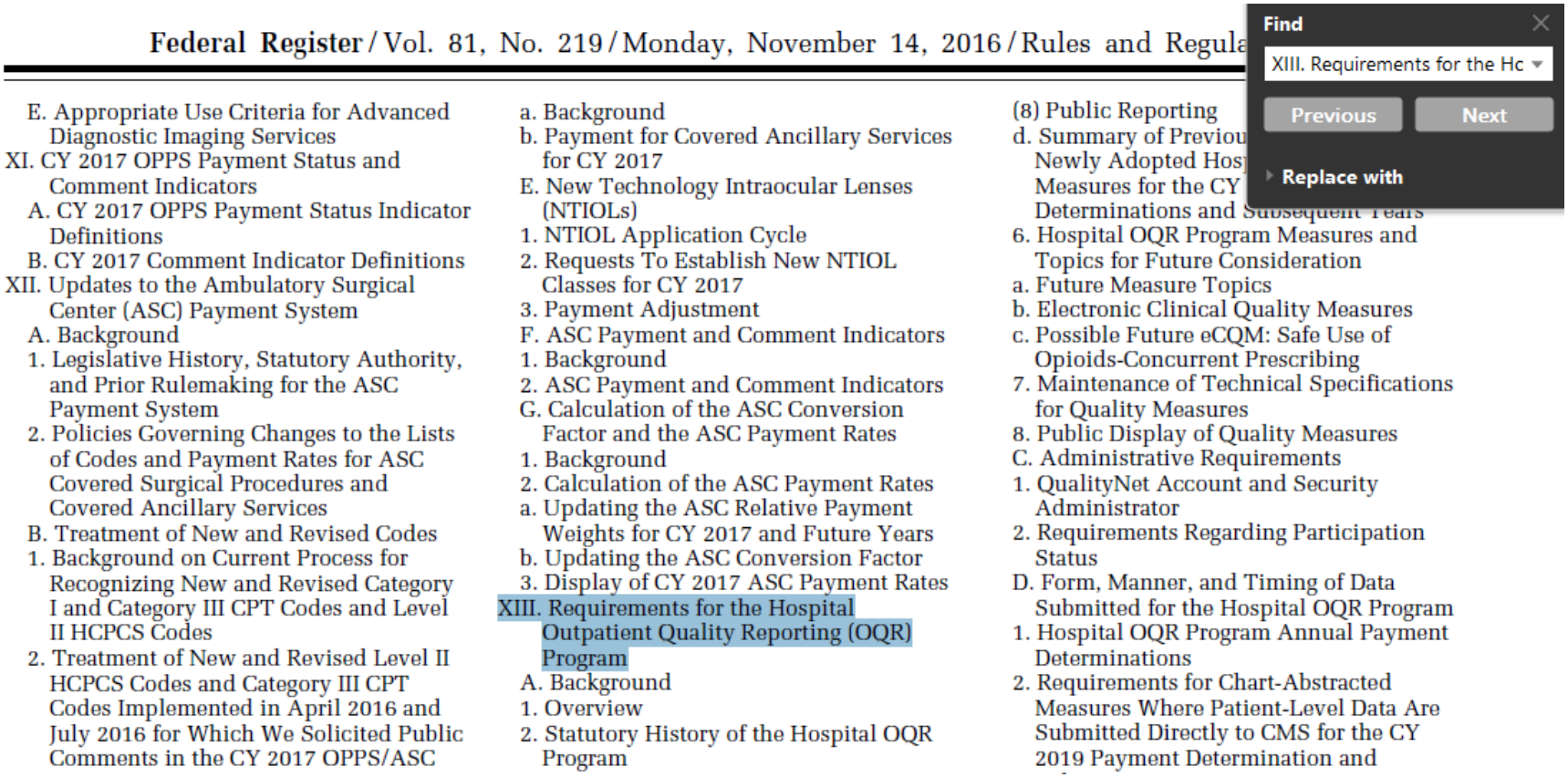

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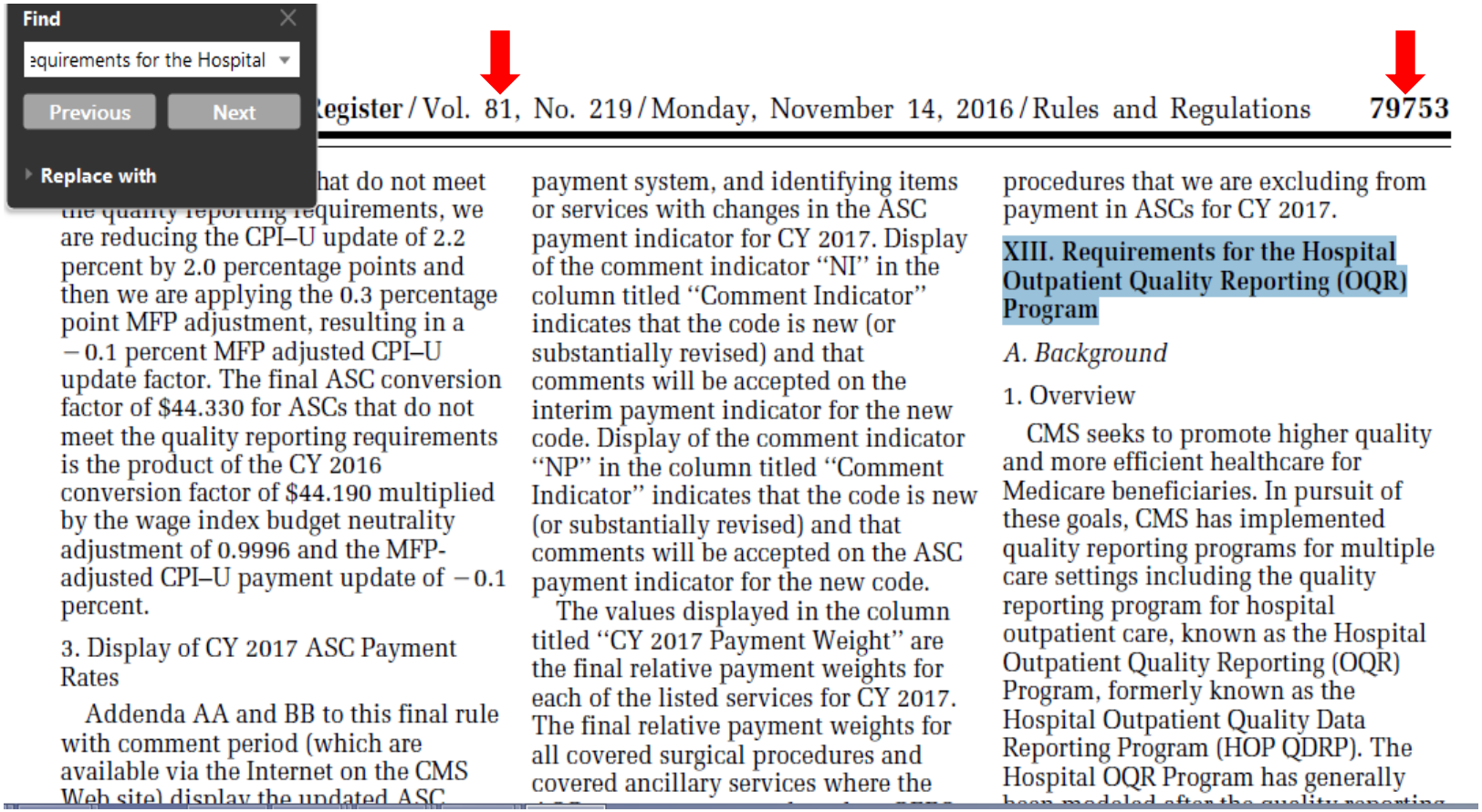

81 FR 79753

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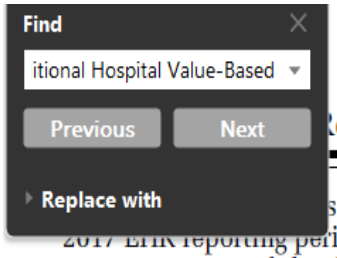


s prior to the 2017 EHR reporting period. These commenters stated that it is important that new participants who intend to transition into MIPS have the opportunity to focus on the measures and requirements specified for the proposed advancing care information performance category in 2017.

Response: We thank the commenters for their suggestion and rationale. We will work with our stakeholders to clearly communicate the availability of the hardship exception application once available. We plan to do this early enough in 2017 to ensure these new participants can focus on the relevant categories under MIPS.

After consideration of the public comments we received, we are finalizing the significant hardship exception for new participants transitioning to MIPS in 2017 as

Response: We thank the commenters for their support. We believe that actions which occur outside of the EHR reporting period should be kept within the same calendar year because it could lead to attesting more than once on the same action but for different calendar year reporting periods.

Comment: Several commenters suggested that CMS revise FAQ 8231 in order to further clarify this change if it is finalized.

Response: We plan to update FAQ 8231 to explain the new policy.

Comment: Several commenters suggested that if CMS were to make a change to the reporting logic, it should be implemented as part of Stage 3, not to the Stage 2 modification.

Response: We thank the commenters for their suggestion. We do not believe that this change should be implemented as part of Stage 3 only. We believe that

occur within the EHR reporting period if that period is a full calendar year, or if that period is less than a calendar year, actions included in the numerator must occur within the calendar year in which the EHR reporting period occurs. This policy applies beginning with EHR reporting periods in CY 2017.

XIX. Additional Hospital Value-Based Purchasing (VBP) Program Policies

A. Background

Section 1886(o) of the Act, as added by section 3001(a)(1) of the Affordable Care Act, requires the Secretary to establish a hospital value-based purchasing program (the Hospital Value-Based Purchasing (VBP) Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance

81 FR 79855

Measures

OP-35

OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

- One or more inpatient admissions or one or more ED visits from any of the following diagnoses: ***anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis*** within 30 days of chemotherapy treatment among cancer patients receiving treatment in a hospital outpatient setting

OP-35: Additional Information

Details on how the measure is calculated, methodology, and the complete list of risk-adjustment variables:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

OP-36

OP-36: Hospital Visits After Hospital Outpatient Surgery

- Outcome:
  - Inpatient admission directly after the surgery

    OR
  - Unplanned hospital visit (ED visits, observation stays, or inpatient admissions) occurring after discharge and within seven days of the surgery

OP-36: Numerator and Denominator

The facility-level measure score is a ratio of the predicted to expected number of post-surgical hospital visits among the hospital's patients.

- **Numerator**:

  Number of hospital visits predicted for the hospital's patients accounting for its observed rate, the number of surgeries performed at the hospital, the case-mix, and the surgical procedure mix

- **Denominator**:

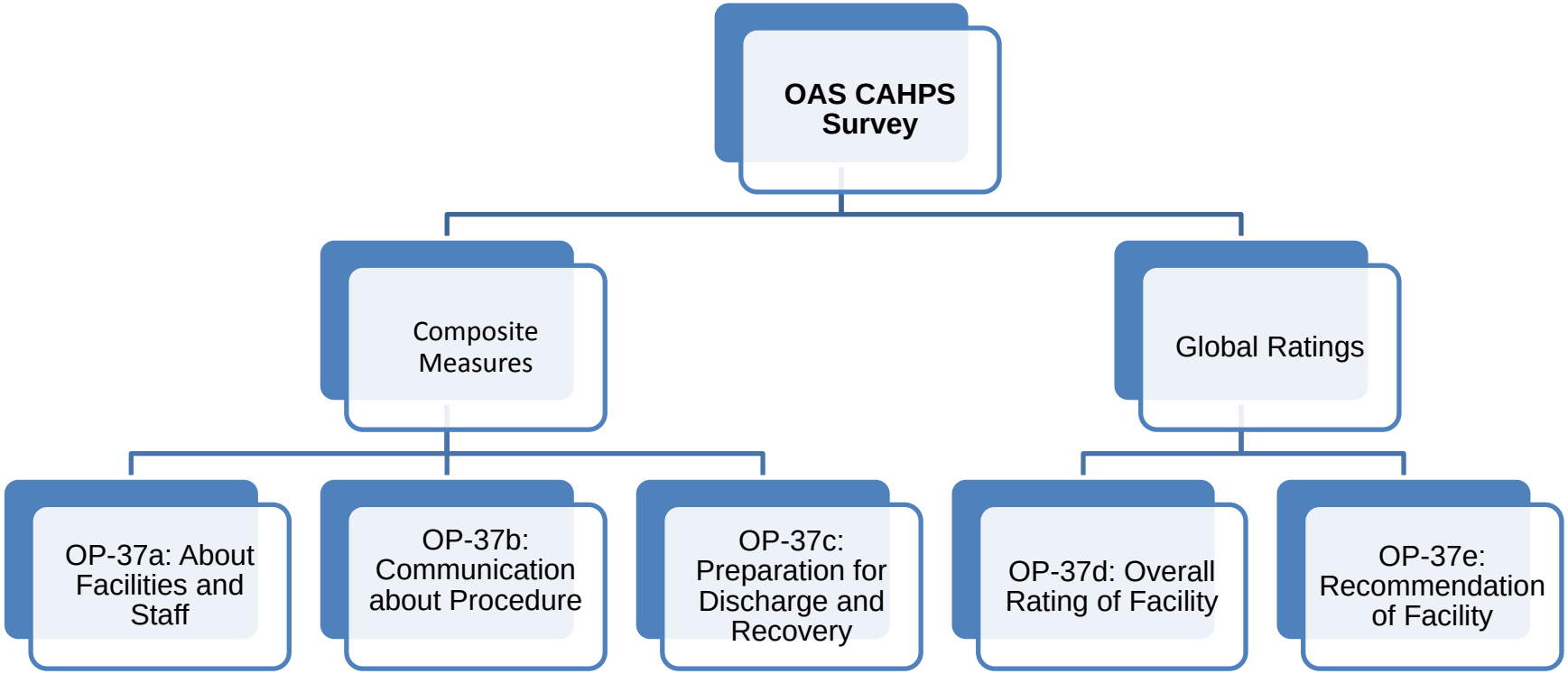
  Expected number of hospital visits given the hospital's case-mix and surgical procedure mix

OP-36: Additional Information

Additional methodology details are available at:

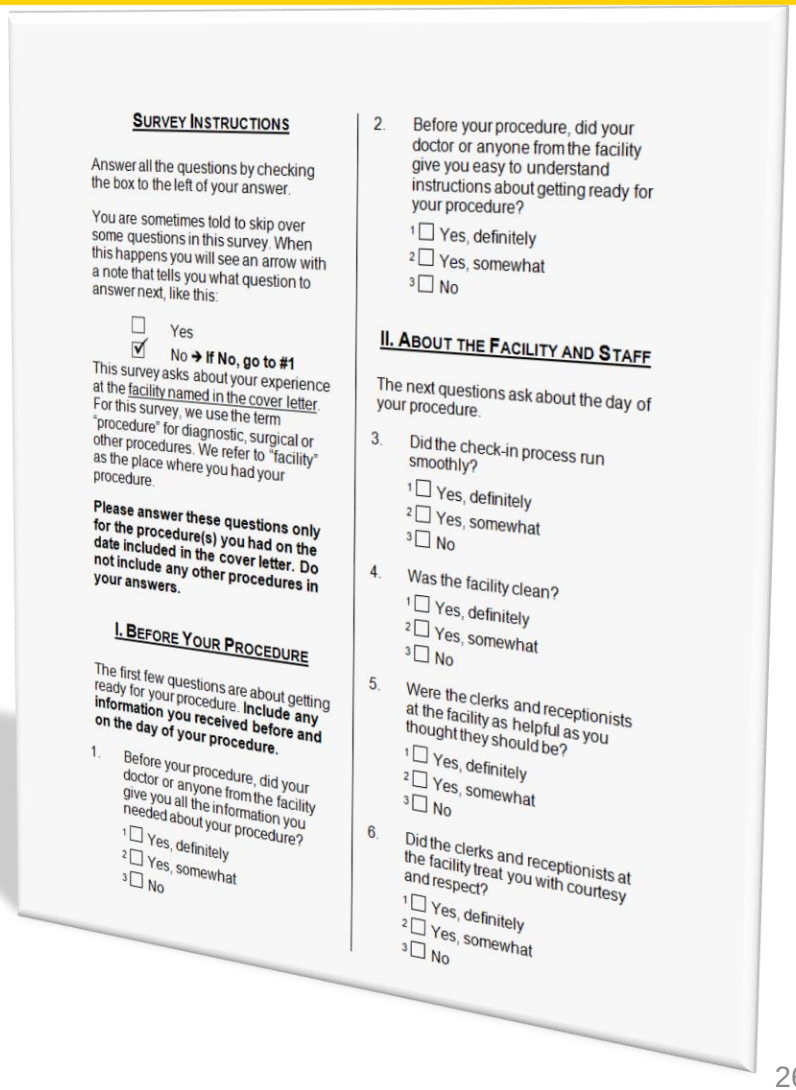
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html under: “2016 Measure Updates and Specifications Report: Hospital Visits after Hospital Outpatient Surgery Measure [PDF, 2MB]”

Survey-Based Measures



OAS CAHPS Survey: Goals

- Survey results will produce comparable data on the patient's perspective that allow objective and meaningful comparisons between facilities on domains that are important to consumers.
- Public reporting will allow consumers to make more informed choices when choosing a facility.
- Survey results will be used by facilities for quality improvement initiatives.



SURVEY INSTRUCTIONS

Answer all the questions by checking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes
☑ No → **If No, go to #1**

This survey asks about your experience at the facility named in the cover letter. For this survey, we use the term "procedure" for diagnostic, surgical or other procedures. We refer to "facility" as the place where you had your procedure.

Please answer these questions only for the procedure(s) you had on the date included in the cover letter. Do not include any other procedures in your answers.

I. BEFORE YOUR PROCEDURE

The first few questions are about getting ready for your procedure. **Include any information you received before and on the day of your procedure.**

1. Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No
2. Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No

II. ABOUT THE FACILITY AND STAFF

The next questions ask about the day of your procedure.

3. Did the check-in process run smoothly?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No
4. Was the facility clean?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No
5. Were the clerks and receptionists at the facility as helpful as you thought they should be?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No
6. Did the clerks and receptionists at the facility treat you with courtesy and respect?
   1 ☐ Yes, definitely
   2 ☐ Yes, somewhat
   3 ☐ No

Survey Topics

The OAS CAHPS Survey:

- Contains 37 questions relating to:
  - Preparation for the surgery or procedure
  - Check-in and pre-operative processes
  - Cleanliness of the surgery facility
  - Surgery facility staff
  - Discharge from the facility
  - Preparation for recovering at home
- Developed following the principles and guidelines outlined by the Agency for Healthcare Research and Quality (AHRQ) and its CAHPS Consortium

Survey Administration

The OAS CAHPS Survey is:

- Administered to a random sample of eligible patients who had at least one outpatient surgery/procedure during the sample month
  - Conducted at the CMS Certification Number (CCN) level
  - Reporting for a CCN must include all eligible patients from all eligible facilities covered by the CCN

Survey Administration

- Administered by one of three methods:
  - Mail-only
  - Telephone-only
  - Mixed mode (mail with telephone follow-up of non-respondents)
- Facilities will contract with a CMS-approved vendor to collect survey data for eligible patients monthly.
- CMS will propose a format and timing for public reporting of OAS CAHPS Survey data in future rulemaking prior to implementation of the measures.

Survey Data Collection

- Data collection period will be the calendar year two years prior to the payment determination year.
- Required to collect data monthly and submit quarterly.
- Target minimum of 300 completed surveys for each 12-month reporting period.
- Protocols and Guidelines Manual - https://oascahps.org/Survey-Materials

Survey Exemption

- Requests for an exemption can be submitted if the facility treats fewer than 60 survey-eligible patients during the eligibility period
  - Eligibility period is the calendar year before the data collection period
- Must be submitted on or before May 15 of the data collection year
  - Form will be available on the OAS CAHPS Survey website: https://oascahps.org

Policies

Policy Updates

CY 2017 payment determination/subsequent years

- Clarification of Reconsideration Process

  Additional information about the Reconsideration Process was presented at a webinar on November 7, 2016. http://www.qualityreportingcenter.com/hospitaloqr/events/

CY 2018 payment determination/subsequent years

- Clarification of Public Display of Data

CY 2019 payment determination/subsequent years

- Change to Extraordinary Circumstances Exemption or Extension (ECE) Policy

Correction

0658	OP–29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.**
0659	OP–30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.***
1536	OP–31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.***
2539	OP–32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
1822	OP–33: External Beam Radiotherapy for Bone Metastases.
N/A	OP–35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy.****
2687	OP–36: Hospital Visits after Hospital Outpatient Surgery.****
N/A	OP–37a: OAS CAHPS—About Facilities and Staff.****
N/A	OP–37b: OAS CAHPS—Communication About Procedure.****
N/A	OP–37c: OAS CAHPS—Preparation for Discharge and Recovery.****
N/A	OP–37d: OAS CAHPS—Overall Rating of Facility.****
N/A	OP–37e: OAS CAHPS—Recommendation of Facility.****

† We note that NQF endorsement for this measure was removed.

*OP–26: Procedure categories and corresponding HCPCS codes are located at: *https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244.*

**We note that measure name was revised to reflect NQF title.

***Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).

****New measure finalized for the CY 2020 payment determination and subsequent years.

Inpatient Hospital Value-Based Purchasing (VBP) Program

Pain Management

- CMS has received feedback that some stakeholders are concerned about the Pain Management dimension questions being used in a program where there is any link between scoring well on the questions and higher hospital payments.
- Some stakeholders believe that the linkage of the Pain Management dimension questions to the Hospital VBP Program payment incentives creates pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension.
- We continue to believe that pain control is an appropriate part of routine patient care that hospitals should manage and is an important concern for patients, their families, and their caregivers.

Pain Management

- CMS finalized the proposal to **remove the Pain Management dimension** of the HCAHPS Survey in the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain **beginning with the Fiscal Year (FY) 2018 program year**.
- The FY 2018 program year uses HCAHPS performance period data from January 1, 2016 to December 31, 2016, to calculate each hospital's Total Performance Score (TPS).
- CMS is continuing the development and field testing of alternative questions related to provider communications and pain, and will solicit comment on these alternatives in future rulemaking.

Finalized HCAHPS Survey Dimensions for the FY 2018 Program Year
Communication with Nurses
Communication with Doctors
Responsiveness of Hospital Staff
Communication About Medicines
Hospital Cleanliness & Quietness
Discharge Information
3-Item Care Transition
Overall Rating of Hospital

More Information

HCAHPS: Overview, Updates, and Hospital Value-Based Purchasing Webinar

- Available at: http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/
- Recorded on Tuesday, November 15, 2016 at 2 p.m. ET
- Provides an overview of the HCAHPS survey, including:
  - Background of HCAHPS Survey
  - Trends of HCAHPS measures
  - HCAHPS and Hospital VBP, including the Care Transition Measure Dimension added to Hospital VBP and the Pain Management Dimension removed from Hospital VBP
  - HCAHPS correlations
- Presented by William G. Lehrman, PhD, Government Task Leader, HCAHPS Division of Consumer Assessment & Plan Performance Centers for Medicare & Medicaid Services

Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Council of Dietetics
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
  - It is your responsibility to submit this form to your accrediting body for credit.

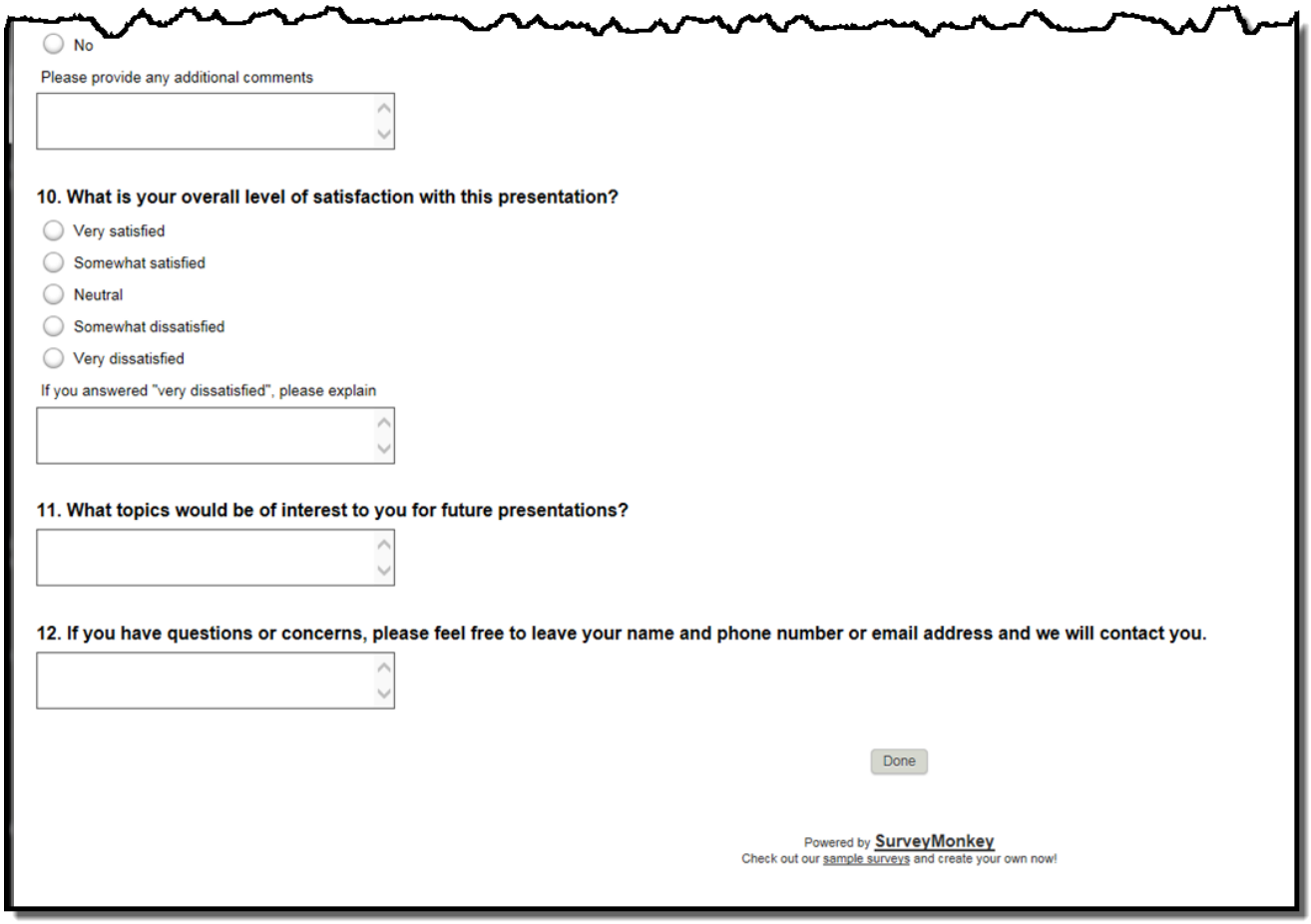
CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click **Done** at the bottom of the screen.
- Another page will open that asks you to register in HSAG's Learning Management Center.
  - This is separate from registering for the webinar. If you have not registered at the Learning Management Center, you will **not** receive your certificate.
  - Please use your **personal** email so you can receive your certificate.
  - Healthcare facilities have firewalls that block our certificates.

CE Certificate Problems?

- If you do not immediately receive a response to the email you used to register in the Learning Management Center, a firewall is blocking the survey link.
- Please go back to the New User link and register your personal email account.
- If you continue to have problems, please contact Deb Price at dprice@hsag.com.

CE Credit Process: Survey



No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain

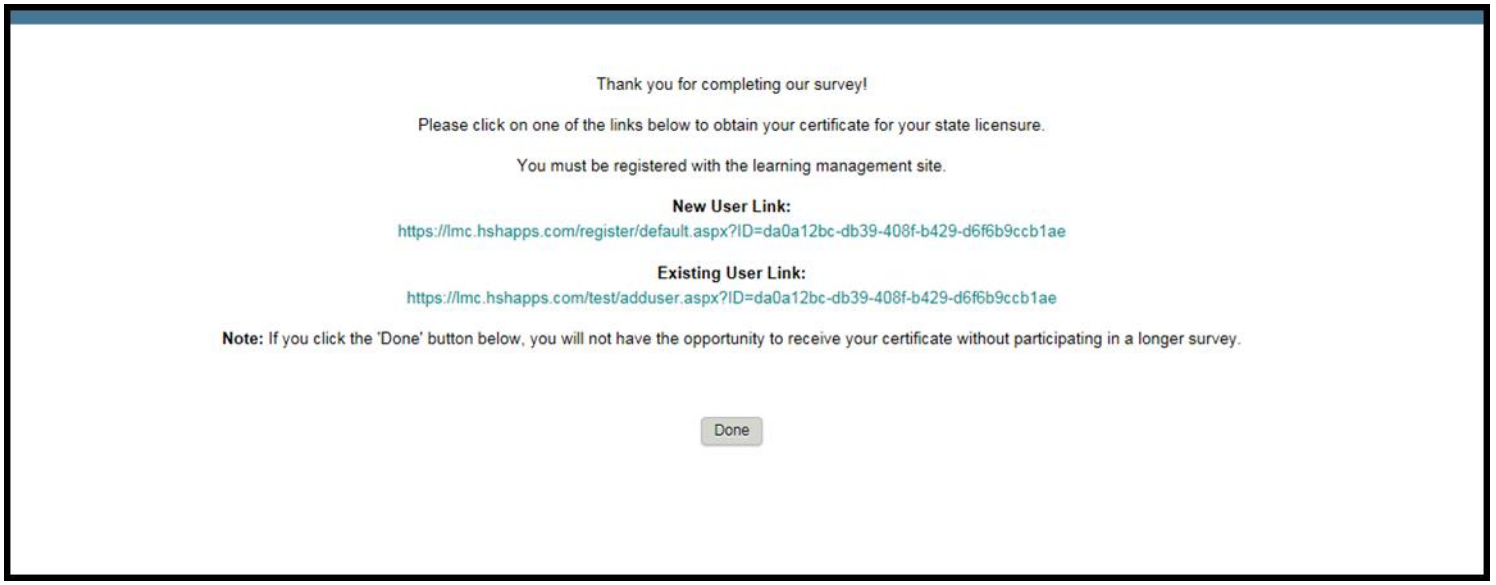
11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

Done

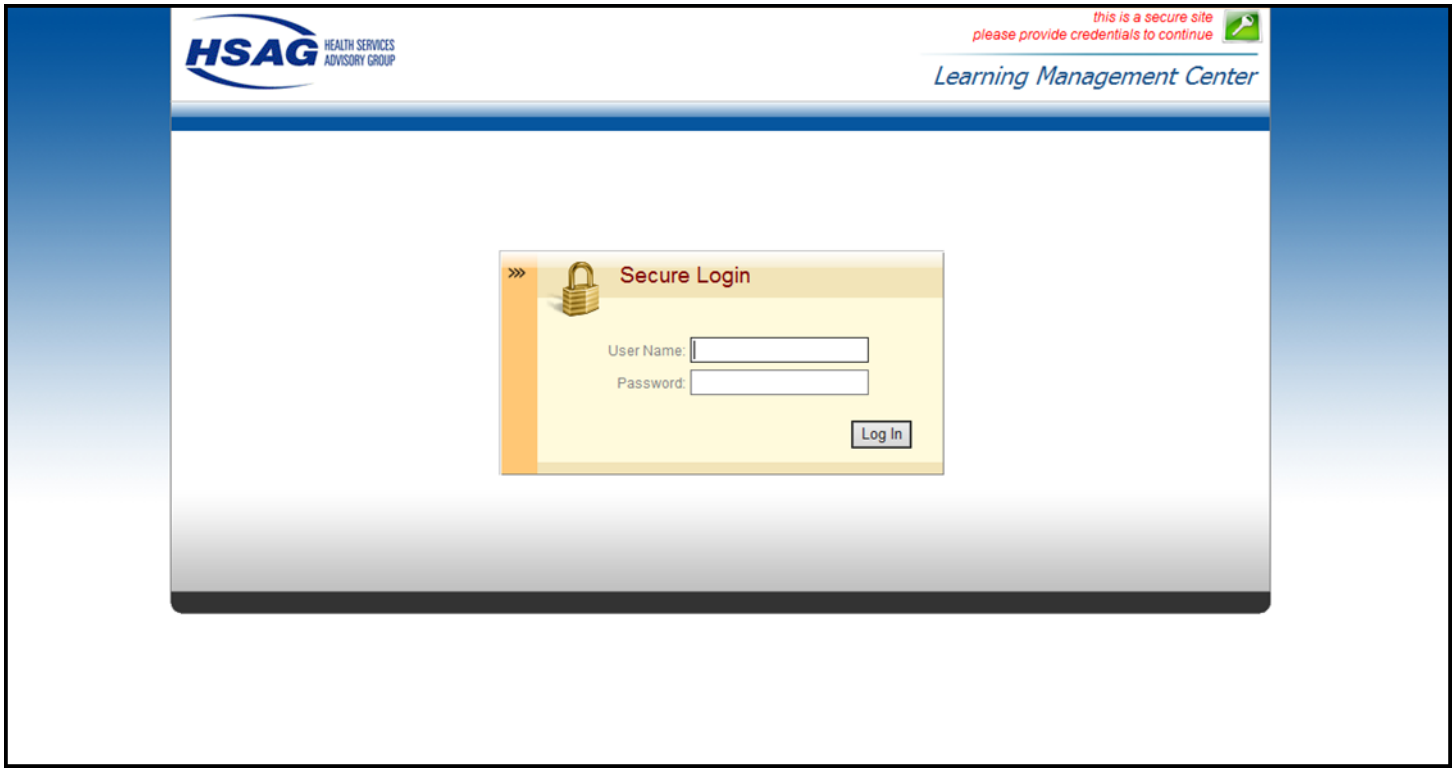
Powered by SurveyMonkey
Check out our sample surveys and create your own now!

CE Credit Process



CE Credit Process: New User

CE Credit Process: Existing User



Thank You for Participating!

Please contact the Support Contractor if you have any questions:

- Submit questions online through the QualityNet Question & Answer Tool at www.qualitynet.org

Or

- Call the Support Contractor at 866.800.8756.

Biographies

Dr. Elizabeth Bainger: Elizabeth joined CMS in June 2014 to become the Program Lead for the Hospital OQR Program. She has a Doctorate of Nursing Practice from 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, flight nursing, and nursing education. 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.

Dr. Vinitha Meyyur: Dr. Meyyur is a healthcare researcher specializing in research, program evaluation, quantitative data analysis, survey/measure development, contract management, and outcomes research with more than 14 years of experience working on U.S. Department of Health and Human Services 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.

Dr. Liz Goldstein: Liz is a Director of the Division of Consumer Assessment and Plan Performance. Since 1997, she has been working on the development and implementation of Consumer Assessment of Healthcare Providers and Systems Surveys, or CAHPS, in a variety of settings. She is responsible for a number of the CAHPS surveys administered by CMS, the Part C Star Ratings, the Star Ratings for Medicare Advantage quality bonus payments, Medicare HEDIS data collection, and Part D enrollment analyses. She received her doctorate in Economics from the University of Wisconsin, Madison.

Grace H. Im: Grace is the Program Lead for the Hospital IQR Program and the Hospital VBP Program, CMS, Center for Clinical Standards and Quality, Quality Measurement & Value-Based Incentives Group. Grace is responsible for all aspects of implementing these programs and works in close collaboration with the Center for Medicare, as well as other hospital quality programs and measure development leads for acute care settings. Grace received her JD from the University of Virginia School of Law and MPH in health policy from the George Washington University Milken Institute School of Public Health.