CY 2023 Hospital OPPS/ASC Payment System Proposed Rule: Streaming Through the Rule Presentation Transcript

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Karen VanBourgondien: Hello, everyone. My name is Karen VanBourgondien, and I'm with the support contractor for this program. We appreciate you joining us today. We're going to start off on our tablet here, and we're going to stream through the proposed rule today.

Our speaker to help us with this presentation 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 the development of the OPPS/ASC [Payment System] 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. I will turn things over to Anita in just a minute.

We have a big show today and you can see our line-up here. We will cover proposals as they relate to the program, requests for information, requests for comment, how to comment, and we're going to also review the measures for this program as well as deadlines.

I'd like to make certain that the content covered on today's call should not be considered official guidance. The webinar is only intended to provide information regarding program requirements.

Please refer to the proposed rule, located in the *Federal Register*, to clarify and provide a more complete understanding of the modifications and proposals for the program which Anita will discuss. The proposed rule was published in the *Federal Register* on July 26. The comment period closes on September 13, so please make sure you comment. CMS really does want your feedback.

So, with that, let me hand things over to Dr. Anita Bhatia and our first network Rule Roundup. Anita?

Anita Bhatia: Thank you, Karen. Hello, everyone, and thank you for attending our show. We will now stream to another channel, Rule Roundup. On this network, we will turn our attention to the proposals set forth in the Calendar Year 2023 OPPS/ASC [Payment System] Proposed Rule. Our program lineup consists of a discussion of a proposal to modify a previously adopted measure, measures and topics for future consideration, and multiple requests for comment.

Our first program on this network is a proposal affecting a previously adopted measure.

Last year, we finalized mandatory reporting for ASC-11 to begin with the calendar year 2025 reporting period. This was to follow a voluntary reporting period to allow ASCs time to prepare for mandatory reporting. However, in this rulemaking cycle, we are proposing to change reporting for ASC-11 from mandatory to voluntary.

ASCs would not be subject to a payment reduction for failing to report this measure during the voluntary reporting period; however, we strongly encourage ASCs to gain experience with the measure. We plan to continue to evaluate this policy moving forward. To be clear, there are no changes to reporting for calendar year 2023 and calendar year 2024, during which the measure would remain voluntary.

As the ASC-11 measure uniquely requires cross-setting coordination among clinicians of different specialties, we believe it appropriate to defer mandatory reporting at this time. We will consider mandatory reporting for later rulemaking because this measure addresses an area of care that is not adequately addressed in our current measure set, and the measure serves to drive the coordination of care. We invite public comment on this proposal.

Let me clarify some considerations behind this proposal.

Since the publication of the Calendar Year 2022 OPPS/ASC [Payment System] Final Rule, concerns were expressed about the reporting burden of this measure given the ongoing COVID-19 public health emergency

and that mandatory reporting would be burdensome due to national staffing and medical supply shortages coupled with unprecedented changes in patient case volumes. These challenges and staffing shortages have lasted longer than initially expected, which has led us to reconsider our previously finalized timeline for mandatory reporting. Therefore, we believe that, due to the continued impact of the COVID-19 pandemic, the two-year delay of mandatory reporting for this measure is no longer sufficient.

Changing programs on this network, we will discuss the requests for comment on measures and topics for future consideration.

So, reminder, RFC is Request for Comment. We are also seeking comment on a potential future direction of quality reporting under the ASC Quality Reporting Program that would allow quality-related data for ASCs to be reported on a customizable measure set that more accurately reflects the care delivered in this setting and accounts for the services provided by individual facilities. Such a reporting structure could benefit ASCs by allowing them to focus on practice-specific measures on a specialty or multispecialty basis. Patients and other interested parties could benefit through the provision of more relevant information on quality and safety within ASCs.

The Merit-Based Incentive Payment System for clinicians adjusts Medicare Part B payment to a clinician based on the clinician's prior performance on four performance categories. While the traditional Merit-Based Incentive Payment System, or MIPS, program is being phased out over time, we do believe that the quality performance category of the program provides an example of a specialty centered approach to quality reporting that is relevant to ASCs as clinically specialized facilities.

It is our belief that quality reporting for ASCs would benefit from measures that consist of limited, connected, and complementary sets of measures and related activities that are meaningful to clinicians; that include measures and activities resulting in comparative performance data that are valuable to patients and caregivers in evaluating clinician

performance and for making choices about clinical care; that promote subgroup reporting that comprehensively reflects the services provided by multispecialty groups; and that include measures selected using the Meaningful Measures approach. A link for more detail on our Meaningful Measures approach is provided on this slide, and there is further discussion in the rule.

Thus, we ask for comment on a set of questions regarding a Specialty-Centered Approach for ASC quality reporting that build upon one another. First, is the general concept of a specialty-centered approach for quality reporting by specialty feasible and desirable for ASCs participating in the ASC Quality Reporting Program. Were we to adopt a specialty centered approach to quality measure reporting for the ASC [Quality Reporting] Program, should CMS require that ASCs report a subset of quality measures that apply broadly to all ASCs? Were we to adopt a specialty-centered approach for quality measure reporting, what would be the appropriate number and type of measures that ASCs be required to report?

It does follow, if we were to adopt a specialty-centered approach for quality measure reporting, we would like your feedback on these questions: What would be the appropriate number and type of measures that ASCs should be required to report? Are there minimum and maximum numbers of measures required for ASCs that provide meaningful information while not being overly burdensome? What is the preferred balance of required quality measures that apply broadly to all ASCs and quality measures that apply to a particular area of specialization? If we were to adopt a specialty-centered approach for quality measure reporting, what areas of specialization would benefit from such an approach? Which would not? Should CMS define a set of measures for particular areas of specialization (ophthalmology), or should measures be self-selected for individual facilities from selected categories, especially given that an ASC may be multi-specialty?

Once we think through questions related to whether or not to pursue a specialty-centered approach for ASC quality reporting, we then consider potential measures for a specialty centered approach.

We list them for your consideration in the proposed rule. We welcome comment on these examples as well as potential future measure sets for other specialization areas.

When viewing these tables, if we were to adopt a specialty-centered approach for quality measure reporting, should ASCs be required to report all measures in such a measure set, or should they be permitted to select a minimum number of measures from their selected measure set?

Lastly, what measures, if any, from the current ASC Quality Reporting Program measure set, should be retained and be incorporated in such an approach?

Here, we have a request for comment related to a quality measure. The ASC Quality Reporting Program previously had the structural measure ASC-7 as part of the program's measure set. This measure collects surgical procedure volume data on six categories of procedures frequently performed in the ASC setting. In the Calendar Year 2018 OPPS/ASC [Payment System] Final Rule with comment period, we removed ASC–7 from the program. We are considering reimplementing the ASC–7 measure or another volume measure because, in addition to being an important component of quality, the shift from the inpatient to outpatient setting has placed greater importance on tracking the volume of outpatient procedures.

We are also considering the reintroduction of a facility-level volume measure to support potential future development of a pain management measure. We did request comment in the Calendar Year 2022 OPPS/ASC [Payment System] Final Rule with comment period on this topic. When considering the need for a pain management measure, we analyzed volume data using the methodology established by ASC-7 to determine the proportion of ASC procedures performed for pain management. The ASC -7 measure was not reviewed or endorsed by the Measure Applications Partnership, or MAP, as they did not begin reviewing measures until after the original adoption of this measure into the program.

Therefore, for ASC–7 to be adopted back into the ASC Quality Reporting Program measure set, the measure would need to first undergo the pre-rulemaking process.

We also seek comment on what volume data ASCs currently collect and if it is feasible to submit these data to the ASC Quality Reporting Program, to minimize the collection and reporting burden of an alternate, new volume measure. Additionally, we seek comment on an appropriate timeline for implementing and publicly reporting the measure data.

Some of the considerations with this potential reimplementation of ASC-7 or other volume indicator is that, over the past several years, innovations in the health care system have been driving migration of procedures to the outpatient setting. The shift from the inpatient to outpatient setting has placed greater importance on tracking the volume of outpatient procedures. When considering the need for a pain management measure, we analyzed volume data using the methodology established by ASC–7 to determine the proportion of ASC procedures performed for pain management. We found that pain management procedures were the third most commonly performed procedure type. Thus, a volume measure would provide Medicare beneficiaries and other interested parties information on numbers and proportions of procedures by category performed by individual facilities, including for ASC procedures related to pain management.

In 2009, under the Health Information Technology for Economic and Clinical Health Act, or HITECH Act, financial incentives were authorized for hospitals and clinicians to adopt and meaningfully use certified electronic health records, or EHR, technology. CMS implemented these financial incentives by establishing the Medicare and Medicaid EHR Incentive Program, which is now known as the Promoting Interoperability Program, to encourage health care providers to adopt and meaningfully use Certified EHR Technology, or CEHRT, and improve health care quality, efficiency, and patient safety.

ASCs were not included in the HITECH Act and were mostly ineligible for the financial incentives under the Promoting Interoperability Program. ASCs still face significant barriers to implementing EHRs as EHRs can be expensive to implement and update, can require many staff hours for training, and may not offer ASCs a meaningful investment given the types of services provided and levels of patient follow-up required.

We finalized changes to the Promoting Interoperability Program, and the Fiscal Year 2023 IPPS/LTCH PPS Proposed Rule for both proposes additional changes to the Promoting Interoperability Program.

Currently, eligible hospitals and critical access hospitals are required to report on four scored objectives, including electronic prescribing, health information exchange, provider to patient exchange, public health and clinical data exchange, and attestations.

We seek comment to explore how ASCs are implementing tools in their facilities toward the goal of interoperability. We are considering a future shift in reporting from QualityNet to eCQMs, to aid in delivering effective, safe, efficient, patient-centered, equitable, and timely care. We are interested in learning more about capabilities for reporting such measures in the future for the ASC Quality Reporting Program.

Generally, we seek input on barriers to interoperability in the ASC setting; the impact of health IT, including certified health IT, which is certified under the ONC Health IT Certification Program, on the efficiency and quality of health care services furnished in ASCs; and the ability of ASCs to participate in interoperability or EHR-based quality improvement activities, including the adoption of electronic clinical quality measures or eCQMs. Additional specifics to these requests for comment are in the proposed rule. We also provide tables with example measures for this request for comment.

Specifically, we invite comment on what do ASCs perceive as the benefits or risks of implementing interoperability initiatives in their facilities?

What improvements might be possible with the implementation of interoperability initiatives in ASCs, including EHR utilization, such as reduced delays, efficiencies, ability to benchmark, etc.? Do ASCs see interoperability initiatives as non-essential or detrimental to their business practices?

We have considered several measures from the Promoting Interoperability Program and from the traditional MIPS Promoting Interoperability measure set that may be applicable for the ASC setting and include these in a table in the proposed rule. We welcome comment on these specific measure examples, including whether ASCs believe these measures would be appropriate and feasible for use in ASCs.

As noted a few slides back, the Promoting Interoperability Program encourages health care providers to adopt and meaningfully use Certified EHR Technology and improve health care quality.

Transitioning to eCQMs would increase alignment across quality reporting programs such as the Hospital Outpatient Quality Reporting Program, which adopted the STEMI eCQM in the Calendar Year 2022 OPPS/ASC [Payment System] Final Rule. We are interested in learning more about capabilities for reporting such measures in the future for the ASC Quality Reporting Program.

No, we move to our public access network, where we will discuss commenting on the rule, proposals, and requests for comment. We are looking forward to your comments and feedback. This is your opportunity to be involved in program decisions.

For details on how to comment, let me turn things back over to Karen. Karen?

Karen VanBourgondien: Thank you, Anita. So, our program line is discussing the comment period, locating the rule, and how to submit comment to CMS.

To be assured consideration, comments must be submitted no later than September 13. CMS cannot accept comments by fax transmission, and CMS does encourage submission of comment by electronic means. You can, however, also submit comment via regular mail, express mail, or overnight mail. These do require separate addresses, and you can find those specific addresses in the proposed rule. Allow sufficient time for any mailed comments to be received by the close of the comment period.

So, again, the proposed rule can be found in the *Federal Register*, and we have the direct link here on the slide. The ASC Quality Reporting Program specifically begins on page 239 of the PDF version. Additional addenda are also available by accessing the link here on the slide.

In this program, we will be talking about how to submit your comment.

When you access the *Federal Register* link, you will be directed to the exact location of the rule in the *Federal Register*. To begin the commenting process, you're just going to select the green Submit a Formal Comment box, right there next to the arrow.

This will redirect you to regulations.gov. This site will be actually where you're inputting and submitting your comment.

Here you can see the top part of that page. You can enter your comment in the Comment field. You can also add a file, if you wish to do so. Then you will scroll down that same page.

You will enter your information in the designated fields. Fill in the information and make sure you click on that "I read and understand the statement above" box. The Submit Comment box will not turn green unless that box is selected. So, once complete, you will just simply click the Submit Comment button. That's it. That's all there is to submitting your comment. Again, please do comment. CMS does look forward to hearing from you about the proposals that Anita went over with us today.

All right, our last network is Classic Rewind. We're just going to review a little bit of program information.

We're going to take a few minutes to review some program measures just to make sure that everyone's on the same page. We're going to review and discuss the measures and talk about some upcoming deadlines.

We do get a lot of questions about dates and deadlines, and some of the terms that are used. So, I'm just going to take just a quick minute to review some of that. Here, we're talking about next year, the reporting year 2023 for the 2025 payment determination.

So, for your web-based measures, the reporting period of 2023 is for the payment year 2025. That reporting period, or the period of time where your patient encounters occurred, when the patient was in your facility, begins January 1 and extends through December 31, 2023.

You will use data from that reporting period, which again is January 1 through December 31. You will submit the data into HQR during the submission period. The submission period is from January 1 through May 15, 2024. You can submit your data or make any changes any time within those months. That will affect your calendar year 2025 payment determination.

On this slide is a list of the measures for the reporting period of 2023. These are the measures that are part of the program, and successful reporting of these measures will affect again the calendar year 2025 payment determination. Here, specifically, I do want to draw your attention to the ASC-1 through ASC-4 measures. The 2023 reporting period will begin the reimplementation of reporting of these measures. So, come January, that will begin the reporting period for those measures. You will not actually enter the data until the following year during the submission period.

So, just as a review, ASC-1 through ASC-4 measures, which are listed here. These measures count sentinel events that should be rare and they should remain rare. When these types of events occur, it is vital to learn from them to prevent their further occurrence and ensure they remain rare.

These measures were previously reported through the use of Quality Data Codes placed on Medicare fee-for-service claims forms. For those of you that remember that, this approach limited reporting for only fee for service Medicare beneficiaries who billed services; this approach was discontinued for these measures. So, CMS last year finalized the resumption of reporting for these measures, but CMS revised the data submission method to be similar to that of the web-based measures. Data collection for the ASC-1 through 4 measures will begin again with that calendar year 2023 reporting period which will affect the 2025 payment determination. Again, these data will be submitted using the web-based data collection tool found in the Hospital Quality Reporting tool. That's where you submit your other web-based measures. We will bring you all information and education well in advance of when you are due to submit those data. We're just reminding you here as to what is coming up for you in the near future.

All right, now, we are skipping over to the calendar year 2025 reporting period, and I am bringing to your attention the ASC-15a–e measures, and they will begin with voluntary reporting in calendar year 2024 with subsequent mandatory reporting for calendar year 2025 reporting period, which of course will be for the calendar year 2027 payment determination.

So, okay, let's talk about that in a little more detail.

So, again, last year during the rulemaking cycle, CMS finalized voluntary reporting of these measures will begin in the calendar year 2024 reporting period, and mandatory reporting will begin in the calendar year 2025 reporting period. So, data will be submitted by CMS-approved vendors. Any further details that you need with respect to reporting for these measures, you can access the link here for those specifics on measures as well as submission deadlines.

All right, ASC-20: COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP). Reporting for this measure began with Quarter 1 2022. For the purposes of this program, you only need to collect data and report data for one self-selected week per month of each quarter.

The Quarter 1 data included January, February, and March, and the submission deadline for the first quarter data was August 15, 2022. So, Quarter 2 data will be for April, May, and June with a submission deadline of November 15, 2022. So, guys, please don't wait until November to enter your Quarter 2 data. Our phone lines were absolutely jam packed with folks that waited until the very last minute and then experienced a variety of issues when trying to enter data. So, we don't want that for you. We don't want that stress for you, so please don't wait until the last minute. There have been some recent updates as it relates to boosters, completed series, and up-to-date [patients].

Beginning with June data, booster doses by vaccine manufacturer are no longer in a drop-down box when you're entering data. The need to create a monthly reporting plan is no longer required. A completed series refers to the cumulative number of healthcare personnel who completed any COVID-19 vaccine series (dose 1 and dose 2 of COVID-19 vaccines requiring two doses for completion or one dose of COVID-19 vaccine requiring only one dose for completion) and that would be at your facility or anywhere else.

Up to date is an individual who received all recommended doses in their primary vaccine series and received at least one booster dose or, it's an individual who recently received all recommended doses of the primary vaccine series but they're not quite eligible for a booster dose yet.

So, I know this can be a little confusing. So, let's just look at this in a little bit more detail. We've had a lot of questions about this. The table here describes up-to-date individuals under the age of 50 on the left and 50 or over on the right. Essentially, those 50 and over are considered up-to-date if they have received a second booster, or they received their first booster less than four months ago and they're not eligible for a second booster yet, or, for both categories, they have recently received all recommended doses in the primary series, but they are not eligible for a booster dose. There are guidelines for individuals with moderate to severe immunocompromised conditions, and you can see those here in the bottom box. We do refer you to the NHSN website for specifics on these elements.

There are a few little tips and tricks to let you know about here. Temporary enrollment numbers that are provided by NHSN are only valid for 30 days. Please don't put the email you receive from NHSN with your temporary enrollment number somewhere and forget about it for weeks. If you go back and you try to use it, it won't work if it's after that 30-day period. If you do use a temporary enrollment number when you're enrolling your ASC, please make sure you go back in and add the CCN into the NHSN system when you complete the enrollment process.

Another important thing is using the same email when registering and enrolling your ASC and your SAMS access request. The NHSN system does like everything to match up. Also, you can use your SAMS credentials from a previous ASC for your new ASC. You just remember to update your current ASC facility in the NHSN system. If you have a new email, change your existing email to the new email in NHSN first and then in the SAMS profile. It seems to mitigate some issues if you change things in NHSN first. Again, we do refer you to NHSN for specifics. They do have a lot of training tools available on their website.

All right, this is the last thing that I want to point out to you with regard to the ASC-20 measure, specifically. When you are entering your ASC-20 data in NHSN, you need to be cognizant of the week you are choosing. You want to make sure that your data are applied to the correct month. We've spoken to a lot of ASCs that have called because they got a notification from us saying that they didn't submit their data when they thought they had. It turned out that, in some of these cases, they entered two weeks for the same month and left another month of the quarter unaccounted. So, you want to make sure that the week you are entering data begins and ends in the month you're intending to submit data.

So, in this illustration on the slide, the last week here starts in September, but it ends in October. So, if you want to submit information and data for September, you're not going to want to choose this because it does not begin and end in the same month you're trying to submit data. So, hopefully, that will clarify things and avoid some of these pitfalls.

So, let's just review some deadlines for the current measures for this program. We're going to go ahead and start with ASC-20 because we are talking about it.

This measure is required. Again, the requirement began in January of 2022, and that is for the calendar year 2024 payment determination. You can see here on this table that Quarter 1 was back on August 15. Your next deadline is for Quarter 2, and that deadline is November 15th. That's the reporting period using April 1 through June 30, 2022. You can also see the deadlines here for Quarter 3 and Quarter 4.

Claims-based measures: These data for these measures are collected via paid Medicare claims for cases that meet the measure criteria. You will not be manually abstracting and reporting data for these measures. You can see here ASC-12, ASC-17, and ASC-18 are current measures, and the data are collected again from those claim forms during the timeframe listed here under Reporting Period. The ASC-19 measure and data for those measures are collected for the reporting period you see here.

So, let's move on to measures you submit through the HQR System. The table we have here is for the 2023 reporting period for the payment year 2025. Now, web-based measures, as a reminder, are submitted once a year. Right now, there are four measures entered into the system, which are ASC-9, 11, 13, and 14. ASC-11 has been voluntary for this program, but it was finalized to be mandatory beginning with the calendar year 2025 reporting period. However, as Anita talked about earlier, there is a proposal for the ASC-11 measure to remain voluntary. We'll have to see how that shakes out in the final rule, but, in any regard, whatever happens with the final rule, ASC-11 will still be voluntary for your next submission period.

So, again, we're going to talk about the ASC-1 through 4 measures, and the reporting period for those measures begins in 2023. I mentioned that a few slides back. These measures will be submitted along with your other web-based measures that we talked about on the previous slide.

Since data collection begins with the calendar year 2023 reporting period, you will use the data, or encounter period, from January 1 through December 31, 2023. You will enter that data during the submission period, which is January 1 through May 15, 2024.

ASC-a–e measure voluntary reporting begins with the calendar year 2024 reporting period, and the mandatory reporting will begin with the 2025 reporting period for the 2027 payment determination. That is a very brief review of our upcoming deadlines.

As always, if you ever need any assistance at all, please give us a call. We're always happy to hear from you. Our help desk number is here on the slide. Of course, you are always able to enter your question in the Question & Answer Tool on QualityNet. NHSN communicates by email only and their address is found here as well.

Remember you can make a difference. So, please submit your comments regarding the proposed rule. Every comment is read, and CMS will respond to commenter feedback in the final rule.

That's all the time we have today. Thank you, Anita, for discussing the proposed rule with us. It's always great to have CMS available to talk about these important proposals.

We thank all of you for joining us as well. See you next time!