

whether an IOL qualifies for a payment adjustment as a member of a new class of new technology IOLs when inserted at an ASC:

(1) The IOL is considered new. CMS will evaluate an application for a new technology IOL only if the IOL type has received initial FDA premarket approval within the 3 years prior to the new technology IOL application submission date.

(2) The IOL shall have a new lens characteristic in comparison to currently available IOLs. The labeling, which must be approved by FDA, shall contain a claim of a specific clinical benefit imparted by the new lens characteristic.

(3) The IOL is not described by an active or expired class of new technology IOLs; that is, it does not share a predominant, class-defining characteristic associated with improved clinical outcomes with members of an active or expired class.

(4) Any specific clinical benefit referred to in paragraph (a)(2) of this section must be supported by evidence that demonstrates that the IOL results in a measurable, clinically meaningful, improved outcome. Improved outcomes include:

- (i) Reduced risk of intraoperative or postoperative complication or trauma;
- (ii) Accelerated postoperative recovery;
- (iii) Reduced induced astigmatism;
- (iv) Improved postoperative visual acuity;
- (v) More stable postoperative vision;
- (vi) Other comparable clinical advantages.

(b) *CMS determination of eligibility for payment adjustment.* CMS reviews the information submitted with a completed request for review, public comments submitted timely, and other pertinent information and makes a determination as follows:

(1) The IOL is eligible for a payment adjustment as a member of a new class of new technology IOLs.

(2) The IOL is a member of an active class of new technology IOLs and is eligible for a payment adjustment for the remainder of the period established for that class.

(3) The IOL does not meet the criteria for designation as a new tech-

nology IOL and a payment adjustment is not appropriate.

[71 FR 68226, Nov. 24, 2006, as amended at 77 FR 68558, Nov. 15, 2012; 80 FR 70604, Nov. 13, 2015]

§ 416.200 Payment adjustment.

(a) CMS establishes the amount of the payment adjustment for classes of new technology IOLs through proposed and final rulemaking in connection with ASC facility services.

(b) CMS adjusts the payment for insertion of an IOL approved as belonging to a class of new technology IOLs for the 5-year period of time established for that class.

(c) Upon expiration of the 5-year period of the payment adjustment, payment reverts to the standard rate for IOL insertion procedures performed in ASCs.

(d) ASCs that furnish an IOL designated by CMS as belonging to a class of new technology IOLs must submit claims using billing codes specified by CMS to receive the new technology IOL payment adjustment.

Subpart H—Requirements Under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

SOURCE: 80 FR 70604, Nov. 13, 2015, unless otherwise noted.

§ 416.300 Basis and scope of subpart.

(a) *Statutory basis.* Section 1833(i)(2)(D)(iv) and (i)(7) of the Act authorizes the Secretary to implement a revised ASC payment system in a manner so as to provide for a 2.0 percentage point reduction in any annual update for an ASC's failure to report on quality measures in accordance with the Secretary's requirements.

(b) *Scope.* This subpart contains specific requirements and standards for the ASCQR Program.

§ 416.305 Participation and withdrawal requirements under the ASCQR Program.

(a) *Participation in the ASCQR Program.* Except as provided in paragraph

(c) of this section, an ambulatory surgical center (ASC) is considered as participating in the ASCQR Program once the ASC submits any quality measure data to the ASCQR Program and has been designated as open in the Certification and Survey Provider Enhanced Reporting system for at least four months prior to the beginning of data collection for a payment determination.

(b) *Withdrawal from the ASCQR Program.* (1) An ASC may withdraw from the ASCQR Program by submitting to CMS a withdrawal of participation form that can be found in the secure portion of the QualityNet Web site.

(2) An ASC may withdraw from the ASCQR Program any time up to and including August 31 of the year preceding a payment determination.

(3) Except as provided in paragraph (c) of this section, an ASC will incur a 2.0 percentage point reduction in its ASC annual payment update for that payment determination year and any subsequent payment determinations in which it is withdrawn.

(4) An ASC will be considered as rejoining the ASCQR Program if it begins to submit any quality measure data again to the ASCQR Program.

(c) *Minimum case volume for program participation.* ASCs with fewer than 240 Medicare claims (Medicare primary and secondary payer) per year during an annual reporting period for a payment determination year are not required to participate in the ASCQR Program for the subsequent annual reporting period for that subsequent payment determination year.

(d) *Indian Health Service hospital outpatient department participation.* Beginning with the CY 2017 payment determination, Indian Health Service hospital outpatient departments that bill Medicare under the Ambulatory Surgical Center payment system are not considered ASCs for the purposes of the ASCQR Program. These facilities are not required to meet ASCQR Program requirements and will not receive payment reductions under the ASCQR Program.

§ 416.310 Data collection and submission requirements under the ASCQR Program.

(a) *Requirements for claims-based measures using quality data codes (QDCs).* (1) ASCs must submit complete data on individual claims-based quality measures through a claims-based reporting mechanism by submitting the appropriate QDCs on the ASC's Medicare claims.

(2) The data collection period for claims-based quality measures reported using QDCs is the calendar year 2 years prior to the payment determination year. Only claims for services furnished in each calendar year paid by the Medicare Administrative Contractor (MAC) by April 30 of the following year of the ending data collection period will be included in the data used for the payment determination year.

(3) For ASCQR Program purposes, data completeness for claims-based measures using QDCs is determined by comparing the number of Medicare claims (where Medicare is the primary or secondary payer) meeting measure specifications that contain the appropriate QDCs with the number of Medicare claims that meet measure specifications, but do not have the appropriate QDCs on the submitted Medicare claim. The minimum threshold for successful reporting is that at least 50 percent of Medicare claims meeting measure specifications contain the appropriate QDCs. ASCs that meet this minimum threshold are regarded as having provided complete data for the claims-based measures using QDCs for the ASCQR Program.

(b) *Requirements for claims-based measures not using QDCs.* The data collection period for claims-based quality measures not using QDCs is paid Medicare fee-for-service claims from the calendar year 2 years prior to the payment determination year. Only claims for services furnished in each calendar year paid by the MAC by April 30 of the following year of the ending data collection period will be included in the data used for the payment determination.

(c) *Requirements for data submitted via an online data submission tool—*(1) *Requirements for data submitted via a CMS*

online data submission tool—(i) *QualityNet account for web-based measures.* ASCs, and any agents submitting data on an ASC's behalf, must maintain a QualityNet account in order to submit quality measure data to the QualityNet website for all web-based measures submitted via a CMS online data submission tool. A QualityNet security official is necessary to set up such an account for the purpose of submitting this information.

(ii) *Data collection requirements.* The data collection period for quality measures for which data are submitted via a CMS online data submission tool is for services furnished during the calendar year 2 years prior to the payment determination year. Beginning with the CY 2017 payment determination year, data collected must be submitted during the period of January 1 to May 15 in the year prior to the payment determination year.

(iii) *Review and corrections period.* For measures submitted to CMS via a CMS online tool, ASCs have a review and corrections period, which runs concurrently with the data submission period. During this timeframe, ASCs can enter, review, and correct data submitted. After the submission deadline, this data cannot be changed.

(2) *Requirements for data submitted via a non-CMS online data submission tool.* The data collection period for ASC-8: Influenza Vaccination Coverage Among Healthcare Personnel is from October 1 of the year 2 years prior to the payment determination year to March 31 during the year prior to the payment determination year. Data collected must be submitted by May 15 in the year prior to the payment determination year.

(d) *Extraordinary circumstances exceptions.* CMS may grant an exception with respect to quality data reporting requirements in the event of extraordinary circumstances beyond the control of the hospital, such as when an act of nature affects an entire region or if CMS determines that a systemic problem with one of its data collection systems directly affected the ability of the hospitals to submit data. CMS may grant an exception as follows:

(1) *Upon request of the ASC.* Specific requirements for submission of a re-

quest for an exception are available on the QualityNet Web site; or

(2) *At the discretion of CMS.* CMS may grant exceptions to ASCs that have not requested them when CMS determines that an extraordinary circumstance has occurred.

(e) *Requirements for Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey.* OAS CAHPS is the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems survey that measures patient experience of care after a recent surgery or procedure at either a hospital outpatient department or an ambulatory surgical center. Ambulatory surgical centers must use an approved OAS CAHPS survey vendor to administer and submit OAS CAHPS data to CMS.

(1) [Reserved]

(2) CMS approves an application for an entity to administer the OAS CAHPS survey as a vendor on behalf of one or more ambulatory surgical centers when the applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official OAS CAHPS Web site, and agrees to comply with the current survey administration protocols that can be found on the official OAS CAHPS Web site. An entity must be an approved OAS CAHPS Survey vendor in order to administer the OAS CAHPS Survey and submit data to CMS on behalf of one or more ambulatory surgical centers.

(f) *Data submission deadlines.* All deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.

[80 FR 70604, Nov. 13, 2015, as amended at 81 FR 79879, Nov. 14, 2016; 82 FR 52636, Nov. 13, 2017; 82 FR 59496, Dec. 14, 2017; 85 FR 86302, Dec. 29, 2020]

§ 416.315 Public reporting of data under the ASCQR Program.

Data that an ASC submitted for the ASCQR Program will be made publicly available on a CMS Web site after providing the ASC an opportunity to review the data to be made public. CMS will publicly display ASC data by the National Provider Identifier (NPI) when data are submitted by the NPI. CMS will publicly display ASC data by the CMS Certification Number (CCN) when data are submitted by the CCNs.

§ 416.320 Retention and removal of quality measures under the ASCQR Program.

(a) *General rule for the retention of quality measures.* Quality measures adopted for an ASCQR Program measure set for a previous payment determination year are retained in the ASCQR Program for measure sets for subsequent payment determination years, except when they are removed, suspended, or replaced as set forth in paragraphs (b) and (c) of this section.

(b) *Immediate measure removal.* In cases where CMS believes that the continued use of a measure as specified raises patient safety concerns, CMS will immediately remove a quality measure from the ASCQR Program and will promptly notify ASCs and the public of the removal of the measure and the reasons for its removal through the ASCQR Program ListServ and the ASCQR Program QualityNet Web site. CMS will confirm the removal of the measure for patient safety concerns in the next ASCQR Program rulemaking.

(c) *Removal of quality measures—(1) General rule for the removal of quality measures.* Unless a measure raises specific safety concerns as set forth in paragraph (b) of this section, CMS will use the regular rulemaking process to remove, suspend, or replace quality measures in the ASCQR Program to allow for public comment.

(2) *Factors for consideration of removal of quality measures.* CMS will weigh whether to remove measures based on the following factors:

(i) *Factor 1.* Measure performance among ASCs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (topped-out measures);

(ii) *Factor 2.* Performance or improvement on a measure does not result in better patient outcomes;

(iii) *Factor 3.* A measure does not align with current clinical guidelines or practice;

(iv) *Factor 4.* The availability of a more broadly applicable (across settings, populations, or conditions) measure for the topic;

(v) *Factor 5.* The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;

(vi) *Factor 6.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;

(vii) *Factor 7.* Collection or public reporting of a measure leads to negative unintended consequences other than patient harm; and

(viii) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(3) *Criteria to determine topped-out measures.* For the purposes of the ASCQR Program, a measure is considered to be topped-out under paragraph (c)(2)(i) of this section when it meets both of the following criteria:

(i) Statistically indistinguishable performance at the 75th and 90th percentiles (defined as when the difference between the 75th and 90th percentiles for an ASC's measure is within two times the standard error of the full data set); and

(ii) A truncated coefficient of variation less than or equal to 0.10.

(4) *Application of measure removal factors.* The benefits of removing a measure from the ASCQR Program will be assessed on a case-by-case basis. A measure will not be removed solely on the basis of meeting any specific factor or criterion.

[80 FR 70604, Nov. 13, 2015, as amended at 83 FR 59178, Nov. 21, 2018]

§ 416.325 Measure maintenance under the ASCQR Program.

(a) *Measure maintenance under the ASCQR Program.* CMS follows different procedures to update the measure specifications under the ASCQR Program based on whether the change is substantive or nonsubstantive. CMS will

determine what constitutes a substantive versus a nonsubstantive change to a measure's specifications on a case-by-case basis.

(b) *Substantive changes.* CMS will continue to use rulemaking to adopt substantive updates to measures in the ASCQR Program.

(c) *Nonsubstantive changes.* If CMS determines that a change to a measure previously adopted in the ASCQR Program is nonsubstantive, CMS will use a subregulatory process to revise the ASCQR Program Specifications Manual so that it clearly identifies the changes to that measure and provide links to where additional information on the changes can be found. When a measure undergoes subregulatory maintenance, CMS will provide notification of the measure specification update on the QualityNet Web site and in the ASCQR Program Specifications Manual, and will provide sufficient lead time for ASCs to implement the revisions where changes to the data collection systems would be necessary.

§ 416.330 Reconsiderations under the ASCQR Program.

(a) *Reconsiderations of ASCQR Program decisions.* An ASC may request reconsideration of a decision by CMS that it has not met the requirements of the ASCQR Program for a particular payment determination year. An ASC must submit a reconsideration request to CMS by no later than the first business day on or after March 17 of the affected payment year.

(b) *Requirements for reconsideration requests.* A reconsideration request must contain the following information:

- (1) The ASC CCN and related NPI(s);
- (2) The name of the ASC;
- (3) The CMS-identified reason for not meeting the requirements of the ASCQR Program for the affected payment determination year as provided in any CMS notification to the ASC;

(4) The ASC's basis for requesting reconsideration. The ASC must identify its specific reason(s) for believing it met the ASCQR Program requirements for the affected payment determination year and should not be subject to the reduced ASC annual payment update;

(5) The ASC-designated personnel contact information, including name, email address, telephone number, and mailing address (must include physical mailing address, not just a post office box); and

(6) A copy of all materials that the ASC submitted to comply with the requirements of the affected ASCQR Program payment determination year. With regard to information on claims, ASCs are not required to submit copies of all submitted claims, but instead may focus on the specific claims at issue. For these claims, ASCs should submit relevant information, which could include copies of the actual claims at issue.

(c) *Reconsideration process.* Upon receipt of a request for reconsideration, CMS will do the following:

(1) Provide an email acknowledgment, using the contact information provided in the reconsideration request, notifying the ASC that the request has been received; and

(2) Provide a formal response to the ASC contact using the information provided in the reconsideration request notifying the ASC of the outcome of the reconsideration process.

(d) *Final ASCQR Program payment determination.* For an ASC that submits a timely reconsideration request, the reconsideration determination is the final ASCQR Program payment determination. For an ASC that does not submit a timely reconsideration request, the CMS determination is the final payment determination. There is no appeal of any final ASCQR Program payment determination.

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

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