Outpatient Quality Program Systems and Stakeholder Support Contractor

Quality Reporting for Hospital Outpatient Departments and Ambulatory Surgical Centers: CY 2021 Program Proposals

Presentation Transcript

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Karen VanBourgondien: Hello everyone. Welcome, and thank you for joining us. My name is Karen VanBourgondien. Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for the Hospital OQR and ASCQR Programs. She received her PhD from the University of Massachusetts at Amherst and her master's in public health from the Johns Hopkins School of Public Health. Dr. Bhatia plays a crucial role in development of the OPPS/ASC proposed and final rulings. Her contributions to the rulings are essential to the continuing success of these programs. We are very fortunate to have Dr. Bhatia's commitment to these programs.

Let me just mention a standard disclaimer before we get started. CMS can only address procedural questions and the submission of comments and cannot address any rule-related questions other than those pertaining to the content. CMS looks forward to your comments as this is your opportunity to provide input on these proposals.

Today, we will chart the hospital outpatient department and the ambulatory surgical center voyage through the Calendar Year (CY) 2021 OPPS/ASC Proposed Rule. While our ship is moored, we will review two guiding principles for what CMS is trying to accomplish for these reporting programs, both for the hospital outpatient department and the ASC settings through the rule-making process. So, how did the proposed rule get to port, and where is it taking us on this voyage? That is what's on the nautical course for our discussion today.

Here we see an outline of our itinerary, aka the learning objectives for this presentation. The program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box, as well as the audio of today's program will be posted on QualityReportingCenter.com at a later date. During the presentation, if you have a question, please put that question in the chat box located on your screen. One of our subject-matter experts will respond. If your question does not get answered for some reason, please know that all questions and answers will be posted on QualityReportingCenter.com.

Before we raise our sails, here are two program announcements.

Beginning with the ASC community, CMS is conducting the initial national analysis known as a "dry run" for Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers, which of course is the ASC-19 measure. The facility reports supplied under this dry run became available beginning August 12 and runs through today, September 9 of 2020. For those of you wondering, "What is a dry run anyway?" Essentially, it sort of like a "practice run." For this dry run, data are collected for the ASC-19 measure and provided to facilities and will not affect payment. This data are provided in the form of a report. Confidential Facility-Specific Reports, or FSRs, will be provided to ASCs. This is your chance to review your facility's data and see what quality changes you can update, if needed, to improve your score. The ASC-19 measure is an outcome measure that was adopted into the program in the calendar year 2020 OPPS/ASC final rule and is included as a program requirement beginning with calendar year 2024 services.

The purpose of the dry run is to provide ASCs with the opportunity to review their facility-specific results for the ASC-19 measure, as well as the underlying case data for calculating the measure. It will also serve to educate ASCs on how to interpret their measure results. CMS collects these administrative data from the Medicare claims submitted and reimbursed for your facility and calculates the measure. The goal is to provide quality of care information for Medicare beneficiaries and other stakeholders, including ASC facilities. You, as clinicians and other ASC staff, everyday do what you do best, and that is taking care of patients. By having access to the information, you can assess what is happening to your Medicare patients after being seen in your facility as related to post-procedure hospital visits and perhaps use these data for tracking or quality improvement. That is always a positive!

Confidential FSRs will be provided to individual ASCs. Again, this is your chance to review your facility's data based on paid Medicare fee for service claims. As this is a dry run, it is important to know that the results contained in these reports will not be publicly displayed. If your ASC has

no cases that meet the measure criteria for ASC-19, then of course, you will not receive that FSR. For more information on the ASC-19 measure and dry run, you can access the link here supplied on the slide to *QualityNet*. Additionally, if you have questions, please feel free to reach out to the measure writers, and their email is also noted here on the slide.

Our second announcement is for both hospitals and ASCs. That is with regard to the most recent preview period, and that began on August 16th. The data that are on that report is scheduled to be displayed next month, in October. Now, CMS did issue a blanket exception related to the COVID-19 pandemic. That exception applied to all CMS quality reporting programs. So, both hospitals and ASCs were excepted from having to report the web-based measures that were due last May, May 15th of 2020. Though that data could have been submitted voluntarily, unfortunately, it is not possible to enter any of that data late. So, if you were, for example, an ASC that was closed, you just returned to work, and you wanted to submit your data after May 15th, you would not have been able to do that. We did get a lot of calls about that. So, unfortunately, it is not possible to submit any of that data late. Hospitals, you did, in addition to web-based measures, you had additional data exceptions for chart-abstracted measures for Q1 and Q2.

So for ASCs, if the web-based measure data that were due on that May 15th were not submitted, or you submitted all zeros, or you do not have cases to meet the measure criteria for ASC-12, you would not receive that preview report. By the way, although the ASC-12 data are on this preview report, that data will not be refreshed. For hospitals, there are other data available for the preview other than those excepted time periods.

In preparation for our journey into this year's program proposals included in the proposed rule, we are going to spend just a very brief time discussing the rulemaking process. One of the reasons we are doing this is because we get a lot of questions, and many people don't really know what the process is and how a measure becomes a measure, and why, things of that nature. So, we are going to very briefly go over the pre-rulemaking and rulemaking processes.

Before quality measure proposals are put forth through a proposed rule, there is a lot of pre-work to be done. This slide diagrams that process. We have explored the measure development and pre-rulemaking process in great detail and a previous webinar called *The Life and Times of a Measure: An Overview of the Measure Development Process*, and that is available on our website, QualityReportingCenter.com, under the Archived Events tab for both the Hospital Outpatient Quality Reporting Program and the ASCQR Program. So, if you really want details on that, we recommend you access that webinar. Today, we are going to just have a brief summary. So, back to the diagram. Early in each calendar year, through a call for quality and efficiency measures, CMS begins the annual pre-rulemaking cycle of collecting and compiling the MUC list. MUC: Measures Under Consideration. Usually this occurs from February through May. Stakeholders are invited to submit proposed quality and efficiency measures. Stakeholders submitting measures include CMS, other federal DHHS (Department of Health and Human Services) agencies, organizations contracted with these federal agencies, and healthcare advocacy and professional groups. Following submission, the pre-rulemaking process includes review and clearance of candidate measures within CMS and DHHS and provides the opportunity for multi-stakeholder groups to offer input. The Measures Under Consideration list, or the MUC list, is then issued by December 1st. The National Quality Forum, or NQF, convenes the Measure Applications Partnership, or MAP, in December of each year to review and comment on the measures proposed on the annual MUC list. Annually, the MAP workgroups and the coordinating committee meet to provide program-specific recommendations by February 1st. Now, as a note, measures that do not undergo this specific process, but are developed and agreed upon by other consensus procedures, can also be considered for the Hospital OQR and ASCQR Programs.

Once the pre-rulemaking process for measures is complete, work toward measure and other program proposals for the rulemaking process begins. Every summer, after months of evaluation, research, and writing, the proposed rule is placed on display on or around July 1, this being an

exceptional year, and then published in the *Federal Register*. The published date begins the required 60-day public comment period. Public comments are incredibly important toward informing and influencing the formation of the final rule. CMS utilizes public comments to make decisions and make changes for policies to be finalized in the final rule. A proposed rule is just that, it's proposed. So, please submit comments. CMS loves to hear from you, the people in the field that are affected by CMS's policies. Your comments can help CMS put forth the best policies possible for these quality reporting programs. The final rule is then placed on display followed by the publication in the *Federal Register* around November 1 of each year.

CMS seeks to promote higher quality and more efficient healthcare for Medicare beneficiaries. Consistent with these goals, CMS has implemented quality reporting programs for multiple care settings. To help us navigate the programs, let's discuss some alignments between these two programs. For this, and the proposals put forth through the proposed rule, I will hand things over to Dr. Anita Bhatia. Anita?

Anita Bhatia: Thank you, Karen. CMS works with stakeholders to define quality of care measures across multiple settings and seeks to align measures for within these programs. The measures listed here on this slide are aligned between the Hospital OQR and the ASC quality reporting program. All of these measures address in-common procedures performed in these two settings.

Karen VanBourgondien: Anita, let's stop here a minute, and let me ask you a question. So, you just talked about measures that are aligned between the Hospital OQR Program and the ASCQR Program. Can you elaborate a little bit on CMS' goals and vision with regard to aligning programs?

Anita Bhatia: Yes, Karen. CMS believes program alignment for our quality reporting programs is important, so that measures can be compared across programs and care settings. This is particularly important for the hospital outpatient department and ASC settings as many of the same surgical procedures are performed in both settings. Alignment of measures would allow Medicare

beneficiaries and other stakeholders to compare quality of care for these two settings where care has been moving to from the inpatient setting. In addition, we seek to align program procedures to the extent possible to reduce the burden of participating for facilities.

Karen VanBourgondien: Thank you, Anita. That is very helpful information.

Anita Bhatia: This year our proposals seek to align the Hospital OQR and ASCQR Programs in policy and procedures to the extent possible. We also seek to codify our policies to the extent possible so that program requirements are available in one place and are more easily available. So, let's take a look at our proposals for this year.

Our first proposal is regarding *QualityNet* access. This proposal applies to both hospital OQR and ASCQR. We previously finalized and codified *QualityNet* Security Administrator requirements for program participation, including setting up a *QualityNet* account and associated timelines. We are proposing in this rulemaking to use the term "Security Official" instead of "Security Administrator," as "Security Official" serves to denote the exercise the authority invested in this role. The term "Security Official" would refer to "the individual(s)" who have responsibilities for security and account management requirements for a facility's *QualityNet* account. The responsibilities associated with this role are not changed; the proposal is only to change the term. If finalized, the new language would read: "Identify and register a *QualityNet* Security Official as part of the registration process." We invite public comment on our proposal to replace the term "Security Administrator" with "Security Official" and to codify this change.

Data Submission Deadlines; The next proposal for both Hospital OQR and ASCQR Programs is the data submission deadlines. To align with a Social Security Act statute, in this proposed rule, we propose one change to our submission deadlines. We propose that all deadlines falling on a nonwork day be moved forward consistent with the Social Security Act. If finalized, the new paragraph would specify that "All deadlines occurring on a

Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for federal employees by statute or executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday, or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order." This proposal would begin with the effective date of this rule, meaning any deadline that would fall on a nonwork day moving forward. We are also proposing to codify this change. Of course, we invite public comment on these proposals.

All right. Now, we are going to continue our voyage with the hospital outpatient department setting; we will next cover current measures and then our proposals for the Hospital Outpatient Quality Reporting Program.

In this rulemaking cycle, we are not proposing any measures be added or removed from the Hospital Outpatient Quality Reporting Program measure set. Listed here are the current claims-based measures for this program. Again, there are no proposed changes for these measures.

On this slide, we have the measures where data are submitted to CMS via a web-based tool. So you have here OP-22, 29, and 31. So, what happened to OP-33? Wasn't that a web-based measure? Well, remember, OP-33 was removed beginning with the calendar year 2022 payment determination and for subsequent years. So, reporting is no longer required for the OP-33 measure.

For the chart-abstracted clinical measures for the Hospital OQR Program, again, there were no proposed changes. These measures will continue to be reported as they have been. The implementation of the survey measures OP-37a through 37e were delayed with the Calendar Year 2018 OPPS/ASC Final Rule, and these measures continue in that status. So, let's talk next about our proposals for this year that are specific to the Hospital OQR Program.

We previously finalized that hospitals sharing the same CCN must combine data collection and submission across their multiple campuses for all clinical measures for public reporting purposes. While we previously finalized this policy, it was not codified. Thus, we are proposing to update the current codified language to include this finalized policy. The new sentence added to the end of the current section would read: "Hospitals sharing the same CCN must combine data collection and submission across their multiple campuses for all clinical measures for public reporting purposes." Again, we invite public comment on this proposal to codify this policy.

Next is a proposal regarding participation status. As a point of review, a participating hospital may withdraw from the Hospital OQR Program by submitting to CMS a withdrawal form that can be found in the *QualityNet* website. A withdrawn hospital will not be able to later sign up to participate in that payment update, is subject to a reduced annual payment update, and is required to renew participation in order to participate in any future year of the Hospital OQR Program. In this proposed rule, we propose to remove the phrase "submit a new participation form." To align with previously finalized policy, submission of this form was removed as a program requirement. If finalized as proposed, the new language would specify that "a withdrawn hospital will not be able to later sign up to participate in that payment update, is subject to a reduced annual payment update, and is required to renew participation in order to participate in any future year of the Hospital OQR Program." Again, we invite public comment on this proposal.

In alignment with our proposal to change submission deadlines, we are proposing one change to our reconsideration deadlines. Specifically, we propose to remove the phrase "the first business day on or after" from existing policy language, to ensure the language of the regulatory text regarding deadlines for reconsideration requests is consistent.

If finalized, the newly re-designated paragraph would read: "A hospital may request reconsideration of a decision by CMS that the hospital has not met the requirements of the Hospital OQR Program for a particular

calendar year. Except as provided in paragraph (e) of this section, a hospital must submit a reconsideration request to CMS via the *QualityNet* website, no later than March 17, or if March 17 falls on a nonwork day, on the first day after March 17 which is not a nonwork day, of the affected payment year as determined using the date the request was mailed or submitted to CMS." Again, we invite public comment on this proposal.

In our previously finalized policy, the Hospital OQR Program implemented a four-month review and corrections period for chart-abstracted measure data, which runs concurrently with the data submission period. During the review and corrections period for chart-abstracted data, hospitals can enter, review, and correct data submitted directly to CMS for these chart-abstracted measures. So, let's say for example, you have entered data for a given quarter, and you realize you left cases out. You can go in any time before that submission deadline and make changes. You can add, delete, or change anything up to the deadline. We now propose to expand that review and corrections policy to apply to measure data submitted via the CMS web-based tool. Thus, hospitals would formally have a review and corrections period for web-based measures, and this would run concurrently with the data submission time period.

However, after the submission deadline, hospitals would not be allowed to change these data. The expansion of the existing policy for chart-abstracted measures to data submitted via the CMS web-based tool would accommodate a growing diversity of measure types in the Hospital OQR Program. If finalized, this policy will begin with data submitted for the calendar year 2023 payment determination and subsequent years. Again, we invite public comment on this proposal.

In the calendar year 2018 final rule, we finalized a policy to formalize the educational review process for chart-abstracted measures, including validation score review and correction, but, again, we did not codify this policy. So, in this proposed rule, we propose to codify those policies by adding a new paragraph which states, "Hospitals that are selected and receive a score for validation of chart-abstracted measures may request an educational review in order to better understand the results within 30

calendar days from the date the validation results are made available. If the results of an educational review indicate that a hospital's medical records selected for validation for chart-abstracted measures was incorrectly scored, the corrected quarterly validation score will be used to compute the hospital's final validation score at the end of the calendar year." We invite public comment on this proposal.

All right. Thanks everyone for your participation in the polling question. Let's turn back to the proposed rule.

The proposed rule this year has some proposals for the Overall Star Ratings on Hospital Compare. While these proposals are separate from hospital OQR requirements, data from the Hospital OQR Program are included in the calculation of these ratings, and we are including a small discussion on this topic. The Overall Star Rating provides a summary of existing hospital quality information based on publicly available data reported through CMS programs. These data are displayed on a CMS website with transparent information on over 100 quality measures for over 4,000 hospitals. This rating was first introduced and reported on Hospital Compare in July of 2016. There have been only minor methodology updates over the past four years. You likely have heard the term "refresh" when it comes to publicly displayed data. What this means is that the most recent data have been recalculated and that updated calculation is then publicly displayed. For the Overall Star Rating, this refresh is done annually.

CMS is proposing a methodology which includes elements of the current methodology as well as updates that aim to increase simplicity of the methodology, predictability of measure emphasis within the methodology over time, and comparability of ratings among hospitals. Also being proposed is the inclusion of VA (Veterans Administration) hospitals, as well as Critical Access Hospitals, or CAHs.

We propose these changes to begin in CY 2021 and then for subsequent years. Because of the production timeline to calculate and distribute the Overall Star Ratings in time for hospitals to preview their ratings, we are putting this proposal forward in the OPPS proposed rule now.

Let's alter our course a bit and discuss another aspect of the Hospital OQR Program which is how the payment penalty for not meeting program requirements is applied. CMS is proposing to continue the previous policy. There is an entire methodology and calculation process, which we will not go into today as our focus is program requirements. We are mentioning this here in brief summary to indicate the policy will continue if finalized as proposed. So, what does this mean? You all know that you report data for this program to be publicly reported. For facilities that have met the program requirements, the payment rate is referred to as the "full national unadjusted payment rate." Any facility that fails the program requirements will incur a reduction of 2.0 percentage points in their outpatient department ,or OPD, fee schedule increase factor, which we refer to as the Annual Payment Update (APU) factor. These payment rates apply to certain outpatient items and services provided by hospitals. In addition, application of the payment penalty will affect beneficiary co-payments.

Okay. Let's move up to the quarterdeck and talk about proposals that relate to the ASC quality reporting program. Again, CMS did not propose to add or remove any measures from the measure set for this program.

Here is a view of the ASC quality reporting measure set. The measures here and on the next few slides are in numeric order so that we can easily view and discuss them. The claims-based measures here, ASC-1 through 4, were suspended, pending further rulemaking; and these measures remain in that status. Then, we have the ASC-9 on this slide, and you will continue abstracting and reporting data for the ASC-9 measure. The next time data are to be submitted for ASC-9 will be beginning in January 2021 and no later than May 15.

So, our measure set continues here. ASC-11 remains voluntary. ASC-12 is a claims-based measure and does not require active abstraction and reporting on the part of you and your ASC. For ASC 13 and 14, there were no changes. You would continue to report these measures as you have been. ASC 13 and 14 are web-based measures.

So, here at the top of the list, we have the OAS CAHPS measures, 15a through 15e, As with these measures in the Hospital OQR Program, these measures remain delayed. We did not propose any changes to the status of this set of measures. ASC-17 and ASC-18 are previously adopted claims-based measures, and their reporting will begin with the calendar year 2022 payment determination. ASC-19 is the measure we talked about at the very beginning of the presentation with the dry run. This measure begins to affect payment with the 2024 payment determination and is fully claims-based. So, no manual abstraction or reporting is necessary for this measure.

So, the first ASC-specific proposal to talk about is one which updates some language. We codified our existing policies regarding data collection and submission. We currently use the phrases “data collection period” and “data collection time period” interchangeably. We believe that using one consistent phrase will streamline and simplify the section that we have in the Code of Regulations as well as our policies to help avoid potential confusion. As such, we propose to remove the phrase “data collection time period” in all instances where it appears and replace it with the phrase “data collection period.” We invite public comment on this proposal.

Next is the review and corrections period for the ASC quality reporting program. Under the ASC quality reporting program, for measures submitted via a CMS online data submission tool, ASCs can submit their measure data to CMS from January 1 through May 15 during the calendar year after the current data collection period. What I mean by that is, for example, ASCs would collect measure data from January 1, 2020, through December 31, 2020, that would be this year, and submit these data to CMS from January 1 , 2021, through May 15, 2021. As with the Hospital OQR Program, we are proposing to formally implement a review and corrections period which would run concurrently with the data submission

time period beginning with the effective date of this rule. During this review and corrections period, ASCs could enter, review, and correct data submitted directly to CMS. However, after the submission deadline, ASCs would not be allowed to change these data. ASCs are encouraged to submit data early in the submission period so that they can identify errors and resubmit data before the established submission deadline. We invite public comment on these proposals.

The last thing I am going to talk about today for ASCs is how the payment reduction is applied; again, this is similar to what happens under the Hospital OQR Program. Per authorizing statute, any annual increase may be reduced by 2.0 percentage points for ASCs that fail to meet the reporting requirements of the ASCQR Program. This year, continuation of previously finalized policies for how to reduce the annual update for ASCs that fail to meet the ASC quality reporting program requirements is proposed. Currently, two conversion factors are calculated: a full update conversion factor and an ASC quality reporting program reduced update conversion factor. The reduced national unadjusted payment rates using the ASC quality reporting program reduced update conversion factor are calculated to apply to ASCs that fail to meet quality reporting requirements for that calendar year payment determination. Application of the 2.0 percentage point reduction to the annual update may result in the update to the ASC payment system being less than zero prior to the application of the adjustment. So, this sums up the proposals for ASCs and the ASC quality reporting program.

Karen VanBourgondien: Let's anchor again. Anita, you mentioned codifying quite a few times when discussing the proposed rule. Would you mind elaborating a little bit on why CMS is seeking to codify certain aspects?

Anita Bhatia: Sure, Karen. Codification is an important program consideration. Our proposed and final rules are published in the *Federal Register,* and this language and this language is called "preamble." Preambles provide the agency's official justification for the regulations introduced and offer guidance about the regulation's meaning and application. This does work

for issuing program requirements. However, as programs like ours continue, there are can be a lot of preamble out there; the Hospital OQR Program first published requirements in the CY 2009 proposed rule and the ASC quality reporting program in CY 2012 proposed rule. So, codification puts program requirements in one place for everyone. Further, regulation holds a higher level in terms of having full force of the law which provides a level legal field of knowledge in regard to final program policy.

Karen VanBourgondien: Thank you, Anita. It is always great to have CMS' perspective. I am going to turn things back over to you. Thank you for answering that question. I appreciate it.

Anita Bhatia: As alluded to earlier, we are going to walk through the commenting process. I cannot stress enough how important commenting is. This is your opportunity to influence and be involved in policies for these programs that seek to improve quality of care for Medicare beneficiaries. I am going to hand things back over to Karen to discuss the commenting process.

Karen VanBourgondien: Thank you, Anita. When commenting and to be assured consideration, comments must be submitted no later than 5 p.m. Eastern Standard Time (EST) on October 5. Because of staff and resource limitations, CMS cannot accept comments by fax (facsimile) transmission. CMS does encourage submission of comment by electronic means to Regulations.gov, and that is the process that I will show you in just a moment. You may also submit comment via regular mail, express mail, or overnight mail. There are separate addresses for these types of mails. So, please resource the specific address found in the proposed rule. Please allow sufficient time for mailed comments to be received before that closed date of the comment period.

So, let's start with finding the rule itself. To access the rule, you can simply click on the link we have here on the top of the slide. You can also go to FederalRegister.gov and insert the document number which I circled here on the slide. You would put that document number as 85 FR 48772. You would put that in your Find box, and just click the Search icon.

That would bring you to the page you see here. Then, you would just simply click on the rule, which is in blue right there by the arrow.

That will take you directly to the rule, which you can view or download as a PDF. To download as a PDF, there is an icon right there next to the arrow. To comment, you're going to select the green Summit a Formal Comment button, and that is boxed in here on the slide.

You will be directed at that point to the comment page, and, on this slide, you only see the top part of that page. You can enter your comment and add a file, if you wish to do so.

If you continue to scroll down that page, then you can enter your information. Please make sure you click on the "I read and understand the statement above." box. Then, you can simply click the Summit Comment button. Please comment. CMS does looks forward to hearing from you about the proposals discussed here today. That's it! Just comment. This concludes our discussion on the CY 2021 Proposed Rule as it relates to these two programs.

Thank you again to Anita. We really appreciate your time. It is always nice to have CMS talk to us about proposals that impact these programs. Again, on this slide the direct link to the proposed rule in the *Federal Register* is here, as well as the direct link to the comment page. As we said and as Anita said earlier, please comment. Additionally, if you wish to view this webinar again or obtain the slides, please use the link here that we have on the slide. That will direct you to our website; you will select the program and then the Archived Events tab.

Anita, we have just a few minutes. Can we take some questions? You can respond to them for everyone that has joined us today.

Anita Bhatia: Yes. Questions would be great.

Karen VanBourgondien: OK. So, the first question I have here is, "Can you go over what the change is in the submission deadlines, and why was this necessary?"

Anita Bhatia: Yes, of course, Karen. This revision was proposed to address when deadlines fall on weekends and other "nonworking" days. We are proposing to revise our policy which uses the term "business day," such that all deadlines occurring on a designated "nonworking day" will be extended to the first day thereafter. A "nonworking day" as defined under the Social Security Act applies to the Medicare program. So, for example, the next submission period for web-based measures, next May 15, falls on a Saturday. Thus, for 2021, the deadline would extend until the following Monday, which is May 17.

Karen VanBourgondien: Thank you, Anita. So, again everybody, in next web-based measure submission period, you have until the following Monday to enter your data for that May 15 deadline. The next question Anita is, "What is the difference between Security Administrator and the new Security Official?"

Anita Bhatia: Karen, this is a change in terminology to align across programs and platforms. This proposed update in terminology would not change the individual's responsibilities or add burden. The term "Security Official" refers to the individuals who have responsibilities for security and account management requirements for a facility's *QualityNet* account. Note that for both the hospital outpatient and ASC quality programs, a Security Administrator, now Security Official, is an administrative requirement for setting up accounts and roles for data submission and report access; it is not a program requirement toward payment determination.

Karen VanBourgondien: Thank you, Anita. Another question: "Can you explain what you mean by the proposed review and corrections period?"

Anita Bhatia: Let me address the Hospital OQR Program first. During the review and corrections period for chart-abstracted data, hospitals can enter, review, and correct data submitted directly to CMS for the chart-abstracted measures. The expansion of the existing policy for chart-abstracted measures to data submitted via the CMS web-based tool would accommodate a growing diversity of measure types in the Hospital OQR

Program. On the ASC side, while ASCs have been able to update their web-based measure data after submission, this proposal aims to notify everyone of this ability, and formalize and codify this part of the program. This review and corrections period would also apply for the ASC quality reporting program for any other measure types, if such are required. Thus, for both the Hospital OQR and ASCQR Programs, facilities are encouraged, but not required, to submit data early in the submission period. So, if any errors are identified, data can be resubmitted before the established submission deadline, as once the submission period ends, the warehouse will close, and no further changes can be made.

Karen VanBourgondien: Thank you so much, Anita. The next question is, "What is CFR and why is it important?"

Anita Bhatia: For us, CFR is the standard acronym for the Code of Federal Regulations. This is the codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government. CMS is one of these agencies. The CFR is divided into 50 titles that represent broad areas subject to federal regulation. Title 42 is the public Health section and all finalized Hospital OQR and ASCQR Program codifications would be under CFR title 42.

Karen VanBourgondien: Thank you, Anita. That was a great explanation. We appreciate that. Also, another trend here in the questions is, "Why does CMS seek to codify policies? Isn't what is in the *Federal Register* good enough?"

Anita Bhatia: Well, Karen, you are correct that what is finalized in the *Federal Register* can be "good enough." *Federal Register* language is called preamble, and preambles provide the agency's official justification for the regulations introduced and offer guidance about the regulation's meaning and application, and this does work for issuing program requirements. However, as programs like ours continue, there is going to be a lot of preamble out there; as we talked about in the presentation, the Hospital OQR Program has been around since Calendar Year 2009, and the

ASCQE Program now has been around for a while too, having first issued policy in the calendar year 2012 proposed rule. So, codification puts program requirements in one place for everyone. Further, regulation holds a higher level in terms of having full force of the law, which provides a level legal field of knowledge in regard to final program policy.

Karen VanBourgondien: Thank you, Anita. I think we have time for just one last question, and the question is, "Why are we talking about aligning the Hospital QOR and ASCQR Programs? Aren't these different care settings?"

Anita Bhatia: Well, Karen, you are correct that the hospital outpatient department and the ambulatory surgical center settings are different settings. Hospital outpatient departments provide more extensive services for a broader patient population than ASCs. However, hospital outpatient departments and ASCs provide many of the same services, and the number of procedures that ASCs can provide has been growing. Thus, so that Medicare beneficiaries and other consumers can compare hospital outpatient departments with ASCs for procedures performed in both settings, we are seeking to align these two programs as possible, given that ASCs tend to specialize; whereas, hospital outpatient departments have services such as emergency departments and can have more complicated patients that ASCs do not have.

Karen VanBourgondien: Thank you, Anita. We appreciate your time today and answering questions. I think we will have to wrap it up for today. Again, thank you, Anita, for joining us. We always really love to hear from CMS. I think that's all the time we have today. Again, everybody, thank you for joining us, and have a great day.