Outpatient Quality Reporting Program

Support Contractor

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

Presentation

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Karen VanBourgondien: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Karen Van Bourgondien. I'm an education coordinator for the Hospital OQR Program.

We have several representatives from CMS today. And we do appreciate their time in lending their expertise with regard to the information they will share with us today.

We have with us today Dr. Elizabeth Bainger, CMS Program Lead for OQR; Dr. Elizabeth Goldstein, CMS Director of the Division of Consumer Assessment and Plan Performance; Grace Im, CMS Program Lead for Hospital Inpatient Quality Reporting; and Dr. Vinitha Meyyur, CMS Measures Lead for the Hospital OQR Program. We do invite you to view their biography placed at the end of this presentation.

Before we begin today's program, I'd just like to highlight some important dates and announcements. January 1st, 2017, begins the submission period for the web-based measures entered through the QualityNet Secure Portal. February 1st, 2017, is the

submission deadline for Clinical Data and Population and Sampling for Quarter 3 2016. This will be for encounter dates from July 1st, 2016, through September 30th, 2016.

Always please keep your NHSN and QualityNet passwords active. The easiest way you can do this is by logging into the NHSN and the QualityNet Secure Portal at least every 60 days. As a reminder, these are two separate platforms; they do not speak to one another. Because of that, there are completely separate registration and requirements for password processes. We don't want your password to be expired when you're trying to enter data, so please make sure you keep these current.

I'd like to let you know of some upcoming events we have planned. Please join us on December 12th for the next webinar, the Hospital OQR Specifications Manual Update. This presentation will review all the changes to the Specifications Manual over the course of the last year. On January 18th, we will be presenting a webinar geared for those who are new to the reporting of this program. It will also be of value to those who have been around a while but you just need a little review. Any information regarding program updates or educational opportunities will be sent by ListServe. If you are not signed up for this automatic email service, you can do so on the QualityNet home page.

Now, without further delay, I will turn it over to our first speaker, Dr. Elizabeth Bainger. Elizabeth?

Elizabeth Bainger: Hello, everyone, and welcome to this webinar about the Hospital OQR portion of the Calendar Year 2017 OPPS/ASC Final Rule. I'd like to start by showing you how to locate the Final Rule on the *Federal Register* website.

The *Federal Register* website has been updated, so you can't get to the rule the way I've described in previous webinars. And I wanted to make this as easy and clear for you as possible because I really want to encourage you to locate and read the final rule. Remember, only the rule serves as a standalone resource – not this webinar, not this slide deck, not this transcript, only the rule stands alone, so I do encourage you to read it.

Okay. So I looked at the new *Federal Register* home page, and I decided I really wanted to keep this search simple. You shouldn't have to know the FR citation to find the rule. You should just be able to do a broad search and find it, at least that's what I hoped. So I decided to search for OQR, as you can see, circled in the red box on the screenshot.

And searching for OQR brought me to this page. And the rule that we're interested in goes right at the top of the list. You can see that this rule has a really long name. It not only includes Hospital OQR and HVBP, Hospital Value-Based Purchasing, but it also includes regulations about organ transplants, the electronic health record, and much more. Although it went on display in early November, it wasn't published in the *Federal Register* until November 14th.

And that long rule name in the blue text, that's a clickable link. And when you click it, it brings us here to the start of the final rule. Now, this is the whole rule. You can still write down this page and read every bit of it in one long column, or you can click the PDF link and see this. It takes you to the PDF version of the rule.

Now if you're wondering what the FR citation for this final rule is, you can see with those red arrows that we are in Volume 81 of the *Federal Register*, page 79562. Remember from previous webinars that the citation is always the volume number, then FR for *Federal Register*, then the page number, so the citation would be 81 FR 79562. That's the shortcut to this rule: 81 FR 79562. You could have searched for that on the home page of the *Federal Register*, but remember, I was trying to show you how to locate the rule as easily as possible with no knowledge required about the page numbers and so on.

Now, again, there is a lot more than just the Hospital OQR and the Hospital Value-Based Purchasing Program in this rule. The rule starts on page 79562, and I know that it ends on page 79892. That's 331 pages. So how are we going to find the Hospital OQR section?

Again, I wanted to keep this simple. I want to assume that we don't know anything about the rule. Use the "Find" feature in your PDF reader, and let's just search for OQR again. You'll need to click through a couple of times, but then you'll come to this table of contents for the rule. And you can see that the requirements for the Hospital OQR Program begin at Roman numeral XIII.

I didn't want to keep clicking through, so I just copy and paste at that section header, Roman numeral and all, right into the search box, and it brings us to the beginning of the Hospital OQR portion of the final rule. It starts on page 79753, so the citation would be, 81 FR 79753. Again, if you knew this ahead of time, you could have searched for the citation on the home page of the *Federal Register*.

Now, some of you are here not just for the Hospital OQR Program, but rather for the HVBP program that Grace Im will be discussing later in this webinar. To get to that section of the final rule, you can do a search in just the same way using HVBP, and it will reach this page. And the citation is 81 FR 79855.

And with that, I'm going to toss the presentation to Dr. Vinitha Meyyur.

Vinitha Meyyur: Thanks, Elizabeth. Let's start out by looking at the newly adopted measures in this recent rule-making process. The first claims-based measure we want to talk about is OP-35. But before we get started on the measure, let me stop here and remind everyone what a claim-based measure is.

A claims-based measure is data that is collected from the claims that your facility submits to Medicare for payment. You or your facility will not have to gather this data, but as this data

will be reported publicly, it is important that you understand the measure. OP-35 addresses patients who present to the ED or inpatient admission 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 aims to assess the care provided to cancer patients and encourage quality improvement efforts to reduce the number of potentially avoidable inpatient admissions and ED visits among cancer patients receiving chemotherapy in a hospital outpatient setting.

OP-35 will affect your 2020 payment determination, so that means this data will be pulled from the 2018 performance period, or patient encounters in the 2019 reporting period, for payment in 2020. 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 measure adopted in the final rule, and that is OP-36. OP-36 is another claims-based measure. This measure looks at unplanned hospital visits within seven days of the outpatient surgical procedure or admission directly after surgery.

What does “hospital visit” mean? Well, for this measure, it includes an inpatient admission, observation stay, or an ED visit within seven days of surgery. This measure also includes the patient that is admitted or placed in observation status directly after the surgery.

Your facility-level measure score is a ratio of the predicted to expected number of hospital visits among the hospital's patients. The numerator of the ratio is the 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. The denominator of the ratio is the expected number of hospital visits given the hospital's case-mix and surgical procedure mix. Now, if you need additional information regarding the methodology for OP-36, then you can access the link provided on this slide.

Now, to go over the survey-based measures, I'm going to hand the presentation over to Liz Goldstein.

Liz Goldstein: Thank you very much. Today, I'm going to be talking about the survey-based measures that were adopted in the final rule. Prior to the development of this survey, there were no standardized surveys available to collect information on the patient's experience for surgeries or procedures performed within the hospital outpatient department or an ambulatory surgery center. Some facilities are conducting their own surveys and reporting these results on their website, 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 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. This slide shows the three composite and two global survey-based measures adopted for the calendar year 2020 payment determination and subsequent years.

The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey, which I mentioned is called 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. It is designed to publicly display comparable data from the perspective of patients. The survey focuses on items that are important from the perspective of patients.

The survey contains 37 questions that cover topics such as preparation for surgery or procedure, check-in, surgery facility staff, discharge, and preparation for recovering at home. Facilities can elect to have up to 15 supplemental questions to the survey. It is important to note that these supplemental questions are not submitted to CMS. This survey development process follows the principles and guidelines outlined by the Agency for Healthcare Research and Quality, which is part of Health and Human Services and the CAHPS Consortium, which is a group of research organizations across the country that helps 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 will be required to participate in the survey. Therefore, the survey data reported for a CCN must include all eligible patients from all locations under the CCN. Facilities that share the same CCN must combine data for data collection and submission for the survey across the multiple facilities.

These results will then be publicly reported on Hospital Compare as they apply to a single CCN. If a facility's data are submitted after the data submission deadline, it will not fulfill the OAS CAHPS quality reporting requirement. The 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 a survey in a way that reflects their actual experiences with care and is not influenced by the facility, facilities must contract with the CMS-approved OAS CAHPS Survey vendor to conduct or administer the survey. The format and timing for public reporting of OAS CAHPS Surveys will be proposed in future rule-making prior to implementation of the measure. Because calendar year 2016 is the first year of voluntary national implementation for the OAS CAHPS Survey, we believe using data from this voluntary implementation will help to inform the displays for public reporting of the survey. CMS will post a format and timing for public reporting of OAS CAHPS Survey data in future rule-making.

The data collection period for the OAS CAHPS Survey measures will 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 will be required for the calendar year 2020 payment determination. Facilities through their CMS-approved survey vendors will 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 critical 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. Smaller facilities will need to include all eligible patients in their administration of the survey.

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. The link is shown on 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 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 will 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. 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 will be May 15th, 2018. This deadline, May 15th, will align with the deadline for submitting web-based measures and also provides facilities with sufficient time to review the previous year's patient list and determine whether they are eligible for an exemption based on patient population size.

This concludes the information regarding the OAS CAHPS Survey. Now I'd like to hand things back over.

Elizabeth Bainger: Thank you, Liz, for that discussion of the OAS CAHPS measure. This is Elizabeth Bainger again, and I'd like to talk with you about the policy updates and clarifications.

These updates are effective with January 1st, 2017, patient encounters for the payment determinations as noted. For the calendar year 2017 payment determination and subsequent years, we are clarifying that hospitals may only file an appeal with the Provider Reimbursement Review Board, or PRRB, if the hospital had submitted a timely request for reconsideration and received the decision on those requests. As an additional note, and this was not part of the final rule, there was a webinar presented earlier this month about the reconsideration process. I provided the link here. As with all PowerPoints, you do need to download the slide deck for the link to work. Otherwise, you'll need to copy and paste the link into your browser.

Now, moving on for the calendar year 2018 payment determination and subsequent years, we will publicly display data on the Hospital Compare website or another CMS website as soon as possible after measure data have been submitted to CMS. In addition, hospitals will generally have approximately 30 days to preview their data. We will also announce the time frames for the preview period on the CMS website or on an applicable ListServe. And, again, that's how we've been doing things. It's just the clarification.

Now here is the change. For the calendar year 2019 payment determination and subsequent years, we are changing the time frame for Extraordinary Circumstances or Exemption, or an ECE request, from 45 days to 90 days from the date that the extraordinary circumstance occurred, so you're getting more time to file for that request.

I also want to note that there was a typo on the table that crosses pages 79784 and 79785. OP-30 should have had only two asterisks rather than three. Two asterisks indicate that the measure name was changed to reflect the NQF title. Three asterisks indicate that the measure is voluntary. And, as you know, only OP-31 is voluntary in the Hospital OQR Program.

I'd submitted this correction to the *Federal Register*, but I wanted to give you a heads-up. So, OP-30 is not voluntary. We should have had only two asterisks to indicate the measure name was changed to match the NQF title.

And now I'd like to pass the presentation along to Grace Im as she discusses the Hospital Value-Based Purchasing Program changes.

Grace Im: Thank you. My portion of today's presentation is related to the Hospital Value-Based Purchasing Program, or the Hospital VBP Program, for the inpatient hospital setting. We at CMS have received feedback that some stakeholders have been concerned about the Pain Management question from the Hospital Consumer Assessment of Healthcare Provider and Systems Survey, 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 questions in the Pain Management dimension of the Hospital VBP Program payment incentives creates pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension. CMS continues to believe that pain control is an appropriate part of routine patient care that hospital should manage and is an important concern for patients, their families, and their caregivers. However, in an abundance of caution, in the calendar year 2017 OPPS/ASC proposed rule, they proposed to remove the Pain Management dimension from the Hospital VBP Program beginning with the FY 2018 program year.

Based on the support we received from public comments, we have finalized our proposal to remove the Pain Management dimension that is part of the Patient Experience domain in the Hospital VBP Program beginning with the FY 2018 program year. The FY 2018 program year uses HCAHPS performance period data from calendar year 2016 and baseline period data from calendar year 2014 to calculate each hospital's total performance score, or TPS, which affects FY 2018 payment. This leaves eight dimensions in the HCAHPS survey for use in the Hospital VBP Program that the table on the slide illustrates.

In order to adjust for the removal of the Pain Management dimension, we continue to assign achievement points that are scored from 0 to 10 points, and improvement points that are scored from 0 to 9 points to each of the remaining eight dimensions in order to create the HCAHPS base score, which is scored from 0 to 80 points. Each of the eight dimensions are of equal weight. Then, HCAHPS consistency points will be calculated and will range from 0 to 20 points. The consistency points consider scores across the eight dimensions and will no longer include the Pain Management dimension.

The final element of the scoring formula is the sum of the HCAHPS base score with the HCAHPS consistency points and ranges from a total of 0 to 100 points. For the FY 2018 program year, we finalized performance standards for the HCAHPS measures in the FY 2016

IPPS final rule, which can be found at 80 FR 49566 of the *Federal Register*. The performance standards for these eight dimensions remain unchanged.

Although we are not aware of any scientific studies that support an association between scores on the Pain Management dimension and opioid prescribing practices, we're 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 drafting alternative questions, cognitive interviews and focus group evaluation, field testing, conducting statistical analyses, obtaining stakeholder input, the requirements of the Paperwork Reduction Act, and the application for NQF endorsement.

While CMS is developing alternative Pain Management questions, HCAHPS Survey data on all dimensions of care, including Pain Management, will continue to be publicly reported under the Hospital Inpatient Quality Reporting, or IQR, Program. This is in recognition that pain control is an important aspect to delivering quality care. And we believe this approach appropriately balances stakeholders' concerns that clinicians could face financial pressure to prescribe opioids without compromising the only source of nationally comparable data on pain management and pain management disparities.

For more information on the HCAHPS Survey, a webinar entitled "HCAHPS Overview, Updates, and Hospital Value-Based Purchasing" was recently held on Tuesday, November 15th, 2016. This webinar presents more detailed information on the HCAHPS Survey that's used in the Hospital VBP Program and the updates regarding the Care Transition measure and the removal of the Pain Management dimension. We recommend that you watch the recorded webinar available on the Quality Reporting Center website. The link is available on the slide.

This concludes my portion of the presentation. Let me hand things over to the next speaker. Thank you.

Karen Van Bourgondien: Thank you, Grace. Thank you to all our distinguished speakers. We do appreciate all their time in discussing this information with us today.

That concludes our presentation. I'm going to turn things back over to our host to explain the CE process. Thanks, again, everyone. Have a great day.

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