Outpatient Quality Program Systems and Stakeholder Support Team

Laying the Foundation to Transform Quality Reporting: Discussing the CY 2023 Hospital OPPS/ASC Payment System Final Rule
Presentation Transcript

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Karen VanBourgondien: Hello, everyone. Thank you for joining us today. This is Karen VanBourgondien, and I am with the Support Contractor. Our speakers today are Shaili Patel, Dr. Anita Bhatia, and me. Shaili is the CMS Program Lead for the Hospital OQR Program. She has a master's in public health. She started her federal career in 2009 with the Social Security Administration and joined CMS back in 2012. We are extremely fortunate to have Shaili involved with the [Hospital] OQR Program. Anita is the CMS Program Lead for the Rural Emergency Hospital Quality Reporting Program. Anita received her PhD from the University of Massachusetts at Amherst and her Master's in Public Health from Johns Hopkins University. Dr. Anita Bhatia plays a crucial role in the development of the OPPS/ASC proposed and final rulings. Her contributions to these rulings are essential to the continuing success of these programs. We are fortunate to have both Shaili and Anita with us today.

We have a solid building plan for today. Shaili will discuss the finalized proposals and some of the Requests for Comment as it relates to the [Hospital] OQR Program. Anita will discuss the finalized proposals and requests for comments as it relates to the REH quality reporting program. We will have a Q&A session after each section, and Shaili and Anita will address any questions specific to the rule. Lastly, I will be reviewing some public reporting information as there is a data refresh this month. I will also show you how to easily access your publicly displayed data.

The learning objectives are listed here and, as usual, in addition to having some questions and answers, we will also have the chat box open.

The published version of the final rule is in the *Federal Register*, and you can access that top link there. That will take you right to the *Federal Register*. We've also included the direct link to the PDF version for those of you that prefer that. The OQR section specifically begins on page 349 of the PDF version, and the REH quality reporting program begins on 390.

So, without any further delay, let me turn things over to Shaili to discuss the final rule as it relates to the Hospital OQR Program. Shaili?

Shaili Patel: Thank you, Karen. Welcome everyone. Let me begin by discussing the finalized proposals put forth in the Calendar Year 2023 OPPS/ASC Final Rule. In the Calendar Year 2022 OPPS/ASC Final Rule, we finalized mandatory reporting for the OP-31 measure, which is Cataract Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, beginning with the calendar year 2025 reporting period for the calendar year 2027 payment determination. Since that final rule, interested parties have expressed concern about the reporting burden of this measure given the ongoing COVID-19 Public Health Emergency.

Based on feedback we received, in this rulemaking cycle, we proposed to change the reporting of the OP-31 measure from mandatory to voluntary beginning with the calendar year 2025 reporting period/calendar year 2027 payment determination. Hospitals would not be subject to a payment reduction for failing to report this measure; however, we strongly encourage hospitals to gain experience with the measure. Given the impact of COVID-19 on this measure, we believe it is appropriate to defer mandatory reporting at this time. We will consider implementation of mandatory reporting of the OP-31 measure through future rulemaking because this measure addresses an area of care that is not adequately addressed in our current measure set and the measure serves to drive the coordination of care.

Some of the considerations for these proposals are that interested parties have indicated that they are still recovering from the COVID-19 PHE and that the requirement to report OP-31 would be burdensome due to national staffing and medical supply shortages coupled with unprecedented changes in patient case volumes. These concerns have led us to reconsider our previously finalized timeline for mandatory reporting. Therefore, we believe that due to the continued impact of the COVID-19 PHE, the two-year delay of mandatory reporting for this measure is no longer sufficient.

After consideration of the public comments we received, we are finalizing our proposal to change OP-31 from mandatory to voluntary beginning with calendar year 2025 reporting period/calendar year 2027 payment determination.

To be clear, there are no changes to reporting for calendar year 2023 and calendar year 2024, during which the measure remains voluntary. We do encourage voluntary submission to gain experience in reporting this measure.

We also proposed to align Hospital OQR Program patient encounter quarters for chart-abstracted measures to the calendar year beginning with the calendar year 2024 reporting period/calendar year 2026 payment determination. To facilitate this process, we proposed a transition period and use only three quarters of data for chart-abstracted measures in determining the calendar year 2025 payment determination. We proposed to align the patient encounter quarters for chart-abstracted measures with the calendar year schedule of the Hospital OQR Program and with those of the Hospital IQR Program since some hospitals may be submitting data for both programs and mitigate confusion regarding submission deadlines and various reporting quarters.

This alignment would also provide more time for APU determinations by increasing the length of time between the last clinical data submission deadline and APU determinations. After consideration of the public comments we received, we are finalizing our proposal to align the patient encounter quarters for chart-abstracted measures with the calendar year beginning with calendar year 2024 reporting period or calendar year 2026 payment determination.

This slide shows the transition year necessary to align the quarters. For the calendar year 2025 payment determination, we will only use three quarters of data. So, Quarter 1 data will not be utilized. This would be for that year that year only. The following year, the quarters will be aligned, and we will, once again, use four quarters of data. The transition year will take place with the calendar year 2023 reporting period, as I just discussed.

Beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination, all four patient encounter quarters for chart-abstracted measures will align with the calendar year. This is what you see here on the slide. Again, this will align with patient encounter quarters for the [Hospital] Inpatient Quality Reporting Program.

The next proposal we made was the targeting criteria for validation. We proposed that a hospital with less than four quarters of data subject to validation due to receiving an Extraordinary Circumstance Exception, or ECE, for one or more quarters and with a two-tailed confidence interval that is less than 75 percent would be targeted for validation in the subsequent validation year. This new criterion to the four established targeting criteria used to select the 50 additional hospitals, beginning with validations affecting the calendar year 2023 reporting period calendar year 2025 payment determination. We also proposed to revise regulation to add the criterion for targeting the additional 50 hospitals for validation to say, "any hospital with two-tailed confidence interval that is less than 75 percent, and that had less than four quarters of data due to receiving an ECE for one or more quarters," which you see here on the slide.

We proposed this additional criterion because such a hospital would have less than four quarters of data available for validation and its validation results could be considered inconclusive for a payment determination. Additionally, this proposal would allow us to appropriately address instances in which hospitals that submit fewer than four quarters of data due to receiving an ECE for one or more quarters might face payment reduction under the current validation policies. We thank the commenters for their support. After consideration of public comments that we received, we are finalizing our proposal to add a fifth criterion to the established targeting criteria used to select 50 hospitals for validation.

In this rulemaking cycle, we also made requests for information and comment. We sought comment on reimplementing the OP–26 measure or another volume measure because of the shift from the inpatient to outpatient settings.

The shift from the inpatient to outpatient setting has placed greater importance on tracking the volume of outpatient procedures. We are considering reimplementing the OP-26 measure or another volume measure because of the shift from the inpatient to outpatient settings. Additionally, we are considering the reintroduction of the facility-level volume measure to support potential future development of quality measures.

Specifically, we sought comment on what volume data hospitals currently collect and if it is feasible to submit these data to the Hospital OQR Program to minimize the collection and reporting burden of an alternative, new volume measure. Additionally, we asked your feedback on an appropriate timeline for implementing and publicly reporting the measure data. We received comment and feedback on these topics which can be reviewed in detail in the final rule. I do encourage you to read the rule for a more comprehensive understanding.

In addition to our proposals, CMS announced its comprehensive health equity strategy. CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and any other factors that affect access to care and health outcomes. We put forth Request for Information addressing disparities in healthcare equity. The RFI titled "Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs" described key considerations that we might take into account across all CMS quality programs when advancing the use of measure stratification to address healthcare disparities and advance health equity across our programs. We refer readers to the full summary of the RFI and comments we received in the Fiscal Year 2023 IPPS/LTCH PPS Final Rule. The direct link to the PDF version is here on the slide.

That concludes my summary of the final rule as it relates to the Hospital Outpatient Quality Reporting Program. Thank you. Back to you, Karen.

Karen VanBourgondien: Thank you, Shaili. Shaili, do you mind if we stop here a minute and just address some questions that relate to the Hospital OQR Program and some of the finalized proposals you just went over?

Shaili Patel: Of course.

Karen VanBourgondien: Okay, so here's the first question: When will patient encounter quarters and submission deadlines be aligned with the calendar year for the chart-abstracted measures?

Shaili Patel: Thank you for the question. Patient encounter quarters for chart-abstracted measures will align beginning with the calendar year 2024 reporting period, which will be for the calendar year 2026 payment determination. Now, to help the transition to calendar year alignment, only three quarters of chart-abstracted data will be required for the calendar year 2023 reporting period or calendar year 2025 payment determination. We talked about this transition a year back on slide 12. We finalized this change, so data for chart-abstracted measures will align with the calendar year schedule of the Hospital Inpatient Quality Reporting Program since hospitals may be submitting data for both programs. Alignment would also provide more time for the annual payment update determinations by increasing the length of time between the last clinical data submission and the APU determinations.

Karen VanBourgondien: Thank you, Shaili. Next question: When are hospitals required to begin reporting data for the OP-40? That's the STEMI eCQM. Shaili?

Shaili Patel: Yes. For OP-40, the STEMI eCQM, hospitals may voluntarily submit data for any quarter beginning with the calendar year 2023 reporting period for the calendar year 2025 payment determination. Just to clarify, there is no payment determination applicable for the voluntary period, which has a submission deadline of May 15, 2024. Mandatory reporting for this measure begins the following year, which is the calendar year 2024 reporting period for calendar year 2026 payment determination.

Hospitals are required to report one self-selected quarter, which would be due by May 15, 2025. Data submissions will progressively increase, one quarter, a quarter of data for each subsequent year with all four quarters being required beginning with the calendar year 2027 reporting period for the calendar year 2029 payment determination and for subsequent years.

Karen VanBourgondien: Thank you, Shaili. So, the next question is about OP-31. The question is: When will the OP-31 cataract measure be required to be reported? I guess they're asking will it be mandatory. When will it be mandatory again?

Shaili Patel: Yes. As discussed in the presentation, based on the feedback we received, we finalized our proposal to change the reporting of OP-31 measure from mandatory to voluntary beginning with the calendar year 2025 reporting period affecting calendar year 2027 payment determination. Many commenters expressed concerns about making this measure mandatory due to the burden of reporting the measure and the impact this additional burden would have during the COVID-19 pandemic. Although we finalized a delay in the implementation of this measure from mandatory back to voluntary reporting, we do strongly encourage hospitals to gain experience with this measure, and we plan to continue to evaluate this policy moving forward.

Karen VanBourgondien: Thank you, Shaili. The next question is: Why is a volume measure being considered for the Hospital OQR Program?

Shaili Patel: Karen, we believe the literature, scientific literature, suggests that volume metrics serve as an indicator of which facilities have experience with certain procedures and assist consumers in making informed decisions about where they receive their care. Many studies have shown that volume does serve as an indicator of quality of care. Also, considering the shift from the inpatient-only list to the outpatient setting has placed greater importance on tracking the volume of outpatient procedures.

Karen VanBourgondien: Thank you. Great, Shaili. I appreciate that. I think we have time for one more question for you and it's about the survey measures. When does mandatory reporting begin for the OAS CAHPS measure?

Shaili Patel: Great question. Thank you. Yes, mandatory reporting for OP-37, the OAS CAHPS, measure begins with the calendar year 2024 reporting period.

That's for calendar year 2026 payment determination. However, facilities can voluntarily report during the calendar year 2023 reporting period.

Karen VanBourgondien: Okay! Great! Thank you, Shaili. We're going to stop for now. We still have to get to Anita. Now, let's turn things over to Dr. Anita Bhatia for discussion of the REH quality reporting program. Anita?

Anita Bhatia: Thank you, Karen. Welcome everyone. I will be covering the new Rural Emergency Hospital Quality Reporting Program. Like Shaili, I will be covering the content of the final rule pertaining to requirements for this program in brief summary. I do encourage you to read the final rule, the section pertaining to this program, for details and clarifications in our provided PDFs on the Quality Reporting Center site of the Calendar Year 2023 OPPS Final Rule. The requirements for REH quality reporting begin on page 389 of the 563 page document, which is page 72136 of *Federal Register* Volume 87.

Rural Emergency Hospitals are a new Medicare provider type. Hospitals with specific characteristics can convert to a Rural Emergency Hospital. The legislation described on this slide, the Consolidated Appropriations Act, is incorporated as a section in the Social Security Act and included the establishment of quality measurement reporting requirements for Rural Emergency Hospitals, or REHs. An REH is a facility that was a Critical Access Hospital, or CAH, or a subsection (d) hospital with not more than 50 beds located in a county in a rural area; or was a subsection (d) hospital with not more than 50 beds that was treated as being in a rural area.

There is more information regarding payment and participation for REHs in the same rule that we are referencing today with requirements in the Calendar Year 2023 OPPS Final Rule. Among other requirements, an REH must apply for enrollment in the Medicare program; provide emergency department services and observation care; at the election of the REH, provide certain services furnished on an outpatient basis; and not provide acute care inpatient services, other than a skilled nursing facility.

For the REH quality reporting program, we seek to adopt a concise set of important, impactful, reliable, accurate, and clinically relevant measures for Rural Emergency Hospitals that would inform consumer decision-making regarding care and further quality improvement efforts in the Rural Emergency Hospital setting. We intend to adopt measures that are tailored to be useful for REHs for their quality improvement efforts, but it is vital that measure information be of sufficient volume to meet case thresholds for facility-level public reporting.

We recognize Rural Emergency Hospitals will be smaller hospitals that have limited resources compared with larger hospitals. For the REH quality reporting program, we intend to seek balance between the costs associated with reporting data and the benefits of ensuring safety and quality of care through measurement and public reporting. The legislation that we cited states that quality measurement reporting requirements for Rural Emergency Hospitals are to be established and that these requirements may include the use of a small number of claims-based measures or patient experience surveys. A Rural Emergency Hospital must submit quality measure data and that procedures to make the data available to the public on a CMS website will be made.

There are several ways we can consider for limiting burden for Rural Emergency Hospitals, including the use of Medicare claims-based measures and the use of digital quality measures in place of chart-abstraction. In addition, we believe that, to the extent possible, existing quality measures should align across Medicare, Medicaid, and other payers to minimize reporting burden. Importantly, the measures included in a Rural Emergency Hospital quality program should reflect the types of services and care delivered in this setting, consistent with having quality measures where data will have sufficient numbers for public reporting.

Thus, we requested comment on a selection of measures for potential future inclusion in the Rural Emergency Hospital Quality Reporting Program. Specifically, the chart-abstracted measures we sought comment on are OP-2, OP-3, OP-4, and OP-18. All measures that are part of the Hospital Outpatient Quality Reporting Program.

Currently, the majority of Critical Access Hospitals, as well as small rural hospitals, report on these measures. We seek to better understand how these measures may help achieve our goal of selecting measures for the Rural Emergency Hospital Quality Reporting Program that focus on areas of care relevant to REHs, especially Emergency Department care which these measures are addressing. As stated, measures with an OP designation represent current or past Hospital OQR [Program] measures, and measure specifications are contained in program specifications manuals, all the way back to calendar year 2013, and these are available on the QualityNet website. We also requested comment on one web-based measure, OP-22, Left Without Being Seen measure; two claims-based measures, OP-10 and OP-32; as well as the Emergency Department Transfer Communications (EDTC) measure. The OP-22 measure is a structural measure currently part of the Hospital Outpatient Quality Reporting program and is reported annually. OP-10, Abdomen Computed Tomography (CT) – Use of Contrast Material, and OP-32, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy, are both claims-based measures. Data for OP-10 and OP-32 are collected via paid Medicare fee for service claims, combined with enrollment information which minimizes hospital burden.

The Emergency Department Transfer Communications, or EDTC, measure is a core measure in the Medicare Beneficiary Quality Improvement Project, or MBQIP, for Critical Access Hospitals and was included in those measures recommended by the National Advisory Committee on Rural Health and Human Services for use in the Rural Emergency Hospital Quality Reporting Program. The EDTC measure assesses how well key patient information is communicated from an Emergency Department to any health care facility. Lastly, to bridge gaps in rural communities, we requested comment on the topics listed on this slide, and we requested suggestions for specific measures to assess the patient experience, outcomes, and processes related to these topics.

Telehealth is particularly impactful in the face of rural facility or departmental closures which can leave gaps in healthcare service access and could contribute or lead to emergency service requirements. Rural Emergency Hospitals could possibly fill gaps in the maternal care continuum, the second item on this list, or play a critical role in a patient's emergency plan by being identified as their closest medical facility equipped to handle a maternal health emergency. Third on the list mental health. Rural areas have high rates of mental health and substance use issues. Rural Emergency Hospitals could fill this need by providing valuable emergency care and other outpatient services for patients experiencing mental health and substance use crises and possibly bridging the gaps in the continuum of care. Lastly, we have the topic of Emergency Department services, which is a setting expecting to be a focus for Rural Emergency Hospitals. Measures for Emergency Department utilization, boarding, and unscheduled Emergency Department return visits, or bounce-backs, could be useful quality metrics for the Rural Emergency Hospital setting. Additionally, we requested feedback on concerns regarding small case numbers and health equity. We thank the commenters for their input as we continue to evaluate appropriate measures for the Rural Emergency Hospital Quality Reporting Program. We will take commenters' feedback into consideration via future rulemaking. For details on the comments that we received and our responses, please access the final rule.

The last topic we will discuss with respect to the Rural Emergency Hospital Quality Reporting Program is a proposal regarding the requirement for a Security Official. For a Rural Emergency Hospital to participate in the Rural Emergency Hospital Quality Reporting Program, they will need to have a current account for the purpose of submitting data to the Hospital Quality Reporting system. If a Rural Emergency Hospital already has an account for a CMS hospital quality reporting program, the Rural Emergency Hospital will be able to fulfill this requirement by updating its existing account with its new Rural Emergency Hospital CMS Certification Number, or CCN. If the Rural Emergency Hospital does not have an account, we proposed that it must register for a new account.

We did finalize this proposal. Therefore, once a Rural Emergency Hospital has an account, it must then have a Security Official. However, since hospitals that become REHs will have new REH CCNs, these hospitals will have to request Security Official access for the new CCN following the standard instructions posted on the QualityNet website. While a Security Official is initially required to enable a hospital's QualityNet account for data submission and allows the set-up of basic user accounts with capabilities including data submission, we note in the rule that it will not be necessary or required to maintain a Security Official. We highly recommend that hospitals have and maintain a Security Official, but , again, we reiterate a Security Official will not be required to be maintained. So, as we did not receive comments on this proposal, as stated, we finalized this proposal without modification. We note that we intend to propose additional administrative requirements for the REH quality reporting program in subsequent rulemaking.

As we look forward in developing this new quality reporting program and the measures being considered for it, you can access the Measures Under Consideration, or MUC, list. Each year CMS invites the submission of candidate measures from measure developers and measure stewards. The submission period closes on a prescribed date to allow time for review and to make the selection of measures to place on the Measures Under Consideration List. Measures selected are proposed in a notice of proposed rulemaking in the *Federal Register*, which allows for public comment and further consideration before a final rule is issued. If a candidate measure is not yet endorsed by the National Quality Forum, then a rationale for the use of the measure must be included in the notice. Measures related to the Rural Emergency Hospital Quality Reporting Program were included in the most recent MUC list and we encourage you to access the link here.

This does conclude my discussion on the Rural Emergency Hospital Quality Reporting Program. Again, I do encourage you to read the rule for a more in-depth discussion of our proposals, what was finalized, and the requests for comment and information.

Karen VanBourgondien: Thank you, Anita. So, we do have a little bit of time. If you don't mind, let's just take a few questions as it relates to the REH quality reporting program. The first question: Are Critical Access Hospitals required to submit an initial enrollment application to convert to an REH?

Anita Bhatia: Thank you, Karen. This is a very important question, and the answer is no. Critical Access Hospitals that want to convert to an REH should submit a CMS Form 855A Change of Information application rather than an initial enrollment application in order to convert from being a Critical Access Hospital to a Rural Emergency Hospital. This simplified process will help expedite the Critical Access Hospital to Rural Emergency Hospital conversion.

Karen VanBourgondien: Thank you, Anita. So, another question here is: What are the size requirements to convert to an REH?

Anita Bhatia: Again, Karen, this is another very important question, and the answer is that a Rural Emergency Hospital is defined as a facility that was a Critical Access Hospital or was a short term acute care hospital, also referred to as a subsection (d) hospital with no more than 50 beds located in a county in a rural area or in an area that's designated as rural, as we noted in the presentation.

Karen VanBourgondien: Okay, Anita, here's the last question: Why is CMS implementing the REH quality reporting program?

Anita Bhatia: Karen, as we noted, the legislation establishing Rural Emergency Hospitals as a Medicare provider type also requires the establishment of quality reporting requirements. By implementing this program, it will provide transparency for the quality of care provided by Rural Emergency Hospitals for rural communities and will also provide information for quality improvement efforts by Rural Emergency Hospitals.

Karen VanBourgondien: Okay! Thank you so much, Anita, for all of your time. Unfortunately, we're running low on time, so we have to wrap up the questions. I do appreciate it. So, thank you, Anita, for your time, and we're going to move on to Public Reporting.

So, now, let's use our tools on hand and discuss Public Reporting. So, as I mentioned earlier, this month there is a refresh. So, for the web-based measures listed here, the data refresh will be for the calendar year 2021 reporting period. So, that would be January 1 through December 31, 2021, encounters. As you can see here, OP-22, that's the percentage of patients who left the emergency department before being seen. OP-29 is the percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy. Lastly, the OP-31 measure is the percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery. The last web-based measure is the OP-38 measure. That's the COVID-19 vaccination measure, and these data reflect a single quarter of data in each quarterly release. The measure displays the percent of healthcare personnel who completed a COVID-19 primary vaccination series. So, the January release actually displays Quarter 1 2022 data. The January refresh for chart-abstracted measures is for the reporting period of Quarter 2 2021 through Quarter 1 2022.

This slide displays the AMI measures of OP-2 and OP-3b. So, for the same reporting period for chart-abstracted measures, the ED throughput measures are seen here on the slide. OP-18c is not displayed in Care Compare, but it is available in the PDC, the Provider Data Catalog.

Also included in the January refresh are the claims-based measures. Data for the claims-based measures are calculated using paid Medicare claims. These measures do not require manual abstraction and submission of data on the part of your facility. For these measures, there are some differences in the reporting periods. OP-32 uses claims from January 1, 2019, through December 31, 2021. OP-35, and OP-36 use claims from January 1, 2021, through December 31, 2021.

So, the imaging measures, they were not included in the January refresh. These measures are refreshed annually in July. So, just a reminder there, they are not included in this January refresh.

So just to remind you, here are some links and resources for your publicly displayed data. You can, of course, access Care Compare. If you wish to download your data, you can do so by accessing the Provider Data Catalog, and that direct link is also here on the slide. By using the Provider Data Catalog, you'll be able to sort and create spreadsheets and things of that nature. We also have a tool on our website where your publicly reported data are available. So, let me show you where that is.

Again, on our website, QualityReportingCenter.com, we do have this facility compare tool available. It's the same data on Care Compare; it's just arranged differently, a little bit easier to get to. We also have other tools and resources on our site as well.

So, if you are not aware, to get to our website, you're going to just access that address right there at the top of the slide, QualityReportingCenter.com. From the homepage, you would select the outpatient icon right there up at the top of the screen.

Once you select that OQR icon, it will bring you to the OQR-specific area. You can see on the left that there are menu options specific to the Hospital OQR Program. There are quite a bit of options and resources. Yet, in the interest of time, I'm only just going to mention a couple and then we're going to show you the facility compare tool.

So, you can see there are program information icons. There are archived events, upcoming events. These are for any educational webinars that we have. The upcoming events, obviously, is what's in the immediate future. The archived Events tab stores our previous webinars. That library is pretty expansive. You can go in there and download slides, watch webinars, all of that at your leisure. For now, though let me just quickly show you that Hospital OQR Program's Tools and Resources tab.

Once you click on that icon, that tab, the information is divided into categories, and you can see them here on the slide. You can just access each category by clicking on the box desired. You can tell from the titles the information that would be available in each of these sections. So, say for example, New to Reporting, we would have things like a New to Reporting guide, information on the program, deadlines, those types of things. I'm not going to show you any of these tabs today, but be sure to check that out for yourself, particularly if you are not familiar with this website. Again, a lot of information! If you are not familiar, please take a look around at what's available.

So, back to publicly reported data. Let me show you the Facility Care Compare Dashboard, and this is the tool that allows you to access your publicly reported data.

So, go back to that primary menu, on the left-hand side of the page. To access the tool, you're going to click on the down-arrow next to Data Dashboard. That will open up a sub menu of options that you see here. You're going to click on the Facility Compare Dashboard.

You would then be directed to this page. Just so you know, there is a guide on the use of this tool. If you wanted to access that, you would just select the Facility Compare Tool User Guide there, boxed in in red.

Below that, you will see a tab, Hospital Outpatient Departments, and you would just click on that down-arrow for information about dates of encounters that are reflected and where to find archived data. So, if you continue to scroll down on this same page, you will see the tool that I'm going to be showing you.

Here we are, the CMS Quality Measures Scorecard. The program reports in this dashboard are easily accessible by clicking on the desired yellow report button where you can view your facility or compare your facility to any other hospital nationwide. So, to begin today, we're just going to select that top yellow button: Explore all measures reported by a single facility.

You will be brought to this page. This report gives the user the flexibility to select a single facility to view all corresponding measures for that facility. So, just for a few points of interest about this page. You can select the large black arrow on the left-side top of the page, and this will return you to that overall page that we just looked at.

At the top right, in light blue, is your search criteria. The Facility: NPI/CCN plus Facility Name auto-populates with just a random facility. So, you would have to click on that down arrow in the box. The drop-down box opens with a list of hospitals. You can either choose from the list, or you can just enter your facility's CCN, or you can enter your facility's CCN or name by just typing the information in. You can hover over the bar in the bar graph to view any additional information about the measure such as the National Score, if higher or lower scores are better for the measure, and things of that nature. To narrow down the list of facilities, you can click on the State or City drop-down menu to filter the list down to specified City or State.

So, let me just show you what that looks like real quick. This is what the drop-down icon option looks like. You have to click on that drop-arrow remember to open the box, and then you can just start typing your hospital's name or your CCN. Once you enter that, the report will load.

This is the display for your Single Facility Report. These data contain Care Compare data for the Hospital OQR Program, and what we're looking at here is the years 2018, 19, and 20. You will see on the left-hand side the measures are grouped into two sections, the Higher Rates are Better section and the Lower Rates are Better section. You can also see the color legend used at the bottom of the screen.

Now, if you hover your cursor over any of the rates, as we have done here for OP-29, you'll be given additional information for the National Score.

So, going back to the initial Scorecard page, we're going to select Now Explore State Comparisons for Related Measures Across Programs option.

This will allow you comparisons of measures that are shared across programs by state. As most of you are aware, the ASC quality reporting program has some of the same measures that the Hospital OQR Program has. So, the State Comparison for the Selected Measures report provides comparative views of states' scores by selecting category, measure ID, name, and year. A state of interest can be selected to view all corresponding facility scores grouped by city on a state map and a list.

So, remember that I showed you on the previous page that, at the top, you would select the state that you want to compare data for. You would do the same thing for this report. Here we are looking at the year 2019 and the state of Florida; that's where our office is. We are comparing measures that are the same for the Hospital OQR and ASCQR Programs. You will see the National Score above the dotted line for each measure. The State Score is also displayed. All states are shown on the graphs in gray, but Florida data are blue because that's the state that we chose to compare in this example. The gold and blue arrows will provide additional information about the selected state data you are comparing.

So, let's just take another look at a measure. We'll choose ASC-9 and OP-29, as they are the first ones here that we're seeing on this slide. OP-29 is the colonoscopy measure for hospitals, and that same measure is ASC-9 for ASCs. Again, the other states will be in gray, and your selected state will be in blue. Notice that, for OP-29, in these data, 51 states reported this information. Florida's rate is 90.2. The National Rate is 91.0. There is a black dotted line showing you this here on the slide. The 90th percentile is 100 percent, and the 10th percentile is 71.0.

Now, we switch over and look at the ASC graph for Florida, and we see the same data for the measure as reported by ASCs. Notice that for the ASC-9 data, 49 states reported data information. Florida's rate is 64.6. The National Score is 78.4, and there is that black dotted line showing you this. The 90th percentile is 100 percent, and the 10th percentile is 51.7. As I mentioned on the previous slide, you will obtain more information by clicking on any of these arrows.

So, for example, if we clicked on the gold arrow next to OP-29, this little pop-up menu will appear with specifics to that measure. You can select any of the blue or gold arrows for a pop-up box with more information.

Okay, so just one more report. We're going to go back to that main scorecard page, and we are going to select Explore State Comparison for all OQR measures, that last box there on the right.

Here we are. Again, we're comparing Florida. The State Comparison for all OQR Measures report displays states comparative scores for current measures for the year that you select. Included are the number of reporting states, the selected state's numeric rate, and a symbol indicating if the score is above or below the national rate. Symbols in blue indicate the selected state's score is better than the national rate; brown symbols indicate that the selected state score is worse than the national rate. At the top of this report, you can select the state and year for comparison. You will see boxes representing the various measures with data related to the measure contained within each box.

So, let's just take a quick closer look at this, and we're going to choose OP-29. So, you will see all states in gray, but, the chosen state, which is Florida, is in blue. The state rate is 90.2; the National Score is 91.0; the 90th percentile is 100 percent;. and the 10th percentile is 71.0. So, as before, you can click on the arrows for additional information.

That is a very brief overview of this interactive tool. We really encourage you to check this out for yourself. It's very helpful because you can sort, analyze, create your own data sheets, and much more. It's a great interactive tool, so give it a try, and I did show you this very, very briefly.

So, as always, if you have any program questions, give us a call. Our phone number is right here at the top. We're always glad to hear from you and happy to help. You can also use the Q&A Tool on QualityNet. That direct link is here on the slide as well. We also have the email for NHSN and the phone number for the Service Center for QualityNet for any technical issues with the reporting system, HQR.

So, that's all the time we have today. Thank you for joining us. Thank you again, Anita and Shaili, for spending time today and letting us know about the final rulings and the impact to these programs. We really appreciate it. Thank you to all of you again. We look forward to seeing you next time. Have a great rest of your day.