Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements: CY 2015 OPPS/ASC Final Rule Presentation Transcript

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Reneé Parks: Hello and welcome, everyone, to this afternoon's session for the Ambulatory Surgical Center Quality Reporting Program educational webinar. Today's program will be covering the ASC Quality Reporting Program Requirements, Calendar Year 2015 OPPS/ASC Final Rule. As Erin stated, my name is Reneé Parks, and I am the Lead Program Coordinator for the ASC Quality Reporting Program.

If you have not had an opportunity to download today's handout, you can do so from our new website at www.qualityreportingcenter.com. Go to the **Events** banner in the center of the page and click on the **Event for Today**. This will take you to the webinar session, and this is where you can locate the handout. You will have one slide per page or three slides per page.

Please remember -- these are the program announcements that I would like to review, as they are reminders and highlights. Please remember to keep your facility's Security Administrator contact information current, as we will

be entering 2015, where you will need your Security Administrator to be active so that you can enter, during the submission time, the web-based measures.

We also recommend a backup Security Administrator. This is highly recommended, as life events do occur, and if one person goes out and you have a backup, you are good to go with entering your web-based measures.

The requirement for the reporting of claims-based measures remains at 50% or greater for the Quality Data Codes that you submit on your CMS-1500 via claims. The submission period for the web-based measures for calendar year 2014, as stated earlier, will open January 1 of 2015 and run through August 15 of 2015. We highly recommend that you enter your data as early as possible to ensure that you are able to submit your data.

ASC-8 is Influenza Vaccination Coverage among Healthcare Personnel. This is submitted on the cdc.gov/nhsn website. We are now in the 2014/2015 flu season, and the submission period for this particular measure is now open.

As we move into Slide 3, I want to highlight that our primary mode of communication is via the ListServe. There are multiple ListServes available, and we recommend that you sign up one or two people from each facility to ensure that someone there has the most current information. And you can do so on qualityreportingcenter.com, where the registration and handouts for each webinar in the future will be posted.

Our next webinar on this slide states January 28. However, this has been pushed into February, and that will be going over the Specifications Manual Update for the ASC Quality Reporting Program.

On Slide 4, today's learning objectives are located here. This program is being recorded, and a transcript of today's presentation and the audio portion of today's program will be posted on qualityreportingcenter.com at a later date. And during today's presentation, please do not use the chat feature on the WebEx screen, as we do not monitor this function during the presentation. We will also follow the presentation with a question-and-answer session until the top of the hour.

And now it is my pleasure to introduce today's speaker, Dr. Anita J. Bhatia. Dr. Bhatia is the government task leader for the ASC Quality Reporting Program and the Hospital Outpatient Quality Reporting Program, and has been with these programs since their inception. ASC's inception was in 2012, and the Hospital Outpatient Quality Reporting Program began in 2007.

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/ASC Proposed and Final Rules. Her contributions to the rules are essential for the continuing success of the ASC Quality Reporting Program. We are very fortunate to have Dr. Bhatia's commitment to this program and ultimately to patient care outcomes.

And now I will turn the program over to Dr. Bhatia.

Anita Bhatia: Thank you, Reneé. Good morning or afternoon, depending on where you are. Thank you for coming to our educational session. We're going to talk

today about the ASC Quality Reporting Program and requirements as set forth in the Calendar Year 2015 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Rule. The Calendar Year 2015 Final Rule displayed on October 31. It was published in the *Federal Register* on November 10. This link will take you to the *Federal Register* version. And as referred to, this Rule applies to many programs, not just ours. It applies to the Hospital Outpatient Prospective Payment System and the Ambulatory Surgical Center Payment System, as well as this quality reporting program and others.

The ASC Quality Reporting Program Section begins on page 66966. However, it's a very large document, so we have supplied the pages of the PDF that contain the requirements for the Ambulatory Surgical Center Quality Reporting Program so you can just put those in and print that out if you so desire.

This slide outlines our history with the rule-making process. We've been talking about the program since the calendar year 2008 OPPS/ASC Rule. This slide provides you the rule reference, the *Federal Register* reference, and the highlights. We begin with the discussion, then we finalize the measures up to where we are now at the calendar year 2015 OPPS/ASC Rule, where we will discuss the one new claims-based measure that we have finalized.

So in the preamble, the section that's all that text called the preamble, we talk about various requirements, some of them which were previously finalized. So we'll begin with ASCQR Program participation.

Once an ASC submits any quality measure data, it is considered to be participating. There is no additional form that needs to be completed or

submitted to CMS to indicate that you are participating. This does differ from some of the other Quality Reporting Programs. If you've heard this idea that there's a participation form for ASC Quality Reporting, there is no separate form.

An ASC that had begun participating by submitting data but wishes to withdraw from the program must, unfortunately, fill out an actual form. We have a withdrawal form that is available on the QualityNet site. The reason that we must have a form is because of the payment implications outlined in the next bullet. An ASC that withdraws from the program will incur a 2% reduction in its annual payment update and any subsequent year that ASC is not participating. This is the payment reduction that occurs for not meeting requirements.

We also note that any and all quality measure data submitted can be made publicly available. If an ASC has submitted it to us, we have the ability to make that publicly available. I will note that, to date, we have not made any data publicly available.

We already mentioned QualityNet accounts and administrators. In order to access a QualityNet account, a Security Administrator, or SA, is required. So the Security Administrator can submit data to CMS via the web-based tool at the QualityNet site. The SA can access reports. We do have reports that are available to you. You can see the information that we have obtained from the data that you have submitted. And the SA can assign roles to basic users. So a basic user is one that doesn't have the right to assign all those roles but can do other things.

Please allow 4 to 6 weeks for the SA process to be completed if you need to embark on that journey, because we want to be certain that you have your Security Administrator in time if you need one.

So as mentioned about withdrawing, an ASC can withdraw from the program at any time up to August 31 of the payment determination year. So this is the latest date that we can allow you to withdraw and still have sufficient time to make payment determinations. This bullet's a little confusing in that, like for this year, we made payment determinations for calendar year 2015, but we're in this year now. You actually had until August 31 of 2014 to withdraw. Once an ASC withdraws in any payment determination year, it is not possible to reinstate participation status for that year. So if you are going to withdraw, please be serious about it.

We see this next bullet as the only reason an ASC would want to actually formally withdraw, and that is so that any quality measure data submitted will not be made publicly available for that payment determination year and any subsequent payment determination years for which the ASC has withdrawn. As the ASC has withdrawn from the point that it submits that withdrawal form, it can, as outlined in an earlier slide, if it wants to participate, it can then begin submitting data again.

So we have a program that's in operation, so we have to have some requirements from when an ASC, if they're a new ASC, when they need to begin participating in the program. So we want facilities to have some time to be operational, so new facilities must be open at least 4 months, based on the Medicare acceptance date, prior to January 1 of the participation year. So that would be, like our next participation year is going to begin January 1, 2015. And they must meet all program requirements.

So for calendar year 2015, a facility would have to be open by September 1, 2014, and would be responsible for all program requirements that are going to come into effect in 2015. So if you've come into being earlier in 2014, you don't have to start meeting requirements immediately. You would begin with the next calendar year.

So we have, now that we have got participating, we have measures that we collect data on. So the next two slides go over the measures that had been previously finalized. These first five are submitted using Quality Data Codes--again, something that Reneé referred to at the start of this presentation. So we have ASC-1, Patient Burn; ASC-2, Patient Fall; 3, Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant; 4, Hospital Transfer/Admission; and 5, Prophylactic Intravenous, or IV, Antibiotic Timing.

Then the next two, 6 and 7 are submitted to CMS via a web-based tool. They are the Safe Surgery Checklist use and the ASC Facility Volume Data on Selected ASC Surgical Procedures.

So continuing on with measures, again also referred to at the beginning, we have ASC-8, the Influenza Vaccination Coverage among Healthcare Personnel. This is the NHSN, National Health Safety Network, measure that is submitted to CDC's system.

The next two, ASC-9 and -10, are Endoscopy Polyp Surveillance Measures. These are submitted directly to CMS using a web-based tool. So while there is data collection involved with these measures, it is aggregate data that is submitted. And 9 is the Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. And 10 is the Colonoscopy Interval

for Patients with a History of Adenomatous Polyps--Avoidance of Inappropriate Use.

For ASC-11, this is a cataract measure, cataract surgery measure. It's Cataracts: Improvement in Patient Visual Function within 90 Days Following Cataract Surgery. This measure was finalized in last year's rulemaking. As noted in this footnote, it was delayed until January 1, 2015. However, in this rulemaking, we have made submission of data for this measure voluntary. ASCs are not subject to payment reduction while this measure is voluntary.

So now that we have measures, we do have to have some mechanism and thoughts towards how we would remove measures from the program. In this rulemaking, we finalized two criteria for removal of measures on the basis that they are topped out, meaning that performance is so high and unvarying that you cannot distinguish between facilities. We are defining this high level of performance such that you have statistically indistinguishable performance at the 75th and 90th percentiles and that the variation, as measured by the truncated coefficient of variation, which is a trimmed measure where you drop the outliers so that you look at, so you don't let those outliers adversely affect your view of the data, that that is less than or equal to 0.10.

However, CMS will assess the benefits of retaining a measure on a case-by-case basis prior to removal. We will not simply use this mathematical topped-out definition, as there may be other programmatic or clinical reasons for retaining a measure.

We discuss, as previously finalized, criteria for adding new measures to the program. So we state that for calendar year 2017 and subsequent years,

measures should apply to both the ASC and hospital outpatient department settings, since they are similar in their delivery of surgical and related non-surgical services. We work to harmonize measures across programs to the extent possible,

This third bullet refers to a statutory requirement that we take into account the views of the Measure Application Partnership, or MAP. Measures that we are considering for inclusion in the program go to this group. They review them, and we incorporate their views. We always look to utilize National Quality Forum, or NQF, endorsed measures for the ASC Quality Reporting Program. However, we are not required to have NQF endorsement before utilizing a measure in the program.

So we also discuss program measures for future consideration. And this is rather our larger strategic view. CMS as an agency seeks to develop a comprehensive set of quality measures available for widespread use for informed patient decision-making and quality improvement in the ASC setting. So to that end, we work to be aligned with the National Quality Strategy, the CMS Strategic Plan, as well as our other quality reporting and value-based purchasing programs as appropriate.

And we seek to align with these domains. And these domains are to make care safer, to strengthen person and family engagement, to promote effective communication and coordination of care, promote effective prevention and treatment of chronic disease, work with communities to promote best practices of healthy living and make care affordable. So in this year's list of measures that we have put forth to the MAP for consideration, we are seeking to fill in some of these domains.

So we do have a new measure for calendar year 2018 and subsequent payment determinations. So this is the year that the data would be used, to where payment would be effective. And this is ASC-12, Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. This measure was also finalized for the Hospital Outpatient Quality Reporting Program. We had initially proposed to use this measure information for calendar year 2017 payment determination, but we finalized, utilized the information for calendar year 2018 payment determination, so that we've pushed this out one year so that we would have time to provide information to you.

This is a claims-based measure completely. It does not involve the submission of any additional information. It does not involve the submission of any Quality Data Codes. It is purely based on claims that your facility submits for payment and that get paid.

And as these two bullets restate what I just said, importantly, for the calendar 2018 payment determination, we would be utilizing paid Medicare fee-for-service, FFS claims, from January 1, 2016, to December 31, 2016.

We will be providing the results of preliminary data analysis to you on a facility basis. Your facility will be able to review your measure results, and you will be able to ask questions and become familiar with the measure methodology. There is a separate entity that is going to be calculating this measure and is responsible for it, and we will provide that information for you so that you may contact them if you so desire.

As stated, we will be utilizing paid Medicare fee-for-service claims. Importantly, we'll not just get the measure, like your percent or total. You

will be receiving facility-specific reports that have a listing of your associated cases, and you will be able to access those and review them.

We discuss in the Rule the possibility of utilizing a minimum volume of colonoscopies to be performed by a facility, but we have not determined a cutoff volume, whether one will be used, or what that cutoff would be. I think for the dry run, we probably would be sending out your information regardless of how many claims you have, but that also you have to be fully decided.

So we had some measures. Now we have to submit them, and we have to submit them by our deadlines, so let's see what those are.

We always have a section which is the form, manner, and timing section for submitting data. And this is previously finalized, and this applies to our calendar year 2016 and subsequent payment determinations. Currently, we will maintain our five Quality Data Code-based measures that facilities will continue to submit that data by submitting the appropriate codes on the CMS-1500 or on the electronic dataset. We note that claims for services furnished in each calendar year must be paid by the Medicare Administrative Contractor, or MAC, by April 30 of the following year, so that you have your, you're submitting your claims across the year, you end up at the end of the year, which is December. This gives you 4 months to get that information in. We do know that ASCs tend to get their claims in faster than that, but we wanted a good time to ensure a high completeness rate.

The four web-based measures, where data is submitted directly to CMS, will continue. They are submitted by the QualityNet secure portal, utilizing a web-based tool. Facilities have from January 1 to August 15 of each year prior to the payment determination year to submit that information.

However, we highly advocate that you do not wait until the very end to submit your data. While you have this large amount of time, you can end up in problems--your Security Administrator disappears, your computer system has issues--so try not to wait until the very end to submit that information.

The one web-based measure, the cataract measure, can be voluntarily reported, and there is one web-based measure, the NHSN measure, that will be reported to the CDC via that NHSN website.

We previously finalized and did not change our policy that for successful reporting to be considered, the ASC would have 50% of their claims meeting measure specifications. They would have the appropriate Quality Data Codes on them. We are utilizing claims with Medicare as the primary or secondary payer. We realize that ASCs don't usually have very many secondary payer claims; however, we still consider that to be an important part of our beneficiary population, so that's why they are included. And that is what we'll be using to determine data completeness for the calendar year 2016 payment determination and subsequent years.

So we talked about the fact that ASCs are to participate and when they should begin participating. However, we do realize that many facilities are very small, so we don't want to unnecessarily burden our very small facilities. So for the calendar year 2017 payment determination and subsequent payment determinations, there is a minimum case volume of 240 Medicare claims, primary and secondary, per year for an average of 60 per quarter, but we don't use the quarterly number for the determination. We use the annual number in determining whether or not an ASC must participate.

ASCs with fewer than this minimum number are not required to participate in the program at all, though they may voluntarily do so. This represents the lowest 10% of ASCs in terms of case volume. We will be monitoring this number to see if it needs to be changed, but this is what is set at this time. So since those ASCs would be exempt, the answering of the web-based measures are also not required if the ASC falls below the minimum case volume.

I do realize that this policy could use some refining. We are going to be looking at that next year. As the policy stands, it's not possible for an ASC to tell in advance whether or not it is exempt. So if you are borderline, you should monitor your claims and participate so that you don't end up at the end of the year suddenly finding out that you had to participate when you thought you didn't. So as stated, I realize this is not perfect. It does allow ASCs a way to exempt out, and we will be looking at this next year.

So we mentioned this, this measure. This is our ASC-8. This is the Influenza Vaccination of Healthcare Worker measure. Last year we had proposed a deadline, but we did not finalize that deadline. This year we did finalize that the deadline for ASC submission to the National Healthcare Safety Network, or NHSN, for the 2014/2015 influenza season data is May 15, 2015. So our reference period for the flu season is October 1, 2014, to March 31, 2015. So note we are already in this time period. We had previously finalized that ASCs are to follow the standards and procedures set forth by the Centers for Disease Control and Prevention, or CDC, for NHSN participation. This is CDC's system, and you are to follow their standards and procedures.

To sign up with NHSN, you will need your CCN to establish an account. We realize that ASCs do not always know their CCN, which is their CMS

Certification Number. This is what is used for survey and certification. So we have provided a CCN lookup tool where you can take your NPI, or your National Provider Identifier, which is what is placed on your CMS-1500 when you submit a bill, and look up your CCN via NPI.

Now, this mapping on NPI and CCN takes into account a large number of datasets. However, we realize that NPIs move around and that facilities can have multiple CCNs, multiple NPIs. So if you find issues in our tool, please contact the support contractor--there will be a number at the end of this presentation--with issues or if you need help.

This is the link for CDC's NHSN website. And as stated, the data are due by May 15 of the year in which the influenza season ends, for all subsequent years. So for this year, our season's going to end on March 31, 2015, so the data are due by May 15 of 2015.

So we have some measures and we have some data, and now we have to make annual payment determinations. And this is also previously finalized information. These bullets actually refer to the statute, the authorizing statute. So ASCs that fail to meet program requirements will receive a 2% reduction in any annual increase provided under the revised ASC payment system for such year. The reduction will not be taken into account in computing any annual increase factor for a subsequent year. And this next bullet, rather, repeats that. This means that the reduction will apply to only one calendar year.

Those of you who are familiar with other quality reporting programs may have heard that, or are likely familiar that those programs have a validation requirement. We do not have a validation requirement for ASC Quality

Reporting at this time. Consistent with our other programs where we're looking at claims-based and web-based measures, we are not validating.

In addition, the number of events reported for Quality Data Code measures is expected to be small. For the most part, these are rare, isolated events. Therefore, we expect that the accuracy for reported events is expected to be high. We don't expect that if you report that you had a burn, that you didn't really have a burn, for the most part. So we are not requiring a data validation process at this time, as it would be excessively burdensome. If we were to be validating, we would be looking for missed cases. And since those are really small, we would have to select a huge number of cases to try to find those, and that would be excessively burdensome, both for ASCs as well as for CMS. We will reassess the need for any measure validation process in the future.

We have some administrative requirements. We have this issue of special requests, extensions, or exemptions. This process was previously finalized. This is our extraordinary circumstances process. We have changed its name. The process will now be referred to as extraordinary circumstance extensions or exemptions process. This process was established in the fiscal year 2013 IPPS/LTCH PPS Rule. If you look back on the slide where we outlined all the years that we had rulemaking, this is the one year that we were involved in the IPPS Rule rather than the OPPS Rule.

We also, CMS may grant a waiver or extension to ASCs without ASCs having to ask for it, or if they do ask for it, for data submission requirements if it is determined that a systematic problem with the data collection system directly or indirectly affected the ability to enter data. This refers to processes or systems that are out of the control of the facility. The form for making this request is available on the QualityNet website.

We also have a reconsideration process. This relates to if a facility does not like or does not agree with the decision that CMS has made regarding the payment determination, the facility may submit a Reconsideration Request Form. That Request Form must be submitted by March 17 of the effective payment year. So we are in 2014. We made payment determinations for calendar year 2015 that will go into effect with your services starting January 1 of 2015. You would have until March 17 of 2015 to submit that form. This form is also available on the QualityNet website, and this process was established in that Fiscal Year 2013 Rule.

We added some clarifications to the process in this year's rulemaking. We state that CMS intends to complete any reconsideration reviews and communicate the results of those reviews within 90 days following the deadline. This is from March 17 of the effective payment year. It is not from when the reconsideration is submitted. So if you submit your reconsideration in December, we still have--we're going to start that clock in terms of when we're going to get back to you from the March 17 deadline.

For those ASCs that submit a request, the Reconsideration Request would be the final program payment determination. There are no appeals of any final ASC Quality Reporting Program payment determination. This is not because we are trying to deny you some additional level of appeal; it is because, per statute, there are no appeals of payment decisions for ASCs.

And with that, I will turn this back over to Reneé, who can let you know about your continuing education approval.

Reneé Parks: Thank you, Dr. Bhatia, for the information you shared with us today. We now have time available to answer your questions until the top of the hour.

The phone lines are open, and here is Erin with the instructions on how to ask your question. Erin?

Operator: The floor is now open for questions. As a reminder, if you have muted your telephone, please unmute it at this time. If you do have a question, please press star-one on your telephone keypad and record your name when prompted. Questions will be taken in the order they are received. If at any point your question has been answered, you may press star-two to disable your request. If you are using a speakerphone, we ask that while posing your question, you pick up your handset to provide favorable sound quality. As a reminder, due to the volume of attendees, you will be muted after your initial questions and comments. Please hold while we wait for the first question.

Reneé Parks: Erin, while we wait for the first question, I'd like to remind everyone that this webinar has been approved for one continuing education credit by the boards listed here on Slide 33. And we now have an online CE process, certificate process, and there are three ways in which you can obtain your CE credit.

If you registered and logged into this webinar through WebEx, you will receive a short program survey via email from WebEx within the next 48 hours. I just want to remind everyone, it will not arrive today. Once you have completed the survey, you will be sent to a site where you will download your certificate.

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The third way that you can obtain your CE credit is if you were listening to the webinar by phone only, since you did not register with WebEx, you will not receive the survey with the link for CE credit. An online version of today's presentation will be posted on our qualityreportingcenter.com website within a few weeks. There you would merely log in, complete a brief post-test to receive your CE certificate.

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