CMS Proposes Quality Reporting Program for Ambulatory Surgery Centers

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On July 1, 2011, the U.S. Centers for Medicare & Medicaid Services (CMS) proposed to begin implementing a quality reporting program for ambulatory surgery centers (ASCs) that could soon lead to a true pay-for-performance program for outpatient freestanding surgical facilities. The proposal appears in a proposed rule that would update the hospital Outpatient Prospective Payment System (OPPS) and ASC payment system for 2012, which was published in the *Federal Register* on July 18, 2011.

Background

The Social Security Act authorizes CMS to impose a quality reporting system on ASCs and reduce payments to ASCs that fail to report, similar to programs already in place under the Inpatient Prospective Payment System and OPPS. Until now, CMS has never exercised this authority for ASC services.

The Patient Protection and Affordable Care Act provided a further push to the Medicare agency, requiring CMS to develop a plan to implement a value-based purchasing (VBP) program or true pay-for-performance system for ASCs. In accordance with the statute, CMS delivered a report to Congress entitled Medicare Ambulatory Surgery Center Value-Based Purchasing Implementation Plan in April 2011. CMS does not currently have authority to implement a VBP for ASC payments, but the proposed quality reporting system is seen as a first step toward a VBP program as it establishes a framework for collecting quality metrics.

Proposal

CMS is now proposing to implement a quality reporting system under which data collection would begin in 2012. For the first two years, ASCs would not be financially penalized for failure to report quality information. However, beginning in 2014, CMS would begin reducing Medicare payments to ASCs that fail to report data on specified quality measures.

CMS proposes eight measures for the initial reporting period:

- Patient Burn
- Patient Fall in the ASC
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- Hospital Transfer/Admission
- Prophylactic IV Antibiotic Timing
- Appropriate Surgical Site Hair Removal
- Selection of Prophylactic Antibiotic (first *or* second generation cephalosporin)
- Surgical Site Infection Rate

Data collection for the first seven measures (*i.e.,* for all except surgical site infection rate) would begin in calendar year (CY) 2012. For these seven measures, CMS proposes to collect data using the claims-based quality data codes data collection mechanism. Surgical site infection rate data would be collected through the National Healthcare Safety Network, which is a secure, internet-based surveillance system maintained and managed by the Centers for Disease Control and Prevention (CDC).

Beginning in 2015, CMS proposes to add two additional measures:

- Safe Surgery Checklist
- ASC Facility Volume Data on Selected ASC Procedures

CMS proposes to add one additional measure beginning in 2016:

- Influenza Vaccination Coverage among Healthcare Personnel

Under the quality reporting program applicable to hospitals, facilities are required to submit data on patient experience of care. CMS is soliciting comments on the appropriateness of also requiring ASCs to submit data on patient experience. In addition, CMS is soliciting comments on the inclusion of procedure-specific measures for cataract surgery, colonoscopy and endoscopy, and for measures of anesthesia-related complications.

Implications and Issues

The ASC industry appears ready to embrace quality reporting by ASCs. Perhaps in response to signals from CMS, the ASC Quality Collaboration, a group comprising national ASC chains and trade associations, has worked over the last several years to develop measures and measure specifications specific to ASCs. The six measures developed by the ASC Quality Collaboration and endorsed by the National Quality Forum are included as proposed measures for CY 2014 ASC Quality Reporting Program. Since January 2011, data from ASC patient admissions have been collected from more than 1,200 ASCs by the Quality Collaboration for these six measures.

To reduce the reporting burden for ASCs, and seemingly to facilitate the transition to quality reporting for ASCs, CMS includes in the initial program year mainly claims-based measures. By focusing primarily on claims-based measures, ASCs will need only to modify slightly the way they code Medicare Fee-for-Service claims by appending specific Category II CPT codes or HCPCS Level II G-code developed as quality data codes. If proposed measures are adopted, quality data codes (QDCs) will be included in the Final Rule and ASC reporting will start January 1, 2012.

Beginning in 2014, CMS is proposing to include a health care associated infection measure, Surgical Site Infection Rate. This measure proposal requires ASCs to participate in the CDC's National Healthcare Safety Network surveillance program, which tracks procedure-associated infections. Participation in this program will require ASCs to track patients and patient infections for more than 40 procedures. CMS appears to acknowledge the burden associated with implementing this measure, and proposes that ASCs report this data for admissions beginning January 1, 2013. Whether this proposal allows ASCs sufficient time to implement the infrastructure that will enable collection of this data is unclear.

Otherwise, the proposed measures for program years 2015 and 2016 appear reasonable—especially given the longer lead times for implementation. What is not clear, however, is the value in the proposed 2015 ASC Volume Data on Selected ASC Procedures. Research has demonstrated that both surgeon and facility volume are correlated with surgical outcomes and that higher volumes correspond to better performance. These data and analyses are specific to discrete surgical procedures. For the ASC procedure volume measure, CMS proposes collecting and reporting surgical volume not for specific procedures, but across a range of procedure codes that will be aggregated and reported by broad categories. It is not clear, however, that the same statistical relationships exist when procedure-specific data are aggregated into much broader categories. A more meaningful approach might be to collect and report procedure-specific volumes for ASCs. Volume collection and reporting should focus on those procedures performed most frequently in ASCs.

The initial years will be an early test of whether ASCs are able and willing to report quality data, and will give CMS important information about whether ASCs are ready for a true pay-for-performance program. However, even beginning in 2014, the quality reporting program would remain, technically speaking, voluntary, in that ASCs would not be obliged to report as a condition of participation and could choose to forego the additional Medicare payments given to facilities that do report. If ASCs find that reporting is too cumbersome, or produces unflattering results, many may choose not to report notwithstanding the financial penalty that will result.

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