Ambulatory Surgical Center Quality Reporting Program

Support Contractor

CY 2017 OPPS/ASC Proposed Rule: Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Presentation Transcript

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July 27, 2016
2:00 p.m.

Karen VanBourgondien: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. Thank you so much for joining us today.

Before we begin today's program, I would like to highlight some important dates and announcements. January 1st began the submission period for the web-based measures that are entered through QualityNet. The submission deadline is August 15, 2016. Hopefully, you did meet the May 15th deadline for this submission of the ASC-8 flu measure.

Please be sure to keep your QualityNet and NHSN passwords active by logging into your accounts on a routine basis. If you do not routinely access these accounts, they will become locked. The easiest way to avoid this issue is to log in about every 60 days or so. If you have any problems with your log-in capabilities for QualityNet, please contact their help desk directly at the number you see here on this slide. And if you have any problems with your NHSN account, please contact them directly at the email you see here.

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

We have two representatives from CMS today, and we do appreciate their time in lending their expertise with regard to the information they will share with us today. Our first speaker is Dr. Anita Bhatia. Anita is the program lead for the ASCQR Program and has been with this program since its inception in 2012. 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 OPPS proposed and final rulings. Her contributions to the rulings are essential to the continuing success of the ASCQR Program. We are very fortunate to have Dr. Bhatia's commitment to this program.

Our second speaker is Dr. Elizabeth Goldstein. Since 1997, Elizabeth has been working on the development and implementation of the Consumer Assessment of Healthcare Providers and Systems surveys in a variety of settings. She is responsible for a number of the surveys administered by CMS, the Part C Star Ratings, the Star Ratings for Medicare Advantage Quality Bonus Payment, Medicare HEDIS Data Collection, and Part D Enrollment Analysis. Without further ado, let me turn it over to our first speaker, Dr. Bhatia. Anita?

Anita Bhatia: Thank you, Karen. Greetings, everyone. We are going to begin speaking about locating the rule.

This slide shows some ASC Quality Reporting Program rule history highlights. We began talking about the ASC Quality Reporting Program, but we did not implement anything until – further along the line, you could see that we have some mention in every calendar year rule from 2009 to our present 2017. We had one odd year where we had a rule in the Fiscal Year 2013 IPPS Rule. I point this out because that rule did finalize our first requirements for the program.

This year, for calendar year 2017, one – our highlight is that we are looking at some new measures for the program.

This slide shows the homepage for the *Federal Register*. On this screenshot, you can see that we've copied and pasted the volume number "81 FR" for *Federal Register* and then the page number. This page number is where the ASC Quality Reporting Program requirement section began. Next, click the magnifying glass in the search box to start the search, and this is what you will see. It will take you directly to the proposed rule.

Now, let's look at the highlighted box that reads "Jump directly to page 45727" in looking at how to navigate the *Federal Register*. When you click on the page number, it will take you directly to that page.

Next, on this slide, you would scroll down a bit, and you'll see the start of the ASC Quality Reporting Program section. This section begins with Roman numeral XIV. Now, this view of the proposed rule is one long column of text. Some people like to view the rule this way, but many others prefer to view the rule as a PDF.

Let's go back to the previous slide. This time, I've highlighted the PDF link seen here surrounded by this red box. And when you click on this, this will take you to the PDF version of Volume 81 of the *Federal Register*. This is how the *Federal Register* appears if you would print it out. You can use your **Find** feature to look for page 45727, the first page of the ASC Quality Reporting Program requirements portion of the proposed rule.

And here you are; here's the beginning of our section. You can see that we're in Volume 81 of the *Federal Register*, page 45727, and the ASC Quality Reporting Program requirements section begins at Roman numeral XIV. So, you see here in our respective red boxes *Federal Register* Volume 81, the page number, and the title of our section.

Now we're going to go and talk about some proposed new measures for the program – new measures. We are proposing to adopt seven new measures. We are proposing to adopt these measures so that they would affect the calendar year 2020 payment determination as well as subsequent years. We are proposing that two of these seven measures will be collected via a CMS web-based tool; whereas, five measures are survey-based measures, and these are the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems, also known as OAS CAHPS, survey-based measures.

So, for the two web-based measures, we are proposing that these two measures – ASC-13, the Normothermia Outcome measure, and ASC-14, the Unplanned Anterior Vitrectomy measure – would be adopted for the calendar year 2020 payment determination and subsequent years.

Note that we have other measures that have been adopted for the program, so we number our measures. This is the latest in our line of measures for the program. This would be ASC-13, Normothermia Outcome. Normothermia

Outcome is the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the Post Anesthesia Care Unit, or PACU.

We are proposing that data submission to CMS would be January 1st to May 15th in the year prior to the affected payment determination. This is if a proposal that we will talk about later in this presentation that the data submission deadline would be May 15th is finalized.

For this measure, it consists of a numerator and denominator. The numerator is the number of surgery patients with a body temperature equal to or greater than 96.8 degrees Fahrenheit or 36 degrees Celsius recorded within 15 minutes of arrival in the PACU. The denominator for this measure is all patients regardless of age undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes in duration.

There are some inclusions and exclusions for this measure. This measure includes all patients regardless of age undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration as outlined in the denominator, but the measure does exclude patients who did not have general or neuraxial anesthesia. It excludes patients whose length of anesthesia was less than 60 minutes, and it excludes patients with documentation of intentional hypothermia for the procedure performed.

This measure – ASC-13, the Normothermia Outcome measure – was included in the Measures Under Consideration, or MUC, list in December of 2014. The Measure Applications Partnership, or MAP, reviewed the measure and conditionally supported it. This measure is maintained by the ASC Quality Collaboration, who is the measure developer and measure steward. Their website can be found here at www.ascquality.org. Additional methodology and measure developmental details for this measure are available at their website in the Quality Measures section.

Our next measure, ASC-14, is the Unplanned Anterior Vitrectomy measure. This measure measures the percentage of cataract surgery patients who have an unplanned anterior vitrectomy. Similar to the ASC-13 measure, we are proposing that the data submission to CMS would be January 1st to May 15th of the year prior to the affected payment determination. So, since we are proposing to have this measure affect the calendar year 2020 payment, we would be looking at having data submitted in 2019 for that determination.

The denominator for this measure, which is all of the patients that you'd be looking at in consideration for this measure, would be all cataract surgery patients. The numerator, or the cases, for this measure are all cataract surgery patients who had an unplanned anterior vitrectomy. There are no additional inclusion or exclusion criteria for this measure.

ASC-14, the Unplanned Anterior Vitrectomy measure, was included in the MUC list in December of 2014. The MAP reviewed this measure and conditionally supported it. This measure is also maintained by the ASC Quality Collaboration, who is the measure developer and measure steward. Additional methodology and measure development details are available from them on these websites, which are the same as the ones that were listed for ASC-13.

This concludes discussion of the new measures that are web-based. I am now going to turn the discussion over to Dr. Goldstein who will discuss the survey-based measures.

Elizabeth Goldstein: Thank you very much. Today, I am going to be talking about the survey-based measures. Currently, there's no standardized survey available to collect information on the patient's overall experience for surgeries or procedures performed within a hospital outpatient department or an ambulatory surgery center. Some facilities are conducting their own surveys and reporting these results on their websites, but there is not one standardized survey to allow valid comparisons across facilities.

Patient-centered experience measures are a component of the 2016 CMS Quality Strategy, which emphasizes patient-centered care by rating patient experiences as a means for empowering patients and improving the quality of their care. In addition to information on patient experience with care at the facility, it is an important quality indicator to help providers and facilities to improve services furnished to their patients and to assist patients in choosing a facility in which they seek care.

The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems survey, which is referred to as OAS CAHPS, was developed as part of the U.S. Department of Health and Human Services Transparency Initiative to measure patient experiences with care in the hospital outpatient department as well as ambulatory surgery centers.

The survey contains 37 questions that cover topics such as access to care, communications, experience at the facility, and interactions with facility staff. Facilities can elect to have up to 15 supplemental questions to the survey. It's important to note that these supplemental questions are not submitted to CMS.

The survey development process follows the principles and guidelines outlined by the Agency for Healthcare Research & Quality, which is part of Health and Human Services. And they work with the CAHPS Consortium, which is a group of research organizations across the country that help develop CAHPS surveys.

The OAS CAHPS Survey is administered to all eligible patients or a random sample of eligible patients. These patients have to have at least one outpatient surgery or procedure during the applicable month. All data collection and submission for the OAS CAHPS Survey measure is done at the CCN level, and all eligible facilities in the CCN would be required to participate in the survey.

Therefore, the survey data reported for CCN must include all eligible patients from all locations under the CCN. Facilities that share the same CCN must combine data for collections and submissions for the survey across their multiple facilities. These results would then be publicly reported on Hospital Compare, as they apply to a single CCN or facility. If a facility's data are submitted after the data submission deadline, it will not fulfill the OAS CAHPS quality reporting requirement.

The proposed survey has three administration methods. The first one is mail-only, the second one is telephone-only, and the third one is mixed mode, which is mail with telephone follow-up of non-respondents. We began voluntary national implementation of the OAS CAHPS Survey in January 2016.

To ensure that patients respond to the survey in a way that reflects their actual experiences with care and is not influenced by the facility, we are proposing that facilities must contract with a CMS-approved OAS CAHPS Survey vendor to conduct or administer the survey. We believe that a mutual third party should administer the survey on behalf of all facilities. It is also our belief that an experienced survey vendor will be best able to ensure reliable results.

We will propose a format and timing for public reporting of OAS CAHPS Surveys in future rulemaking prior to implementation of the measures. Because calendar year 2016 is the first year of voluntary national implementation through the OAS CAHPS Survey, we believe using data from the voluntary national implementation will help inform the displays for public reporting of the survey. We are not proposing a format and timing for public reporting of OAS CAHPS Survey data at this time.

We are proposing that the data collection period for the OAS CAHPS Survey measures would be the calendar year two years prior to the applicable payment determination year. For example, for the calendar year 2020 payment determination, facilities would be required to collect data on a monthly basis and submit this collected data on a quarterly basis for January 1, 2018 through December 31, 2018 data. This would be required for the calendar year 2020 payment determination. Facilities, through their CMS-approved survey vendor, would be required to collect data on a monthly basis and report that data to CMS on the facility's behalf by the quarterly deadlines established for each data collection period.

To ensure reliability of the reported result, a target minimum of 300 completed surveys has been set for each facility over each 12-month reporting period. This is an average of 25 completed surveys per month. We realize that some smaller facilities may not be able to meet this target minimum. However, we believe it is important that we still capture patient experiences of care for these smaller facilities. Therefore, except exempt facilities, those facilities receiving less than 300 completed surveys over each 12-month reporting period will be included in the OAS CAHPS Survey-based measures.

On the other hand, a facility that treats a high volume of patients may choose to administer the OAS CAHPS Survey on a random sample of its eligible patient population. For anyone needing more information regarding the survey, they should see the protocols and guidelines manual. That link is shown on the bottom of this slide.

We understand that facilities with lower patient census may be disproportionally impacted by the burden associated with administering the survey and the resulting public reporting of OAS CAHPS Survey results. Therefore, we are proposing that facilities may submit or request to be exempted from participating in the OAS CAHPS Survey-based measures if they treat fewer than 60 survey-eligible patients during their eligibility period. The eligibility period is a calendar year before the data collection period. For

example, for the calendar year 2020 payment determination, this exemption request would be based on treating fewer than 60 survey eligible patients in calendar year 2017, which is a calendar year before the data collection period of 2018 for the calendar year 2020 payment determination. All exemption requests will be evaluated and reviewed by CMS.

To qualify for the exemption, facilities must submit a participation exemption request form. For example, the deadline for submitting an exemption request form for the calendar year 2020 payment determination would be May 15th, 2018. We've determined the May 15th deadline in order to align with the deadline for submitting web-based measures and because we believe this deadline provides facilities sufficient time to review the previous year's patient list and determine whether they are eligible for an exemption based on patient population guides.

Facility rates on each composite OAS CAHPS Survey-based measure would be calculated by determining the proportion of top-box responses. That is **Yes** or **Yes, Definitely**, depending on the question. We would then average these proportions over all questions in the composite measures, so it's important to note that the composite measure consists of multiple survey items. For example, to assess facility performance on the composite measure ASC-15a, which is about facilities and staff, we would calculate the proportion of top box responses for each of the measure's six questions, add those proportions together, and divide by the number of questions in the composite measure that is fixed for this measure.

Facility performance on each of the two global OAS CAHPS Survey-based measures will be calculated by the proportion of respondents providing the highest responses – that is a nine to 10 rating or **Definitely Yes** – to the survey questions over the total number of respondents. For example, if the hospital receives 45 nine and 10 ratings out of 50 responses, this hospital will receive a 90 percent raw score, which would then be adjusted for differences in the characteristics of patients across facilities for the purposes of public reporting.

The OAS CAHPS survey is administered to all eligible patients or random sample who had at least one outpatient surgery procedure during the applicable month. Eligible patients regardless of insurance or method of payment can participate. For purposes of each survey-based measure captured in the survey, an eligible patient is a patient 18 years or older. It excludes patients who reside in a nursing home, who are discharged to hospice care following their surgery or procedure, who are identified as a prisoner, and

patients that request that facilities not release their names and contact information to anyone other than facility personnel. I just want to remind you that these procedures are defined in the OAS CAHPS Survey protocols and Guidelines Manual.

There are a few categories of otherwise eligible patients who are excluded from the measures. Those exclusions are here on this slide -- patients whose address is not a U.S. domestic address, patients who cannot be surveyed because of state regulations, patients whose surgery or procedure does not meet the eligibility CPT or G-codes (and these codes are as defined in the OAS CAHPS Protocols and Guidelines Manual), and patients who are deceased.

These measures were included in the www.qualityforum.org website under the Measures Under Consideration list for December of 2014. If you need more information about these measures and the list of approved vendors, you can go to the oascahps.org website, https://oascahps.org, and the link is on the second bullet on this slide. The third bullet point link is for the OAS CAHPS Survey Questions Protocols and Guidelines Manual, https://oascahps.org/Survey-Materials.

Now, I am going to turn it over to discuss future measures.

Anita Bhatia: Thank you. We are now going to turn our attention towards a measure for future consideration. In this proposed rule, we are inviting public comment on one measure developed by the ASC Quality Collaboration for potential inclusion in the ASC Quality Reporting Program that we would put forth in future rulemaking, the Toxic Anterior Segment Syndrome, or TASS, measure.

The Toxic Anterior Segment Syndrome measure looks at this condition: TASS is an acute, noninfectious inflammation of the anterior segment of the eye. TASS is a complication of anterior segment eye surgery that typically develops within 14 hours after surgery. As stated, this measure is developed by the ASC Quality Collaboration. They are the measure developer and steward. This measure assesses the number of ophthalmic anterior segment surgery patients that are diagnosed with TASS within two days of surgery.

The type of patients that are being looked at for this measure, the denominator, is all anterior segment surgery patients. The numerator for this measure is all anterior segment surgery patients diagnosed with TASS within

two days of surgery. We invite public comment on the possible inclusion of this measure in the ASC Quality Reporting Program measure set in the future.

And here is some additional information regarding the TASS measure. The TASS measure was included in the 2015 MUC list. This measure was conditionally supported by the MAP, and the MAP noted the high value and urgency of this measure being included in a program. A summary of the MAP recommendations for this measure can be found at this website: http://www.qualityforum.org/Projects/im/MAP/2016_Final_Recommendations.aspx. The specifications for this measure in the ASC setting can be found at this website: http://ascquality.org/documents/ASC%20QC%20Implementation%20Guide%203.2%20October%202015.pdf.

In this rule, we also have some proposed changes to the existing policies. The ASC Quality Reporting Program previously finalized how data submitted to the program would be displayed when the data is displayed publicly, and it previously finalized that data will be displayed as per the level of aggregation where the data is submitted through CMS. So, data that is submitted by the National Provider Identifier will be displayed by the National Provider Identifier, or NPI; whereas, data that is submitted by the CMS Certification Number, or CCN, will be displayed by that same identifier or CCN.

In this rule, we are placing some more formalized parameters around the public display of data that is submitted for the program. So we are proposing that data submitted to the program will be available on the Hospital Compare website, which is a site that we utilize for the display of data submitted for a number of quality reporting programs including the ASC Quality Reporting Program. And this display would be on at least a yearly basis. Per statutory requirements, facilities have the right to view their data prior to it being made publicly available. We are formalizing that facilities will generally have approximately 30 days to preview their data. This is consistent with our current practice. We just have not formalized that practice.

We have a proposal to change the submission deadline for some data, and we will discuss that in a little bit. But that proposal, if finalized, would enable public reporting of data by December of the same year, which was a little bit sooner than it's possible under the current deadline scheme.

So, speaking of that and looking at data submission, we had previously finalized that quality measure data when submitted by a CMS online data submission tool – that data would be submitted from January 1st to August 15th in the year prior to the affected payment determination year. For data related to ASC-8, which is measure data submitted to the CDC/NHSN system, we had previously finalized the submission deadline for that data is May 15th of the year when the influenza season ends. The ASC-8 measure is the Influenza Vaccination Coverage among Healthcare Personnel.

So, here is our proposal. We are proposing to change the submission deadline from August 15th to May 15th in the year prior to the affected payment determination for all data submitted via a CMS web-based tool for the calendar year 2019 payment determination and subsequent years. This proposal essentially aligns the data submission deadlines for the data that's submitted directly to CMS via a web-based tool and for that data that is submitted to the CDC's NHSN web-based tool. And as such, the submission deadlines for ASC-8 would remain May 15th.

Now that we have discussed what is in our proposed rule for the ASC Quality Reporting Program, let's now address our last objective for this presentation, which is how to comment on the proposed rule. And I want to take the time to emphasize the importance of your comments. Really, we want your comments. CMS wants your comments. This is your opportunity to impact the measure development process and policy proposals. Please submit your comments. And to help you in that regard, we're going to go over how to submit your comments to us.

But first, I want to refer you to the proposed rule page 45604 on how to submit your comments. Comments can be submitted using various methods including electronically, regular mail, express or overnight mail, and by hand or courier. The deadline to submit comments is 5 p.m. Eastern Time on September 6, 2016. Please refer to the proposed rule for the necessary addresses. And keep in mind that you must enter comments so that it is received by the deadline. To facilitate your comments being received by the deadline, CMS encourages the electronic submission of comments using the regulations.gov website, www.regulations.gov. All responses that are submitted in this fashion will be addressed, and responses will be published in the final rule which has a scheduled display date of November 2016.

Submitting comments – on this slide, you can see a screenshot of just what you'll see when you go to the regulations.gov website. In the search box,

enter "CMS." This will allow you to search for rules that have been posted related to the Centers for Medicare & Medicaid Services, and select the **Search** button.

On this next screen, you will set your filters. Here, I want you to set your filter. Be sure your comment period is set for **Open** and the document type is **Proposed Rule**. So you see this circled in red here on the left, comment period, document type. Notice that the deadline for comment submission is September 6, 2016 at 11:59 p.m. Eastern for an electronic submission. And here you can see the title of our rule.

When submitting comments, the system will guide you through a three-step process. Here we are on step one. Here, you would enter your comment. Note that there are a maximum number of characters that you can provide in this comment box. Here, we continue with the process of how to comment on the proposed rule. Rather than typing in a comment, you can upload a file here at the box marked with **C** if you choose to do so. In the box marked **D**, you can enter your contact information. In section **E**, if you are submitting a comment on behalf of a third party, enter the organization name in this area. When you are finished entering your comment and contact information, you select the continue button seen here marked by **F**.

Step two on how to comment on the proposed rule. Here in step two you will receive a preview that shows how your comment and information will appear on the regulations.gov site. This includes your comment and the file that you uploaded. Country and state or province is all that will appear on the regulations.gov site. Your name, ZIP code, or postal code and organization name will not appear on the regulations.gov site. You may select **A** here to edit your comments or contact information. When you have finished previewing and found what you've entered is acceptable, you check the box here at **B** to acknowledge that you have read and understand the provisions of commenting. If you view all of this information now as correct, you select the **Submit Comment** button marked here as **C**.

Step three is you receive a receipt for submitting your comment. Your comment is assigned a tracking number. You will want to keep track of that if you want to look to see that it is displayed on the site. You can find it afterward. You can also use that now if you ever need to refer to it elsewhere. So, we recommend taking a screenshot of this page or saving your tracking number in a safe place, and then you can use your tracking number to find the status of your comment.

This concludes my presentation. I can now turn this presentation back to Karen.

Karen VanBourgondien: Thank you, Anita. I'd like to thank both of our speakers for all the great information and letting us know what is developing in the near future for the ASCQR Program. Please comment on these proposals. This is your opportunity to have influence on programs. The link here on this slide will take you directly to the comments section, so keep it for your records: https://www.regulations.gov/comment?D=CMS_FRDOC_0001-1994.

That's all we have for you today. I thank you for joining us. Thanks, everyone. Have a great day.