Hospital Outpatient Quality Reporting Program

Support Contractor

Hospital Outpatient Quality Reporting (OQR) Program Requirements: CY 2015 OPPS/ASC Final Rule

Presentation Transcript

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Mollie Carpenter: Hello and welcome to the Hospital Outpatient Quality Reporting Program webinar. Thank you for joining us today. My name is Mollie Carpenter, and I am the Educational Coordinator.

If you have not yet downloaded today's handouts, you can get them from our new website at www.qualityreportingcenter.com. On the right-hand side of the page, go to Upcoming Events, click on the link under the November 19th event, and you'll find the handouts at the bottom of the page.

February 1st is the next submission deadline for clinical data and population and sampling submission from Q3 2014, for July 1, September—July 1 through September 30, 2014. The CDAC will send requests for Q2 2014 records in December.

ListServe announcements will be forthcoming for future Hospital OQR Program webinars as we get closer to those dates. There will not be an educational webinar in December. Then on January 21, 2015, we will be

presenting the Specifications Manual update.

The learning objectives for this program are listed here on slide number 4. This program is being recorded. A transcript of today's webinar presentation and the audio portion of today's program will be posted at www.qualityreportingcenter.com at a later date.

During today's webinar, please do not use the chat feature on the WebEx screen since we do not monitor this function during the program. We will follow this presentation with a question-and-answer session until the top of the hour.

I am pleased to introduce today's speaker, Elizabeth Bainger. Elizabeth joined CMS in June to become the lead for the OQR Program. She is with the Center for Clinical Standards and Quality in the Division of Value, Incentives and Quality Reporting. Elizabeth received her bachelors of science in nursing from the Franciscan University of Steubenville, her masters of science as an Adult Health Clinical Nurse Specialist from the University of Delaware, and she is currently pursuing her doctorate in nursing practice at the University of Maryland with an administrative focus on quality improvement.

She has a broad clinical background, including behavioral health, ambulatory surgery, cardiac care, and critical care. Elizabeth also served as a flight instructor in the Air Force Reserves for 10 years. She has worked as both adjunct and full-time faculty in a community college nursing program. Elizabeth's quality improvement background includes positions as a performance improvement coordinator and senior abstraction specialist. She is a Certified Professional in Healthcare Quality and an active member of the National Association for Healthcare Quality. And now I will turn the floor over to Elizabeth. Elizabeth, the floor is now yours.

Elizabeth Bainger: Thank you, Mollie. Good morning, everyone. My name is Elizabeth Bainger, and I am the Hospital OQR Program Lead. I work at the Centers for Medicare & Medicaid in Baltimore, but I'm coming to you live today from my home in Maryland instead of my office in Baltimore. That has led to a little bit of technical difficulties. I had some trouble getting on today, so I apologize that we started about five minutes late. And I also wanted to let you know the reason I'm coming from my home is because we're having a “shelter in place” exercise at CMS today, which is perfectly normal. They want organizations to be ready if there's a tornado coming or inclement weather. But I didn't want you to hear alarms all of a sudden overhead and for me to cut off, so I'm coming from home on my cell phone. And if we have any problems with the connection, we do have some back-ups in place. So, I just want to let you know that.

Today I'll be giving you a general overview of the Hospital Outpatient Quality Reporting Program, and I'll point out changes that are new with the calendar year 2015 OPPS/ASC Final Rule, which from now on I'm just going to refer to that as the 2015 Final Rule. After I've run through the slide presentation, we'll open up the floor for questions. And during that portion we'll also have some support from the Florida Medical Quality Assurance Incorporated, which is FMQAI.

Now I know we started late and this is a long program that I have a lot to get through, so we are going to let the question-and-answer run over for a little bit so that we can accommodate as many people as possible.

And I want to start with my standard disclaimer, and here it is: I want you to know that while I hope this slide deck and this webinar will provide you with useful information, neither one is a substitute for reading the Final Rule. [Neither] the slide deck nor the transcript can stand on their own as a complete resource, but the Final Rule can, so I really want you to refer to

that.

So where do you find the Final Rule? Well, one way to get to it is by using the link on this slide. This link will take you to a PDF version of the rule. And it's long. The PDF is 266 pages. The other way to find it is by going to the *Federal Register* website. That's www.federalregister.gov, and I'll tell you more about that website in a couple of slides. But no matter which way you choose to get to it, you want to go down to section Roman numeral XIII, the "Hospital Outpatient Quality Reporting Program Updates." You'll find that on pages 66940 through 66966 of the *Federal Register*, or pages 172 to 198 of the PDF. Next slide, please.

As you know, we invited public comment on the rule for a period of 60 days, and that ended September 2nd. I want you to know that we at CMS read every comment. And as a result of your comments, what we finalized in some cases is not what we proposed. Your comments caused us to reconsider what we were initially proposing, and that's really important because I want you to know that your comments impacted this rule, and I want to encourage you to comment next summer when we propose the 2016 rule.

This rule that I'll be talking about today is effective with January 1, 2015, patient encounters. And the link to the Specifications Manual is provided on this slide. Just go to qualitynet.org, click on Hospitals-Outpatient, and then choose Specifications Manual from the drop-down list. Version 8.0 has been updated for patient encounters from January until September 2015, so that version of the Specs Manual will be a resource to you for those nine months, and then we'll be updating the Specs Manual again.

This slide provides some historical perspective. You can see that we just completed our 7th rule-making cycle for the Outpatient Quality Reporting Program. You can review each of the Final Rules by using the link at the

top of the far right column, which will take you to the *Federal Register*. Just copy and paste the reference numbers into the search box on the home page of the *Federal Register*, and it will take you to the formal rule for that particular calendar year. So, if you click the link to the *Federal Register,* then copy and paste 79 FR 66769 into the search box, that will take you to the 2015 Final Rule. So there are two ways to get to this rule: by using the link to the PDF that was provided on slide 6 or by using the link on this page.

Now we move on to our program requirements, and we'll start with the Hospital Outpatient Quality Reporting participation requirements. CMS did not propose or finalize any changes to these policies, so we'll move through them pretty quickly.

To participate, hospitals must register with QualityNet, have and maintain a QualityNet Security Administrator, complete an online Notice of Participation, and collect and submit data as we specified. These presentation requirements can be found on the QualityNet website.

I do want to point out that if you're signed up for the Hospital OQR Program, you remain signed up until you take action to withdraw. You only need to sign up once. However, if a hospital has formally withdrawn from the program and later wants to resume participation, then that hospital would need to reapply.

So let's move on. When we talk about Notice of Participation requirements, we divide hospitals into two groups. First we have the old or resuming hospitals, and second we have the new hospitals. This slide pertains to the old or resuming hospitals that have a Medicare acceptance date before January 1, 2015. The Notice of Participation for these facilities would be due July 31, 2015. They would begin submitting data with first quarter 2015 encounters, and the first submission deadline is August 1st.

Now, a couple of years ago it was decided to extend the Notice of Participation deadline to allow resuming hospitals the maximum amount of time to make their decision. But please be aware that the July 31st due date does put it right up against the August 1st submission deadline. Next slide.

So what's a new hospital? A new hospital has a Medicare acceptance date on or after January 1 of the year prior to the effective payment determination year. For new hospitals the Notice of Participation is due 180 calendar days from their CASPER Medicare acceptance date. CASPER stands for Certification And Survey Provider Enhanced Report. The first date of submission for encounter dates begins with the first full quarter following the Notice of Participation, which is to say, for new hospitals data submission will begin with the first full quarter after signing up for the program.

In the final calendar year 2013 Final Rule – I should say in the calendar year 2013 Final Rule – we codified a policy that when we adopt measures for the Hospital OQR Program, these measures are automatically adopted for all subsequent years' payment determinations unless we propose to remove, suspend, or replace the measures.

In the *Federal Register* on page 66955, there is a table that lists measures that we adopted for the calendar year 2017 payment determination and subsequent years under the Hospital OQR Program. On the next page, 66956, you'll find the measure set for calendar year 2018 payment determination and subsequent years. Those might be good pages to tab so that you can find them easily.

This year we adopted two statistical criteria for topped-out measures, and they're listed on this slide. But what they boil down to is this: when measure performance among hospitals is so high and unvarying that we can no longer draw useful statistical distinction among individual hospitals, then

that leads us to believe that there's no further room for improvement, and those measures are considered topped out.

We have adopted these same statistical criteria for measures in other CMS quality reporting programs, including the Inpatient Quality Reporting Program, Hospital Value-Based Purchasing Program, and in the Ambulatory Surgical Center Quality Reporting Program. We are working hard to align our programs to the extent possible, and this is one way that we have aligned our programs.

Now, with that being said, the statistical criteria are just one of many criteria that we use to determine whether to remove measures from the OQR Program. And these criteria do not serve as a substitute for clinical judgment. We assess the benefit of retaining a measure on a case-by-case basis before proposing to remove a measure.

We are removing two topped-out measures effective with January 1, 2015, patient encounters. Those are OP-6 and OP-7, both of which have to do with antibiotic use among surgical patients. Again, we will no longer be collecting data with regard to these two measures effective with January 1, 2015 patient encounters.

Now here's an example of where your comments impacted the Final Rule. We had proposed to remove OP-4, Aspirin on Arrival, believing that it was topped-out. In fact, we had proposed to remove OP-4, OP-6, and OP-7 because we believed they were all topped-out. And we actually received quite a few comments asking that we reconsider and keep all three measures. Because of your comments, we took a deeper dive into the statistics, and here's what we found out. Hospital performance on OP-6 and -7 was very high and unvarying across all hospitals. But for OP-4, among hospitals that had a small number of cases, their performance was still low. We couldn't see this initially because the large hospitals, hospitals with high

case numbers, were doing very well with OP-4. It took a deeper look into the data to find this out about OP-4. And so, because some hospitals have room for improvement, we are retaining that measure.

Nothing has changed with regard to OP-15. That's the Brain CT in the ED. It continues to be deferred. This is a claims-based measure. We will continue not to use this claims-based data in payment determination. We will continue not to publicly report this data that we get. We are going to keep working on this measure, and we'll let you know what we're going to do with it, likely within the next year.

OP-29 and -30 are both related to endoscopy/polyp surveillance. We didn't make any changes in the Final Rule with respect to these measures, but we did provide a review of what had happened to date with these. Both of these measures were adopted in the calendar year 2014 OPPS/ASC Final Rule. They are chart-abstracted, but aggregate data is collected via an online web-based tool.

In December 2013 we issued a three-month delay in the implementation of OP-29 and OP-30, so the encounter period became April 1st through December 31, 2014, with a submission period of July 1 to November 1, 2015. We delayed implementation because we felt it would be too burdensome to require hospitals to implement OP-29 and OP-30 by January 1, 2014. However, we feel that the hospitals have now had time to accommodate this – these measures, and in subsequent years the encounter period will remain January 1 through December 31 as it had been previously finalized. So in 2015 the patient encounter period is January 1 through December 31, and aggregate data can be submitted July 1 through November 1, 2016.

Moving on to OP-31. This is our cataract measure. Looking back in time, this is a measure whose implementation was initially delayed for three

months also. OP-31 was initially delayed because CMS was concerned that it might be operationally difficult for hospitals to collect and report this measure because of the use of inconsistent surveys and because of the difficulty of sharing survey results across clinicians. Because of continuing concern, CMS issued findings in April 2014, delaying the implementation again.

Now with the 2015 Final Rule, we are excluding OP-31 from the measure set for the calendar year 2016 payment determination, and we are changing OP-31 from required to voluntary for the calendar year 2017 payment determination and subsequent years. Facilities will not be subject to payment reductions with respect to OP-31 while the measure is voluntary. But to note, the voluntary data that is submitted will be publicly reported.

And I want to give you a little aside here. When we consider measures for inclusion in the OQR Program, we actually consider a range of domains that address the continuum of care, and one of those domains that we consider is the coordination of patient care. We are keeping OP-31, albeit as a voluntary measure, because we believe it offers an opportunity for hospital outpatient departments to partner in care with physicians and other clinicians, and this is something we want to encourage.

Now we did finalize a new measure this year, but it doesn't go into effect until calendar year 2018. So for the calendar year – well, for 2018 payment determinations – I'm sorry. Let me be clear on that. This goes into effect for calendar year 2018 payment determinations and subsequent years. We've added this new outcome-based measure that is OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. This is a claims-based measure.

So why did we think this measure was important? Although colonoscopies are among the most frequently performed outpatient procedures in the

United States, they are associated with a range of preventable adverse events. While hospital visits are generally unexpected after outpatient colonoscopy, the majority appear to occur within the first seven days. So we believe this measure will reduce adverse patient outcomes by capturing all unplanned hospital visits following the procedure, thereby making unplanned hospital visits more visible to patients and providers.

We received a lot of comments about this proposed measure, and here is what we've come up with. In 2015 CMS will conduct a preliminary data analysis. This is sometimes referred to as a dry run, and you'll see dry run mentioned in the *Federal Register*. This is very thoroughly explained in the *Federal Register* starting on page 66951, and I encourage you to read about it. Let me just hit the highlights.

The preliminary data analysis will include three to four years of paid Medicare Fee-for-Service claims, and it will be used to generate confidential, facility-specific, patient-level reports. So you'll be able to see which patients had a hospital visit, the type of visit, and their discharge diagnosis. We're hoping that you'll use this information to assess gaps in care and develop quality improvement strategies.

These dry run results are not linked to public reporting or to payment determinations. We finalized that this measure, beginning with the calendar year 2018 payment determination, will start with Medicare Fee-for-Service claims from January 1 through December 31, 2016. Let me repeat that because I've heard there's been some confusion on this issue already. We will start with Medicare Fee-for-Service claims from January 1 through December 31, 2016. And of course we will continue to provide the patient-level reports for your continued quality improvement efforts.

Okay, we're going to fly through the next four slides. They're for your reference and include measures that you're probably familiar with already.

The measures are segmented out into columns showing which are chart-abstracted, claims-based, web-based, and our newest category for the flu vaccine is the NHSN.

Continuing on, I'll give you a chance to glance at these. I also want to note that this information is available at the QualityNet website. Let's move on. And this is another slide for your review. And now we're to the last of these slides.

We're going to talk more about OP-27 in a moment. That's the flu vaccine measure. But first, I want you to note the asterisk at the bottom of this slide that calls out OP-31, which we already discussed. And I also want to note that OP-32 is not on this slide because it is not effective until the calendar year 2018 payment determination.

Again, we're going to move through the next set of slides quickly. I want to provide you with an overview of the Hospital OQR Program, but for most of you this is old stuff, and I want to be sure to emphasize what's changed. However, if your facility is new to the program, or even if you're not new and you have questions, please bring them up in the question-and-answer portion of this webinar. We'll have a toll-free number that you'll see listed at the end of the presentation. I am happy to go into greater detail if that's helpful, but we're only halfway through the slide presentation, so I want to move quickly along and answer any questions later.

So the data are to be submitted under the CCN under which the care is furnished. The submission deadlines are posted on the QualityNet website, and that's the same place where you can find the Specifications Manual with the population and sampling scheme and additional details about each measure.

If you go to the Table of Contents of the Specifications Manual, you will see

that individual metrics have been grouped together in measure sets. For example, OP-1 through OP-5 are all grouped together in the AMI/Chest Pain Measure Set. So why is that important? Well, in order to reduce the burden on hospitals that treat a low number of patients for a particular quality measure, hospitals that have five or fewer cases in any quarter – in a quarter for any measure set – are not required to submit patient-level data for the entire measure set for that quarter. But I want to note that even if hospitals are not required to submit patient-level data because they have five or fewer cases for any measure set in a quarter, they may voluntarily do so.

This slide presents various data types and the way that they can be submitted. I want to give a quick word about web-based measures. Please, please try not to wait until the last day or two of the submission period to submit these data. As many of you can attest, when many facilities wait until the very end and everyone tries to submit their data at once, this leads to considerable slowing of the system. We allow fairly lengthy submission periods, and I encourage you to take advantage of that. The earlier you can submit, get it off your plate, the better, especially with regard to running into the risk of these system delays.

And as always, document any problems that you experience with submitting data. Report your problems to the Help Desk. Get a ticket number. On our end we don't know that you're having a problem if you don't report it, and often facilities don't report problems until the very end of the submission period when they're worried about not meeting the deadline. This doesn't allow CMS sufficient time to address the issues. At CMS we truly do want to reduce the burden hospitals are experiencing related to data submission. So when we can, we look for claims-based measures that don't require facilities to do anything more than what they already do to submit a payment. As the electronic health records become more prevalent, we will

look toward electronic measures to reduce the submission burden even more.

Okay. So for chart-abstracted data, the submission period goes from July 1st through June 30th the following year. So that's Q3 and Q4 of one year, and then Q1 and Q2 of the next. When a quarter ends on the last day of a quarter, then you still have about another four months to submit that data. The data that facilities voluntarily submit for population and sampling follows the same deadline as for our chart-abstracted data.

The Specifications Manual offers detailed information about population and sampling, so I want to refer you there. If you download the entire PDF version of 8.0 of the specs manual, you'll find information starting on page 285 out of 936 pages. This will describe population and sampling. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics. A sample is a fragment of the population that statistically is representative of the entire population. Sampling allows CMS to estimate a hospital's performance without collecting data for its entire population.

Claims-based data are calculated from claims that you've already submitted. And as I mentioned before, we like these type of measures because they reduce submission burden on the hospitals. However, depending upon the gaps of care that we're trying to address, claims-based measures aren't always suitable.

For the most part, payment determinations for claim-based measures include patient encounters from July 1 of one year to June 30th of the next year. But of course, there's always an exception, and here it is: our brand new OP-32. That's the colonoscopy measure that will be used for calendar year 2018 payment determinations and beyond. For this claims-based measure we are using the calendar year, so patient encounters from

January 1st through December 31st starting in 2016. Again, because this is claims-based, you won't have to do anything different above and beyond what you're already doing to submit for payment. So even though this measure is not currently aligned with other claims-based measures, that should not increase your submission burden at all.

Generally, web-based measures include calendar year patient encounters, so from January 1st through December 31st. But remember, as I mentioned earlier, there were delays in implementing OP-29, OP-30, and OP-31. And now OP-31 is voluntary. In 2015 the submission period for all web-based measures remains July 1st through November 1st. And here's my plea once again not to wait until the end of the submission period to submit these web-based measures. You've got four months. Please, please don't wait until the last four days.

These were listed on the previous slide, slide 32, but it made that slide look too busy to include their full name, so here they are for your reference.

And on slide 34 you can also see the web-based measures that were listed on slide 32. Again, it's just providing the full name and also calls out OP-31, as I've mentioned previously.

OP-27 is unique. It's the only measure submitted through the CDC website. This measure looks at flu vaccine coverage among healthcare personnel. The current period for data collection began October 1st of this year and goes through March 31st of next year. You can submit data through May 15th of next year, 2015. I had checked the link on this page earlier and it was working, but I just checked it again this morning and it's not. So we will be sure to send out a working link for you to use.

I do want to refer you to the CDC website because they are the experts regarding data collection for this measure. Hospitals submit their data to the CDC, and, in turn, the CDC shares that data with CMS. So it's the CDC data submission protocols you want to follow. You're going to be reporting these through the National Healthcare Safety Network. And we'll get you that updated link. On the CDC webpage you'll see recorded webinars that can walk you through data submission.

Moving on to validation. The process for the validation selection of hospitals is unchanged. This is referring to chart-abstracted data submitted directly to CMS. We will be maintaining the number of randomly-selected hospitals at 450. We sample an additional 50 hospitals on a targeted basis, and we're not proposing any new targeting criteria at this time. And we didn't finalize any, either. We will continue to sample up to 48 cases, 12 per quarter for hospitals, assuming that a selected hospital has that many cases. And we will continue to calculate a match rate for the passing validation score of 75% or greater.

Sometimes there are questions about what we mean by targeting criteria. Those were previously finalized in the calendar year 2011 Final Rule, and they were discussed again in the 2013 Final Rule. We are referring to hospitals that either fail to meet the 75% validation requirement or hospitals that have outliers in their data submissions. That's where we draw those additional 50 hospitals from.

Here is what has changed with the 2015 Final Rule, and we discussed this on page 66965 of the *Federal Register*. We had proposed that hospitals would be eligible for random selections for validation if it's submitted at least one case during the quarter containing the most recently available data based on when the random sample was drawn. And I should mention our thinking on that. We believe that this change was necessary because it

increased the likelihood that selected hospitals would have current data in the warehouse to be validated. Previously, hospitals that did not have any data from the current year could still be collected for – could still be selected for validation.

Now this is an example where your comments changed our proposed policy. Instead of requiring one case to be submitted, we are instead requiring at least 12 cases be submitted to the Clinical Data Warehouse during the quarter containing the most recently available data. This is in keeping with our policy that we collect up to 12 cases per quarter for validation, and I just mentioned that on the previous slide.

So what do we mean by the quarter containing the most recently available data? Well for example, if we draw a validation sample in December 2015, then the most recent data available from that will be from the second quarter of 2015, which ended June 2015, or will end June 2015, because the submission deadline for that would be November 1, 2015. Yes, a lot of dates here. I want to point this out because that's what we mean when we say recently available data is based on when the random sample is drawn. We did give examples of this in the *Federal Register,* and we really look at what is the most recent submission deadline.

Okay, here is another change. Beginning in 2015 hospitals can submit chart-abstracted data for validation in paper form or via encrypted electronic media. And I need to emphasize that if you download patient information onto a CD, DVD, or flash drive, then that media must be encrypted. Or alternatively, data can be submitted via the QualityNet secure file transfer. Again, please don't wait until the deadline to submit electronic data this way.

Now, because I know this question has come up, let me share this. And let me preface this by saying that although I'm the Program Lead for Hospital

Outpatient Quality Reporting, I'm not the government task leader for its validation contractor. And I know that's a little confusing if you're not familiar with the way the government works, but what it means is that there's another person here at CMS who's responsible for validation across all the CMS quality reporting programs.

I went to that person, and I told her that some hospitals are asking if they can submit patient charts electronically, even though the Final Rule doesn't go into effect until January 2015 patient encounters. And here is her emailed reply, which I'm going to read to you word-for-word.

"We are already accepting HOQR files via encrypted media. Because there was nothing finalized in OPPS about reimbursement, hospitals that wish to select this option must forego all reimbursement. Some of the hospitals have chosen this option, and the rest are still sending things the old way."

So that was her response. So if you want to submit electronically now, you can, but you won't be reimbursed. Effective with January 2015 patient encounters, you can be reimbursed at three dollars per patient chart, and you can find that on page 67026 of the 2015 Final Rule.

I want to mention another change to our validation procedure. Hospitals must now identify the medical record staff responsible for submission of records under the Hospital OQR Program to the designated CMS contractor. This CMS contractor may be a contractor other than the state QIO. This change is secondary to the 11th Statement of Work, which changed the role of QIOs.

So moving on to annual payment determinations. This does not represent a change, and this slide is presented for your information. Per statute, if a hospital does not meet requirements, they have a 2% reduction in their annual payment update factor, and it's only applied to the payment year

involved. It is not cumulative. It does not get carried forward. And finally, not all services that a hospital outpatient department gets reimbursed for under Medicare are subject to the annual payment update. So the reduction is applied only to those services that are subject to the annual payment update.

And we're coming to the home stretch with special circumstances. We are not making any substantive changes, but we did tweak this a bit. We changed the phrase “extension or waiver” to the phrase “extension or exemption.” So we now refer to the process as the Extraordinary Circumstances Extension or Exemptions Process instead of the Extraordinary Circumstances Extension or Waiver Process.

We also revised the Extraordinary Circumstances Disaster Extension or Exemption Request Form so that a hospital or facility may apply for an extension for all applicable quality reporting programs at one time. You can find information about this at the QualityNet website.

The submission date for reconsidered requests remains the same; that is the first business day in February of the affected payment year. And finally, CMS may grant an extension or exception in the event of extraordinary circumstances beyond the control of a hospital, such as when an act of nature affects an entire region or locale; for example, Super Storm Sandy, or due to the systematic – I'm getting tongue-tied at the very end here – or due to a systemic problem with data collection systems affecting the ability of hospitals to submit data. This is at CMS’ discretion.

Public reporting. As you know, we collect data in the Hospital OQR Program that we use for payment determination, but we are also statutorily obligated to publicly report that data. The data are published by CMS certification number, CCN, and where there are multiple campuses we combine it by CCN. The data are available at the Hospital Compare website

and have also been migrated to the data.medicare.gov website.

Okay. Now we really are in the home stretch, and we'll be opening up the Q&A after we do a brief discussion of the measures process.

HHS has a – next slide, please, slide 47. Thanks. HHS has a statutory obligation to make a list of measures – let me start this over. I really am getting tongue-tied after speaking for 45 minutes.

HHS has a statutory obligation to make a list of measures under consideration publicly available by December 1st of each year. We call that our MUC list: Measures Under Consideration. If a measure is not on the MUC list, we cannot propose it in the upcoming rules cycle. That's important because it impacts the upcoming rule-making cycle that will be starting in spring of next year. We do plan to provide a ListServe notice when the MUC list becomes available to the public, but it's a little bit out of our control because it's controlled by the MAP, the Measures Application Partnership. And on slide 48 you'll see a link to the MAP. They're convened by the National Quality Forum, and they're the ones who actually post the MUC list.

So I know this was a bit rushed, especially the review of old information. If you have any questions, we'll open up our floor. And I do want to take this opportunity to thank you for joining us today. I realize that your time is valuable, and I appreciate that you spent some of it with us here today. Thank you.

Mollie Carpenter: Thank you, Elizabeth, for the information that you shared with us today. While we wait for the first question, I'd like to remind you that this webinar has been approved for 1 continuing education credit by the boards listed here on slide 49. We now have an online CE process, and there are three methods for receiving your CEs: two through WebEx, and one by the phone

only.

If you registered for the webinar through WebEx, you'll receive a survey within the next 48 hours. It will not arrive today. Once you've completed the survey, you'll be sent to a site to download your CE certificate. If you're listening to this webinar with a colleague that logged onto WebEx, have them forward you the survey from WebEx so that you can get your CE. And if you're listening to the webinar by phone only, since you did not register with WebEx, you will need to go to the online version of the webinar where you can receive your CE certificate, and that's going to be at www.qualityreportingcenter.com.

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