Outpatient Quality Reporting Program

Support Contractor

CY 2018 Hospital Outpatient Quality Reporting (OQR) Program Proposed Rule

Presentation

Moderator:
Pam Harris, BSN, RN
Project Coordinator, Hospital OQR Program Support Contractor

Speaker:
Anita Bhatia, PhD, MPH
Program Lead, Hospital OQR Program Centers for Medicare & Medicaid Services (CMS)

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Pam Harris: Good day to everyone 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.

If you have not yet downloaded today's handouts, then you can get them from our website at qualityreportingcenter.com. Once you get there, you go to the "Events" banner on the right-hand side of the page. Click on today's event and this will direct you to the link that will allow you to access and print the handouts for today's webinar.

Our speaker today is Dr. Anita Bhatia. Dr. Bhatia is the Government Task Leader for both the Hospital OQR Program as well as the ASCQR Program. She received her PhD from the University of Massachusetts, Amherst and her Masters in Public Health from Johns Hopkins University. Dr. Bhatia plays a crucial role in the development of the OPPS proposed and final rulings. Her contributions to the rulings are essential to the continuing success of the Hospital OQR Program. We are fortunate to have Dr. Bhatia's commitment to this program, and ultimately, to patient care outcomes.

Before we begin today's presentation we would like to make an announcement on behalf of the measure writers regarding OP-35 and -36. They would like to inform you of some information regarding the Dry Run, also called The National Confidential Reporting Periods that are forthcoming for OP-35 and OP-36.

Now, there are two dates, two runs. OP-35 dry run will be from August 15, 2017 through September 14, 2017, and this is the Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy measures.

Then from September 1, 2017 through September 30, 2017; this is OP-36's dry run, the Hospital Visits after Hospital Outpatient Surgery measure.

The purpose of the dry runs is to familiarize facilities with the measures in advance of public reporting and payment determination.

CMS will provide facilities with the confidential Facility-Specific Reports (FSRs) for the measure via the QualityNet Secure Portal at the start of each dry run. FSRs contain patient-level data, facility-specific results, and state and national results for the measure.

CMS will hold national provider calls to present measures, methodology, and address questions.

You can see on this slide the two dates that are scheduled to host the calls. The first one being Wednesday, August 23, 2017 at 1p.m. Eastern, and that's on OP-35, and then there is another one on Thursday, September 14, 2017 at 1p.m. Eastern and that is on OP-36.

Now you can get the information about the measures and the upcoming dry run from the websites that are here posted on the slide. Now, CMS encourages facilities to review their measure results and ask questions about the measures during the dry run periods. For any questions, you can refer to the emails noted at the bottom of the slide.

So, now let's turn our attention back to the Proposed Rule. The learning objectives for this program are listed on this slide. The 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 at www.qualityreportingcenter.com at a later date.

During the presentation, as stated earlier, if you have a question please put that question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having live chat we hope to accommodate your questions timely and have real-time feedback. If your question does not get answered, please know that all questions and answers will be posted on the qualityreportingcenter.com website.

Let us just mention, before we get started, a standard disclaimer for our proposed rules. CMS can only address procedural questions and comment submissions; any rule-related questions cannot be address.

Now, without further ado, I will turn it over to our speaker Dr. Anita Bhatia. Anita?

Anita Bhatia: Welcome, everyone. I am Anita Bhatia, the Program Lead for the Hospital Outpatient Quality Reporting Program. Today we are discussing program proposals contained in the calendar year 2018 OPPS/ASC Proposed Rule. For those of you who are new to the Hospital OQR program, here is a very simplified version of the rule process. On or around July 1, every year after months of evaluation, research and writing, the OPPS/ASC Proposed Payment Rule is placed on display, and then subsequently published. From the display date there is a 60-day period available to submit public comment on proposal. Then, on or around November 1, after reviewing and considering all comments, CMS places the OPPS/ASC Final Rule on display. Your comments are extremely important to CMS and the rule making process, every comment is reviewed and considered. At the end of this webinar we will go over how to submit a comment to CMS regarding proposals contained in the rule. So, let's begin on the proposals for this year.

So after display, the Proposed Rule is published in the *Federal Register*. So, here on this slide, we find the links to the *Federal Register* and the proposed rule. To find the calendar year 2018 OPPS/ASC Proposed Rule and the Hospital OQR Proposal contained in that rule, you go to the link as shown here.

Once you click here and the link opens, you would use your find feature and enter 33671; that is the page where the Hospital OQR portion begins. So, let's go find the OQR portion of the proposed rule from the home page of the *Federal Register*.

This slide shows the homepage for the *Federal Register* and you can see the web address at the top of the screenshot. On this screenshot, in the red box, you can see that we've entered the volume number 82, FR for *Federal Register*, and then the page number, which for Hospital OQR Program is page 33671. Once you have entered this information, just click the "enter" key on your computer.

This will bring up the link to the Proposed Rule; you can see it here in the red box highlighted in blue. Above that you can see descriptor 82 FR 33671 that we originally entered. When you click the title in blue, it will take you directly to the Proposed Rule.

This is the page you will see next. Let me just point out a couple of things here. First, you can now scroll about two thirds of the way down this page and you'll see the start of the Hospital OQR portion. It begins with the Roman numeral thirteen (XIII). Or, you can use your “find” feature and enter “33671;” I have this here in a red box at the left upper corner. This will take you straight to the hospital OQR section.

Some people like to view the Proposed Rule as a PDF document. To utilize that view, you would just click on the “PDF” icon I have circled here in red. Again, you would use your find feature and enter the “33671.” On that version, you would just have to scroll down a little on the page to see the thirteenth section, or XIII, that relates to the Hospital OQR Proposed Rule section.

You can submit a comment from here as well; I have placed a red arrow next to that box. I will discuss commenting on proposals regarding the hospital OQR Program later in the presentation.

Now that you know how to find the Proposed Rule, let’s discuss the proposals in the rule.

In this Proposed Rule, we are seeking comment on the use of social risk factors in measures. We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support, certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors, play a major role in health.

One of our core objectives is to improve beneficiary outcomes regarding reducing health disparities in care, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care.

So, regarding social risk factors, there has been a review of reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of measuring and accounting for social risk factors in CMS’ value-based purchasing and quality reporting programs and considering options on how to address the issue in these programs.

This report also included considerations for strategies to account for social risk factors in these programs. The National Quality Forum or NQF has undertaken a 2-year trial period in which new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for

selected social risk factors is appropriate for these measures. At the conclusion of this 2 year trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures, and CMS will closely review its findings.

We are also seeking comment on whether we should account for social risk factors in the Hospital OQR Program, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include: confidential reporting to providers of measure rates stratified by social risk factors; public reporting of stratified measure rates; and potential risk adjustment of a particular measure as appropriate based on data and evidence.

We are also seeking public comment on which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to, dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence.

CMS is seeking comments on which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk.

For the Hospital OQR Program, we have previously proposed criteria for removing measures and in this proposed rule, we are not proposing any changes to our policy to immediately remove measures as a result of patient safety concerns.

We are proposing to remove some measures. Before we discuss the measures proposed for removal, let's just take some time to discuss the criteria.

Measure Removal Criteria. The benefits of removing a measure from the Hospital OQR Program will be assessed on a case-by-case basis. We note that under this case-by-case approach, a measure will not be removed solely on the basis of meeting any specific criterion.

The criteria we do use are: 1. Measure performance is so high and unvarying that meaningful improvements can no longer be made. We consider measures that have done this to be "topped-out." This essentially means there is statistically indistinguishable performance at the 75th and 90th percentiles of the national performance and that the measure's truncated coefficient of variation is less than or equal to 0.10.

Another criteria that we use for removing measures, is that performance or improvement on the measure does not result in better patient outcomes.

To continue with our measure removal criteria, we look at these factors: 1. whether a measure does or does not align with current clinical guidelines or practice. 2. Whether the availability of a more broadly applicable measure is available for the topic. 3. We look at the availability of a measure that is more proximal in time or more strongly associated with desired patient outcomes, as well as, 4, the collections or public reporting of a measure would lead to a negative unintended consequence such as patient harm.

Again, as we stated earlier, measures removed from the Hospital OQR Program are assessed on a case-by-case basis.

So, now let's look at the measures that are proposed for removal from the Hospital OQR Program. By removing measures, our intent is to alleviate the maintenance costs and administrative burden to hospitals associated with retaining the measures and reporting on these measures.

Measures proposed for removal. In this proposed rule, we are proposing to remove a total of six measures from the Hospital OQR Program. Specifically, beginning with the CY 2020 payment determination, we are proposing to remove:

OP-21: Median time to Pain Management for Long Bone Fracture

OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures

Additionally, beginning with the CY 2021 payment determination, we are proposing to remove:

OP-1: Median Time to Fibrinolysis

OP-4: Aspirin at Arrival

OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional

OP-25: Safe Surgery Checklist

By removing these six measures, our intent, again, is to alleviate burden for hospitals. So, let's look at these proposals.

Proposed removal of OP-21: Median time to Pain Management for Long Bone Fracture. This measure assesses the median time from emergency department

arrival to time of initial pain medication administration for emergency department patients with a principal diagnosis of long bone fracture.

We have proposed to remove this measure beginning with the CY 2020 payment determination and then for subsequent years, due to concerns of misinterpretation of the intent of the measure, and that this measure may create undue pressure for hospital staff to prescribe more opioids. We note that the measure only assesses the time to initial, acute administration of pain medication in a specific acute clinical situation, and does not promote long-term pain medication prescriptions. In fact, this measure assesses an element of appropriate pain management and specifically the time to pain medication administration in the case of long bone fracture. However, in an abundance of caution, we are proposing to remove this measure.

Proposed Removal of OP-26: *Hospital Outpatient Volume on Selected Outpatient Surgical Procedures*; this measure is submitted to CMS via a web-based tool and collects surgical procedure volume data on eight categories of procedures frequently performed in the outpatient hospital setting.

We believe there is a lack of evidence to support this measure's link to improved clinical quality and does not offer insight into a facility's overall performance or quality improvement in regards to surgical procedures. Accordingly, this measure meets the following measure removal criterion: performance or improvement on the measure does not result in better patient outcomes.

We believe that the burden of this measure outweighs the value to continue having it in the program and therefore, we are proposing to remove OP-26 from the Hospital OQR program.

Proposed removal of OP-1: *Median Time to Fibrinolysis*. This is a chart-abstracted measure that assesses the median time from ED arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the ECG performed closest to ED arrival and prior to transfer.

We believe that this measure meets the following measure removal criteria; the availability of a measure that is more strongly associated with desired patient outcomes for this particular topic. Specifically, OP-2: *Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival* has been designed with a threshold that is based upon a clinical standard and provides meaningful and clinically relevant data on the receipt of fibrinolytic therapy.

OP-1 measures only the median time from door to administration and does not note whether or not that value exceeds the clinical best practice of 30 minutes. Thus, we do not believe that the reporting of OP-1 improves quality of care or

patient outcomes. And we also believe that continuing to the collect the data for OP-1 is redundant, thus we are proposing to remove this measure from the program.

Proposed removal of OP-4, *Aspirin on Arrival*; OP-4 is another chart-abstracted measure. This measure assesses the rate of patients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department.

We have previously finalized two criteria for determining when a measure is "topped-out" under the Hospital OQR Program: (1) when there is a statistically indistinguishable performance at the 75th and 90th percentiles of national facility performance; and (2) when the measure's truncated coefficient of variation is less than or equal to 0.10.

Based upon our analysis of data for OP-4, we have determined that performance on this measure is so high and unvarying that meaningful distinctions in improvement cannot be made. Specifically, our analyses show that there is a statistically indistinguishable performance at the 75th and 90th percentiles of national facility performance.

Thus, we believe the burden of reporting this chart-abstracted measure is not justified by the value of retaining it in the program and are proposing to remove OP-4.

Here you can see the analysis performed for this measure. As you can see there is no distinguishable difference in hospital performance between the 75th and 90th percentiles for the OP-4 measure and the truncated coefficient of variation has been below 0.10 since the first quarter of 2014. Therefore, the OP-4 measure meets both "topped-out" measure criteria for the Hospital OQR Program.

Proposed removal of OP-20: *Door to Diagnostic Evaluation by a Qualified Medical Professional*.

This also is a chart-abstracted measure. During our regular measure maintenance, specific concerns about OP-20 were raised by a Technical Expert Panel, or TEP, which was comprised of experts representing a variety of stakeholders and was convened by a CMS contractor. These concerns include: 1. Limited evidence linking the measure to improved patient outcomes; 2. Validity concerns related to wait times and the accuracy of door-to door time-stamps; and 3. Potential for skewed measure performance due to disease severity and institution-specific confounders. After our own analysis, CMS agrees with these concerns. As a result, we believe the burden of continuing to include this chart-abstracted measure in the program outweighs

the benefits, and thus, we are proposing to remove OP-20 from the program beginning with CY 2021 payment determination. Specifically, the criteria not being met are that performance or improvement does not result in better patient outcomes.

Proposed removal of OP-25, *Safe Surgery Checklist Use*.; this is a structural measure of hospital process that assesses whether a hospital employed a safe surgery checklist that covered each of the three critical perioperative periods for the entire data collection period. We are proposing to remove this beginning with the CY 2021 payment determination.

Based upon our review of reported data for this measure, this measure meets our first criterion for measure removal that measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

We believe that removal of this measure from the Hospital OQR Program measure set is appropriate, as there is little room for improvement. We believe that the safe surgical checklist is widely used and that hospitals will continue its use. In addition, removal of this measure would alleviate burden to the hospitals.

So here is the analysis for that measure, OP-25. As you can see, the national rate of "Yes" response is nearly 1.0, or 100 percent, nationwide, and has remained at this level for the last two years. In addition, the truncated coefficient of variation has decreased such that it is trending below 0.10 and there is no distinguishable difference in hospital performance between the 75th and 90th percentiles.

So, that concludes measures that we are proposing for removal. Now we are going to look at changes to existing measures, specifically the survey measures. These measures assess patient's experience of care following a procedure or surgery in a hospital outpatient department, by rating patient experience, as a means for empowering patients and improving the quality of their care.

In this proposed rule, we are proposing to delay implementation of the Survey Based Measures OP-37a-e beginning with the CY 2020 payment determination, which corresponds to CY 2018 data collection, as a start, and subsequent years. Since the adoption of these measures, we have come to believe that we lack important operational and implementation data. Specifically, we want to ensure that the survey measures appropriately account for patient response rates, both aggregate and by survey administration method; we wish to affirm the reliability of national OAS CAHPS or Outpatient and Ambulatory Surgery Consumer Assessment of

Healthcare Providers and Systems survey data; and appropriately account for the burden associated with administering the survey in the outpatient setting of care.

We believe that it is important that we fully analyze the information that we have. We plan to conduct analyses of the voluntary national implementation data to see if any modification to the survey tool and/or CMS systems is necessary before implementing for the Hospital OQR Program. We also believe it is important to allow time for any modifications before requiring the survey under the Hospital OQR program.

We do continue to believe that these measures address an area of care that is not adequately addressed in our current measure set and will be useful to assess aspects of care where the patient is the best or only source of information. We continue to believe these measures will enable objective and meaningful comparisons between hospital outpatient departments. Therefore, we are proposing to delay implementation of these measures beginning with the CY 2020 payment determination, corresponding to 2018 data collection, until further action in future rulemaking. We are not proposing to remove these measures from the program.

Let's move on the Hospital OQR Program measures and some future consideration topics. Through future rulemaking, we intend to propose new measures that will help further our goal of achieving better health care and improved health for Medicare beneficiaries who receive health care in hospital outpatient settings, while aligning quality measures across the Medicare program.

In this proposed rule, we are seeking public comment on: (1) Any outcome measures that would be useful to add to the program as well as any clinical process measures that should be eliminated from the program, as well as (2) an option to develop OP-2: *Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival* as an electronic clinical quality measure or eCQM.

Future measure topics; for future measure topics, we are seeking to develop a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the hospital outpatient setting. The Hospital OQR Program includes measures that assess process of care, imaging efficiency patterns, care transitions, ED throughput efficiency, Health Information Technology or health IT use, care coordination, and patient safety. The measures that we have are of various types, including those of process, structure, outcome, and efficiency.

Through future rulemaking, we intend to propose new measures that help further our goal of achieving better health care and improved health for

Medicare beneficiaries who receive health care in hospital outpatient settings, while aligning quality measures across the Medicare program.

We are moving towards the use of outcome measures and away from the use of clinical process measures across our Medicare quality reporting and value-based purchasing programs.

We invite public comments on possible measure topics for future consideration in the Hospital OQR Program. We specifically request comment on any outcome measures that would be useful to add to the Hospital OQR Program as well as any clinical process measures that should be eliminated from the Hospital OQR Program.

So, as mentioned, a few slides back, we are looking at a possible eCQM. We are looking at the possible Future Adoption of the Electronic Version of OP-2. We have previously stated that automated electronic extraction and reporting of clinical quality data could significantly reduce the administrative burden on hospitals. In the CY 2017 OPPS/ASC final rule with comment period, this was last year's final rule, some commenters supported CMS' goal to incorporate electronic clinical quality measures (eCQMs) in the Hospital OQR Program.

We are considering developing OP-2: *Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival* as an eCQM and we are considering proposing this eCQM in future rulemaking. It must be noted that OP-2 is not yet fully developed as an eCQM, but we are considering OP-2 in particular because we believe it is the most feasible out of all the existing Hospital OQR Program measures to be developed into an eCQM. We very much invite your comment on this.

Public display of OP-18; so, let's turn our attention to the public reporting of OP-18. OP-18 addresses ED efficiency in the form of the median time from ED arrival from time of departure from the ED for patients discharged from the ED, also known as ED throughput. Reducing the time patients spend in the ED can improve the quality of care.

In this proposed rule, we are proposing to update public reporting of the OP-18 measure. The OP-18 measure data, if one consults the specifications manual, is stratified into four separate calculations: (1) OP-18a is defined as the overall rate; (2) OP-18b is defined as the reporting measure; (3) OP-18c is defined as assessing Psychiatric/Mental Health Patients; and (4) OP-18d is defined as assessing Transfer Patients.

Currently, what is publicly reported is the OP-18b data, for measure calculation. That is the median time from emergency department arrival to

emergency department departure for discharged emergency department patients. This calculation excludes psychiatric/mental health patients and transfer patients.

We believe that it is important to publicly report the data for OP-18c, which includes the information for psychiatric mental health patients.

Therefore, we are proposing to also publicly report OP-18c and begin this public reporting as early as July of 2018, using data from patient encounters beginning with the third quarter of 2017. We would make corresponding updates to our measure information forms to reflect these proposals.

Administrative requirements; alright, let's look at some the proposed changes in Hospital OQR administrative requirements. The previously finalized QualityNet security administrator requirements, including setting up a QualityNet account and the associated timelines, are described and finalized in the CY 2014 OPPS/ASC final rule with comment period. In that final rule, we codified these procedural requirements. So, in this proposed rule, we are proposing changes to the Notice of Participation submission deadline, beginning with CY 2020 payment determination.

We are proposing to change the Notice of Participation submission deadlines such that hospitals are required to submit Notice Of Participation any time prior to registering on the QualityNet website rather than by the deadlines previously finalized. For example, under this proposal, a hospital submitting data for Q1 2019 encounters would be required to submit the Notice of Participation only prior to registering on the QualityNet website. Registering on the QualityNet website must be done prior to the data submission; in this case, the deadline would be August 1, 2019. We believe this proposed timeline is appropriate because registration with the QualityNet website is necessary to submit data. This essentially extends the Notice of Participation submission deadline and will better enable hospitals to meet the Hospital OQR Program participation requirements. We also are proposing to make conforming changes in regulatory text.

Annual payment determination; in this proposed rule, for the CY 2020 payment determination and subsequent years, we are proposing to revise the data submission requirements for hospitals that did not participate in the previous year's Hospital OQR Program. Specifically, we are proposing to revise the first quarter for which newly participating hospitals are required to submit data. We are proposing that hospitals must submit data beginning with encounters occurring during the first calendar quarter of the year prior to the affected annual payment update. This, again, will make it easier for hospitals to meet Hospital OQR reporting requirements.

We are not proposing changes to the previously finalized data submission deadlines for each quarter.

Validation requirements; this is a clarification of a previously finalized proposal. In this proposed rule, we are: (1) clarifying that the hospital selection process previously finalized for validation; and (2) proposing to codify the procedures regarding the targeting of hospitals for validation purposes and (3) proposing to update our educational review process.

So, regarding validation selection, we previously finalized a process where we select a random sample of 450 hospitals for validation purposes, and we select an additional, up to, 50 hospitals based on the following specific criteria: Hospital fails the validation requirement that applies to the previous year's payment determination, or the hospital has an outlier value for a measure based on the data it submits. We define an "outlier value" for the purposes of targeting as a measure value that appears to deviate markedly from the measure values for other hospitals. Specifically, we will select hospitals for validation, as an outlier, if their measure value for a measure is greater than 5 standard deviations from the mean, placing the expected occurrence of such a value outside this range at 1 in 1,744,278; meaning it is very much outside the range of what most hospitals have reported for that measure.

We note that the criteria for targeting the 50 outlier hospitals previously did not specify whether high or low performing hospitals will be targeted. In this proposed rule, we are clarifying that hospitals with outlier values indicating specifically poor scores on a measure will be targeted for validation. In other words, an "outlier value" is a measure value that is greater than 5 standard deviations from the mean of the measure values for other hospitals and indicates a poor score. And, as for other such proposals, we are proposing to codify these changes.

Educational review changes; so, under the Hospital OQR program, hospitals can request an educational review. Under the current informal process, if the results of an educational review, which is regarding the results of validation on record, indicate that either the contractor that handles validation, CDAC, or CMS, has incorrectly scored a hospital after validation, those scores are not changed, but are taken into consideration if the hospital submits a reconsideration request.

Stakeholder feedback has indicated that while the educational review process is helpful to hospitals that participate, it is limited in its impact, given that a hospital's score is not corrected even after an educational review determines that CMS reached an incorrect conclusion regarding a hospital's validation score for a given quarter.

Based on this feedback, we are proposing to formalize and update the Hospital OQR Program's chart-abstracted measure validation educational review process.

Our goal is to reduce the number of reconsideration requests by identifying and correcting errors before the final yearly validation score is derived. By identifying and correcting any mistakes early on, this process could help reduce the burden during the annual reconsideration process, both for hospitals and CMS.

Therefore, in an effort to streamline this process, in this proposed rule, we are proposing to: (1) formalize this process; and (2) specify that if the results of an educational review indicate that we incorrectly scored a hospital, the corrected score would be used to compute the hospital's final validation score at the end of the calendar year.

We are proposing that if an educational review requested for any of the first 3 quarters of validation yields incorrect CMS validation results for chart-abstracted measures, according to the review process, we would use the corrected quarterly score, as recalculated during the educational review process, to compute the final confidence interval.

We note that for the last quarter of validation, because of the need to calculate the confidence interval in a timely manner and the insufficient time available to conduct educational reviews prior to the annual payment determination, the validation score review and correction would not be available. Instead, the existing reconsideration process would be used to dispute any unsatisfactory validation results for this final quarter.

Process changes; so, this continues the process that would be changed. Under the informal process, hospitals that were selected and received a score for validation may request an educational review in order to better understand their results and specifically to request a review of data element discrepancies. Many times, hospitals request an educational review if they believe the score is incorrect or if they have questions about their score.

Currently, hospitals receive validation results on a quarterly basis and can request informal educational reviews for each quarter. Under this informal process, a hospital has 30 calendar days from the date the validation results are posted on the QualityNet Secure Portal website to contact the Validation Support Contractor to request an educational review. In response to a request, the Validation Support Contractor will obtain medical records directly from the Clinical Data Abstraction Center or CDAC, review it, and provide feedback.

To determine whether a score was correct, we are proposing to use a similar process as the one finalized for reconsideration requests to evaluate whether or not validation results are correct. Specifically, we are proposing that to evaluate a validation score during an educational review request, we would review data elements that were labeled as mismatched, between the originally calculated measure score and the measure score calculated in validation, in the original validation results. We would also take into consideration written justifications provided by hospitals in the Educational Review.

Extraordinary circumstances extensions or exemptions; in the review of our value-based purchasing and quality reporting programs, we noted there were some discrepancies with process and language regarding the Extraordinary Circumstances Extensions or Exemptions or ECEs. In reviewing the policies for these programs, we recognized that there were 5 areas with variance. These were related to who could sign the form, the time to submit the form, some inconsistencies regarding specifications for formal response, some inconsistency regarding specification of our authority to grant ECEs due to CMS data systems and, of note, what we termed the process referring to the program as "extraordinary extensions/exemptions" versus as "extraordinary circumstances exceptions."

So, in this rule we are addressing these five areas, as appropriate, to improve administrative efficiencies for affected facilities or hospitals. Regarding ECEs, in order to align the Hospital OQR Program with the other quality reporting programs, we are proposing two changes to the Hospital OQR ECE process. One, we will begin referring to the process as the Extraordinary Circumstances Exceptions process, and two, CMS will strive to complete our review of each ECE request within 90 days of receipt. CMS does review each ECE as quickly as possible; however, we recognize that the number of request we receive, and the complexity of the information provided impacts the actual timeframe for review.

You may remember that in CY 2017 Final Rule, we finalized an update to our extraordinary circumstances exception or ECE policy to extend the request deadline for both chart-abstracted and web-based measures from 45-days following an event causing hardship to 90 days following an event causing hardship, and that was effective for ECEs requested on or after January 1, 2017.

Measures moving forward; let's take some time to review the measures and the proposed measures and changes we have discussed here today.

Claims-based measures as proposed; there will be a total of nine claims-based measures for the CY 2020 payment determination and subsequent years and they are listed here on this slide. In this Proposed Rule, we are not proposing

any changes to our claims-based measures submission policies for the CY 2020 payment determination and subsequent years.

Measures submitted via a web-based tool as proposed; in this proposed rule, we are proposing to remove OP-25: *Safe Surgery Checklist Use*, beginning with CY 2021 and we are proposing to remove OP-26: *Hospital Outpatient Volume on Selected Outpatient Surgical Procedures*, beginning with CY 2020. If these proposals are finalized as proposed, this slide demonstrates the web-based quality measures previously finalized and retained in the Hospital OQR program that will require data to be submitted via a web-based tool. The web-based tool would be the QualityNet web site or the National Health Safety Network web site; the NHSN web site, which would correspond to the healthcare worker influenza measure for the CY 2020 payment determination and subsequent years.

Chart-abstracted measures requiring patient-level data as proposed; so, remember, we discussed that for this proposed rule, we are proposing to remove OP-21: *Median Time to Pain Management for Long Bone Fracture* beginning with the CY 2020 payment determination and subsequent years and OP-1: *Median Time to Fibrinolysis,* and OP-4: *Aspirin at arrival*, and OP-20: *Door to Diagnostic Evaluation by a Qualified Medical Professional* for the CY 2021 payment determination and subsequent years. If these proposals are finalized, as proposed, this slide shows the Hospital OQR Program chart-abstracted measures that will require patient-level data to be submitted for the CY 2020 payment determination and subsequent years.

Commenting; this is very important. Now that we have discussed the proposed changes for the Hospital OQR program, let me just make the very important point that CMS wants your comments. We very much want to know what you think about these proposals. The comment process provides the opportunity to be involved in the program development process. We very much take seriously the comments from the people in the field that do the work and take the time to make these comments to us. So now, I will show you how to submit your comments to CMS.

It's important to know what the deadline for comments is. Comments for the CY 2018 OPPS/ASC proposed rule can be submitted using various methods including electronically, regular mail, express or overnight mail, and by hand or courier. The deadline for comments is 5:00 p.m. Eastern Time on September 11, if delivered by regular mail, express or overnight mail, or by hand or courier.

Comments submitted electronically will be accepted until 11:59 p.m. Eastern Time. We encourage the submission of electronic comments to the

www.regulations.gov site and responses to comments will be contained in the Final Rule to be issued on or around November 1, 2017.

Submitting comments; on this slide, you can see a screenshot of just what you'll see when you go to regulations.gov site. In the search box, enter **CMS** and then select the **Search** button.

On the next screen, you will see, as depicted on this slide; here, I want you to set your filters. Be certain that your comment period is set for **Open** and the document type is **Proposed Rule** because there are lots of rules on this site. Scroll down until you find the rule. Then you can select the **Comment Now** button. Notice that the deadline is September 11, 2017 at 11:59 p.m. Eastern Time for an electronic submission.

So, Step 1: When submitting comments the system will guide you through a three-step process. For step 1 you would enter your comments, you can see that here illustrated by the letter "a." It has a character count of your comment, displayed on this slide with the letter "b."

In addition to entering the comment for Step-1, you will also enter your contact information. Note that you do not have to submit your contact information; you can comment anonymously. You can choose to upload a file if you choose as well; once all that is completed, select the **Continue** button.

So, here is Step-2. Step-2 allows you to preview your comments and edit your comment if need be. Be certain that you have checked the box that you have read and understand the provisions of commenting. Once all steps are completed, you may select the **Submit Comment** button.

So, Step-3, this is the receipt. You will then be assigned a tracking number for your comment. It is recommended that you take a screenshot of this page or save your tracking number. The tracking number will allow you to follow the status of your comment.

So, that's all I have for you today regarding the CY 2018 OPPS/ASC Proposed Rule, and the proposals for the Hospital Outpatient Quality Reporting program contained within. Thank you for very much for your attendance; I will now turn things back over to Pam.

Pam Harris: Thank you, Anita, for the great information that was provided today. We have some quick links here for the Proposed Rule, as well as the direct link to comment. Let me just mention that if you use the direct link seen on this slide instead of just regulations.gov for the comment site, it will start on the "your information" page, which eliminates the first two steps we previously covered.

Remember that you can make a difference. Please submit your comments regarding the proposed rule. Every comment is read.

That's all of the time we have for today; our thanks again to our prestigious CMS speaker, Dr. Anita Bhatia. As a reminder, if your question did not get answered in the chat box, please know that all questions and answers are posted on our website at www.qualityreportingcenter.com. We appreciate you joining us today.