Quality Reporting Program

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CY 2019 OPPS/ASC Proposed Rule: Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Presentation Transcript

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Karen VanBourgondien: Hello everyone, and welcome to the ASC Quality Reporting Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Lead for the ASC Quality Reporting Program. If you have not yet downloaded today's handouts, you can get them from our website at www.qualityreportingcenter.com. Just click on today's event, and you will be able to download and print any handouts that you want for today's webinar. They are also attached to the invite you received for this event.

Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for the ASC Quality Reporting Program, as well as, the Hospital Outpatient Quality Reporting Program. She has been the program lead for this program since its inception in 2007. She received her PhD from the University of Massachusetts Amherst and her Master's in Public Health from John Hopkins University. Dr. Bhatia plays a crucial role in the development of the Proposed and Final Ruling. Her contributions to the rulings are essential to the continuing success of this program. We are very fortunate to have Dr. Bhatia's commitment to this program.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation including all of the questions and answers received in the chat box and the audio portion of today's program will be posted at our website www.qualityreportingcenter.com at a later date. During the presentation if you have a question, please put that question in the chat box located on the left side of your screen.

Before we get started, let me just mention a standard disclaimer. CMS can only address procedural questions and comments submission and cannot address any rule-related questions. CMS does look forward to your comments as this is your opportunity to provide input on these proposals. So, without any further delay, let me turn things over to our speaker Dr. Bhatia. Anita?

Anita Bhatia: Welcome everyone. Today we are discussing proposals for the ASC Quality Reporting Program contained within the Calendar Year 2019 OPPS/ASC Proposed Rule with comment period. For those of you who are new to the ASC Quality Reporting Program here is a very simplified version of the rule process. On or around July 1st after months of evaluation, research, and writing, proposals for the OPPS/ASC payment rule are placed on display and subsequently published. Requirements for the ASC Quality Reporting Program are included in this rule as the program can affect facility payment. From the Proposed Rule display date there is a 60-day public comment period where comments regarding proposals can be submitted. Then, on or around November 1, after reviewing and considering all comments, a Final Rule is placed on display and then published. Your comments are extremely important to CMS and the rule-making process. Every comment is reviewed, considered, and receives a response in the Final Rule. At the end of this webinar we will cover how to submit comments.

To comment on the Proposed Rule, we first need to find it. Let's walk through the process of finding the publicly available Proposed Rule.

The OPPS/ASC Proposed Rule is published annually in the *Federal Register*. To find this year's Proposed Rule affecting the Calendar Year 2019 payment, I put the direct link here in blue lettering on this slide. This link will open at the starting point of this document. The ASC Quality Reporting requirements portion begins on Page 37193.

And here we are. Let me point out a couple of things here. You can submit a comment regarding this Proposed Rule by clicking on the green "submit a formal comment" icon. You can then scroll down this page until you see the start of the ASC Quality Reporting section which begins with the Roman Numeral 14 or XIV or you can also access the PDF version and use your "find" feature. If you click on the PDF icon, circled here in red, the PDF version will open at the beginning of the document.

You can use the "find" feature to find the portion that relates to this program. To do so, on your keyboard select the "control" key and the "F" key simultaneously. This will give you a dropdown box. Enter our page number of interest, 37193. You can see this number at the top of the screen boxed in red. You would now hit your "enter" key, and your screen will move to where the ASC Quality Reporting

section begins. So, now that you know how to find the section of the Proposed Rule for the program, let's discuss our proposal.

To get our bearings, here we can see a view of the current quality measures for the ASC Quality Reporting Program as per last year's Final Rule. Note that the OAS CAHPS Survey measures were adopted, but their implementation is delayed. We have no proposal regarding the OAS CAHPS measures in this Proposed Rule. So, their status is unchanged, and these measures remain not required. In this Proposed Rule, we are proposing a number of new policies. We developed these proposals after conducting an overall review of the program under our new Meaningful Measures Initiative.

CMS has developed the Meaningful Measures Initiative for minimizing costs for facilities and CMS. Our efforts to reduce costs, seen here on this slide, include consideration of the facility information collection and data submission burden for quality measures, the facility costs associated with complying with other quality program requirements. Next, the facility costs associated with participating in multiple quality programs and tracking multiple similar or duplicative measures within or across those programs, the costs to CMS associated with the program oversight of a measure including measure maintenance and public display and the facility costs associated with compliance with other Federal and/or state regulations.

Our proposals also reflect our efforts to improve the usefulness and usability of the quality data that we publicly report by streamlining how facilities are reporting and accessing data while maintaining or improving understanding of these data. This framework will allow ASCs and consumers to continue to obtain meaningful quality of care information about ASCs and incentivize quality improvement while streamlining the measure sets to reduce duplicative measures and program complexity.

CMS works with stakeholders to align measures within the Hospital Outpatient and the ASC Quality Reporting Programs which are both for the outpatient surgical setting. The measures listed here are aligned for these two programs.

In the Calendar Year 2018 Final Rule we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We noted the National Quality Forum or NQF undertook a two-year trial period in which certain new measures and the measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate. So, in this year's rule-making, we provide an update on these efforts. The 2-year trial period ended in April 2017, and the final report is now available at the link provided on this slide. This report

concluded that measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship between social risk factors and the outcomes measures. Now, this discrepancy could be explained in part by the method used for adjustment and the limited availability of robust data on social risk factors. So, the NQF is now undertaking an extension of the socioeconomic status trial to further examine the role of social risk factors in outcomes measurement.

Next, we have proposals to update Measure Removal Factors. The benefits of removing a measure from the ASC Quality Reporting Program are assessed on a case-by-case basis using specified factors.

The current factors for determining whether to remove a measure are listed on this and the next slide. These Removal Factors are for measures where 1) Performance is high and unvarying, that is "topped out;" 2) Another measure is available that has a stronger relationship to patient outcomes; 3) A measure is no longer aligned with current practice or guidelines; 4) There is a measure that is more broadly applicable for the topic; 5) The availability of a measure closer in time to desired patient outcomes for the topic; 6) The availability of a measure more strongly associated with desired outcomes; and 7) When the collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

This year we are proposing to remove one factor and to add two new factors. We are also making one clarification to Measure Removal Factor 1. We received comments in previous rule-making remarking on the duplicative nature of Measure Removal Factor 2 "availability of alternative measures with a stronger relationship to patient outcomes" with Measure Removal Factor 6 "the availability of a measure that is more strongly associated with desired patient outcomes for a particular topic." We agree that Measure Removal Factor 2 is repetitive with Factor 6. As noted earlier, we want the ASC and Hospital Outpatient Quality Reporting Programs to be aligned to provide consistency across these two outpatient surgical quality reporting programs. In evaluating the two programs' Removal Factors, we became aware that the Hospital Outpatient Program includes one factor not currently in the ASC Program. The Hospital Outpatient Program's second Measure Removal Factor specifies "performance or improvement on a measure does not result in better patient outcomes." Therefore, we are proposing to add this hospital outpatient factor as the new Removal Factor 2 under the ASC Program.

Here is the second additional factor we are proposing to adopt when evaluating measures for removal from the program measure sets - Factor 8 "the costs associated with a measure outweigh the benefit of its continued use in the program," and we want to clarify Factor 1 regarding "topped-out measures." We previously finalized two criteria for determining when a measure is considered to be "topped-out." First, when there is statistically indistinguishable performance at

the 75th and 90th percentiles of national facility performance, and second, when the measure's truncated coefficient of variation or TCOV is less than or equal to 0.10. We are not proposing any changes to our methodology. We are clarifying our process for calculating the truncated coefficient of variation for measures where low values indicate higher performance. These measure removal additions and clarification would be implemented with the effective date of the Calendar Year 2019 Final Rule.

Thus, if the proposed changes to the Removal Factors are finalized, they will be as they appear on the next two slides. Factor 1 – Measure performance among ASCs is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made ("topped-out measures"). Factor 2 – Performance or improvement on a measure does not result in better patient outcomes. Factor 3 – A measure does not align with current clinical guidelines or practice. Factor 4 – The availability of a more broadly applicable across settings, populations, or conditions measure for the topic. Factor 5 – The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic. Factor 6 – The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic. Factor 7 – Collection or public reporting of a measure leads to negative unintended consequences other than patient harm. Factor 8 – The costs associated with a measure outweigh the benefit of its continued use in the program. Removal Factor 8 is also proposed for the Hospital Outpatient Quality Reporting Program as well as other quality reporting and value-based purchasing programs.

In weighing the costs against the benefits of a measure we evaluate the benefits through the framework of our Meaningful Measures Initiative discussed earlier in this presentation. One key aspect of patient benefits is assessing the improved beneficiary health outcome if a measure is retained in our measure set. We believe that these benefits are multi-faceted and are illustrated through the Meaningful Measures framework's 6 domains and 19 areas. This diagram depicts this vision. When these costs outweigh the evidence supporting the benefits to patients with the continued use of a measure, we believe that it's appropriate to remove a measure from a program.

Our goal is to move the ASC Quality Reporting Program forward in the least burdensome manner possible while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. To this end we are proposing to remove several measures.

These are proposals. So here is a good place to pay attention for measures that you do or do not believe should be removed.

We are proposing to remove four claims-based measures, ASC-1, -2, -3, and -4 beginning with the Calendar Year 2021 Payment Determination and subsequent

years. Note that we talked about what payment year can be affected not the data collection timeframe. Our primary basis for proposing removal of these four measures is Removal Factor 1 - "measure performance among ASCs is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made." Removal would also alleviate maintenance costs and administrative burden to ASCs associated with retaining these measures.

We are also proposing to remove ASC-8: Influenza Vaccination Coverage among Healthcare Personnel beginning with the Calendar Year 2020 Payment Determination under proposed Measure Removal Factor 8 – "the costs associated with this measure outweigh the benefits of its continued use." We initially adopted this measure based on our recognition that influenza immunization is an important public health issue and a vital component to preventing healthcare associated infections. CMS recognizes that ASCs face challenges with respect to the administrative requirements which are unique to the underlying reporting system for this measure, the National Healthcare Safety Network, or NHSN, which include annually completing NHSN system user authentication. Enrolling in NHSN is a five-step process and is estimated to require an average of 263 minutes per facility. Unlike acute-care hospitals which submit data to NSHN for multiple measures, ASCs are only required to participate in NHSN to submit data for this one measure. This may unduly disadvantage smaller ASCs, specifically, those that are not part of larger hospital systems because these ASCs do not have NHSN access for other quality reporting or value-based payment programs, and the costs associated with this measure outweigh the benefits of its continued use.

We are also proposing to remove ASC-9: Endoscopy/Polyp Surveillance: Follow-up Interval for Normal Colonoscopy in Average Risk Patients and ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use. Removal would begin with Calendar Year 2021 and for subsequent years under Measure Removal Factor 8 – "the costs associated with this measure outweigh the benefits of its continued use in the program." The costs of collection and submission of chart-abstracted measure data are burdensome for facilities. Thus, for this proposal, we discussed the availability of another required colonoscopy-related measure, ASC-12, that does not require chart abstraction and similarly contributes data on quality of care related to colonoscopy procedures. While ASC-12, which measures hospital visits following colonoscopy within 7 days of the procedure, the measure does not specifically track processes such as follow-up interval. However, we believe that by capturing data for only ASC-12 ASCs can avoid the burden costs associated with chart abstraction for ASC-9 and -10 when reporting on a measure that covers the same procedure. The potential adverse effects of removing these measures are mitigated by the existence of the same measures for gastroenterologists in the Merit-based Incentive Payment System or MIPS for the 2019 performance period in the Quality Payment Program or QPP.

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We are proposing to Remove ASC-11 beginning with the Calendar Year 2021 Payment Determination and subsequent years. ASC-11 is Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. We are proposing removal under the proposed Measure Removal Factor 8 – "the costs associated with this measure outweigh the benefits of its continued use in the program." We originally adopted ASC-11 because we believe ASCs should be a partner in care with physicians and other clinicians using their facility and that this measure would provide an opportunity to do so. However, upon reviewing this measure within our Meaningful Measures framework, we have become aware that it is overly burdensome for facilities to report this measure due to the difficulty of tracking care that occurs outside of the ASC setting. Further, only 118 facilities have reported data for this measure. This is only 2.3% of over 5,000 total facilities for all other measures. Consequently, we have been unable to uniformly offer pertinent information on how this measure assesses ASC performance. Because of the lack of sufficient data, this measure may be difficult for patients to interpret or aid their choice of where to obtain care. Thus, we believe the benefits of this measure are limited.

In the Calendar Year 2015 OPPS/ASC Final Rule we finalized the adoption of a measure we just mentioned, ASC-12, which is "Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy," and we finalized to use a reporting period of one year. At that time, we noted we would complete a dry run of the measure using three or four years of data and from the result we would review the appropriate volume cutoff for facilities to ensure statistical reliability in reporting the measure score. We are now proposing to increase the reporting period for ASC-12 from one year to three years beginning with the Calendar Year 2020 Payment Determination as our analyses indicate that a larger proportion of facilities have scores measured with higher reliability using this longer time period. The annual reporting requirements for ASCs for this measure would not change because this is a claims-based measure; however, with the three-year reporting period we are proposing that the most current year of data would be supplemented by the addition of two prior years.

On to the future. We seek to develop a comprehensive set of quality measures to be available for widespread use for making informed decisions and for quality improvement in the ASC setting.

Thus, we are requesting public comment on possible future validation of ASC Quality Reporting Program measures. Currently there is no validation of ASC measure data, and we believe ASCs may benefit from the opportunity to better understand their data and the opportunity to examine potential discrepancies. Additionally, ASCs may benefit from the opportunity to produce a more reliable estimate of whether an ASC's submitted data have been abstracted correctly and provide more statistically reliable estimates of the quality of care delivered at each selected ASC, as well as, at the national level. We believe the Hospital Outpatient

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Program validation could be a good model for the ASC Program and are requesting comment on the validation methodology in identifying one measure with which to start. The Hospital Outpatient Program required validation of its chart-abstracted measures in which the facility meets the validation requirements with respect to a calendar year if it achieves at least a 75% reliability score as determined by CMS. We are also requesting comment on the possibility of starting with only one measure, specifically ASC-13, the Normothermia outcome measure.

The measures listed here and on the next few slides are in numeric order, and we can easily view the proposed changes which include the proposed removal of ASC-1, -2, -3, -4, and -8.

On this slide we see the proposed measure removal beginning with the Calendar Year 2021 Payment Determination of ASC-9, -10, and -11. ASC-12 is being retained with an increase to the reporting period proposed.

ASC-13 and ASC-14 are newer measures, and the encounter period for these two measures began January 1, 2018. ASC-17 and -18 listed here are claims-based measures beginning with the Calendar Year 2022 Payment Determination.

This brings us to the important topic of commenting. We very much want your comments regarding our proposals. This is your opportunity to impact development of the ASC Quality Reporting Program and its policies going forward. We look forward to your comments about our proposals.

Comments can be submitted using various methods including electronically, regular mail, express or overnight mail as well as by hand or courier. The deadline for all comments are to be received is no later than the times listed for each submission venue on September 24, 2018. Please refer to the Proposed Rule for the necessary addresses and keep in mind that you must send in your comments so that they are received by the deadline. We encourage the electronic submission of comments, and a direct link for this is on this slide in our blue lettering. Responses to comments will be published in the Final Rule which is scheduled for display on November 1, 2018. You can use the direct link here on this slide to access the comment section directly. And with this we conclude our discussion on the Proposed Rule. I can now return the presentation to Karen.

Karen VanBourgondien: Thank you Anita. We appreciate your time in discussing the Proposed Rule with us. We do have the direct link to the Proposed Rule and the direct link to comment both of which Anita discussed earlier, and remember, you do make a difference, so please submit your comments regarding the Proposed Rule. As a reminder, we will send out a ListServe when the Final Rule is published. We will also bring forth this information to you in the form of a webinar. CMS will

present the Final Rulings and discuss them in some depth similar to what we did today with the Proposed Rule. So, don't miss that. It's a great way to know what the changes are for the program, what they will be, and it'll assist you in dealing with any changes that may be forthcoming for this program. We will notify you of the date of the webinar for the Final Rule via ListServe. We do have an enormous amount of resources, tools, and documents on our website at www.qualityreportingcenter.com. Once the Final Rule is published all of those documents, resources, and tools will be updated to reflect any changes as a result of the Final Ruling. Additionally, we will have a Specifications Manual webinar likely in January, and that webinar will discuss any changes that will affect the manual based on the Final Ruling. A ListServe will be sent out announcing that webinar, so be on the lookout for that towards the end of the year and after the Final Rule. If proposals are finalized as they are proposed, the only measure immediately affected will be ASC-8, the flu vaccination measure, and what that means to you is you would not report for that measure in May of 2019. As Anita mentioned, the comment period is the first business day after 60 days from the display of the Proposed Rule. So, for any method other than the electronic method used for commenting, the deadline is 5:00 pm EST on September 24, 2018. For commenting electronically, the deadline is 11:59 pm on the same day of September 24. All comments are read and are addressed in the Final Rule. It's a good way to see what others are thinking of the proposals put forth by CMS. So, again, please have your comments in by the deadline of September 24. CMS does encourage electronic submission of comments.

Anita, it looks like we have a little bit of time. I wonder if you wouldn't mind responding to some of the questions we've received in the chat box. There are a few that seem to be asked by multiple people.

Anita Bhatia: That would be great Karen.

Karen VanBourgondien: Ok, Anita, the first question is, if they finalize removal of ASC-9 and ASC-10, when would we stop submitting that data?

Anita Bhatia: That's a good question Karen. The answer is, if the removal of ASC-9 and -10 is finalized as proposed, the last time you will report data for these measures would be in the 2020 submission period using your data from 2019 encounters. Removal of these measures from the program would then begin with the Calendar Year 2021 Payment Determination.

Karen VanBourgondien: Anita, here's another question, and the question is, if CMS removes ASC-1 through 4, will they replace these measures with alternate measures submitted via Medicare FFS claims data?

Anita Bhatia: That's another very good question. ASC-1 through 4 are very important patient safety-related measures. However, the answer is, that any additions or changes to the program will go through the rule-making process.

Karen VanBourgondien: Thank you Anita. Another question is regarding Factor 1, and they are asking why it is necessary to clarify Factor 1?

Anita Bhatia: I can understand why there might be questions regarding this particular proposal. We are clarifying the process for calculating the truncated coefficient of variation or TCOV with respect to measures like ASC-1 through -4 because these measures have maintained a very low rate which is the preferred outcome by utilizing the mean of the non-adverse events in our calculation of the truncated coefficient of variation. The results are comparable to those calculated for other measures where the preferred outcome is a high level or high rate of performance, and thus allow us to assess rare event measures by still using our previously finalized "topped-out" criteria.

Karen VanBourgondien: Thank you, Anita. We have time only just for one more question, so let me ask this one. Why is CMS proposing to start validating ASC measure data with ASC-13?

Anita Bhatia: Well Karen, first, let's clarify this question. We are asking for comments on potential validation schemed for the ASC Quality Reporting Program, so we aren't proposing to begin validation with ASC-13, but we are considering utilizing ASC-13 as a starting point. We chose ASC-13: Normothermia outcomes because it assesses surgical cases and has a larger population of cases from which to obtain a sample to validate. We're requesting comments from the ASC community on whether the validation policies of the Hospital Outpatient Quality Reporting Program would be an appropriate model for the ASC Quality Reporting Program and whether ASC-13 would be a good place to start.

Karen VanBourgondien: Thank you Anita. Thank you for that clarification. That's all the time we have today. Thank you, Anita, so much for discussing the Proposed Rule and responding to some questions. We all always appreciate it. That's all for us today.