Outpatient Quality Reporting Program

Support Contractor

Hospital Outpatient Quality Reporting (OQR) Program Reconsideration Process Calendar Year 2018

Presentation

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Anita Bhatia: Thank you. Good morning, everyone. Welcome to the Hospital Outpatient Quality Reporting Program Reconsideration Process Webinar. My name is Anita Bhatia. I am the CMS Program Lead for the Hospital Outpatient Quality Reporting Program. Recently, the Centers for Medicare and Medicaid Services, or CMS, provided notification of the annual payment update payment determination for the Hospital Outpatient Quality Reporting Program. These are affecting calendar year 2018 Outpatient Prospective Payment System, or OPPS payment. We understand you may have questions regarding the reconsideration process for these payment determinations. We appreciate this and want to get you key information on the process as well as on how to submit a reconsideration. This is your opportunity to submit a reconsideration of any adverse payment determination, and for us to be able to reconsider and potentially reverse that payment determination.

When you request your reconsideration, it is important to keep in mind that the reconsideration process is designed to examine circumstances beyond the control of the hospital. Also important, please be as specific as possible. We want to hear in detail of any and all attempts to comply with the CMS requirement or requirements listed in the notification letter.

In addition, we want to hear why your hospital did not meet these requirements, whether it be, for example, a data submission or a validation requirement. Being specific means including information such as your attempt to contact Help Desk or submit data, which dates and to whom you spoke with. This will help us to determine what you attempted to do to comply with the requirement, and whether CMS systems or federal systems or our communications might have adversely impacted your ability to meet requirements.

Here today to discuss this process in detail is Ms. Reneé Parks. Reneé is the director for both the ASC Quality Reporting and the Hospital Outpatient Quality

Reporting programs. Reneé received her Bachelor of Science degree in Nursing from the University of Central Arkansas. She has worked in the healthcare industry for many years at various levels and has vast clinical, management, healthcare policy and administration experience.

Reneé is going to walk all of us through our process. After this short presentation, we will then take questions. I want to thank you again and now let me turn things over to Reneé. Reneé?

Reneé Parks: Thank you, Anita. Welcome, everyone. We appreciate your time. As Anita mentioned, the purpose of today's presentation is to provide information regarding the Hospital OQR Reconsideration Process for payment year 2018. We hope that by participating in the presentation, you'll understand the Hospital OQR Program requirements for the reconsideration process, and you'll understand how to submit a reconsideration request.

In the event that the original finding is upheld through the reconsideration process, you'll also learn how to file an appeal if you should choose to do so. There are currently 3,226 Outpatient Prospective Payment System, or OPPS, hospitals eligible to participate in the calendar year 2018 Hospital OQR Program to receive the annual payment updates; 3,135 or 97.2% of eligible hospitals met all program requirements; 72 or 2.2% chose not to participate; and 19 or 0.6% did not meet the program requirements.

Now, this information I just mentioned is publicly available and you can go to the QualityNet website to obtain that information. Eligible facilities paid under the Outpatient Prospective Payment System, or OPPS that do not meet all of the OQR program requirements may receive a 2% point reduction in their payment updates.

Now, let's briefly look on the next slide at the program requirements outlined here. The OQR program requires patient-level chart-abstracted data to be submitted for quarters two, three, and four of calendar year 2016 and quarters one of the year 2017. These data apply to patient encounters through the calendar year 2016, so from January through December of 2016. The outcome measure, or OP-32, now this is a claim space measure, with data also from January 1 through December 31, 2016.

Then, we have the submission of web-based measures using two platforms. The measures submitted through QualityNet apply to patient encounters through the calendar year 2016. The flu vaccination measure with the reference period of the applicable flu season is from October 1, 2016 through March 31, 2017. This measure is reported through the National Healthcare Safety Network, or NHSN, website.

All of the measures submitted using a web-based tool either through QualityNet or through the NHSN website; all of those measures were due by May 15, 2017. To provide another rundown of the program requirement, this slide also lists the administrative requirements and the validation requirements in addition to the data submission requirements that were provided on the previous slide.

A hospital must register with QualityNet and maintain an active security administrator, complete and submit the hospital OQR Notice of Participation and submit that via the QualityNet secure portal. The hospital must collect and submit the patient level chart abstracted data. On this slide, that's referred to as clinical data, but we were talking about that patient level chart abstracted data as we just discussed on the previous slide.

Also, moving down, collect and submit the data using the web-based tool and that's either via the CMS QualityNet online tool or via the NHSN or CDC's online submission tool. If selected for validation, your hospital must pass the validation process. The form and manner of data submission is clearly defined in the federal register as is the hospital OQR validation process and administrative requirements.

Let's take a look on the next slide. APU's determination notification letters were mailed on November 3 via Federal Express to the hospitals that did not meet one or more of the program requirements. These letters were sent to the hospitals not meeting one or more of the Hospital Outpatient Quality Reporting Program requirements resulting in a 2 percent annual payment update reduction for calendar year 2018.

Any requests for reconsideration must be submitted on or before March 17, 2018. I strongly urge anyone not to wait until the deadline for reasons I'll go over in the next few slides. An overview of the reconsideration process, including the reconsideration request form, can be found on the CMS QualityNet website at www.QualityNet.org or by the direct link that is provided in this slide.
Let's walk through QualityNet and how you locate things. To access the resources related to the reconsideration process from the home page on QualityNet, select Hospital Outpatient circled here in red from the dropdown seen here on the slide. From the dropdown menu, select the Hospital Outpatient Quality Reporting Program link as displayed here with the red arrow. To get to the reconsideration overview page, select APU Reconsideration, circled here in red, and then click on the bolded Hospital OQR Reconsideration Process for calendar year 2018 APU determination link. This page will provide you with the resources to assist you in filing for reconsideration and you'll be able to access the form itself.

The reconsideration request deadline for this year is actually March 19. According to the regulations governing the program, the deadline is March 17 or the first business day following this date should it fall on a weekend or holiday. As this date falls this year on Saturday, the deadline will revert to the following Monday, which is March 19.

When submitting your request for reconsideration, as Anita stated earlier, it is important to ensure that you filled out this form completely and accurately. All fields that contain an asterisk are mandatory. You must provide a CMS identified reason for why your facility did not meet the Hospital OQR requirements. This information was provided in the notification letter your hospital received. Requests for reconsideration should be specific, complete and include all details.

If your hospital is requesting a reconsideration related to validation results, send a copy of the reconsideration form, Part 2, to the validation contractor. I'm going to say that again. If your hospital was selected for validation, and if CMS determined that your hospital did not meet program requirements due to a confidence interval validation score of less than 75 percent, then you must complete and submit Part 2 of the reconsideration form.

Along with that form, you must send a copy of the entire medical record as previously sent to the Clinical Data Abstraction Center contractor, or CDAC, for the appealed element. Again, you will send Part 2 of the reconsideration request form and the medical records to the validation contractor. All of this information is available on the QualityNet website. Include specific reasons why you feel your hospital met the program requirements and why you should receive a full payment update.

There are three methods for submitting Part 1 of the reconsideration request form. First, you could submit that form via the secure file transfer to the APU Group but please note that this method does not allow you to attach additional documentation. If you use this method, you can only submit the reconsideration request form. Alternatively, you may submit via the secure fax and that number is listed here on the slide at 877-789-4443 or by email at QRSupport@HCQIS.org.

The last two methods will allow you to attach additional documentation along with the reconsideration request form. This might include Help Desk ticket numbers, corresponding screenshots, emails or a correspondence from NHSN. I strongly encourage you to attach this supporting documentation. Say, for instance, if you reached out repeatedly to the Help Desk through QualityNet, then please send us those ticket numbers. Again, screenshots and correspondence are very helpful for your case. This is your opportunity to make your case and help us understand your efforts to comply with program requirements.

After CMS receives your completed reconsideration request form, they will send an email acknowledgement to the designated hospital contact using that information that was provided in the reconsideration request notifying them that the hospital's request has been received and is being processed. We usually acknowledge receipt on the same day the reconsideration form is received, but it could take up to 48 hours. That means, if you wait until the deadline and then a few days go by, and you reach out to CMS wondering why you never received the acknowledgement, now you've missed the deadline, and we have had this happen in the past.

We've had a hospital that waited until the deadline to fax their form in transposed the numbers so, therefore, the fax number went to the wrong number, and we were never in receipt of their request. Therefore they missed the reconsideration deadline. Please don't let this happen to you. We expect that process to be completed within 90 days following the deadline for submitting a reconsideration request form.

As we stated, that deadline for this year is March 19. So, 90 days from March 19 is on or around June 19, remembering that the actual deadline in the rule states March 17. This is when you would expect to see your written response from CMS, on or about June 19, 2018.

Now, if your hospital is not satisfied with the results of the reconsideration, you may file an appeal with the Provider Reimbursement Review Board, or PRRB, for short. An appeal can only be filed with the PRRB if you submitted a reconsideration request by the deadline, again, this year March 19 and you went through the reconsideration process.

To be clear, you must file a reconsideration request form first and then if you're dissatisfied, you can appeal that to the Provider Reimbursement Review Board. If you missed the reconsideration deadline, then you've not only lost your opportunity for reconsideration, you've also lost your opportunity to request a review from the Provider Reimbursement Review Board. Hospitals can submit an appeal to the Provider Reimbursement Review Board up to 180 days following the Hospital Outpatient Quality Reporting reconsideration notification date.

These slides and a transcript of the presentation, as well as the questions and answers will be on the Quality Reporting Center website shortly after the presentation is concluded. Please reach out to the Help Desk if you have any questions. They're willing to assist you. That number is 866-800-8756 as seen here on this slide. I would anticipate that many of you are familiar with this number for calling in with any questions prior to this webinar. As we stated earlier, we're here to help you. Again, we will be happy to assist you and walk you through the process.

Now, we'd like to open the lines up for questions, however I do want to point out that we likely will not be able to respond to hospital-specific questions but we can point you toward the proper resources.

With that, I will turn it back to Cammie, our operator, who can open the lines for questions.

Operator: Thank you. This begins our question and answer session. Once again, if you have a question, please press star, then one on your touch-tone phone. If you wish to be removed from the question queue, you can press the pound sign or the hash key. Also, if you are using a speakerphone, you may need to pick up the handset first before pressing the numbers. Once again, as a reminder, to ask a question it is star then one on your touch tone phone and I am standing by for any questions. At this time, I have no questions in the question queue.

Reneé Parks: Thank you, Cammie. With that, and there are no questions but if one should come to mind after the call has ended, please call and contact the call center as we are here to help you. I'd like to thank Anita for joining us today and again, that number is 866-800-8756. Thank you.