Outpatient Quality Program Systems and Stakeholder Support Team

CY 2025 Hospital OPPS/ASC Payment System Final Rule: Ambulatory Surgical Center Quality Reporting Program Presentation Transcript

Speakers

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Karen VanBourgondien: Hello everyone. My name is Karen VanBourgondien. I with the Outpatient Quality Reporting Program Support Team. Thank you for joining us today as CMS discusses the finalized proposals related 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. Dr. Bhatia plays a crucial role in development of the proposed and final rulings. Her contributions to the rulings are essential to the continuing success of this programs. We are fortunate to have Dr. Bhatia's commitment.

The objectives for today's webinar are listed here on the slide. We will show how and where to locate the rule in the *Federal Register,* we will review the finalized action for each proposal, and we will review deadlines for the program. If you have not yet downloaded the slides from our website, QualityReportingCenter.com, you can get the slides now; just click on the icon on the right side of the screen in the menu box.

We will be stopping during the presentation and Anita will be responding to comments.

Here is the direct link to the rule. We do recommend you read the rule yourself for a more complete understanding of the finalized actions that Anita is going to be discussing with us today. Without any further delay, let me hand things over to Dr. Bhatia. Anita?

Anita Bhatia: Thank you, Karen and everyone attending our presentation. We will be discussing the finalized proposals as well as a request for information for the ASC Quality Reporting Program.

In this rule cycle, some new measures were adopted for the program. CMS is committed to advancing health equity and improving health outcomes through our quality reporting programs. The CMS Framework for Health Equity acknowledges that addressing health and healthcare disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities.

To further the agency priority of health equity, the addition of three measures was proposed: The Facility Commitment to Health Equity or the 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. The goal for adopting these measures across our quality reporting programs is to incentivize facilities to identify critical equity gaps and implement plans to address such.

The Facility Commitment to Health Equity measure assesses a facility's commitment to health equity through responses in sets of questions in five domains. As finalized, reporting will begin with the calendar year 2025 reporting period for calendar year 2027 payment determination. The measure domains are listed here and there are additional details on these domains and the element specificity in the final rule.

The Facility Commitment to Health Equity measure is calculated based on a facility's answers to the five attestation-based domains. The numerator is the total number of domains to which the facility is able to attest affirmatively, up to a maximum of five domains. We proposed that a facility would receive a point for a domain only if it attested "yes" to all of the elements, that is, the questions within that domain. We will not accept an attestation whereby a facility attests "yes" to some, but not all of the elements; in the event a facility is not be able to attest "yes" to one or more elements within a domain, or the entirety of a domain, they will respond "no." The denominator of this measure constitutes a total of five points (that is, one point per domain). And as noted on this slide, this measure was finalized as proposed.

Next, we address quality metrics for Health-Related Social Needs. Health-related social needs, or HRSNs, are social and economic needs that affect an individual's ability to maintain their health and well-being. Five selected evidence-based domains to screen for HRSNs are listed here on the slide. These domains and their descriptions are in the final rule.

So, we now have some measures applying these Health-Related Social Need domains. We selected five evidence-based domains for screening. These domains have established evidence of their association with health status, risk, and outcomes, these five domains were selected because they can be assessed across the broadest spectrum of individuals in a variety of settings. Screening for Social Drivers of Health, or SDOH measure is a process measure that assesses the total number of patients, who were 18 years or older on the date of service, screened for social risk factors - specifically, the five HRSNs we just discussed. We proposed that reporting will begin with voluntary reporting for the calendar year 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period which would apply to the calendar year 2028 payment determination.

For the Screening for Social Drivers of Health measure, facilities would use a self-selected screening tool. This flexibility aims to reduce burden and is in recognition that some healthcare facilities may already be screening their patients for Health-Related Social Needs. In alignment with other CMS quality reporting programs, we proposed ASCs could confirm the current status of any previously reported HRSNs in another care setting and inquire about others not previously reported, in lieu of re-screening a patient within the reporting period. While there are potential benefits of requiring all healthcare facilities to use the same screening instrument or a prescribed set of standards around the number or types of screening questions used, we view the benefits of providing healthcare facilities with flexibility to customize screening and data collection to their patient populations and individual needs. Evidence-based resources like the SIREN website for screen tool options as well as the Accountable Health Communities, or AHC Model screening tool on CMS.gov site are available.

The Screening for SDOH measure is calculated as a percentage. The numerator is 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 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 are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

ASCs will aggregate data collected for the numerator and the denominator and the submission of patient-level data will not be required for the screening for SDOH measure. We are requiring aggregate data because we believe patient-level reporting is unnecessary and would cause undue burden due to the transfer of large quantities of data. We believe that beginning with a voluntary reporting period followed by mandatory reporting will provide a transition period for facilities to select and integrate screening tools into their clinical workflow. As noted on the slide, the proposal to adopt the Screening for SDOH measure was finalized as proposed beginning with voluntary reporting for the CY 2025 reporting period for application to the CY 2027 payment followed by mandatory reporting beginning with the CY 2026 reporting period as it applies to the CY 2028 payment or program determination.

Last is our third proposed health equity measure, the Screen Positive Rate for SDOH. The Screen Positive Rate for SDOH is a process measure that provides information on 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 and who screened positive for one or more of those HRSNs. As with the Screening for SDOH measure, we proposed to adopt this measure beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period as it applies to the CY 2028 payment or program determination. This measure is not intended for comparison of screen positive rates of HRSNs between healthcare facilities but is rather to provide transparency in the delivery of care and actionable information to healthcare facilities on the unmet needs among their patients.

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 HRSN, 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, and these are also listed here on the slide.

While this measure will require ASCs to collect patient-level data on their patients' SDOH screening results, consistent with the Screening for SDOH measure, we proposed to adopt this measure as an aggregate measure. As such, ASCs will 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. As noted, this measure was finalized as proposed.

For all three of these equity measures we are proposing that the reporting period for each measure will be January 1 through December 31 of the year two years prior to the applicable payment determination year. ASCs will 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 HQR System beginning January 1 through and including May 15 in the year prior to the applicable payment determination year. This is the same schedule s for other, current web-based measures in the program. ASCs will be able to enter, review, and correct data during the data submission period.

For additional information on how to apply and report these screenings, a FAQ document regarding this measure in the Hospital IQR Program is available on the Quality Reporting Center website. We will develop a similar Frequently Asked Questions document for the Hospital OQR, REHQR and the ASCQR Programs as part of providing educational and training materials. This document will be conveyed through routine communication channels.

The measure specifications for these measures can be found on the QualityNet website, and the direct link is here on the slide.

In this rulemaking cycle, we have one policy modification.

We proposed and finalized to modify the current immediate measure removal policy, so it is more appropriately referred to as immediate measure suspension policy beginning with CY 2025. Under this immediate measure suspension policy, in cases where there is evidence that the collection and reporting of a measure raises potential patient safety concerns, we will suspend the measure from the program until potential removal can be proposed through the rulemaking process. We will notify ASCs and the public of the decision through standard communication channels, including, program-specific listservs and program guidance. We will then address the suspension and propose policies regarding any such suspended measure in the next feasible rulemaking cycle. As noted, this change was finalized as proposed.

Karen VanBourgondien: So, Anita do you mind if we just pause her for a minute and talk about some of the information that you just covered?

Anita Bhatia: Of course, Karen. I think that would be a great idea.

Karen VanBourgondien: We have had some comments about the equity measures and there seemed to be there be several commenters that recommended CMS either include voluntary reporting, or delay mandatory reporting, for the health equity measures; and they are saying this would allow facilities adequate time to expand health equity improvement initiatives and create, build, and deploy processes; or even phase in measure domains incrementally; some even suggested that by delaying mandatory reporting that would provide CMS with more time to better define each domain, and to continue to evolve and potentially respecify the measures to reduce burden on providers. What is CMS' perspective on some of these comments?

Anita Bhatia: So, Karen, you are correct. We received a lot of great feedback and recommendations regarding these measures; and we considered concerns about the timing of mandatory reporting. In the end, as achieving health equity is a pressing issue which deserves serious focus and rapid action these equity measures will be an annual measure with mandatory reporting beginning with the calendar year 2025 reporting period as it applies to the calendar year 2027 payment determination. This will still allow facilities more than a year to prepare for the submission deadline of May 15, 2026. Facilities can spend the remainder of calendar year 2025 addressing potential barriers for positive attestations for the FCHE measure as well as setting up data collection for the other measures. As equity is a pressing issue, we view this measure as a building block for a more comprehensive suite of measures that would assess progress in providing high-quality healthcare for all patients.

Karen VanBourgondien: Okay, so Anita, in the final rule, there were a few commenters that recommended CMS communicate with stakeholders to refine its portfolio of health-equity related measures while creating a streamlined measure set that is applicable and standardized across settings, such as recommending that CMS evaluate the results of these measures in conjunction with stakeholder communication before expanding measure requirements. Can you share CMS' perspective on something like that?

Anita Bhatia: Sure, Karen. Again, we reiterate that stakeholders convened by the PRMR, or Pre-rulemaking Measure Review entity previously reviewed the equity measures and provided feedback during the PRMR process. The purpose of the PRMR process is to solicit and provide multi-stakeholder input on the selection of quality and efficiency measures under consideration for use in CMS quality programs. There is discussion in the final rule about this process if any are interested in knowing more about it.

Karen VanBourgondien: Thank you, Anita. That is helpful. We have heard some stakeholders have apprehension about the FCHE measure and what they see as a "one size fits all" approach to implementing this measure and that the measures are maybe not appropriately tailored to the ASC setting. What can you share with us with regard to those types of comments?

Anita Bhatia: So, Karen. While we do acknowledge that the measures were initially developed for the general acute care setting. The inclusion of the FCHE measure in other care settings, including inpatient hospitals, PPS-Exempt cancer hospitals, and dialysis facilities, demonstrates the broad applicability of the measure concept and specifications for different healthcare facility types. Facilities of every type could benefit from this commitment to health equity, as they serve to incentivize the collection and utilization of data across the five domains to identify critical equity gaps, implement plans to address these gaps, and ensure that resources are dedicated toward addressing health equity initiatives, and therefore resulting in actionable initiatives and change. Additionally, there were modifications to Domains 2 and 5 of the FCHE measure as compared to the Hospital Commitment to Health Equity measure on the hospital side, which were constructed to address nuances within non-hospital settings.

Karen VanBourgondien: Anita, a question we have been getting about the Screening for SDOH measure is the facility screens the patient for all five Health Related Social Needs (HRSNs) and the patient answers some questions, but refuses to answer others; would those case be excluded from the denominator?

Anita Bhatia: Yes, if the patient or authorized representative declines to answer one or more questions related to an HRSN, the patient can be excluded from the denominator of the Screening for Social Drivers of Health (SDOH) measure and the Screen Positive Rate for SDOH measure. Additionally, if the patient is medically unable to response or has no legal guardian or caregiver able to respond on the patients' behalf, the patient would be excluded from the denominator of the Screening for SDOH measure.

Karen VanBourgondien: Thank you, Anita, and I think maybe one more question before we move on. This is with regard to the finalized immediate measure suspension policy, once a measure is suspended, are facilities still penalized for non-compliance with the requirements for the suspended measure in the subsequent payment determination year?

Anita Bhatia: Great question, Karen! Under the immediate measure suspension policy, once a measure is suspended, data collection and reporting would cease until permanent action could be determined in a subsequent rulemaking cycle. Facilities would not be penalized for non-compliance with the suspended measure as the requirement to collect and report data would not be in effect.

Karen VanBourgondien: Perfect. Thank you very much Anta for that clarification. So, I think I am going to hand it back over to you Anita to discuss the requests for information. So, back to you.

Anita Bhatia: All right, Karen. So, here is our Request for Information. In this year's rulemaking cycle, we sought comment on two potential future frameworks, the Specialty-Select Framework and the Specialty Threshold Framework. These frameworks seek to add the use of case minimums for specialty measures, remove the zero-case attestation, and implement 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.

For details, specific questions, and considerations regarding this RFI, you can access the final rule in the Federal Register. We have the direct link here on the slide. We thank commenters for their feedback, both positive and negative, regarding these frameworks and will consider this feedback for any future rulemaking.

Karen VanBourgondien: Thank you, Anita. Let's stop here again and discuss maybe some comments about the requests for information that you just went over. Before we get into comments specific to the request for information, let me just go back and touch on the discussion we had previously regarding the equity measures. The FCHE measure is the only one of the three that begins with mandatory reporting. The reporting period for this measure has begun and is from January first and runs through December 31, 2025. So, that's the reporting period. You will then submit that data any time between January 1 and May 15 this year, 2026. That submission will be for your calendar year 2027 payment determination. So again, the FCHE measure is the only one of the three that begins with mandatory reporting.

The Screening for SDOH and Screen Positive Rate for SDOH measures begin with voluntary reporting and then move into mandatory reporting the year after. So, the voluntary reporting period for those two measures has also begun and that began January first through December 31, 2025; and you will submit that data any time between January 1 through May 15, 2026, and that is the same as the FCHE measure I just reviewed. So, the FCHE measure begins with mandatory reporting and the other two begin with voluntary reporting.

The mandatory reporting period for the Screening for SDOH and Screen Positive Rate for SDOH measures will begin next year from January first through December 31, 2026, and of course, you will submit that data the following year between January 1 through May 15, 2027, and will apply to the calendar year 2028 payment determination.

Again, all three new health equity measures, ASCs will be required to submit the data annually and you would put them in the HQR system just as you do your other web-based measures. I will hit on this again in a few minutes.

With regard to the specialty-focused frameworks, several commenters offered recommendations like measure additions and modifications to the ASCQR Program measure set to support a specialty-focused framework.

Some of the recommendations were the inclusion of the Toxic Anterior Segment Syndrome measure, the TASS measure and including that in the program and areas for measure development to support a specialty framework, including ASC discharges with subsequent unplanned hospital visits, pain management, and surgical site infections. What does CMS think about some of those recommendations?

Anita Bhatia: Okay, thank you, Karen. Yes, we did put forth the RFI because we wanted feedback, and we received some really great comments We thank the commenters for their insights and input and appreciate the many recommendations received regarding the specialty-focused frameworks. We will take these comments into consideration for any future rulemaking on this topic.

Karen VanBourgondien: Thank you, Anita. We will look forward to what happens with those recommendations. With regard to the current zero-case attestation requirement, there were a lot of recommendations from commenters, and one was that implementation of automated data validation checks to identify incomplete fields, to alert an ASC of missing information during the completion of the zero-case attestation requirement. Can you shed some light on that particular commenter?

Anita Bhatia: Yes, I can, Karen. An important point to make here is that the HQR or Hospital Quality Reporting system already has mechanisms in place which ensure facilities are aware of missing data entry information. These mechanisms include an online lookup tool where facilities can download data entry reports. In addition, we supply phone call and fax reminders regarding missing data.

Karen VanBourgondien: Yes. Thank you, Anita. I appreciate it. Thank you, Anita for spending some time and answering and responding to comments that CMS has received. Before we wrap things up for the day, I do want to review the measure deadlines, and this is going to include the three new equity measures that Anita discussed.

So, here, starting with the web-bases measures that are submitted into the Hospital Quality Reporting system, or HQR, you can see the patient safety measures ASC 1-4; and the reporting period is January 1 through December 31, 2024, and that submission period for that data is open and is open from January 1 through May 15, 2025; and that is the deadline, May 15, 2025. Please don't wait until May 15, 2025.

Continuing on with web-based measures submitted into HQR, you can see here ASC-9, -11, -13, and -14 and they have the same reporting and submission period. As a reminder, the ASC-11 is voluntary. So, you can report that data or not. Please know that if you are a facility that reports that data, that data will be publicly displayed.

Here, these measures are the new health equity measures. They will be reported through the HQR system also. We have the reporting period of January 1 through December 31, 2025, and that submission period will be next year January 1 through to May 15, 2026, and that is the deadline for these measures, May 15, 2026; your reporting period, or data collection period, is now. Remember the FCHE measure, the Facility Commitment to Health Equity is mandatory, but the Screening for SDOH and Screen Positive Rate for SDOH measures is voluntary for the reporting period of 2025. So, they are all on one slide, but we have the disclaimer here that the bottom two are voluntary during this current reporting period.

Our next web-based measure is submitted through the NHSN system. That's the ASC-20: COVID-19 Vaccination Coverage Among Healthcare Personnel. So, your next submission is February 17, 2025. So, next month, it is the 17th because the 15th falls on a Saturday, so we revert to the following Monday for the deadline. That will be for your Q3 2024 data.

Here are the claims-based measures for the program, ASC-12, -17, -18, and -19. We do have the reporting periods lists but as a reminder, for claims-based measures, the ASC does not need to abstract or manually report data. Data for these measures are captured through paid Medicare claims.

Here is a snapshot of the reporting dates for the THA/TKA measure which was finalized in last year's rulemaking cycle. January first began the voluntary reporting for this measure. You can see here that this measure is under voluntary reporting for three years. So again, you can report or not. It will not affect your payment update if you do not voluntarily report data. The data are reported through the HQR system, and the pre and postdates you can see them here on the slide. You are going to submit those data between January 1 and the May deadline, just as you would any other web-based measure.

So, last is the survey measure and the mandatory reporting began January 1, 2025. So, your Q1 data will be due July 9, 2025, and that will be January 1 through March 31, 2025. Data are submitted by a CMS-approved vendor, not by your ASC. If you have not selected a vendor yet, oh boy, we highly recommend you do so immediately. We do understand that a lot of the approved vendors are no longer accepting new clients so please do not delay this part of the process. You must choose a CMS-approved vendor to submit your data. Your chosen vendor will submit the data to the OAS CAHPS website. If you have any questions, you can certainly give us a call, or shoot us your question in the QualityNet Q&A tool. Please by all means, if you have not selected your vendor for the submission of these data, please do so immediately.

Okay! I think that's about all the time we have. Anita, thank you for joining us today and talking about the finalized proposals in this year's rulemaking cycle. We appreciate your time and we do hope that was helpful to you.

Before we leave today, let me mention a few important program reminders. First, the ASC-20 measure: The submission tool in NHSN begins on a Monday and ends on a Sunday. We have so many ASCs that enter data in the first or last week of the month and if these weeks begin in one month and end in another, then the data may be applied to a month you did not intend. Always make sure that week your submitting data for begins and ends in the same month and is the month you are intending to report.

To avoid any chance of reporting to the wrong month, we just recommend that you submit data in either the second or third week of the month. This works well and avoids this issue reporting for the wrong month. We do send targeted messages to ASCs before the submission deadline if they have not submitted data yet. If you get one of these messages, always call us, even if you are questioning the notice. Do not ignore it. The first thing you would want to check is to make sure that your one self-selected week that you submitted data for is in the month you are intended to report. As we just talked about, there is some submission to the wrong month and people think they have submitted to a month, and it was actually applied to another month. So, you have data for two months and you don't have data in another month. We cannot express to you how often this happens. So please make you are submitting data for the intended month. If you do get one of those targeted messages saying, "Hey, you didn't submit your data yet," give us a call. We don't mind; that is what we are here for. It is better that you follow-up and find, you know, that it's a data cross and we do see your data than ignore it and you think you have submitted your data, and you haven't.

Second is regarding the ASC-1 through -4 measures. We often get asked if an ASC can check: "Please enter zeros for I have no data to submit" box for ASC-1 through ASC-4. The answer is No. You cannot check that box for the ASC-1 through ASC-4 measures. If you select the "Please enter zeros for I have no data to submit" box, what you are actually saying is that you had no patients for the reporting period. Remember, the denominator for these measures is All ASC Admissions. The definition of admission is "completion of registration upon entry into the facility." So, this measure would apply to every ASC that has had a patient "admitted." So, you cannot select that box for those measures. You must submit your numerator and denominator. Third, to stay "in the know" if you will, make sure you have subscribed to the Email Updates service on the QualityNet website home page. It is clearly marked Subscribe to Email Updates right on the home page, and I think it is on the left side of your screen. We will put the direct link in the chat box. This is a no-cost email distribution. You

will receive emails on important program information, webinars, deadlines, and a whole lot more. It's really a must-do.

You can easily sign-up again on the QualityNet home page, and it's just a really an easy way to stay in touch with what you need to know for successful in your reporting.

You will also need to keep your passwords active for both NHSN and HQR. You must log in every 60 days to keep your passwords active. When you log in, you don't have to perform any specific tasks, you just need to log in. You really just don't want your account being dismantled because you did not log in. There is nothing worse than going to submit your data only to find out your account is deactivated. This is especially problematic if you wait to the last minute to enter your data and believe me, this happens, and it is why I am mentioning this to you. Please keep your passwords active by logging in every 60 days.

Lastly, just as a reminder, we do have quite a bit of resources available to you to assist you with successful reporting. To find these resources, you can access the qualityreportingcenter.com website. We have webinars tools, important dates documents, successful guides, and much, much more. So, please access that website.

We will be posting a Frequently Asked Questions webinar very soon. This webinar is based on the questions you all ask us the most. So, it is very likely the questions you have right now will be answered in that presentation. Stay tuned for an email announcing this presentation. You will receive this email if you have subscribed to the email updates on Quality Net that I just talked about. If you need any program assistance, reach out to us, the Support Team is always here to help, and our number is right at the top here. The Center for Clinical Standards and Quality Service Center is available for technical support with HARP and HQR access, and the SAMS help desk is available only for technical support with SAMS related issues or access. NHSN is available for support via email for system issues, but we always recommend that you give the program support team a call anytime you need anything. We are always

happy to hear from you. That is all we have time. Enjoy the rest of your day. See you next time.