# Outpatient Quality Reporting Program

## Support Contractor

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

### Presentation Transcript

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**July 25, 2016**

**Pam Harris:** Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Pam Harris, a project coordinator for the Hospital OQR Program.

Before we begin today's program I would like to highlight some important dates and announcements. August 1, 2016, is the submission deadline for clinical data and population and sampling for Quarter 1 2016. This will be for encounter dates from January 1 through March 31, 2016. And always, please be sure to keep your NHSN and *QualityNet* access active. The easiest way you can do this is by logging into the NHSN and QualityNet Secure Portal at least every 60 days.

Please join us on September 21st for the next Outpatient Quality Reporting webinar, "Secrets of the Question and Answer Tool." Please join us.

Let us just mention before we get started a standard disclaimer. CMS can only address procedural questions and comment submissions 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.

We have several representatives from CMS today; we have Elizabeth Bainger, Program Lead Hospital OQR; we have Vinitha Meyyur, Measures Lead

Hospital OQR; Liz Goldstein, Director, Divisions of Consumer Assessment & Plan Performance and Grace Im, Program Lead Hospital Inpatient Quality Reporting. We do appreciate their time in lending their expertise with regards to the information they will share with us today. We invite you to view their biographies at the end of the presentation.

And without further ado, I'll turn it over to our first speaker, Dr. Elizabeth Bainger. Elizabeth.

**Elizabeth Bainger**: Hi, everyone. I'm Elizabeth Bainger. I want to thank you for joining us today. I do want to let you know this presentation has been prerecorded. We did this for a couple of reasons. First, as you could see on the earlier slide, there are four presenters. Just by way of background, when we talk about the Centers for Medicare & Medicaid Services, there are actually six different centers. Over the last couple of years, you probably have become used to hearing from me and from Dr. Meyyur when we are presenting a new proposed or final rule that's being published for the Hospital OQR Program.

Vinitha and I worked together in the Center for Clinical Standards and Quality, or CCSQ. But this year's proposed rule also includes CAHPS survey measures. All of the CAHPS surveys across all of the quality reporting programs are developed and maintained by a different center, the Center for Medicare, or CM, so we invited Dr. Goldstein from CM to present those survey measures, and she graciously agreed.

And finally, this presentation will briefly jump out of the Hospital OQR Program and into the Hospital Value-Based Purchasing Program. Grace Im – whose name you might recognize as the Program Lead for Hospital IQR and for the Hospital Value-Based Purchasing Program – she'll be presenting information about a rider to the OPPS/ASC OQR proposed rule.

You can see this presentation took a lot of coordination. It's chock-full of information. To accommodate so many different schedules and to ensure we get in all the essential information, we decided to prerecord. However, during this presentation I will be on live, and hopefully others will be able to be on live also so that we can respond to each question in chat. You do have live representatives from CMS on right now.

And that brings me to another point. While CMS will respond to questions as we're able, we are statutorily restricted to providing any additional information beyond what can be found in the proposed rule. Remember that this presentation, the accompanying slide deck, the transcripts -- they're not stand-alone resources. Please refer to the proposed rule, as that is the only resource that's stand-alone.

By law, CMS must ensure that responses to comments and questions are available to all interested parties, not just those participating in this webinar. In some cases we won't be able to answer your question, and instead, we'll just let you submit your question or comment using one of the public comment submission methods that I'll describe later.

But let's start now with finding out how to find the Calendar Year 2017 OPPS/ASC Proposed Rule text. This slide provides some historical perspective. You can see that from calendar year 2008 to calendar year 2016 the rule has been finalized. For calendar year 2017 we have published the proposed rule.

I want to draw your attention to the far right column -- at the top you can see the links for the *Federal Register*. Let's look at that first light blue row in the far right column. That first number, 81: that represents the volume of the *Federal Register*. FR stands for *Federal Register*, and 45709 is the first page of the Hospital OQR portion of the proposed rule. So remember, volume 81, 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 number 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 you the home page for the *Federal Register* where, in this screenshot, you can see that we've copied and pasted the volume number, 81, FR for *Federal Register*, and then the page number, 45709. 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 link for the proposed rule.

We've highlighted a box that starts with the words, "jumps 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 45603 and ends on page 45788. It's a really long document. It contains payment rules, fee schedules, the HVBP rider that Grace will be talking about, and much more. The Hospital OQR portion is just one part of this proposed rule.

Now, let's take a look at the highlighted box that reads, "jump directly to page 45709." 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 Roman numeral 13, or XIII. Now this view of the proposed rule is one long column of text. Some people like to view it this way, but many others prefer to view the rule as a pdf. Let's go back to the previous slide.

This time we've highlighted the pdf link, and when you click it, this will take you to the pdf version of the volume 81 of the *Federal Register*. You can use your find feature to look for page 45709, the first page of the Hospital OQR portion of the proposed rule, and there you go. You can see that we're in volume 81 of the *Federal Register*, page 45709, and the Hospital OQR portion of the rule that starts with Roman numeral 13.

And now I'm going to pass this presentation along to Dr. Vinitha Meyyur, who is the Measures Lead for the Hospital OQR Program.

**Vinitha Meyyur:** Good morning. Thank you, Elizabeth. This is Vinitha Meyyur. I'm the Measures Lead for the OQR Program.

Let's move to our second learning objective for today which is identifying the proposed new measures to the Hospital OQR Program. For the Hospital OQR portion of the Calendar Year 2017 OPPS/ASC Proposed Rule, CMS has recommended the adoption of seven new measures for the calendar year 2020 payment determination and subsequent years.

There are two proposed claims-based measures and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems, or OAS CAHPS, proposed survey-based measures. The claims-based measures are OP-35 which is Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy and OP-36 which is Hospital Visits after Hospital Outpatient Surgery.

Both OP-35 and OP-36 are claims-based measures. Claims-based measures pull data from claims submitted by the facility for payments. It uses part A

and Part B Medicare administrative claims data from Medicare FFS beneficiaries age 65 and older with outpatient same day surgery. The performance period for the measure is one year; that is, the measure of calculation includes eligible outpatient same day surgeries occurring within a one year time frame. For example, for the 2020 payment determination the performance period would be calendar year 2018; that is January 1st, 2018 through December 31st, 2018.

The five proposed survey-based measure categories of OP-37 are listed here on this slide. These categories can have multiple survey questions that the patient answers regarding their outpatient survey or procedure experience. We will discuss these measures in more detail later in the webinar, but right now let's look at the proposed measure OP-35.

With cancer becoming an increasingly prevalent condition associated with considerable morbidity and mortality, CMS has placed cancer care as a priority area for outcome measurement. Hospital admissions and ED visits among cancer patients receiving chemotherapy often are caused by predictable and manageable side effects from treatments. Recent studies of patients receiving chemotherapy in the outpatient setting showed that the most commonly cited symptoms and reasons for hospital visits are pain, anemia, fatigue, nausea and/or vomiting, fever and/or febrile neutropenia, shortness of breath, dehydration, diarrhea, and anxiety or depression. These hospital visits may be due to conditions related to the cancer itself or to side effects of chemotherapy. However, treatment plans and guidelines exist to support the management of these conditions. Hospitals that provide outpatient chemotherapy should proactively implement appropriate care to minimize the need for acute hospital care for these adverse events.

OP-35 addresses patients who present to the emergency department and/or inpatient admissions for one or more diagnoses of anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis within 30 days post-chemotherapy treatment. This measure includes only outcome conditions demonstrated in the literature as being potentially preventable in this patient population.

The denominator for each ratio is the number of patients expected to have the measured adverse outcome based on the average national performance and the hospital's observed case mix. The national observed rate is the national

unadjusted number of patients who have the adverse outcome among all qualifying patients who had at least one chemotherapy treatment in a hospital.

The numerator of the ratio is the number of patients predicted to have the measured adverse outcome, an inpatient admission for RSAR (Risk-Standardized Admission Rate) or RSEDR (Risk-Standardized Emergency Department Rate) with one or more of the diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis within 30 days, based on the hospital's performance with its observed case mix.

Inclusion of OP-35 includes Medicare Fee-for-Service patients 18 years and older at the start of the performance period with the diagnosis of any cancer, except leukemia, that has received at least one hospital outpatient chemotherapy treatment. Exclusions are patients not enrolled in Medicare FFS part A and B in the year before the first outpatient chemotherapy treatment, or, if the patient does not have at least one outpatient chemotherapy treatment, the continuous enrollment in Medicare 30 days after the procedure. And as we said prior, the exclusion of the diagnosis of leukemia.

Now before we leave this slide, let me expand a little on why the measure excludes leukemia. The studies show that, due to leukemia's high toxicity of treatment and recurrence of the disease, admissions for leukemia patients may not reflect poorly managed outpatient care, but rather disease progression and relapse.

OP-35 addresses the National Quality Strategy priority of promoting the most effective prevention and treatment practices for the leading causes of mortality. And the MAP, or the Measure Applications Partnership, recommended that OP-35 be submitted for NQF endorsement with a special consideration for sociodemographic status adjustments and the selection of exclusions. You can find the MAP 2016 final recommendations at the website listed on this slide. For additional details on how OP-35 is calculated, methodology details, and a complete list of the risk adjustment variables, you can access the website displayed on this slide.

Now let's look at the next proposed measure, and that is OP-36. Outpatient same day surgery is common in the United States. Nearly 70 percent of all surgeries in the U.S. are now performed in the outpatient setting, with most performed as same day surgeries at hospitals.

That's why most outpatient surgery is safe. But there are well described and potentially preventable adverse events that occur after outpatient surgery such as uncontrolled pain, urinary retention, infections, bleeding, and venous thromboembolism, which can result in unanticipated hospital visits. Similarly, direct admissions after surgery that are primarily caused by non-clinical patient considerations – such as lack of transport to home upon discharge or even facility logistical issues such as delayed start of surgery – these are some of the common causes of unanticipated yet preventable hospital admissions following same day surgery. This is the reason CMS has proposed this measure for the Hospital Outpatient Quality Reporting Program.

Now the proposed OP-36 measure, which is Hospital Visits after Outpatient Surgery, would look at the measure outcome of any of the following hospital visits: an inpatient admission directly after the surgery or an unplanned hospital visit that would include ED visits, observation stays, or unplanned inpatient admissions occurring after discharge and within seven days of the surgery. If more than one unplanned hospital visit occurred, it is only the first hospital visit within the outcome time frame that is counted in the outcome.

The facility-level measure score is a ratio of the predicted to expected number of hospital visits among the hospitals' patients. The numerator of the ratio is the number of hospital visits predicted for the hospital patient accounting for its observed rate, the number of surgeries performed at the hospital, the case mix, and the surgical procedure mix. The denominator of the ratio is the expected number of hospital visits given the hospital case mix and surgical procedures mix.

OP-36 includes Medicare FFS patients age 65 years and older undergoing same day surgery, except eye surgery, in the hospital. The measure cohort excludes eye surgeries. Although eye surgeries are considered as substantive surgery, its risk profile is more representative of minor surgery. Essentially, it is characterized by high volume and a low outcome ratio.

Same day surgeries are substantive surgeries, and procedures are listed on Medicare's list of covered ASC procedures. Medicare developed this list to identify surgeries that can be safely performed as same day surgeries and do not typically require an overnight stay. Surgeries in the ASC list of covered procedures do not involve or require major or prolonged invasion of body cavities, extensive blood loss, major blood vessels, or care that is either emergent or life-threatening.

Although Medicare developed the list of surgeries for ASCs, we use it for the hospital outpatient measure for two reasons. First, it aligns with our target cohort of surgeries that have a low to moderate risk profile and are safe to be performed at same day surgeries. By only including surgeries on this list in the measure, we effectively do not include surgeries performed at hospitals that typically require an overnight stay which are more complex, higher risk surgeries. Second, we use this list of surgeries because it is annually reviewed and updated by Medicare and includes a transparent public comment submission and review process for the addition and/or removal of procedure codes.

The proposed OP-36 meets the National Quality Strategy priority of effective communication and coordination of care, and has received NQS endorsement as of September 3, 2015. In addition, the MAP, which is the Measure Applications Partnership, supported the measure for program use, citing the vital importance of a measure that helps facilities reduce unnecessary hospital visits. If you need additional information regarding the methodology of the proposed measure OP-36, then you can access the links provided on this slide.

For a listing of the 2016 Outpatient Surgical Procedures, you can access the link provided on this slide. So now that we've gone over the two claims-based measures, now I'm going to hand the presentation over to Dr. Liz Goldstein.

**Elizabeth Goldstein:** Thank you very much. Today, I am going to be talking about the survey-based measures. Currently, there's no standardized survey available to collect information on the patient's overall experience for surgeries or procedures performed within a hospital outpatient department or an ambulatory surgery center. Some facilities are conducting their own surveys and reporting these results on their websites, but there is not one standardized survey to allow valid comparisons across facilities.

Patient-centered experience measures are a component of the 2016 CMS Quality Strategy, which emphasizes patient-centered care by rating patient experiences as a means for empowering patients and improving the quality of their care. In addition to information on patient experience with care at the facility, it is an important quality indicator to help providers and facilities to

improve services furnished to their patients and to assist patients in choosing a facility in which they seek care.

The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey, which is referred to as OAS CAHPS, was developed as part of the U.S. Department of Health and Human Services Transparency Initiative to measure patient experiences with care in the hospital outpatient department as well as ambulatory surgery centers.

The survey contains 37 questions that cover topics such as access to care, communications, experience at the facility, and interactions with facility staff. Facilities can elect to have up to 15 supplemental questions to the survey. It's important to note that these supplemental questions are not submitted to CMS.

The survey development process follows the principles and guidelines outlined by the Agency for Healthcare Research & Quality, which is part of Health and Human Services. And they work with the CAHPS Consortium, which is a group of research organizations across the country that help develop CAHPS surveys.

The OAS CAHPS Survey is administered to all eligible patients or a random sample of eligible patients. These patients have to have at least one outpatient surgery or procedure during the applicable month. All data collection and submission for the OAS CAHPS Survey measure is done at the CCN level, and all eligible facilities in the CCN would be required to participate in the survey.

Therefore, the survey data reported for CCN must include all eligible patients from all locations under the CCN. Facilities that share the same CCN must combine data for collections and submissions for the survey across their multiple facilities. These results would then be publicly reported on Hospital Compare, as they apply to a single CCN or facility. If a facility's data are submitted after the data submission deadline, it will not fulfill the OAS CAHPS quality reporting requirement.

The proposed survey has three administration methods. The first one is mail-only, the second one is telephone-only, and the third one is mixed mode, which is mail with telephone follow-up of non-respondents. We began voluntary national implementation of the OAS CAHPS Survey in January 2016.

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To ensure that patients respond to the survey in a way that reflects their actual experiences with care and is not influenced by the facility, we are proposing that facilities must contract with a CMS-approved OAS CAHPS Survey vendor to conduct or administer the survey. We believe that a mutual third party should administer the survey on behalf of all facilities. It is also our belief that an experienced survey vendor will be best able to ensure reliable results.

We will propose a format and timing for public reporting of OAS CAHPS Surveys in future rulemaking prior to implementation of the measures. Because calendar year 2016 is the first year of voluntary national implementation through the OAS CAHPS Survey, we believe using data from the voluntary national implementation will help inform the displays for public reporting of the survey. We are not proposing a format and timing for public reporting of OAS CAHPS Survey data at this time.

We are proposing that the data collection period for the OAS CAHPS Survey measures would be the calendar year two years prior to the applicable payment determination year. For example, for the calendar year 2020 payment determination, facilities would be required to collect data on a monthly basis and submit this collected data on a quarterly basis for January 1, 2018 through December 31, 2018 data. This would be required for the calendar year 2020 payment determination. Facilities, through their CMS-approved survey vendor, would be required to collect data on a monthly basis and report that data to CMS on the facility's behalf by the quarterly deadlines established for each data collection period.

To ensure reliability of the reported result, a target minimum of 300 completed surveys has been set for each facility over each 12-month reporting period. This is an average of 25 completed surveys per month. We realize that some smaller facilities may not be able to meet this target minimum. However, we believe it is important that we still capture patient experiences of care for these smaller facilities. Therefore, except exempt facilities, those facilities receiving less than 300 completed surveys over each 12-month reporting period will be included in the OAS CAHPS Survey-based measures.

On the other hand, a facility that treats a high volume of patients may choose to administer the OAS CAHPS Survey on a random sample of its eligible patient population. For anyone needing more information regarding the survey, they should see the protocols and guidelines manual. That link is shown on the bottom of this slide.

We understand that facilities with a lower patient census may be disproportionally impacted by the burden associated with administering the survey and the resulting public reporting of OAS CAHPS Survey results. Therefore, we are proposing that facilities may submit or request to be exempted from participating in the OAS CAHPS Survey-based measures if they treat fewer than 60 survey-eligible patients during their eligibility period. The eligibility period is a calendar year before the data collection period. For example, for the calendar year 2020 payment determination, this exemption request would be based on treating fewer than 60 survey eligible patients in calendar year 2017, which is a calendar year before the data collection period of 2018 for the calendar year 2020 payment determination. All exemption requests will be evaluated and reviewed by CMS.

To qualify for the exemption, facilities must submit a participation exemption request form. For example, the deadline for submitting an exemption request form for the calendar year 2020 payment determination would be May 15th, 2018. We've determined the May 15th deadline in order to align with the deadline for submitting web-based measures and because we believe this deadline provides facilities sufficient time to review the previous year's patient list and determine whether they are eligible for an exemption based on patient population guides.

Facility rates on each composite OAS CAHPS Survey-based measure would be calculated by determining the proportion of top-box responses. That is **Yes** or **Yes, Definitely**, depending on the question. We would then average these proportions over all questions in the composite measures, so it's important to note that the composite measure consists of multiple survey items. For example, to assess facility performance on the composite measure ASC-15a, which is about facilities and staff, we would calculate the proportion of top box responses for each of the measure's six questions, add those proportions together, and divide by the number of questions in the composite measure that is fixed for this measure.

Facility performance on each of the two global OAS CAHPS Survey-based measures will be calculated by the proportion of respondents providing the highest responses – that is a nine to 10 rating or **Definitely Yes** – to the survey questions over the total number of respondents. For example, if the hospital receives 45 nine and 10 ratings out of 50 responses, this hospital will receive a 90 percent raw score, which would then be adjusted for differences in the characteristics of patients across facilities for the purposes of public reporting.

The OAS CAHPS survey is administered to all eligible patients or a random sample who had at least one outpatient surgery procedure during the applicable month. Eligible patients regardless of insurance or method of payment can participate. For purposes of each survey-based measure captured in the survey, an eligible patient is a patient 18 years or older. It excludes patients who reside in a nursing home, who are discharged to hospice care following their surgery or procedure, who are identified as a prisoner, and patients that request that facilities not release their names and contact information to anyone other than facility personnel. I just want to remind you that these procedures are defined in the OAS CAHPS Survey protocols and Guidelines Manual.

There are a few categories of otherwise eligible patients who are excluded from the measures. Those exclusions are here on this slide. Patients whose address is not a U.S. domestic address, patients who cannot be surveyed because of state regulations, patients whose surgery or procedure does not meet the eligibility CPT or G-codes (and these codes are as defined in the OAS CAHPS Protocols and Guidelines Manual), and patients who are deceased.

These measures were included in the www.qualityforum.org website under the Measures Under Consideration list for December of 2014. If you need more information about these measures and the list of approved vendors, you can go to the oascahps.org website, https://oascahps.org, and the link is on the second bullet on this slide. The third bullet point link is for the OAS CAHPS Survey Questions Protocols and Guidelines Manual, https://oascahps.org/Survey-Materials.

Now, I am going to turn it over to discuss future measures.

**Vinitha Meyyur:** Thank you, Liz, for passing this on to me. I'm going to talk about the safe use of opioids. Unintentional opioids overdose fatalities have become an epidemic in the last 10 years and a major public health concern in the United States. Health and Human Services, or HHS, has made addressing opioids misuse dependence and overdose a priority. HHS is implementing evidence-based initiatives focused on informing prescribing practices to combat misuse and overdose deaths. Several other organizations, including the Centers for Disease Control and Prevention, the Federal Interagency Workgroup for Opioid Adverse Drug Events, the National Action Plan for Adverse Drug Prevention, and the Substance Abuse & Mental Health Services Administration have joined the effort. Prescribing opioids to patients already

using an opioid or patients using benzodiazepines, which is a sedation inducing central nervous system depressant, increases the risk of respiratory depression and death.

To address concerns associated with overlapping or concurrent prescribing of opioid or opioids and benzodiazepines, we are in early development of a new electronic clinical quality measure for the Hospital IQR and OQR Programs that would capture the proportion of patients 18 years of age and older who had an active prescription for an opioid and have an additional opioid or benzodiazepine prescribed to them during the qualifying care encounter. This measure is being defined to reduce preventable death as well as reduce costs associated with the treatment of opioid-related ED use by encouraging providers to identify patients at high risk for overdose due to respiratory depression or other adverse drug events.

I'd like to now pass this presentation to Elizabeth Bainger.

**Elizabeth Bainger**: Thank you, Vinitha and Liz, for addressing the measures proposed for the Hospital OQR Program as well as future measure consideration. I do want to mention again that the seven proposed measures, as Vinitha and Liz discussed, would be effective for the calendar year 2020 payment determination, so calendar year 2018 patient encounters. Now I'd like to talk about proposed policy changes.

This first one really isn't a change; we simply wanted to formalize our current process. CMS is formally stating that we will publicly display the data we collect on the Hospital Compare website as soon as it is feasible to do so. We will continue to announce a preview period on the CMS website or applicable ListServes, and hospitals will have approximately 30 days to preview their data.

Now this slide is a policy change. The Division of Value, Incentives, and Quality Reporting is currently one of the many hospital/ASC quality reporting programs, and we noted that different quality reporting programs had different deadlines for requesting an Extraordinary Circumstances Exemption, or ECE. It varied anywhere from 30 days to 90 days, and we want to fix that. So,

within the Division of Value, Incentives, and Quality Reporting, we are aligning to a 90-day deadline.

CMS believes that extending the deadline to 90 days would allow hospitals more time to determine whether it is necessary and appropriate to submit an ECE request and to provide a more comprehensive account of an extraordinary circumstance. For the Hospital OQR Program these proposals become effective with ECEs requested on or after January 1, 2017.

Here's another clarification of our current process, and this is our current process for the Hospital OQR Program. We want to make it explicitly clear. Currently, the Hospital OQR Program makes an initial payment determination, and we notify hospitals by the end of the calendar year. That's historically been in late December. If your hospital disagrees with our initial findings, you must submit a reconsideration request to CMS via the QualityNet website no later than the first business day on or before March 17 of the effective payment year. If your hospital still is not satisfied with the reconsideration findings, then you may file an additional appeal with the Provider Reimbursement and Review Board, or PRRB. This is clarifying policy regarding the appeal procedure. Specifically, if a hospital fails to submit a timely reconsideration request to CMS via the QualityNet website by the applicable deadline, then that hospital will not subsequently be eligible to file an appeal with the PRRB.

Now for the next few slides, I'm going to jump briefly out of the Hospital OQR Program and over to the Hospital Value-Based Purchasing Program. Many hospitals participate in both programs, and we wanted to get this rider information with as many participating hospitals as possible, so I'm passing the presentation to Grace Im.

**Grace Im:** Thank you. In the calendar year 2017 OPPS/ASC/PPS Proposed Rule, we also have a proposal related to the Hospital Value-Based Purchasing, or VBP, program. Please note that other Hospital VBP Program requirements will be set forth in an upcoming IPPS final rule to be issued on or around August 1, 2016.

For the Hospital VBP Program, we received feedback that some stakeholders are concerned about the Pain Management dimension questions in the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS Survey being used in a program where there's any link between scoring well on the question 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.

Many factors outside the control of CMS quality program requirements may contribute to the perception of a link between the Pain Management dimension and opioid prescribing practices, including misuse of the survey (such as using it for outpatient emergency room care instead of inpatient care, or using it for determining individual physician or facility performance) and failure to recognize that the HCAHPS Survey excludes certain populations from the sampling frame, such as those with a primary substance use disorder diagnosis. Because hospitals have identified patient experience as a potential source of competitive advantage, we have heard that some hospitals may be disaggregating their raw HCAHPS data to compare, assess, and incentivize individual physicians, nurses, and other hospital staff. Some hospitals may also be using the HCAHPS Survey to assess the emergency and outpatient department, when the survey has been intended only for inpatient hospital use.

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 the patient, their families and their caregivers. It's important to note that the HCAHPS Survey does not specify any particular type of pain control method. In addition, appropriate pain management includes communication with patients about pain related issues, setting expectations about pain, shared decision making, and proper prescription practices.

Although CMS is not aware of any scientific studies to support an association between scores on the Pain Management dimension question and opioid prescribing practices, we are developing alternative questions for the Pain Management dimension in order to remove any potential ambiguity in the HCAHPS Survey. We are following our standard survey development processes which include addressing alternative questions, cognitive interviews and focus group evaluation, field testing, statistical analysis, incorporating stakeholder input, and NQF endorsement requirements. And HHS is also

conducting further research to help better understand stakeholder concerns and determine if there are any unintended consequences that link the Pain Management dimension question to opioid prescribing practices. We note the measure specifications will be posted on the CMS webpage, and the public will have an opportunity to provide feedback before we make any proposals with respect to alternative pain management questions.

Due to some potential for confusion about the appropriate use of the Pain Management dimension questions in the Hospital VBP Program and the public health concern about the ongoing prescription opioid overdose epidemic, while we await the results of our ongoing research and the above-mentioned modifications to the Pain Management dimension questions, in this calendar year 2017 OPPS/ASC/PPS proposed rule, we're proposing to remove the Pain Management dimension of the HCAHPS Survey in the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain, within the Hospital VBP Program beginning with the 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, or TPS, which affects FY 2018 payment adjustments. When the modified Pain Management questions for the HCAHPS Survey become available for use in the Hospital VBP Program, we intend to propose to adopt them in future rulemaking.

If the proposal to remove the Pain Management dimension is finalized, this would then leave eight dimensions in the HCAHPS Survey for use in the Hospital VBP Program in the FY 2018 program year, and that's what the table on the slide illustrates.

In order to adjust for the removal of the HCAHPS Pain Management dimension from the Hospital VBP Program, we are proposing to continue to assign Achievement Points (0 to 10 points) and Improvement Points (0 to 9 points) to each of the remaining eight dimensions in order to create the HCAHPS Base Score, which would range from 0 to 80 points. Each of the remaining eight dimensions would be of equal weight so that the HCAHPS base score would range from 0 to 80 points. In addition, HCAHPS Consistency Points would then be calculated and would range from 0 to 20 points. The Consistency Points would consider scores across the remaining eight dimensions, and would not include the Pain Management dimension.

The final element of the scoring formula would be the sum of the HCAHPS Base Score and the HCAHPS Consistency Points and this would, for the remaining, range from 0 to 100 points. So in this proposed rule, to summarize, we are proposing to remove the Pain Management dimension of the HCAHPS Survey in the calculation of the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain score in the Hospital VBP Program beginning with the FY 2018 program year. We note that the performance standards for the other eight dimensions, not including the Pain management dimension, will remain unchanged.

Also, please note that other Hospital VBP Program requirements will be set forth in an upcoming IPPS final rule to be issued on or around August 1, 2016.

That concludes the Hospital VBP Program portion of the presentation. Now I'll turn things over to the next speaker. Thank you.

**Elizabeth Bainger:** Thank you, Grace, for providing the information about the rider for the Hospital Value-Based Purchasing Program in the OPPS/ASCQR Proposed Rule. Let's move on to submitting comments. 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. I want to refer you to the proposed rule, page 45604, about how to submit your comments.

Comments can be submitted using various methods: electronically, regular mail, express or overnight mail, and by hand or courier. The deadline for most of those methods is 5 p.m. Eastern Time on September 6, 2016. Please refer to the proposed rule for necessary addresses, and keep in mind that you must send your comments so that they will be received by the deadline. However, CMS encourages the electronic submission of comments using regulations.gov. If you use this method, then comments submitted electronically will be accepted until 11:59 p.m. Eastern Standard Time. Now again, that's on September 6, 2016. Responses will be published in the final rule which should be issued in November 2016.

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, and it will bring you to this screen. 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 then you can select a **Comment Now** button.

When you get to this page, 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. And then, in addition to entering your comments, you will need to also enter your state, ZIP code, and country. You can enter your name and email address, but it's not required.

Step two allows you to preview your comments and edit, if necessary. Once completed, select the **Submit Comment** button. I do want to take a moment and backtrack to the discussion we had back in December while I talk about how to make comments or make your comments substantive. If you think we have the science wrong, provide a firm foundation for your arguments.

Step three: you'll be assigned a tracking number that will allow you to follow the status of your comment. Again, CMS values your comments; they read your comments; we consider and discuss your comments. I have seen one comment change the course of the proposed rule. So please, I encourage you to read the proposed rule and to submit comments. Thank you.

**Pam Harris:** Thank you, Elizabeth. Thanks to all of our speakers and all the great information they provided today. Remember that you can make a difference. Please submit your comments regarding the proposed rule. Every comment is read by CMS. That's all the time we have for today, thanks again to our prestigious speakers Elizabeth Bainger, Vinitha Meyyur, Elizabeth Goldstein, and Grace Im.