



Hospital Outpatient Quality Reporting Program Support Team

Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System Proposed Rule Presentation Transcript

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Karen

VanBourgondien: Hi, everyone. My name is Karen VanBourgondien, and I am with the [Hospital] Outpatient Quality Reporting Program Support Team. Thank you so much for joining us today as CMS discusses the proposals as they relate to the ASC Quality Reporting Program.

Our speaker today is Dr. Anita Bhatia. Anita is the CMS program lead for the ASC Quality Reporting Program. She plays a crucial role in the development of the OPPTS/ASC proposed and final rulings. Her contribution to these rulings is essential to the continued success of these programs, and we are certainly fortunate to have Dr. Bhatia with us today.

The objectives for today's webinar are listed here on the slide. As always, we do have the chat box open for any questions that you may have.

I'd like to just make a quick point here and make certain that the content covered on today's call should be not considered official guidance. The webinar is here only to provide information regarding program requirements. Please refer to the proposed rule to clarify and provide a more complete understanding of the modifications and proposals for the program which Anita will be discussing.

So, here are the direct links to the rule. We have also included addenda that are located in the [cms.gov website](https://www.cms.gov).

Anita Bhatia: Thank you, Karen and everyone attending our presentation. We will be discussing proposals and a request for information for the ASC Quality Reporting Program as contained in the calendar year 2025 OPPTS/ASC proposed rule. Today will be an overview. Details are available in the published rule, and information for accessing this document online will also be covered.

Last year, we finalized an immediate measure suspension policy for the Rural Emergency Hospital Quality Reporting Program that incorporated stakeholder input received through public comment.

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We seek to align a similar policy under the ASC Quality Reporting Program with this updated version. Under this proposal regarding immediate measure suspension in cases where there is evidence that the collection and reporting of a measure raises potential patient safety concerns, we would suspend the measure from the program until potential removal can be proposed through rulemaking. This language more accurately represents the process, which includes soliciting public input. We would provide notification via standard communication channels such as Listservs and a CMS designated website posting such as on QualityNet. We would then address the suspension and proposed policies regarding any such suspended measure in the next feasible rulemaking cycle.

There are also proposals for adoption of new measures for the program in this proposed rule.

Inequities related to the social drivers of health may affect health related social needs, or HRSNs, which are individual-level, adverse social conditions that negatively impact an individual's health or healthcare and are associated with worse health outcomes and increased healthcare utilization. Adopting health equity quality measures would support CMS's national quality strategy goal of advancing health equity and whole person care. Thus, three health equity measures are proposed for adoption: Facility Commitment to Health Equity, or FCHE measure; Screening for Social Drivers of Health, or SDOH, measure; and the Screen Positive Rate for SDOH measure. These measures have been adopted for other CMS Quality Reporting Programs. It is CMS's belief that adopting these measures across Quality Reporting Programs can incentivize facilities to identify critical equity gaps and implement plans to address such.

The Facility Commitment to Health Equity, or FCHE, measure assesses a facility's commitment to health equity through responses in sets of questions designated by letters and five domains listed here on this slide. Note that for ASCs, Question C under Domain 2 requires facilities to use EHR technology, but it does not require the use of Certified EHR Technology, or CEHRT, to attest Yes to the question.

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This is a variation to this question for the hospital programs because we recognize that some ASCs have not adopted CEHRT but may use some EHR technology. If your facility does not use any EHR technology, you would attest No to this question. We are proposing that reporting for this measure would begin with that calendar year 2025 reporting period to affect the calendar year 2027 payment determination.

The Facility Commitment to Health Equity measure is calculated based on a facility's answers to the five attestation-based domains. The numerator would capture the total number of domains to which the facility is able to attest affirmatively, up to a maximum of five domains. We propose that a facility would receive a point for a domain only if it attested Yes to all of the elements, also known as questions within that domain. The denominator of the FCHE measure would be a total of five points. That is one point per domain.

Five selected evidence-based domains to screen for health-related social needs are noted here on the slide. These domains and their descriptions are found in Table 88 on page 59445 of the proposed rule.

So, we now have some measures applying these Health-Related Social Need domains. The Screening for Social Drivers of Health measure assesses the total number of patients who are 18 years of age or older on the date of service that were screened for these health related social risk factors. It is proposed that reporting for this measure would begin with a voluntary period for the calendar year 2025 reporting period, followed by mandatory reporting beginning with the calendar year 2026 reporting period to effect calendar year 2028 payment determinations. CMS believes that screening patients consistently for these factors could support quality improvement initiatives and better patient outcomes.

For data collection of the Screening for Social Drivers of Health measure, we propose that healthcare facilities would use a self-selected screening tool. This is to reduce burden and in recognition of the fact that some healthcare facilities may already be screening their patients for health-related social needs.

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In alignment with other CMS Quality Reporting Programs, we propose that ASCs could confirm the current status of any previously reported health-related social needs in another care setting and inquire about others not previously reported in lieu of rescreening a patient within the reporting period and that the ASC could use that information for purposes of reporting the measure in lieu of screening the patient. Two sources for screening tools are listed here, the SIREN website as well as CMS.gov site which has the Accountable Health Communities screening tool.

The Screening for SDOH measure is calculated as a percentage of patients screened of all patients. Specifically, the numerator is defined as the number of patients admitted to an ASC who are 18 years or older on the date of admission and are screened for all five HRSNs. The denominator is defined as the number of patients who are admitted to the ASC and who are 18 years or older. The measure excludes patients who opt out of screening or who are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf. It is proposed that ASCs would aggregate data collected for the numerator and the denominator and the submission of patient-level data would not be required. As stated, a few slides back, the reporting of this measure would begin with voluntary reporting followed by mandatory reporting. The one year voluntary reporting period would provide a transition period for facilities to select and integrate screening tools into their clinical workflow.

The third and final proposed measure is the Screen Positive Rate for SDOH measure, which is calculated as a percentage of patients who screened positive of those patients that were screened. This measure calculates the percent of patients receiving care at an ASC who were 18 years or older on the date of service, who were screened for all five HRSNs discussed earlier. As with the Screening for SDOH measure, we are proposing to adopt this measure, beginning with voluntary reporting for the calendar year 2025 reporting period, followed by mandatory reporting beginning with the calendar year 2026 reporting period to affect calendar year 2028 payment determinations.

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While the Screening for SDOH measure enables identification of individuals with HRSNs, the Screen Positive Rate for SDOH measure enables healthcare facilities to determine the magnitude of these needs by requiring healthcare facilities to report the rates of patients who screen positive for each of the five core HRSNs. Capturing the rate of positive HRSNs estimates the impact on healthcare utilization and quality of care and would enable the development of individual patient action plans and lead to improved patient outcomes.

The Screen Positive Rate for SDOH is a process measure, and results of this measure are calculated and reported as five separate rates, one for each HRSNs, each calculated with the same denominator. The numerator is defined as the number of patients receiving care at an ASC who are 18 years or older on the date of admission, who were screened for all five HRSNs, and who screen positive for having a need in one or more of those HRSNs. The denominator is defined as the number of patients receiving care at the ASC who are 18 years or older on the date of admission and are screened for all five HRSNs during their care. This measure has the same exclusions as the SDOH screening measure, which are relisted on this slide. While this measure would require ASCs to collect patient-level data on their patients' SDOH screening results consistent with the Screening for SDOH measure, we propose to adopt this measure as an aggregate measure. As such, ASCs would be required to submit aggregated data representing the total numerator results for each of the five screening areas and the total number of patients screened for all five of the HRSNs. Like the Screening for SDOH measure, a voluntary period would allow time for facilities to prepare for reporting of the measure. For all three proposed measures, we are proposing that the reporting period for each measure would be January 1 through December 31 of the year two years prior to the applicable payment determination year. ASCs would be required to submit the data for each of these three measures annually using a CMS approved web-based data collection tool available within the Hospital Quality Reporting, or HQR, system, starting January 1 through and including May 15 in the year prior to the applicable payment determination year.

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So, that sounds a bit complicated, but this is the same as for other current web-based measures in the program. Similarly, ASCs would be able to enter review and correct data during the data submission period.

The ASC Quality Reporting Program's current measure set measures clinical quality across all ASCs, including specialty clinical procedures performed only by a subset of ASCs. Thus, a portion of the ASC Quality Reporting Program measure set only applies to an ASC if it performs specific specialty procedures. We seek to ensure the most meaningful measures apply to each facility, as requiring an ASC to report on measures minimally relevant to their patient population increases burden with minimal benefit.

Therefore, we are seeking comment on two potential future frameworks, the Specialty-Select framework and the Specialty Threshold framework. These frameworks would achieve the outcomes of the addition of case minimums for specialty measures, the removal of the zero case attestation for measures, and the verification of individual measure case counts, using claims data to determine which specialty measures would potentially be required for reporting for individual ASCs. Verifying case counts, using claims data, would allow confirmation that individual ASCs are reporting on measures meeting or surpassing case minimums.

Under these potential frameworks, we are considering revising the data reporting requirements for the program to only require that ASCs report data to CMS on quality measures that are related to their medical interventions, policies, processes, and procedures or that can be abstracted from claims information. These potential frameworks would require ASCs to report measures generally applicable to all program participants and to those specialty-specific measures relevant to individual ASCs.

The current ASC Quality Reporting Program measure set has seven generally applicable measures for which reporting would be required in both frameworks for all ASCs:

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four patient safety measures, the patient burn, the patient fall, the wrong site/wrong patient/wrong procedure/ wrong implant, and the all-cause hospital transfer admission measures; one general surgery measure, which is the Facility-Level, Seven-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers; one vaccination measure, the COVID-19 Vaccination Coverage Among Healthcare Personnel; and one patient experience of care survey measure, the OAS CAHPS. In addition, we have proposed to adopt the three new measures we covered earlier, the FCHE, the Screening for SDOH, and the Screen Positive Rate for SDOH, which ASCs would also be required to report if those measures are finalized for adoption.

Here are some of the specialty-specific measures that are part of the measure set for this program. Five of these measures are not claims-based and, under this potential framework, would not be applicable or required for all ASCs to report, but they instead would be available for selection upon meeting a specified case threshold minimum. We acknowledge that currently there are few nonclaims-based, specialty-specific measures from which to choose to report. However, we are interested to learn if such a framework with both mandatory measures applicable to all ASCs and selectable specialty-specific measures could lay the groundwork for providing higher quality data to patients while ensuring ASCs are not reporting data on measures that are minimally relevant or not relevant to their patient population.

Under our first potential framework, a Specialty-Select framework, all ASCs would be required to report on all specialty-specific claims-based measures because these measures are not administratively burdensome. Additionally, ASCs would also be required to select a specified number of the remaining nonclaims-based specialty-specific measures to report if those measures are applicable to that ASC. We would define the number of nonclaims-based, specialty-specific measures that ASCs would be required to report in future rulemaking. To determine if a nonclaims-based specialty-specific measure is applicable to an ASC, we are considering the implementation of a case threshold minimum.

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We would specify that in future rulemaking for each measure. We would determine if case threshold minimums defined as the number of cases for specific measures that must be met or exceeded to potentially require reporting have been met by using claims data. Once an ASC met the measure's case threshold minimum, that measure would become available for that ASC to select to meet reporting requirements.

For example, if we decide that each ASC must select three out of the available nonclaims-based specialty-specific measures to report, and an ASC surpasses the specified case threshold minimum for all of those measures, the ASC would then choose three out of those to report. If an ASC surpasses the specified case threshold minimum for only one or two of the nonclaims-based specialty-specific measures, the ASC would no longer have a choice and must report all of those measures meeting the case threshold minimum. However, if an ASC does not meet the case threshold minimum for any nonclaims-based, specialty-specific measures, reporting for any of those measures would be voluntary. Under such a framework, ASCs could not utilize the claims-based measures to meet specialty select reporting requirements, nor could ASCs opt out of reporting these measures. ASCs, which do not have one or more cases for a given measure, would no longer be required to provide an attestation of having zero cases.

Next is the Specialty Threshold framework. As an alternative to the Specialty-Select framework, we are considering requiring reporting for all non-claims based specialty-specific measures for which case counts reach a specified case threshold minimum. This case threshold minimum would not apply to claims-based specialty-specific measures as their reporting would be mandatory and since these measures are not administratively burdensome to ASCs. Under this alternative Specialty-Threshold framework, mandatory data reporting for specialty-specific, nonclaims-based measures would occur only if an ASC met established case threshold minimums. Essentially an ASC would be required to report on all specialty-specific measures for which the ASC reaches the case threshold minimum.

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For example, if an ASC has 30 or more qualifying patients for a measure during the applicable reporting period, which is the current minimum case threshold required for public reporting for some measures, the ASC would be required to report data for these measures. Likewise, if an ASC had fewer than 30 patients for that measure, data reported on the measure would be voluntary. There are details and specific questions and considerations in the proposed rule for which we request feedback. We invite public comment on both the Specialty-Select framework and the alternative Specialty Threshold framework for potential inclusion in the ASC Quality Reporting Program.

This completes my summary. We would love to hear what you think about our proposals. Please comment and provide feedback. Every comment must be addressed, and this input is utilized in our decisions to finalize or not finalize proposals. This is your opportunity to be involved and instrumental in the decisions made regarding the ASC Quality Reporting Program. On details on how to comment. Let me now turn things back over to Karen.

Karen

VanBourgondien: Thank you, Anita. OK. To be assured consideration, comments must be submitted no later than September 9, 2024. CMS cannot accept comments by fax, and they do encourage submission of comment by electronic means. However, you can submit comment by regular mail, express mail, overnight, those types of things. Be aware that to provide comment in those ways there are separate addresses, and you can resource those addresses. They are listed in the proposed rule. If you do mail in your comment, please allow sufficient time for those mailed comments to be received by that close of the comment period of September 9.

So, to access the rule in the *Federal Register*, the direct link is here on the slide. It will take you to the exact location of the rule in the *Federal Register*. To begin the commenting process, you're simply going to select the green Submit a Formal Comment box.

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You will enter your comment in the comment field. You can also attach files. If you choose, there is a green Attach File button there, and you'll continue to fill in your information.

So, you'll scroll down that same page and continue to enter your information in the designated fields. Once you have filled in the designated areas, you will need to click on "I read and understand the statement above." That's really just telling you that your information may be shared in relation to your comment. So, select that box and then select the green Submit Comment box, and that's it. Your comment will be sent over to CMS. Again, please do comment. CMS looks forward to hearing from you about the proposals that were discussed today, and that is your opportunity to be involved in those CMS decisions. Anita, before I get into this last section, would it be okay if we just responded to a few questions?

Anita Bhatia: That would be great. Karen, that's okay.

Karen

VanBourgondien: All right. First question with the proposed health equity measures: What if our ASC doesn't use certified EHR technology? What would they do, Anita?

Anita Bhatia: Well, thank you, Karen, for this question. I realize that there is some concern in the ASC community about this. For the reporting of the FCHE measure, there is a difference for hospital versus ASC. ASCs are required to use EHR technology to attest Yes to this question, but Certified EHR Technology is not required. If an ASC has neither of these in use, the facility would answer No to the question.

Karen

VanBourgondien: Thank you, Anita. The next question has to do with Screening for the SDOH, and the question is: Is there an existing screening tool that we can use to screen patients for the Screening for the SDOH reporting measure?

Anita Bhatia: Yes, there are, Karen. There are existing screening tools that are publicly available. We included links to two websites with publicly available tools on slide 16.

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They are the University of California, San Francisco, SIREN website and the cms.gov site with the Accountable Health Communities screening tool.

Karen

VanBourgondien: Thank you, Anita. We will put those direct links in the chat box right now as well. Okay. Next question for the Specialty-Specific framework. CMS would include nonclaims-based measures, but currently there are only a few such measures for this program. Is having those few claim-based measures enough?

Anita Bhatia: So, Karen, we acknowledge that currently there are few nonclaims-based measures that are specialty-specific from which to choose. One of the questions we pose in the rule is this: How many nonclaims-based, specialty-specific measures should we require ASCs to report? Through our request for information in the proposed rule, we are interested in public feedback to inform our efforts to utilize these potential frameworks.

Karen

VanBourgondien: Thank you, Anita. Here's another question about the request for information. It seems like the Specialty-Specific framework is similar to what we report for physician-based programs. Why are we double reporting?

Anita Bhatia: So, again, thank you, Karen. Yes, the frameworks are similar. However, the statutory charge for the ASC Quality Reporting Program is to collect information at the facility-level. The potential future specialty-specific framework would provide important facility-level data for measures that are not collected under the physician-based programs. Importantly, this potential future framework could be an important way to assess quality measurement in the ASC setting. ASC services for Medicare beneficiaries are generally limited to certain commonly performed outpatient procedures in a given specialized ASC facility.

Karen

VanBourgondien: Well, thank you, Anita, for answering a couple of those questions. We appreciate that.

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So, just as an FYI, every rule contains information at the beginning, and it includes addresses for comments if you intend to mail in your comment, which I just spoke about a few minutes ago. All of that information is at the beginning. There's a section on important CMS contact information, which would include specific people as they relate to the various programs. You will see Anita's contact information there, as she is the program lead for the ASC Quality Reporting Program. There will be access links to addenda, and we did include the link for the ASC Quality Reporting Program at the beginning of this presentation, but this section in the rule does provide more detail on the addenda and for various programs. It will also have a table of contents for the entire rule, and this is pretty handy. If you are looking for something specific, you can access the table of contents, and you can go right to the section that you are interested in. Lastly, there is a summary and a background section, and this includes an executive summary of the entire proposed rule. So, just a little FYI there.

Before we wrap up today, I do want to just hit on a couple of program reminders. These are sort of like common things people forget, I guess you would say. To keep your HQR and NHSN accounts active, you have to sign into the system every 60 days, and this will really help avoid any issues with account locking and things of that nature. You don't have to do anything specific. You just have to simply log into the system. This is especially important for HQR, because ASCs only enter data there once a year. We do have people, they forget, they forget their password, they forget how to log in, those types of things. So, again, please do not let your account lay dormant until you're ready to enter data. You've got to go in both systems every 60 days and just simply log in. For the safety measures ASC-1 through ASC-4, those you do enter into the HQR system, you need to enter a numerator and denominator. We have an awful lot of people that are checking that box. Please enter zeros for I Have No Data to Submit for these four measures. This box does not apply to those measures. The denominator for these measures are all patients that have been admitted into your ASC. So, you may have a zero numerator, meaning you didn't have any events, but you're not going to have a zero denominator.

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So, please make sure that you enter the data for ASC-1 through ASC-4 correctly. When you are submitting data into the NHSN system, always ensure that your one self-selected week of the month ends in the month you are intending to report. You should choose maybe the second or third week of the month, and that'll make sure that the week begins and ends in the same month and it's the month you're intending to report. The weeks in the NHSN system begin on a Monday and they end on a Sunday. So, make sure that your data are submitted for the month you're intending and not the next month or the previous month.

For example, if you were entering data at the end of August, and you chose the last week in August, and that week ended in a week of September, then your data would actually be applied to the month of September and not August. So, again, just be cognizant of that. The easiest way to go about that is to just choose the second or the third week of the month when entering data into NHSN. So, all of this and more is covered in an extremely comprehensive Open House 2024 webinar that we did. It is currently in our Archived Events tab on QualityReportingCenter.com. We do have the direct link here on the slide. We will put it in the chat box as well, but that that is a very comprehensive webinar. It walks you through data submission for HQR and NHSN, really, literally step-by-step instructions for just about anything you would need. So, if you need help, or you're new, that's definitely something you want to look at.

Okay, so, I think that's about all the time we have today, Anita, again, thank you so much for joining us and talking about CMS proposals. We really appreciate you, and we appreciate you taking a few questions as well. We did cover a lot today. If you have any questions, please contact us. Our number is up at the top. We do have some other resources here listed, and that's all the time we have today. We hope this presentation helped you to prepare for the upcoming finalized proposals that may be coming our way for the program. So, thanks again for joining us. Have a great day.