



Quality Reporting Program

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CY 2020 OPPTS/ASC Proposed Rule: Ambulatory Surgery Center Quality Reporting (ASCQR) Program

Presentation Transcript

Speaker:

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Karen: Hello everyone and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the education lead for the ASC Quality Reporting Program.

Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for the ASCQR Program and has been with the program since its inception in 2014. She received her PhD from the University of Massachusetts Amherst and her Master's in Public Health from Johns Hopkins University. Dr. Bhatia plays a crucial role in the development of the OPPTS ASC proposed and final rulings. Her contributions to the rulings are essential to the continuing success of this program. We are fortunate to have Dr. Bhatia's commitment to this program. Before I hand things over to Anita, let me just briefly cover a few housekeeping items.

Anita will be going over proposals for the Ambulatory Surgical Center Program contained in the CY 2020 OPPTS/ASC Proposed Rule with us today, and she will also briefly discuss the way CMS is navigating us all to success through the various quality programs, initiatives, and goals. Additionally, by reducing the traffic congestion, or provider burden, CMS will assist providers with their involvement in quality reporting and improving patient outcomes. The learning objectives for this program are listed here on this slide.

This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box, and the audio portion of today's program will be posted on our website at www.qualityreportingcenter.com at a later date. If you have not yet downloaded the slides for this presentation, you may do so on that website, and again that is qualityreportingprogram.com. Just click on today's event, and you will be able to access the slides. Additionally, the slides were attached to the email reminder that you received for this event.

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During the presentation, if you have a question, please put that question in the chat box, that you can see on your screen. And please note that the raised hand feature is not monitored during this presentation. So again, if you have a question, just put it in that chat box, and one of our subject matter experts will respond.

Let me just mention a standard disclaimer before we get started. CMS can only address procedural questions 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.

Now, without further delay, let me turn things over to our speaker, Dr. Bhatia. Anita.

Anita: Hello everyone! Thank you for attending our presentation today. Before I delve into our proposals for the Ambulatory Surgical Center Quality Reporting Program contained in the current Proposed Rule, let me begin by outlining the current CMS quality reporting program framework for our vision for quality reporting. The reason for this discussion is that we change and refine our programs through rulemaking, but we are working toward specified goals; our current working model with these goals is the Meaningful Measures Initiative.

CMS launched the Meaningful Measures Initiative in October of 2017. The purpose of this initiative is to provide a new approach to quality measurement and reporting. This initiative evolved from CMS's increased understanding of the quality reporting terrain having experienced all the curves and bumps over the years. Further, CMS is adapting to the terrain to keep the quality reporting programs evolving as the needs of providers and other stakeholders also evolve.

So, are you thinking, what is the purpose of the Meaningful Measures Initiative and what are the intended benefits?

Great thinking out there! There are several reasons why the Meaningful Measures initiative is beneficial to Medicare beneficiaries, patients, as well as clinicians and healthcare providers. This Initiative identifies high priority areas for quality measurement and improvement with the goal of improving outcomes for patients, their families, and providers while also reducing burden on clinicians and providers to the extent possible.

So, here we see a graphic of the Strategic Goals of the Meaningful Measures Initiative putting the patient first here in the center; the patient is to be supported by CMS initiatives including Patients over Paperwork, Rethinking Rural Health, Price Transparency, Better Care for Dual Eligibility, eMedicare, Fighting the Opioid Epidemic, Modernizing Medicare, Innovation, Lowering Drug Prices, and MyHealth Edata. These supporting initiatives promote the larger goals of Strengthening Medicare, Transforming Medicaid, Marketplace Choice and

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Affordability, Protecting Taxpayer Dollars, Ensuring Safety and Quality, and Innovating Payment Models. The outer layer contains the overarching principles of Empowering Patients, Unleashing Innovation, and Focusing on Results. This slide shows the objectives CMS is seeking for its quality measures.

This framework will allow Ambulatory Surgical Centers, Medicare beneficiaries, and other stakeholders to obtain meaningful quality of care information about the care delivered in Ambulatory Surgical Centers. As shown here, we want to incentivize quality improvement while streamlining the measure sets to reduce duplicative measures and program complexity.

Our Ambulatory Surgical Center Quality Reporting Program proposals 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.

We seek quality measures that relate to Meaningful Measurement Areas. These areas are the connectors between the CMS Strategic Goals we discussed where the patient is the focus and is supported by CMS initiatives for achieving high quality outcomes for patients. Meaningful Measurement Areas can focus efforts on the quality areas to:

- Promote alignment across quality initiatives and programs which will minimize provider burden
- Promote more focused quality measure development towards outcomes that are meaningful to patients, families, and their providers
- Identify the big picture quality issues that are the highest priority in improving the health and healthcare of patients and communities. And to
- Communicate how CMS programs and measures improve patients' health and how we plan to deliver value, better care, smarter spending, healthier communities, to meet the needs of patients.

ASC-1 through ASC-4, the never events, such as patient burn, patient fall, etc., are in the Meaningful Measures Area of Preventable Healthcare Harm. As noted on this slide, data submission for these measures is currently suspended, but these measures remain in the program and later on in the presentation we will discuss a proposal for these measures.

ASC-9 and ASC-10, two colonoscopy measures, fall under the Preventive Care category for Meaningful Measures. ASC-10 was finalized for removal from the program in the Calendar Year 2019 Final Rule.

ASC-11, the improvement in visual function after cataract surgery measure, is in the Meaningful Measures area of Seamless Transfer of Health Information.

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ASC-12, the hospital visit rate after colonoscopy measure, falls under Admissions and Readmissions to Hospitals.

The measures ASC-13, (normothermia), ASC -14 (unplanned anterior vitrectomy) measures, ASC-17 (hospital visits after orthopedic surgeries) and ASC-18 (hospital visits after urology surgeries), all fall under the Preventable Healthcare Harm area. Lastly, the OAS CAHPS survey measures, ASC 15a through 15e, which have been delayed, are under Patient's Experience and Functional Outcomes.

So, we have scheduled construction! As mentioned, a goal of the Meaningful Measures Initiative is to reduce burden associated with our quality reporting programs to the extent possible. To initiate program changes, that is construction, we must utilize the rulemaking process. Now let's discuss what changes to the Ambulatory Surgical Center Quality Reporting Program are being proposed in the CY 2020 OPPTS/ASC Proposed Rule.

Here we have a proposal to adopt one new measure, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers, for the Calendar Year 2024 payment determination and subsequent years.

As you are likely aware, the majority of all surgeries, nearly 70%, in the US are performed in an outpatient setting with an expanding number and variety of procedures being performed at stand-alone ASCs.

While ambulatory surgery is considered low-risk for complications, there are well-described and potentially preventable adverse events that can occur after ambulatory surgery leading to unplanned care at a hospital, such as emergency department visits, observation stays, or hospital admissions.

Quality measurement of unplanned hospital visits following general surgery procedures performed at ASCs coupled with transparency through public reporting, can make these outcomes more visible to Medicare beneficiaries, patients, and other stakeholders. This measure can provide information about the quality of care that can be used by patients when making decisions about what facilities to utilize for care.

This measure was developed in conjunction with ASC-17: Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures and ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures.

All three measures assess the same patient outcome for care provided in the ASC setting and use the same risk-adjustment methodology. These three measures

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differ in surgical procedures considered, which are orthopedic, urological, and general surgery.

This new measure aligns with the Admissions and Readmissions to Hospitals and Preventable Healthcare Harm domain of our Meaningful Measures Initiative. This measure was also included on the List of Measures under Consideration for December 1, 2017.

Here are some specifics about this new measure. The ASC-19 measure is claims-based and uses Part A and Part B Medicare administrative claims and Medicare enrollment data to calculate the measure. We are proposing that the data collection period for the proposed ASC-19 measure would be the 2 calendar years ending 2 years prior to the applicable payment determination year. For example, for the Calendar Year 2024 payment determination, the data collection period would be calendar years 2021 to 2022. Because the measure data are collected via claims, ASCs will not need to submit any additional data directly to CMS.

This measure's metric reports a risk-standardized ratio because the diverse mix of procedures included in ASC-19 can have varying levels of risk of unplanned hospital visits. As discussed in more detail in the proposed rule, the ASC-17 and ASC-18 claims-based measures which also look at hospital visits following specified procedures at an ASC.

The patient cohort for the proposed ASC-19 measure includes all Medicare beneficiaries ages 65 and older undergoing outpatient general surgery procedures at an ASC who have 12 months of Medicare Fee for Service (Medicare Parts A and B) enrollment. The target group of procedures includes those that are 1. routinely performed at ASCs, involve some increased risk of post-surgery hospital visits, and 2. are within the scope of general surgery training.

This measure does not include gastrointestinal endoscopy, endocrine, or vascular procedures, other than varicose vein procedures, because these procedures, reasons for hospital visits are typically related to patients' underlying comorbidities. Again, more details on these statistical considerations are contained in the proposed rule.

Procedures included in the measure cohort are on Medicare's list of covered ASC procedures, for example, abdominal, alimentary, breast, etc.

CMS developed this list to identify surgeries that have a low-to-moderate risk profile. Surgeries on the ASC list of covered procedures do not involve or require major or prolonged invasion of body cavities, extensive blood loss, major blood vessels, or care that is either emergent or life threatening. CMS annually reviews and updates this list for the Medicare program and the agency includes a

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transparent public comment submission and review process for addition and removal of procedure codes.

Again, as we stated, for the ASC-19 measure as well as our other claims-based, hospital event measures, we define an unplanned hospital visit as including an ED visit, observation stay, or unplanned inpatient admission; planned inpatient admissions are not included.

To ensure that all patients included under this measure have complete data available for outcome assessment, the measure calculation excludes patients who survived at least 7-days following general surgery procedures at an ASC but were not continuously enrolled in Medicare Fee for Service that's Medicare Parts A and B) during the 7-days after surgery. There are no additional patient inclusion or exclusion criteria for this proposed measure.

If the ASC-19 measure is adopted, CMS would publicly report results only for facilities with sufficient case numbers to meet moderate reliability standards.

OK, so here are some statistical notes. CMS will determine the case size cutoff for meeting moderate reliability standards by calculating reliability at different case sizes using the ratio of true variance to observe variance during the measure dry run. We would provide confidential performance data directly to all facilities, including those which do not meet the criteria for sufficient case numbers for reliability considerations, so that all facilities can benefit from seeing their measure results and individual patient-level outcomes. We believe that the measure will provide beneficiaries with information about the quality of care for general surgery procedures in the ASC setting. In addition, we believe that these data may help ASCs track their patient outcomes and provide information on their cases that facilities can use to improve quality of care.

CMS intends to conduct a dry run which is a preliminary test data analysis before the official data collection period or any public reporting. To review, a dry run is a period of confidential reporting and feedback during which ASCs may review their preliminary measure results, and in addition, become more familiar with the measure methodology and ask questions. For this dry run, CMS will use the most current 2-year set of complete claims, usually 12 months prior to the start date, available at the time of the dry run.

For example, if the dry run began in June 2020, the most current 2-year set of data available would likely be July 2017 to June 2019. The dry run would generate confidential feedback reports for ASCs, including patient-level data indicating whether the patient had a hospital visit and, if so, the type of visit (ED visit, observation stay, or unplanned inpatient admission), the admitting facility, and the principal discharge diagnosis. These confidential dry run results would not be publicly reported and would not affect payment.

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Our GPS indicates system updating! Yes, we strive to continually update and improve our program. As stated, we are moving towards greater use of outcome measures and away from the use of clinical process measures across our Medicare quality reporting programs to better assess the results of care. Through future rulemaking, we intend to propose new measures that support our goal of achieving better health care and improved health for Medicare beneficiaries and other patients who receive health care in the ambulatory surgical setting.

ASC 1 through ASC 4: In this proposed rule, we are considering one topic for future implementation: updates to the data submission method for ASC-1: Patient Burn, ASC-2: Patient Fall, ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant, and ASC-4: All-Cause Hospital Transfer/Admission.

In the CY 2019 OPPTS/ASC final rule, we expressed our concern that the data submission method for these measures may impact the completeness and accuracy of the data due to the inability of ASCs to correct errors in submitted Quality Data Codes, or QDCs, that are used to calculate these measures. A facility that identifies an error or has missing QDCs is unable to correct or add a QDC if the claim has already been submitted to Medicare and been processed. We stated that revising the data submission method for the measures would address these issues and allow facilities to correct any data submission errors, resulting in more complete and accurate data. We believe that these measures provide critical data to Medicare beneficiaries and further transparency for care provided in the ASC setting that can be useful in choosing an ASC for care.

As the ASC-1 through ASC-4 measures are important, in this proposed rule, CMS is requesting comment about the potential to make future updates to the data submission method. Specifically, we are considering updating the data submission method. We believe that using a CMS online data collection tool would address our concern about the ability of ASCs to correct data submission errors because ASCs would simply report their data via the online tool.

The data collection time period for quality measures for which data are submitted via a CMS online tool is for services furnished during the calendar year 2 years prior to the payment determination year. ASCs would then submit their data for ASC-1, ASC-2, ASC-3, and ASC-4 via QualityNet during the data submission period, January 1 through May 15 in the year prior to the payment determination year. ASCs would be able to submit and modify their data throughout the data submission period and could correct any errors during this period.

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So, here are the current Ambulatory Surgical Center Quality Reporting Program measures for the CY 2021 payment determination year. The measures here and on the next few slides are in numeric order so that we can easily view the current status of each measure.

To begin, the claims-based measures ASC-1 through ASC-4 have been suspended, pending further rulemaking decisions which we just discussed. So, please comment. We want to know your thoughts about these measures and possible changes in data submission method for these measures.

There were no proposed changes to the measures listed on this slide. A few points of interest here are:

- ASC-11: Cataracts, Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, remains voluntary.
- ASC-12: Facility 7 Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy is claims-based and does not require active abstraction and reporting on the part of the ASC.
- ASC-13: Normothermia and ASC-14: Unplanned Anterior Vitrectomy are new and were reported for the first time with the last data submission back in May.
- ASC-15a through 15e, the OAS CAHPS measures remain delayed.

For the CY 2022 payment determination year, we have ASC-17, -18,

ASC-17 and ASC-18 are hospital visit measures and are claims-based. These measures begin with the Calendar Year 2022 Payment Determination. If the proposal for ASC-19 is finalized, the results for this measure would apply beginning with the Calendar Year 2024 Payment Determination. And that sums up our proposals for this year's CY 2020 OPSS/ASC proposed Rule.

Now we are going to discuss how to comment on the proposals within the Proposed Rule. I really want to emphasize, and I can't say this enough, we very much want your comments. This is your opportunity to impact the measure development process and policy proposals. CMS truly benefits on receiving comments on our proposals. So, let's go over how to submit your comments.

So, submitting comments; comments can be submitted using various methods including electronically, regular mail, express or overnight mail. The deadline for all comments to be received is no later than the times listed for each submission venue on September 27, 2019. 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 I do have a direct link on this slide for electronic submission of comments.

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Responses to comments will be published in the Final Rule which is scheduled for display on or around November 27, 2019.

For your convenience, I have the direct links placed here for both the Proposed Rule and the link to comment. Please comment. We really want to hear from you with regard to these proposals. This concludes our discussion for today. Now, let me turn things back over to Karen. Karen?

Karen: Thank you, Anita. It is great to have you here and have CMS' perspective to explain the Proposed Rule. Anita, since we have a few minutes, can we go over some of the questions that have come into the chat box. That will give you the opportunity to respond to some of these questions

Anita: Sure, Karen.

Karen: OK, so here is the first question. CMS is proposing a new measure, ASC-19, but the proposed rule state that it does not go into effect until the 2024 payment determination year. Why is this beginning so far ahead?

Anita: Great question, Karen! The proposed data collection period for ASC-19 is comprised of 2 calendar years which ends 2 years prior to the applicable payment determination year. Due to the length of the collection and reporting period for this proposed measure, more planning time is required

ASCs will not need to submit any additional data directly to CMS because the measure data are collected via claims. So, for the CY 2024 payment determination, the data collection period would be calendar years 2021 to 2022. Remember, there is a dry run before the official data collection period or any public reporting. The dry run will use the most current 2-year set of complete claims available at the time of the dry run and this typically occurs 12 months prior to the measure reporting start date. If the dry run begins in June 2020, then the most current 2 year set of data would likely be July 2017 through June 2019. Only paid, final action Medicare claims are used. We feel beginning with CY 2024 payment determination is reasonable for this new measure as this process takes time.

Karen: Great, thank you, Anita, and here's another question that is very, very common and I will take this question. The person wants to know, can you clarify the term Calendar Year and Payment Determination Year. And again, we get this question a lot. Alright, so very simply put, the term calendar year designates a specific time period which is just that, a calendar year; the time frame of January first through December thirty-first for any given year. The payment determination year refers to the year your ASC receives payment for the data you reported; for example, a CY 2020 payment determination made in 2019 would affect payments occurring for services provided in 2020. So, another way to look at that is you have patient

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encounters in 2019, you enter that data into QualityNet in 2020, and you get paid for that in 2021. And that would be your payment determination year. I hope that clarifies things a little bit.

Karen: Here's a great question, because I know you love to have people comment, and the question is; What does CMS do with the comments, and why should we comment?

Anita: Yes, Karen, we do enjoy the comments that we receive. I cannot stress enough the importance of commenting. Having your input and feedback is essential. This is your opportunity to effect policy making decisions. There have been many occasions where we did not move forward with a proposed measure or concepts after receiving your comments and feedback. Responses to your comment are published and can be read in the Final Rule. Please remember to submit your comment by the deadline of September 27, 2019.

Karen: Great, thank you Anita, appreciate that. Next question, this is a good question; I thought the measures ASC-1 through ASC-4 were removed. Why are we proposing a new submission method for them?

Anita: Karen, thank you for giving me the opportunity to clarify the status of ASC-1 through ASC-4. ASC-1 through ASC-4 were not removed from the program, data collection for these measures were suspended. In the CY 2019 Final Rule, we expressed concern that the data submission method for these measures may impact the accuracy and completeness of the data. By submitting data for these measures through Quality Data Codes, or QDCs, ASCs were not able to correct or add QDCs if the claim had already been adjudicated, and we believed that revising the data submission method would address these issues. These measures are important and provide crucial data to beneficiaries and further transparency for care provided in the ASC setting. Please provide your feedback on this issue. This will assist us in any potential future updates.

Karen: Oh, Anita, here's a question about the Specifications Manual, and I can go ahead and answer that. And the question is: I saw the Specifications Manual 9.0 came out. Is that the manual that we use now for data collection and reporting? And again, this is a great question, we actually get these types of questions a lot. So, the 9.0 Version of the Specification Manual is for the reporting period, or what some folks refer to as the Patient Encounter Period, for January 1, 2020, through December 31, 2020. So, you would use that Version for the data that you will be reporting to CMS for Payment Determination Year 2022. To submit your data for Payment Determination 2021, you would use the Specifications Manual Version that uses Encounter dates of January 1, 2019 through December 31, 2019. I hope that clarifies that question.

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Here's the next question; we are hearing a lot about the Meaningful Measures Initiative. What is the benefit of this initiative, particularly across programs?

Anita: The Meaningful Measures Initiative was developed collaboratively with the input from a wide variety of stakeholders. This Initiative also draws on previous work performed by the Health Care Payment Learning and Action Network, the National Quality Forum, the National Academies of Medicine, and other Federal Agencies. This initiative includes perspectives from patient representatives, clinicians and providers, measure developers, and other experts such as the Core Quality Measures Collaborative. Meaningful Measures will help programs identify and select individual measures. Meaningful Measure areas are intended to increase measure alignment across CMS programs and other public and private initiatives. Additionally, the Meaningful Measures Initiative will point to high priority areas where there may be gaps in available quality measures while helping guide CMS's effort to develop and implement quality measures to fill those gaps.

Karen: OK, great, this is a good question, the question is; What does it mean that the removal of the measure is being "proposed?" What determines if the removal will be finalized or not?

Anita: Yes, Karen, this is another really good question. CMS proposes changes and then opens a public comment period for 60 days, which we are in right now. During this time feedback and comments are gathered from providers and stakeholders and utilized by CMS to finalize these proposals. These proposals are then issued in the final rule, which is typically published in November.

Karen: Next question, and Anita if you don't mind, I can take this one as well, and the question is: How do we report the Orthopedic Measure ASC-17? And the answer is ASC 17, Hospital Visits after Orthopedic Ambulatory Surgery Center Procedures is a claims-based measure, so what that means is that data are collected from paid Medicare claims that meet the measure criteria. No manual abstraction is necessary on the part of the ASC. You do not have to abstract data or enter it into QualityNet. All that data is collected from paid Medicare claims.

So here is a question, and Anita I can respond to this one as well. The person wants to know: I am aware that the ASC-1 through ASC-4 measures were suspended in last year's rule making cycle, however, is there any penalty for our ASC if we are continuing to apply those quality data codes. And the answer is No. Yes, you are correct in that those measures were suspended, they are not currently required, but there is no penalty if your ASC is applying those Quality Data Codes. It's not an issue

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OK, I think we have time for just one more question, Anita, this is not really specifically to the proposed rule, but we have gotten this question quite a bit. The question is: For the ASC-13 measure, do we count just Medicare patients, or do we count Medicare, Medicare replacement, and private insurance patients?

Anita: OK Karen, for ASC-13, Normothermia, you would use Medicare and Non-Medicare data. The denominator requirements in the ASC Specification Manual, specify that “All patients, regardless of age, undergoing general or neuraxial anesthesia of greater than or equal to 60 minutes duration.”

Karen: Great, thank you. Anita, that’s about all the time that we are going to have for questions. I really do thank you for being here and explaining the proposals and responding to the questions. So right now, I am going to turn things back over to our host. Thank you everyone for joining us today and have a great day.