Quality Reporting Program

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CY 2020 OPPS/ASC Proposed Rule: Hospital Outpatient Quality Reporting (OQR) Program

Presentation Transcript

Speaker:
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Karen: Hi everyone and welcome to the Hospital Outpatient Quality Reporting Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Lead for the Hospital OQR Program.

Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for this Program. She received her PhD from the University of Massachusetts Amherst and her Master's in Public Health from Johns Hopkins University. Dr. Bhatia plays a crucial role in development of the OPPS/ASC proposed and final rulings. Her contributions to the rulings are essential to the continuing success of this program. We are fortunate to have Dr. Bhatia's commitment to this program.

Before I hand things over to Anita, let me just briefly cover a few housekeeping items.

Now, Anita will be going over the Proposed Rule with us today, and she will also briefly discuss the way CMS is navigating all of us to success through the various quality programs, initiatives, and goals. Additionally, by reducing the traffic congestion, or in other words, provider burden, CMS will assist providers with being involved in quality reporting and improving patient outcomes.

The learning objectives for the program are listed 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 our website at www.qualityreportingcenter.com at a later date. If you have not yet downloaded the slides for this presentation, you can get them from that some website. Just click on today's event. Additionally, the slides were attached to the email reminder you received for this event.

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During the presentation, if you have any questions, please put those questions in the chat box. If time allows, we will try to respond to some of those questions at the end of the presentation.

Now, before we get started with Dr. Bhatia, let me just mention a standard disclaimer before we get started. CMS can only address procedural questions and comment submission and cannot address any rule-related questions. CMS does look forward to your comments as this is your opportunity to provide input on these proposals.

So, without further delay, let me hand things over to our speaker, Dr. Bhatia. Anita

Anita: Hello, everyone! Thank you for attending our presentation today. Before I delve into our proposals for the Hospital Outpatient Quality Reporting Program contained in the current Proposed Rule, let me begin by outlining the current CMS quality reporting program framework that formulates our vision for quality reporting. The reason for this is discussion is that we change and refine our programs through rulemaking, but we are working toward specified goals; our current working model with these goals is the Meaningful Measures Initiative.

CMS launched the Meaningful Measures Initiative in October of 2017. The purpose of this initiative is to provide a new approach to quality measurement and reporting. This initiative evolved from CMS' increased understanding of the quality reporting terrain with all the curves and bumps encountered over the years. Further, CMS is adapting to the terrain to keep the quality reporting programs evolving as the needs of providers and other stakeholders also evolve.

So, are your thinking, what is the purpose of the Meaningful Measures Initiative and what are the intended benefits?

Great thinking out there! There are several reasons why the Meaningful Measures initiative is beneficial to Medicare beneficiaries, patients, as well as clinicians and healthcare providers. This Initiative identifies high priority areas for quality measurement and improvement with the goal of improving outcomes for patients, their families, and providers while also reducing burden on clinicians and providers to the extent possible.

The Meaningful Measures Initiative aims to streamline the number of quality measures for which providers are required to meet requirements, reduce regulatory burden, promote innovation in the healthcare industry as it transitions from fee-for-service to value-based payment, reward positive outcomes rather than micromanaging processes, and is geared toward reducing burden to healthcare providers.

So here we see a graphic of the strategic goals of the Meaningful Measures Initiative putting the patient first here in the center; the patient is to be supported by CMS initiatives including Patients over Paperwork, Rethinking Rural Health, Price Transparency, Better Care for Dual Eligible, e-Medicare, Fighting the Opioid Epidemic, Modernizing Medicare, Innovation, Lowering Drug Prices, and MyHealth E-data. These supporting initiatives promote the larger goals of Strengthening Medicare, Transforming Medicaid, Marketplace Choice and Affordability, Protecting Taxpayer Dollars, Ensuring Safety and Quality, and Innovating Payment Models. The outer layer contains the overarching principles of Empowering Patients, Unleashing Innovation, and Focusing on Results.

Our Hospital Outpatient Quality Reporting Program proposals also reflect efforts to improve the usefulness and usability of the quality data that we publicly report by streamlining how facilities are reporting and accessing data while maintaining or improving understanding of these data.

This framework will allow Hospital Outpatient Departments, Medicare beneficiaries, and other stakeholders to obtain meaningful quality of care information about the care delivered in Hospital Outpatient Departments. Further, we want to incentivize quality improvement while streamlining the measure sets to reduce duplicative measures and program complexity.

Here is our framework. Meaningful Measurement Areas are the connectors between CMS Strategic Goals and individual measures or initiatives that demonstrate how high-quality outcomes for patients are being achieved. These areas are concrete quality topics which reflect core issues that are most vital to high quality care and better patient outcomes and can encompass bundles of related measures. Meaningful Measurement Areas can focus efforts on the quality areas and lend specificity, which can help:

- Promote alignment across quality initiatives and programs which will minimize provider burden
- Promote more focused quality measure development towards outcomes that are meaningful to patients, families, and their providers
- Identify the big picture quality issues that are the highest priority in improving the health and healthcare of patients and communities, and
- Communicate how CMS programs and measures improve patients' health and how we plan to deliver value—better care, smarter spending, healthier communities— to meet the needs of patients.

So, we have scheduled construction! As mentioned, a goal of the Meaningful Measures Initiative is to reduce burden associated with our quality reporting programs to the extent possible. To initiate program changes, we must utilize the

rulemaking process. Now let's discuss what changes to the Hospital Outpatient Quality Reporting Program are being proposed in the CY 2020 Outpatient Perspective Payment System, or OPPS, Ambulatory Surgical Center, or ASC, Proposed Rule.

In this proposed rule, we are proposing to remove one measure from the Hospital Outpatient Quality Reporting Program. We propose to remove OP-33: External Beam Radiotherapy for Bone Metastases beginning with the CY 2022 payment determination. We propose the measure removal under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

We adopted this measure to address a performance gap in External Beam Radiotherapy (EBRT) treatment variation, to ensure appropriate use of EBRT, and to prevent the overuse of radiation therapy.

These goals remain valid. However, we have identified issues with reporting this particular measure, finding that more questions are received about how to report the EBRT measure than any other current measure in the program. In addition, the measure steward has received feedback on data collection of the measure in the outpatient setting and has indicated new and significant concerns regarding the "radiation delivery" CPT coding used to report the EBRT measure.

There are also challenges in determining aspects of the numerator, denominator, and sampling for the measure. Manual review of patient records by staff is also required and is labor-intensive, this contributes to burden and difficulty in reporting for this measure.

The measure was also adopted into the PPS-exempt Cancer Hospital Quality Reporting (or PCHQR) Program. This program has also proposed to remove the measure due to it being overly burdensome. In their discussion of their proposal to remove this measure, the PCHQR program also stated that because the measure steward is no longer maintaining the measure there is no assurance that the measure is in alignment with clinical guidelines and standards.

Therefore, we are proposing to remove this measure beginning with the CY 2022 payment determination and for subsequent years. We note that in crafting our proposal, we considered removing this measure beginning with the CY 2021 payment determination, but we decided on proposing to delay removal until the CY 2022 payment determination to be sensitive to facilities' planning and operational procedures given that data collection for this measure begins during CY 2019 for the CY 2021 payment determination. Please note that there was mention of this measure with proposed removal beginning with October 2020 encounters. This was an error and this error will be corrected in the Final Rule as

it was determined that a formal technical correction was not necessary, due to other language referencing the correct encounter time frame.

Our GPS indicates system updating. Yes, we strive to continually update our program. As stated, we are moving towards greater use of outcome measures and away from the use of clinical process measures across our Medicare quality reporting programs to better assess the results of care. Through future rulemaking, we intend to propose new measures that support our goal of achieving better health care and improved health for Medicare beneficiaries and other patients who receive health care in the hospital outpatient setting.

To this end, we are seeking comment on the potential future adoption of four patient safety measures for the Hospital Outpatient Quality Reporting Program that were previously adopted for the Ambulatory Surgical Center Quality Reporting Program, a quality reporting program for another outpatient setting. We are considering having these measures specified for the hospital outpatient setting and would seek collaboration with the measure steward if we do so; these measures designated as: ASC-1: Patient Burn, ASC-2: Patient Fall, ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant, and ASC-4: All-Cause Hospital Transfer/Admission.

We adopted these measures in the CY 2012 OPPS/ASC final rule for the Ambulatory Surgical Center Program. In this proposed rule, we noted that data collection for these measures was suspended in the Ambulatory Surgical Center Quality Reporting Program due to concerns with their data submission method, but not with the measures themselves.

Additionally, in this proposed rule, the ASCQR Program is requesting public comment on updating the submission method for these measures to use a CMS online data submission tool, that is from what we know as “web-based measures”

We believe these measures could be valuable to the Hospital OQR Program because they would allow us to monitor these types of events and prevent their occurrence to ensure that they remain rare, and because these measures provide critical data to beneficiaries and further transparency for care provided in the hospital outpatient setting that could be useful in choosing a hospital. Additionally, these measures address an important Meaningful Measure Initiative quality priority “Making Care Safer by Reducing Harm Caused in the Delivery of Care.”

We have reviewed studies demonstrating the high impact of these events because they are serious reportable events in healthcare and because these events are preventable.

The future addition of these measures would further align the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs, which would benefit patients because these are two outpatient settings of care that patients may be interested in comparing, especially if they are able to choose in which of these two settings, they receive care.

We are seeking public comment. In this proposed rule, we are also requesting public comment on future measures for the Hospital Outpatient Quality Reporting Program. Specifically, we are requesting public comment on any outcome measures that would be useful to add, as well as any process measures that should be eliminated from the program. We want your feedback to further our goal of developing a comprehensive set of quality measures for informed decision-making and quality improvement in the hospital outpatient setting.

Through future rulemaking, we intend to propose new measures that support our goal of achieving better health care and improved health for Medicare beneficiaries who receive health care in this setting, while aligning quality measures across the Medicare program to the extent possible.

To sum things up, here's another way of looking at our program's measure set – by measure type as per data submission method.

Listed here are the claims-based measures for this program. In this Proposed Rule, we did not propose any changes to these measures. And these measures are. OP-8, OP-10, OP-13, OP-32, OP-35, and OP-36.

On this slide we have the web-based measures listed. These are measures that are submitted via a Web-Based tool.

We proposed removal of OP-33, External Beam Radiotherapy for Bone Metastases measure, beginning with the calendar year 2022 payment determination and subsequent years.

Here we have our Chart-Abstracted Measures. We did not propose any changes to the chart-abstracted clinical measures, for this program.

The implementation of the survey measures OP-37a through 37e were delayed with the CY 2018 Final Rule, and that delay continues.

Payment Reduction – this section is not part of the Hospital Outpatient Quality Program per se, but it describes how the payment reduction is calculated and applied. This methodology has come up as an issue, so depending on the services your facility provides, such as partial hospitalization, it may behoove you to take a look at this section:

With regard to payment reduction – CMS is proposing to exclude services paid under New Technology APCs. CMS is proposing to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the Hospital OQR Program reporting requirements.

CMS is also proposing to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the program.

Additionally, CMS is proposing to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

CMS is proposing to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the Hospital Outpatient Quality Reporting Program, reporting requirements. Additionally, we will continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the Program.

Similarly, we are proposing to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

Now we are going to discuss how to comment on the proposals within the Proposed Rule.

I really want to emphasize, and I can't say this enough, we very much want your comments. This is your opportunity to impact the measure development process and policy proposals. CMS truly benefits from receiving comments on our proposals. So, let's go over how to submit your comments regarding the Hospital Outpatient Quality Reporting Program in this Proposed Rule.

These parameters for submitting comments apply not only to the Hospital Outpatient Quality Reporting Program proposals, but you also can comment on anything that is contained in this rule. Comments can be submitted electronically, by regular mail, by express or overnight mail.

The deadline for all comments to be received is no later than the times listed for each submission venue on September 27, 2019.

Please refer to the Proposed Rule for the necessary addresses, and keep in mind that you must send in your comments, so that they are received by the deadline. We encourage the electronic submission of comments. And I have a direct link here on this slide. You can use the direct link here to access the comment section directly. Please comment. CMS really wants to hear from you with regard to these proposals.

Responses to comments will be published in the Final Rule which is scheduled for display in the next few months.

We also have some quick links here for the Proposed Rule as well as the direct link to comment.

Remember that you can make a difference, so please submit your comments regarding the proposals contained in the proposed rule. Every comment is read. CMS will respond to commenter feedback in the Final Rule.

That concludes our discussion on the Proposed Rule in terms the Hospital Outpatient Quality Reporting Program; So Now, let me turn things back over to Karen.

Karen: Thank you so much, Anita. It is great to have you here and have CMS' perspective to explain the Proposed Rule to us, thank you. Anita, if it's okay with you, can we take a few minutes to answer some of the questions that have been coming in the chat box?

Anita: Yes, Karen, that would be great.

Karen: OK, so We got quite a few on the OP-33 so let me try to summarize this, so here's the question; In the Proposed Rule, it stated the removal of OP-33 would begin with encounters for October of 2020, so does that mean?

Anita: Thank you for bringing this proposal up. While we generally noted calendar year when discussing measures, the October reference is an error that will be addressed in the final rule. As you likely are aware, the data submission for OP-33 is via a web-based tool and data are reported annually. We are proposing to remove the OP-33 measure for the CY 2022 payment determination and for subsequent years. If the proposal to remove OP-33 is finalized, data will be reported for this measure for the last time by May of 2020 using encounters from January 1, 2019 through December 31, 2019.

Karen: Thank you, Anita. Also, with regards with OP-33 here is another question; If OP-33 was originally adopted to address performance gaps in EBRT treatment and

payment variations, and to monitor appropriate variations, why is CMS removing this measure?

Anita: OK, Karen, as we mentioned earlier, in our presentation, one of CMS' quality reporting objectives is to minimize level of burden for providers; the burden to collect data for a measure should not outweigh the benefits of reporting. In this case of this measure, issues with the CPT codes required for the measure and with reporting have been identified. First, hospitals do not have access to physician billing data, and this makes it operationally difficult to use radiation planning CPT codes for the measure. Second, providers must also manually review and abstract the patient's record, for this measure, which adds undue burden. Third, the measure steward for this measure is no longer maintaining the measure, so the measure may become outdated or inaccurate. In addition, the proposed removal of this measure from the Hospital OQR Program is consistent with its recent, proposed removal from the PPS- exempt Cancer Hospital Quality Reporting Program also due to a view that it is overly burdensome and because the measure steward is no longer maintaining the measure.

Karen: Thank you, Anita, here is one that's not exactly related to the proposed rule, but we get this quite a bit, so I will answer this. This question is: When will our OP-36 Facility Specific Reports be available? And the answer to that is the OP-36 Hospital Visits after Hospital Outpatient Surgery Facility Specific Reports are scheduled to be released in October of this year. And that report will include 2018 data.

So here Anita, is another question for you. Well actually, I will take this one too if you don't mind, because we get this one a lot; Can you clarify the terms calendar year and payment determination year?

OK, so the answer to this is; the term calendar year designates a specific time period which is just that, a calendar year; the time frame of January first through December thirty-first for any given year. The payment determination year refers to the year your hospital receives payment for the data you reported; so, let's say for example, a CY 2020 payment determination made in 2019 would affect payments occurring for services provided in 2020. If anybody has any further questions about this, please feel free to enter your question in the QualityNet Q&A tool, or you can simply give our help desk a call, we do get that question a lot, so if you need further clarification, by all means let us know.

OK, Anita, here is a question for you; I saw the Specifications Manual, version 13.0, came out. Is that the manual we use now use for data collection and reporting?

Anita: Okay, Karen, as far as the Specifications Manual, the 13.0 version of the Specifications Manual is for the reporting period, also what some people refer to as the patient encounter period, so in this case, would be for January 1, 2020 through December 31, 2020. You will use version 13.0 for the data you will be reporting to CMS for the payment determination year 2022. To submit your data for payment determination year 2021, you will reference the Specifications Manual Version 12.0a. This version uses the reporting period of January 1, 2019 through December 31, 2019.

Karen: Thank you, Anita. And again, we have another question about OP-33. The person wants to know; if OP-33 is removed, when would we stop collecting data?

Anita: Yes, Karen, this is a very important question. And the answer is the proposed removal of OP-33 is just that, it is a proposal. If this removal is finalized, it will follow the rulemaking process and will be brought forward in the Final Rule. That said, we did propose to remove the measure beginning with CY 2022 payment determination which means data collection would cease after December 31, 2019 encounters.

Karen: Thank you, Anita, and just to reiterate, the last time you will report this data, if this measure is finalized for removal, will be for your data submission deadline of May 15, 2020.

OK, next question; CMS is asking for public comment on four patient safety measures that were included in the ASC program. Why would adding these measures for the hospital setting be beneficial?

Anita: So, Karen, we discussed this in our Proposed Rule, and we believe these patient safety measures could be valuable as they would provide important information to beneficiaries, would allow public monitoring of these types of events, and would facilitate quality improvement efforts toward preventing their occurrence. Although these events are rare, they provide critical data to beneficiaries and provide transparency for the care provided. These measures are also important to the Meaningful Measure Initiative of Making Care Safer by Reducing Harm Caused in the Delivery of Care.

Karen: And along those lines; you said the patient safety measures were part of another program but were suspended. Why are these measures being proposed for this program?

Anita: Okay, Karen, these measures were our part of the ASCQR program. For this program data collection for these measures was suspended due to concerns with the data submission method, but not for the measures themselves. In the current Proposed Rule for that program, we have asked for public comment on an alternate submission method. Additionally, if these measures were adopted for

this program, we would seek collaboration with the measure steward for the measures to be specified for the Hospital Outpatient Department setting and for this program. This would further align the Hospital OQR and ASCQR programs, which would benefit beneficiaries, particularly if they are able to choose in which of these two care settings they receive care. Through future rulemaking, we intend to propose new measures that support our goal of achieving better health care for beneficiaries who receive care in the HOPD setting. We hope to accomplish this while aligning quality measures across programs as much as possible. This alignment is our goal toward seeking information toward adopting these measures for the Hospital Outpatient Department settings.

Karen: Thank you, Anita. Here is a really good question, because I know you feel strongly that people should comment, so the question is; What does CMS do with the comments regarding the proposed rule? Why should we comment?

Anita: Karen, I cannot stress enough the importance of commenting. This is the publics opportunity to effect policy making decisions. There have been many occasions when we have proposed measure additions, measure removals, concepts, etc., but after receiving comment and feedback, we did not move forward with what was proposed. Having this public input and feedback is essential and all comments received must be addressed in the Final Rule. Please remember to submit your comment per the methods outlined in the proposed rule by the deadline of September 27, 2019.

Karen: Thank you, Anita, hopefully many people will comment. Next question and people have talked a lot about this, so hence the question; We are hearing a lot about the Meaningful Measures Initiative. What is the benefit of this initiative, particularly across programs?

Anita: The Meaningful Measures Initiative was developed collaboratively with the input from a wide variety of stakeholders. This initiative draws on previous work performed by the Health Care Payment Learning and Action Network, the National Quality Forum, the National Academies of Medicine, and other federal Agencies. This initiative includes perspectives from patient representatives, clinicians and providers, measure developers, and other experts such as the Core Quality Measures Collaborative. Meaningful Measures will help programs identify and select individual measures. Meaningful Measure areas are designed to increase program alignment across CMS programs and other public and private initiatives. Additionally, the Meaningful Measures Initiative will point to high priority areas where there may be gaps in available quality measures while helping guide CMS's effort to develop and implement quality measures to fill those gaps.

Karen: Thank you, Anita. I think we have time for just one more question, so here is the question; What does it mean that the removal of the measure is being "proposed"?

What determines if the removal will be finalized or not? And I think you have touched on this, but perhaps we just need a little bit more elaboration here.

Anita: Yes, Karen. We talk about this a lot, but it can be a confusing concept. CMS proposes changes via a proposed rule, and then opens a public comment period for 60 days, for this particular rule. And we are in that comment period right now. But this comment period ends September 27th. During this comment period time, feedback in the form of comments are gathered from anyone that wants to comment, including providers and other stakeholders. These comments are considered by CMS in finalizing or not finalizing these proposals. The decisions on these proposals are then issued in the Final Rule, which is typically placed on display and then published in November.

Karen: Thank you, Anita.

That's about all the time we have today. Thank you again Anita for being here, explaining the proposals and responding to some questions. I'm sure that is much appreciated. We appreciate your time. OK, now I am going to turn things back over to our host. Thanks again, everyone, for joining us today, and have a great day.