Outpatient Quality Program Systems and Stakeholder Support Team

Exploring Quality Provisions of the CY 2022 OPPS/ASC Proposed Rule

Presentation Transcript

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Karen VanBourgondien:

Hello everyone. Welcome. Thank you for joining us. My name is Karen VanBourgondien. Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for the ASC Quality Reporting Program. 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 development of the OPPS/ASC proposed and final rulings. Her contributions to the rulings are essential to the continuing success of these programs. We are fortunate to have Dr. Bhatia's commitment. Anita will be discussing the OPPS proposed rule as it relates to the ASC Quality Reporting Program. So, without any further delay, let me hand things over to Anita. Anita?

Anita Bhatia: Thank you, Karen. Today, we will be exploring the quality provisions contained in this year's [Hospital] Outpatient Prospective Payment System and ASC [Payment Systems]fee schedule proposed rule, which is scheduled to become effective with calendar year 2022 payments. We will focus on ASC Quality Reporting Program requirements, but other quality provisions are of interest as these have the potential to impact the ASC Quality Reporting Program as CMS seeks to align quality reporting and value-based purchasing programs to the extent possible.

Let's begin with our main focus, proposed changes to the ASC Quality Reporting Program. In this rulemaking, we are proposing one addition to the existing measure set and we are also proposing some important updates to previously adopted measures.

Let's begin with our proposal to adopt a new measure.

The COVID-19 pandemic has had and continues to have significant effects on the healthcare setting. Although personal protective equipment and other infection control precautions can reduce the likelihood of transmission in health care settings, COVID-19 can spread between staff and patients as well as from patient to patient given the close contact that may occur during the provision of care.

Given the impact of COVID-19 on healthcare, we believe it is important to require ASCs to report healthcare personnel vaccination information to assess vaccination coverage. Therefore, we are proposing to adopt a new measure, COVID-19 Vaccination Coverage Among Healthcare Personnel, or HCP. The measure would assess the percentage of a facility's health care workforce that has been fully vaccinated against COVID-19 beginning data collection January 1, 2022, for use toward calendar year 2024 payment determinations.

COVID-19 healthcare personnel measure information can inform patient and consumer health care choices in regard to healthcare access.

The Centers for Disease Control and Prevention views vaccination as critical in countering the spread of COVID-19 and the data available indicate that the vaccines in current use are effective in limiting the severity of infection.

CMS believes it is important to propose the measure as quickly as possible to address the urgency of the COVID-19 public health emergency and especially its impact on vulnerable populations. The COVID-19 Vaccination Coverage Among Healthcare personnel measure is a process measure developed by the CDC to track COVID-19 vaccination coverage.

The denominator for this measure is the number of healthcare personnel eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC.

The numerator is the number of healthcare personnel in the denominator who have received a complete vaccination course against COVID-19 using a Food and Drug Administration, or FDA,-authorized vaccine for COVID-19.

Vaccination coverage for this measure is defined as the estimated percentage, since there can be week-to-week variation, of healthcare personnel eligible to work at the ASC for at least one day who have received a complete COVID-19 vaccination course.

For reporting, facilities would count healthcare personnel working at all facilities that share the same CMS Certification Number, or CCN. If you need assistance with identifying your facility CCN, we continue to maintain our NPI CCN look-up tool on the Quality Reporting Center website or you can contact our Help Desk. Complete measure specifications are available on the CDC website link shown here.

ASCs would be required to report data quarterly through the CDC's National Healthcare Safety Network, or NHSN, web-based surveillance system. While the ASC Quality Reporting Program does not currently require use of the NHSN web-based surveillance system, we previously did so for the influenza healthcare personnel vaccination measure. Therefore, an NHSN account would be required for reporting.

ASCs would collect the numerator and denominator for the measure for at least one, self-selected week during each month of the reporting quarter and submit the data to the NHSN before the quarterly deadline. This method is designed to account for changes in scheduled personnel especially for large facilities, so this may not be as useful for smaller facilities with fewer staff.

The CDC would calculate a single quarterly COVID-19 healthcare personnel vaccination coverage rate for each CCN by calculating the average of the data from the three submission periods submitted for a quarter.

We have proposed that CMS would publicly report each quarterly COVID-19 healthcare personnel vaccination coverage rate as calculated by the CDC. Once four quarters are available, data would be refreshed on a quarterly basis with the most recent four quarters. This quarterly average would be publicly reported. However, it should be noted that in finalizing the adoption of this measure for inpatient quality reporting, the finalized reporting method was modified regarding the use of this rolling four quarter method. We look forward to your comments regarding this proposal.

We now move to discussion of our proposals regarding some modifications to previously adopted measures.

The ASC-1 through ASC-4 measures are patient safety, outcome measures that were suspended through previous rulemaking. We considered removing the measures at that time but stated that we had re-evaluated removal due to public comment and studies demonstrating the importance of measuring and reporting the data for these types of measures. It became clear to us that these measures are more valuable to stakeholders than we had initially perceived.

However, at that time, we explained that the data submission method for these measures, which involved adding specific Quality Data Codes onto eligible Medicare claims, may impact the completeness and accuracy of the data. We stated that we believed that revising the data submission method for the measures, such as via a web-based tool could address these issues and allow facilities to correct any data submission errors, resulting in more complete and more accurate information.

To review, these outcome measures are ASC-1: Patient Burn, the percentage of ASC admissions experiencing a burn prior to discharge; ASC-2: Patient Fall, the percentage of ASC admissions experiencing a fall at the ASC; ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant, the percentage of ASC admissions experiencing one of these events; and ASC-4: All-Cause Hospital Transfer/Admission measure. the rate of ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.

Thus, we are proposing to again require and resume data collection for the previously suspended ASC-1 through four measures. Facilities would submit data via the Hospital Quality Reporting, or HQR, System. The HQR submission tool was formerly referred to as the *QualityNet Secure Portal*. This requirement would begin with the calendar year 2023 reporting period/calendar year 2025 payment determination and for subsequent years.

We believe that with a web-based submission method, reporting will be easier and more efficient and will allow for the review and correction of any data submissions errors, resulting in more complete and accurate data.

Facilities would be able to review and correct their data submissions up to the data submission deadline.

We believe that the public views it as important to monitor these types of events and to provide this information to patients, in order to prevent their occurrence, and to ensure that these events remain rare considering the potential negative impacts to patients' morbidity and mortality. We invite public comment on this proposal.

Another proposal relates to our previously adopted measure, ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. This measure has been voluntary since the 2017 payment determination due to concerns raised about the burden of collecting pre-operative and post-operative visual function surveys. Mandatory reporting was not implemented because we understood it was operationally difficult for ASCs to collect and report on the measure. Notably, the results of the survey used to assess the pre-operative and post-operative visual function of the patient were not consistently shared across clinicians, making it difficult for facilities to have knowledge of the visual function of the patient before and after surgery.

This measure assesses the percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery. The measure data consists of pre-operative and post-operative visual function survey information. The allowable surveys vary in the number of questions but are scientifically validated to provide the same outcome measurement.

This measure addresses a high-impact condition, visual function not visual acuity, that is not otherwise adequately addressed in our current measure set. Additionally, ASC-11 serves to improve patient-centered care by representing an important patient reported outcome, providing opportunities for care coordination as well as direct patient feedback.

At this point, we have learned more about this measure and possible implementation.

ASCs have had the opportunity to become familiar with ASC-11 and to practice reporting the measure. We have also seen consistent reporting of this measure under the Hospital Outpatient Quality Reporting Program by some facilities. Therefore, we are proposing to require facilities report on ASC-11.

Data submission would be through the HQR System and would begin with the calendar year 2023 reporting period for the calendar year 2025 payment determination and for subsequent years. We invite public comment on this proposal. Lastly, we will discuss the proposal regarding the OAS CAHPS Survey measures.

We previously adopted ASC-15a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems measures to assess patient experience with care following a procedure or surgery in an ASC setting. These survey-based measures rate patient experience as a means for empowering patients and improving the quality of their care.

In the Calendar Year 2018 OPPS/ASC Final Rule, we delayed implementation of these measures due to lack of sufficient operational and implementation data. At that time, we expressed interest in investigating the feasibility of offering the OAS CAHPS Survey using a web-based format. As a result, we have made revisions and have assessed the impact of adding web-based survey administration.

Having had the opportunity during the delayed implementation to investigate concerns about patient response rates and data reliability, we believe that patients are able to respond to OAS CAHPS questions and that those responses are reliable based on prior experience collecting voluntary data for public reporting since calendar year 2016.

We are proposing to restart the ASC-15a–e measures as part of the ASC Quality Reporting Program. Note that the national OAS CAHPS voluntary reporting program which began in 2016 is independent of the ASC Quality Reporting Program.

For the ASC Quality Reporting Program, we are proposing initial voluntary data collection and then mandatory reporting beginning with the calendar year 2023 reporting period, followed by mandatory data collection and reporting beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination.

We believe that patients are able to respond to OAS CAHPS questions and that those responses are reliable based on our prior experiences collecting voluntary data for public reporting since calendar year 2016. We reaffirm that the OAS CAHPS survey-based measures assess important aspects of care where the patient is the best or only source of information.

Additionally, the benefits of these measures, such as giving patients the opportunity to compare and assess quality of care in the ASC setting in a standardized and comparable manner, outweigh the burden. The implementation of these measures will enable objective and meaningful comparisons between ASCs and rating patient experience provides important information to ASCs. For reimplementation of these measures, we are proposing to incorporate two additional administration methods than previously provided. The methods in total would include mail-only, telephone-only, mail with telephone follow-up, web with mail follow-up, and web with a telephone follow-up.

ASCs would be required to contract with a CMS-approved OAS CAHPS Survey vendor to conduct or administer the survey. We believe that a neutral third-party should administer the survey for facilities, and it is our belief that an experienced survey vendor will be best able to ensure reliable results. These vendors are already required in other CMS quality reporting and value-based purchasing programs.

ASCs would register on the OAS CAHPS Survey website in order to authorize a CMS-approved vendor to administer the survey and to submit data on their behalf by the specified data submission deadline.

For all five proposed modes of administration, we are proposing that data collection must be initiated no later than 21 calendar days after the month in which a patient has a surgery or procedure at an ASC and completed within six weeks, or 42 days, after the initial contact of eligible patients begins.

ASCs, through their CMS-approved survey vendors, must make multiple attempts to contact eligible patients unless the patient refuses or the facility or vendor learns that the patient is ineligible to participate in the survey.

We are also proposing that facilities, via their CMS-approved survey vendor, collect survey data for eligible patients using the established quarterly deadlines to report data to CMS for each data collection period, unless the facility has been exempted from the OAS CAHPS Survey requirements under our minimum case volume for program participation. The low volume exemption for the survey exempts facilities that treat fewer than 60 survey-eligible patients during the eligibility period. This exemption policy is separate from the low claims volume exemption for the entire program.

The eligibility period for the OAS CAHPS survey is the calendar year before the data collection period. If the facility uses this exemption, the ASC will have to submit the participation exemption request form, which will be made available on the OAS CAHPS Survey website on or before May 15 of the data collection year.

All data collection and submission for the OAS CAHPS Survey measures would be reported at the CCN level, and if data collection and reporting becomes mandatory in the calendar year 2024 reporting period as proposed, then all eligible facilities in a CCN would be required to participate in the OAS CAHPS Survey. However, this would exclude those facilities that meet and receive an exemption for having fewer than 60 survey eligible patients during the year preceding the data collection period.

The survey data reported for a CCN must include eligible patients from all eligible facilities covered by the CCN; or, if more than 300 completed surveys are anticipated, a facility can choose to randomly sample their eligible patient population. We invite public comment on this proposal.

Moving into the future and the expanding ASC Quality Reporting Program, CMS does seek to adopt a comprehensive set of quality measures for widespread use to inform decision-making regarding care and for quality improvement efforts in the ASC setting. Thus, we have several requests for comment and information in this rule.

The first request for comment under discussion is for a measure for outcomes after total hip or knee arthroplasty.

As technology and surgical techniques advance, we recognize that there may be a need for more measures that inform decision-making regarding care and for quality improvement efforts, particularly focused on services that become newly eligible for payment in the outpatient setting.

In light of this, we seek comment on potential future adoption and inclusion of an ASC-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty, also known as THA/TKA.

We are also requesting comment on the potential future adoption of a respecified version of a patient-reported, outcome-based performance measure, which we refer to as PRO-PM for two such procedures. These two procedures are the elective primary total hip arthroplasty, or THA, and total knee arthroplasty, or TKA. For further details and information regarding these measures, please visit the website provided here on this slide.

The second request for comment for discussion involves quality measurement for pain management procedures.

With advances in techniques and growing recognition that pain is a treatable condition, we invite comment on the potential adoption of a pain management measure.

We see pain management surgical procedures as a significant portion of procedures performed in the ASC setting and that an applicable measure would provide important quality of care information for a specialty not currently included in the ASC Quality Reporting Program measure set. Pain management services have seen rapid growth as a form of early intervention and more such procedures are being performed in ASCs. ASCs specializing in pain management services are also growing as a share of overall number of ASCs.

We invite public comment on the development and future inclusion of a measure to assess pain management surgical procedures performed in ASCs.

Third, we have a request for information regarding rural emergency hospitals. This is a new provider type for Medicare. For details on this request for information, please see page 268 of the PDF version of the proposed rule in the *Federal Register*.

Fourth, we have a request for information regarding equity.

Significant and persistent inequities in health care outcomes exist in the U.S. Such disparities in health outcomes are the result of a number of factors, including social, economic, and environmental factors, but importantly for CMS programs, although not the sole determinant, negative experiences, poor access, and provision of lower quality health care can contribute to health inequities.

Our ongoing commitment to closing the equity gap in CMS quality programs is demonstrated by a portfolio of programs aimed at making information on the quality of health care providers and services, including disparities, more transparent to consumers.

The CMS Equity Plan for Improving Quality in Medicare outlines a path to equity which aims to support Quality Improvement Network Quality Improvement Organizations, also known as QIN-QIOs; federal, state, local, and tribal organizations; providers; researchers; policymakers; beneficiaries and their families; and other stakeholders in activities to achieve health equity.

In this proposed rule, we are seeking comment on closing the equity gap by use of mapping tools, stratified reports, rural-urban disparities in healthcare in Medicare reports, standardized patient assessment data elements and CMS Innovation Center's accountable health communities model.

ASCs have some characteristics to be considered in regard to measuring and addressing equity issues.

So, specifically for ASCs, what are ways to address the unique challenges of measuring disparities? For example, small sample sizes, ASC specialization, as well as the smaller proportion of patients with social risk factors.

What is the utility of neighborhood-level, socio-economic factors toward measuring disparities in quality-of-care outcomes? What are ways social risk factors influence the access to care, quality of care, and outcomes for specific ASC services, or in general?

Fifth, we have a request for information regarding digital quality measurement applicable across programs.

As CMS plans to modernize its quality measurements, we would like your input on the future of digital quality measurement. Specifically, input is requested on the potential definition of Digital Quality Measurement, or dQMs: How does leveraging advance technology? For example, Fast Healthcare Interoperability Resources (FHIR®) and Application Programming Interfaces (APIs) to access and electronically transmit interoperable data for dQMs could reinforce other activities to support quality measurement and improvement.

We then request comment on four potential future actions that would enable transformation to a fully digital quality measurement enterprise by 2025.

1. Leveraging and advancing standards for digital data and obtaining all electronic health record, or EHR, data required for quality measures via provider FHIR-based APIs

2. Redesigning quality measures to be self-contained tools

3. Building a pathway to data aggregation in support of quality measurement

4. Potential future alignment of measures across reporting programs, federal and state agencies, and the private sector

We covered a lot of information today. Our proposals include one new measure adoption (the COVID-19 Vaccination Coverage Among Healthcare Personnel measure); resumption of data reporting for the ASC-1, -2, -3, and -4 measures; and changes to two existing measures (ASC 15a–e OAS CAHPS Survey measures and the ASC-11 measure).

We are also requesting information and comments on the potential adoption of a THA/TKA measure, potential future adoption of a pain management measure, information on rural emergency hospitals, health equity, and the future of dQMs.

So, this presentation is a summary of these quality provisions. I encourage you to read the actual proposed rule for details and a more comprehensive portrayal of our proposals.

This concludes my discussion of the quality provisions contained in this year's proposed rule. I would like to hand this presentation back to Karen to discuss how to comment. Karen.

Karen VanBourgondien: Thank you, Anita. You covered a lot of great information. As Anita did mention, CMS does want your feedback. So, please comment.

To be assured consideration, comments must be submitted no later than September 17th.

CMS cannot accept comments by fax transmission and does encourage submission of comment by electronic means. You may also submit comment by regular mail, express mail, or overnight mail. There are separate addresses for these types of mail, so you must resource the specified addresses found in the proposed rule.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

To begin the commenting process, from the direct Federal Register link, select the green Submit a Formal Comment box.

This box will open, and you can enter your comment into the Comment box. You can also attach files.

As you scroll down that same page, you can enter the rest of your information, your name, facility type, email, things such as that. You can remain anonymous by the way if you choose to do so. After you finish filling in your information, you're going to select the box "I read and understand the statement above." Once you select that box, you will just click on the Submit Comment, that green box down at the bottom. That's it. That's all you have to do to submit your comment.

The direct link to the proposed rule in the *Federal Register* is here on the slide.

Remember that you can make a difference, so please submit your comments regarding the proposals Anita went over today. Every comment is read and CMS will respond to commenter feedback in the final rule.

As always, if you have program-related questions or you need any assistance, give our help desk a call. Our number's here on the slide. We're always happy to hear from you.

Well, that's all the time we have today. We appreciate you joining us. Thank you, Anita. It's always wonderful to have CMS with us to discuss these very important proposals. Appreciate your time with us today.

Also, folks, please let us know on the survey that will pop up after this event. We are asking for your feedback on what topics you would like to see, education on for the ASC Quality Reporting Program. We really do appreciate your input as always.

Thanks again everyone. Have a great rest of your day.