ASC Quality Collaboration

September 13, 2022

VIA ELECTRONIC SUBMISSION

Chiquita LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1772-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re CMS-1772-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals

Dear Administrator LaSure:

Please accept the following comments from the ASC Quality Collaboration (ASC QC) regarding CMS-1772-P (87 FR 44502, July 26, 2022) Section XV. Requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program and related proposals. The ASC QC is a non-profit organization dedicated to advancing high quality, patient-centered care in ambulatory surgery centers (ASCs) through a collaborative membership of ASC stakeholders. These stakeholders include leaders from ASC management companies, industry associations, professional physician and nursing associations, accreditation organizations and an information technology company (please see Appendix A to this letter for a complete listing). Collectively, these organizations represent over 1,800 ASCs.

The ASC QC appreciates the agency's willingness to consider how best to balance the benefits of quality measurement and reporting against the burdens of participating in the ASCQR Program, especially as centers manage the continuing challenges created by the Coronavirus Disease 2019 (COVID-19) pandemic.

I. Implementation Issues Surrounding ASC-20: COVID-19 Vaccination Coverage Among Healthcare Personnel Measure

At the time the ASC-20: COVID-19 Vaccination Coverage Among Healthcare Personnel was proposed and finalized last year, the measure was still in development and had not been tested or endorsed. As a result, the healthcare provider community has been the testing ground for the measure - an added strain to resources during the COVID-19 public health emergency (PHE).

The implementation of ASC-20 has been rocky. Among the issues that have come to our attention are the following:

- Multiple emails from ASCs to the National Healthcare Safety Network (NHSN) requesting support have gone unreturned for weeks despite repeated efforts
- There is no NHSN support phone number ASCs can call for assistance
- Available educational materials are targeted for other facility types such as long-term care facilities and nursing homes
- Changing definitions of key measure specifications have resulted in confusion
- Reference documents are not revised or posted timely to provide current measure specifications and reporting instructions at the time they are announced by NHSN
- Incorrect advice on data entry requirements for reporting has been given by the Centers for Disease Control's NHSN personnel

NHSN uses the COVID-19 vaccination data for public health purposes, and therefore applies the same data submission protocols to a variety of healthcare settings and providers. However, the reporting requirements for the ASCQR Program differ, which has created confusion and hours of additional work on the part of ASCs who are already challenged by staffing shortages.

Given these issues, we ask CMS to consider whether it is fair and reasonable to withhold the payment update of centers that have otherwise successfully met the reporting requirements of the ASCQR Program if they fail to meet the reporting requirements for ASC-20. Data submitted for the 2022 data collection period should be publicly reported, but not used for the 2024 payment determination.

II. Proposal Regarding Voluntary Reporting for ASC-11: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

ASC-11 assesses the percentage of patients aged 18 years and older who had cataract surgery and experienced improvement in visual function within 90 days following surgery. The results of this patient-reported outcome measure are based on patients' completion of formal surveys of both pre-operative and post-operative visual function.

In the CY 2014 OPPS/ASC final rule, CMS finalized the adoption of ASC–11 for inclusion in the ASCQR Program over many objections regarding the implementation burden and concerns regarding the feasibility and actionability of the measure. Shortly after adopting the measure, the agency delayed implementation twice before deciding to make reporting strictly voluntary.

In last year's rulemaking cycle, CMS proposed to make ASC-11 mandatory, and finalized implementation beginning with the CY 2025 reporting period/CY 2027 payment determination. However, CMS is now proposing to delay mandatory reporting for ASC-11 due to the ongoing impact of the COVID-19 PHE, including staffing shortages and supply chain disruptions. If finalized, reporting the measure would remain voluntary for the time being. The agency states it will consider mandatory reporting of ASC-11 after the COVID-19 PHE declaration officially ends.

We appreciate the consideration the agency has shown in proposing to allow voluntary reporting to continue for the duration of the COVID-19 PHE. We support the proposal to retain a voluntary reporting status for this measure.

A. ASC-11 Remains Impractical as a Mandatory Measure

The ASC QC does not support ASC-11 as a mandatory measure at any point in the future. At the time the agency originally decided on a voluntary status, CMS stated it understood it "can be operationally difficult for ASCs to collect and report this measure" because the results of the surveys may not be shared, "making it difficult for ASCs to have knowledge of the visual function of the patient before and after surgery" (79 FR 66984).

Current guidance for ASC-11 in the Ambulatory Surgical Center Quality Reporting Specifications Manual states, "[w]hile it is recommended that the facility obtain the survey results from the appropriate physician or optometrist, the surveys can be administered by the facility via phone, mail, email, or during clinician follow-up. For this measure, the same data collection instrument (i.e., survey) must be used pre-operatively and post-operatively."

The physician measure corresponding to ASC-11 is Quality ID #303: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. The measure is in use in the current Quality Payment Program for clinicians. We have reviewed the specifications for the Quality ID #303 and determined that the survey methodology poses both significant barriers and significant burdens. Per the Clinical Quality Measure Specification for MIPS Quality ID #303, "[t]he survey should be administered, collated and scored by the registry, or by a third-party intermediary, to prevent or minimize bias which might be introduced if it is an in-office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey (third party intermediary or registry only), depending on their preferences and abilities."

Therefore, to get the required data for ASC-11, ASCs might have to obtain the preoperative and postoperative survey data from the registry or third-party intermediary with whom the patient's ophthalmologist or optometrist has contracted to perform data collection for the measure. This is not easily done due to the low number of clinicians reporting on the measure. When ASC-11 was originally proposed, we found that under the (then named) Physicians Quality Reporting System only 215 of the more than 7,300 cataract physicians in the US reported on the measure in 2013. Under the present-day ophthalmology track for the (now named) the Quality Payment Program, clinicians choose measures to report. There is no requirement that cataract surgeons choose Quality ID #303 when selecting measures to report.

The most current data for the clinician measure is presented in the 2020 Quality Payment Program Experience Report dated 7/29/2022, posted online at data.cms.gov. Review of the data shows that of the 15,781 ophthalmologists with QPP data, only 49 (approximately 0.31%) reported data for Quality ID #303. Of the 10,418 optometrists with QPP data, only 25 (approximately 0.24%) reported data for Quality ID #303. With these low rates of data submission, it is difficult to envision how all ASCs that perform cataract surgery will manage to

obtain the data necessary to report on ASC-11 from the cataract surgeon, or even an optometrist who may have been involved in the patient's care preoperatively. Very few clinicians are paying a registry or third-party intermediary to collect the survey data ASCs would need.

If ophthalmologists and optometrists are not typically arranging for the collection of patient data on formal preoperative and postoperative visual function surveys, how are ASCs to come by this information? The ASCQR Program Specifications Manual suggests that, as an alternative to getting survey data from the clinician, ASCs can administer the surveys "via phone, mail, email, or during clinician follow-up". However, ASCs do not see patients prior to the day of surgery, nor do ASCs see patients for follow-up after discharge. As you know, CMS regulations at 42 CFR §416.2 prohibit ASCs from offering anything beyond limited surgical services or separate, but integral ancillary services immediately before, during or immediately after a surgical procedure. The suggestion made in the Specifications Manual that surveys be performed "during clinician follow-up" are certainly at odds with this.

ASCs have been very purposefully limited by the Federal government to providing care narrowly focused to the day of surgery, and expectations that centers will easily be able to perform the extended follow-up for CMS quality measures is not very realistic. ASC-11 was originally developed as a physician measure, and never intended to be applied in the ASC setting. Most ASCs would find it challenging to conduct phone, mail or emails surveys of cataract surgery patients both pre-operatively and 90 days post-operatively.

It is true that a small number of ASCs have voluntarily reported the measure; however, we think it is unlikely additional ASCs would be able to do so. Therefore, we strongly urge CMS set aside the idea of any future proposal for mandatory reporting and continue with strictly voluntary reporting of this measure. An alternative measure should be used to address the topic of ophthalmologic surgery.

B. An Alternative Measure Addresses the Topic of Ophthalmic Surgery

CMS has repeatedly stated it is interested in additional measures related to ophthalmologic surgery. As in years past, we recommend the Toxic Anterior Segment Syndrome (TASS) measure, which assesses the number of patients diagnosed with TASS within two days of undergoing anterior segment surgery in the ASC. The ASC QC developed this measure to fulfill a need to assess outcomes related to frequently performed ophthalmic surgeries, including cataract surgery, in ASCs. It also addresses care coordination.

The number of anterior segment surgeries performed in ASCs is substantial, numbering in the millions each year, with that number expected to grow as the population ages. Studies in the literature have reported TASS complication rates of 1.8 to 2.1%, pointing to a significant opportunity for improvement.

Prevention of TASS is important. The American Society of Cataract and Refractive Surgery (ASCRS) and American Society of Ophthalmic Registered Nurses have published recommended practices for cleaning and sterilizing intraocular surgical instruments aimed at the prevention of TASS. These recommended practices were developed with guidance from AORN, APIC, SHEA,

CDC and the FDA. In addition, the American Academy of Ophthalmology (AAO), American Society of Cataract and Refractive Surgery (ASCRS) and the Outpatient Ophthalmic Surgery Society (OOSS) have released recommendations regarding the use of enzyme detergent for cleaning intraocular surgical instruments. Inclusion of the TASS measure in the ASCQR Program would help promote these recommended practices. The ASCRS also has a TASS registry, highlighting the importance of identifying and reporting occurrences.

The ASC QC TASS measure has been fully tested in the ASC setting and is currently in use among our members. Aggregate data is published online in our quarterly public report of ASC quality data. The measure has been reviewed by the MAP and received conditional support pending endorsement by the NQF. As you know, NQF endorsement is not always necessary. The statutory requirement that quality measures reflect consensus among affected parties was met through our collaboration within the ASC industry, as well as our inclusion of the AAO, ASCRS and OOSS in the review of the measure early in the development process.

Some have asserted data for TASS is difficult to collect and that ASCs would not be notified if TASS were diagnosed outside of the facility. The experience of our members indicates this is not true. In fact, ASCs performing ophthalmic surgery monitor this outcome closely due to its severity. Data regarding occurrences is routinely collected and each event is thoroughly investigated. The large number of anterior segment surgeries performed means TASS is a very important outcome. CMS should propose adoption into the ASCQR Program in the next rulemaking cycle. As we discuss in more detail below, CMS should also propose adoption of this measure for the Hospital OQR Program.

III. CMS Request for Comment: A Potential Future Specialty Centered Approach for the ASCQR Program

In this proposed rulemaking, CMS has requested comment on the idea of moving the ASCQR Program toward a specialty-centered approach to quality measurement. The agency has mentioned the clinician Merit-Based Incentive Payment System (MIPS) as a model for a specialty-based approach. Most ASC services for Medicare beneficiaries are concentrated in a few specialties, and the agency is suggesting a reporting structure that would be specific to an individual ASC's procedures. The agency has put forth tables of MIPS and MIPS Value Pathways (MVP) measures that it thinks could be appropriate for the ASCQR Program.

A. Aligning Consumer Quality Data Across Surgical Sites of Service

CMS did not include any language in the proposed rulemaking suggesting that it is considering the potential for a specialty-specific approach for the Hospital OQR Program. The need to align program measurement is of major interest to us. In the past several years, CMS has been diligent in its efforts to ensure coordination of modifications to the two Programs. We do not understand why CMS has not addressed the possibility of panels of surgical subspecialty measures for HOPDs. Our belief is that if the agency is considering a change for one program that touches on outpatient surgical quality measurement, the same change should be considered for the other. For example, if an endoscopic ASC is going to be asked to report on a panel of specialty measures at

some point in the future, the endoscopy unit of an HOPD should also be asked to report on that panel of specialty measures as well. We cannot support the contemplated change unless it is applied to both settings.

The ability to make comparisons across the ASCQR Program and Hospital OQR Program is already very limited. Consumers lack, and need, a more robust way to compare outpatient surgical facilities. We have been hoping to see greater alignment, not further divergence. At present there are only three sets of related measures across the ASCQR and Hospital OQR Programs. The measures are:

- ASC-9 and OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients,
- ASC-11 and OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, and
- ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy and OP-32: Rate of Unplanned Hospital Visits After Colonoscopy. (However, and notably, consumers cannot use the data from these measures to make comparisons - the measure methodologies are not the same and do not result in comparable data.)

These measures are limited to colonoscopy and cataract surgery. They do not give consumers a strong sense of how well an outpatient surgical facility delivers on the aspects of care that are squarely its responsibility to manage. After over a decade of outpatient surgical facility quality program development and reporting, more needs to be done to support consumers in this area. It is a major gap that needs to be closed.

In the future, consumers will be able to compare ASC and HOPD data on COVID-19 vaccination rates among healthcare personnel, although the significant delay between data collection and public reporting will make the information dated and irrelevant by the time it is posted. We don't expect this measure to be any more impactful than past data regarding influenza vaccination rates among healthcare personnel (which has been removed from both programs).

We look forward to the future reporting of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures, which promise to be the most meaningful measures yet for consumers because they are applicable to all facilities that offer outpatient surgery, regardless of specialty or affiliation, offering a truly valuable opportunity for consumer insight across settings of care.

CMS should move to establish additional such important points of comparison across sites of service. There are several meaningful actions the agency should take in future rulemaking to support consumers in ways that are useful and consequential. These include applying ASCQR Program measures to the Hospital OQR Program and moving to adopt measures that have already been developed, including a measure of surgical site infection (SSI), for both settings of care.

1. Give Consumers the Means to Compare Safety Outcomes Across Sites of Service

As measures of serious reportable events, ASC–1: Patient Burn, ASC–2: Patient Fall, and ASC–3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant are essential to efforts to help ensure patients are protected from harm while receiving care. In CMS-1717-P, CMS sought public comment on the potential future adoption of these measures for the Hospital OQR Program but has taken no action since then.

These measures are straightforward and could readily be applied to HOPDs. Though currently specified for the ASC setting, they could easily be modified to allow use by HOPDs. Tracking these events is essential to assuring quality and safety in the outpatient surgical setting, and we feel confident HOPDs are already collecting this type of information for their internal use. There is little burden associated with collecting and reporting the data. Monitoring and publicly reporting these events helps maintain the focus on efforts to prevent their occurrence.

All three measures are of enduring interest to patients because they address matters of personal safety. They are also applicable to all facilities, regardless of specialty, giving patients access to pertinent quality data regardless of their planned procedure. Including these patient safety measures in both the Hospital OQR and ASCQR Programs would allow public insight into the relative success of patient safety protocols across all ASCs and HOPDs and would be valuable in broadening the points of comparison across sites of outpatient surgical service. CMS should propose to adopt these three measures into the Hospital OQR Program in the next rulemaking cycle.

2. Give Consumers the Means to Compare Patient Disposition After an Episode of Care Across Sites of Service

ASC–4: All-Cause Hospital Transfer/ Admission gives consumers data regarding how likely they are to be transferred or admitted to a hospital instead of going home as anticipated. In CMS-1717-P, CMS sought public comment on the potential future adoption of this measures for the Hospital OQR Program. We supported this idea as a means of allowing consumers an additional point of comparison between ASCs and HOPDs.

As with ASC-1, ASC-2 and ASC-3 above, this is an uncomplicated measure that could be modified to be applicable to both sites of service. HOPDs are likely to track patient disposition after an episode of outpatient care as a matter of routine, so implementation would not require new data collection processes.

In addition, it can be applied to all facilities, increasing the number of measures that consumers can use to compare settings of care. Proposing to adopt this measure for inclusion in the Hospital OQR Program would increase the alignment of measures and, most importantly, would allow consumers another opportunity to compare outcomes across settings of outpatient surgical care.

3. Give Consumers the Means to Compare Additional Outcomes Across Sites of Service

The current ASCQR Program includes two measures that are not included in the Hospital OQR Program but are good candidates. The two measures are ASC-13: Normothermia Outcome and ASC-14: Unplanned Anterior Vitrectomy. These measures are derived from data that can be captured during the patient's episode of care and would be feasible for an HOPD to collect.

We also encourage CMS to adopt two previously proposed measures that have already been through the Measure Applications Partnership (MAP) review process and are eligible for inclusion in the ASCQR Program: the Toxic Anterior Segment Syndrome Measure already mentioned above, and the Ambulatory Breast Procedure Surgical Site Infection Outcome Measure. Both measures would be appropriate for inclusion in both programs.

The Ambulatory Breast Procedure Surgical Site Infection Outcome measure was developed by the CDC. This measure assesses the risk-adjusted Standardized Infection Ratio (SIR) for SSIs for adult patients following breast procedures. The measure compares the reported number of SSIs with a predicted value based on nationally aggregated data. This measure would fill an important gap in data related to healthcare-associated infections. The measure is fully developed and tested and is currently being used in several State-based quality reporting programs.

4. **Summary of Options to Increase Data Regarding Outcomes Across Sites of Service**

In summary, CMS has at least eight ready opportunities to meaningfully advance the ability of consumers to compare clinically meaningful facility-level measures of care. These are:

- Patient Burn measure
- Patient Fall measure
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant measure
- Hospital Transfer/Admission measure
- Normothermia Outcome measure
- Unplanned Anterior Vitrectomy measure
- Toxic Anterior Segment Syndrome (TASS) measure
- Ambulatory Breast Procedure Surgical Site Infection Outcome measure

CMS has adopted measures across programs in the past. CMS selected measures that were not specified for, or tested in, the ASC setting and finalized them for inclusion in the ASCQR Program. There are many examples of this, including the Safe Surgery Checklist Use, ASC Facility Volume on Selected ASC Surgical Procedures, Influenza Vaccination Coverage Among Healthcare Personnel, Improvement in Patient's Visual Function within 90 Days of Cataract Surgery, Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients, and Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps measures. CMS could clearly take measures not originally specified for the HOPD setting and propose them for inclusion in the Hospital OQR Program.

We hope the agency will see the importance of moving forward in efforts to make data around the quality of care in ASCs and HOPDs more accessible to consumers, particularly when it comes to measures that are applicable to all facilities regardless of service lines. We believe this information would be meaningful and helpful to prospective patients. We urge CMS to take prompt action in the next rulemaking cycle toward creating more options for comparing settings of outpatient surgical care.

B. Measures for a Potential Specialty-Specific Approach

If the agency decides that it will take the step of including the Hospital OQR Program in its vision for a potential specialty-specific approach, then the idea of a specialty-specific approach could be of interest.

Unfortunately, the emphasis CMS has placed on using clinician-level MIPS performance measures to achieve this reconceptualization misses the mark. Consumers can already compare clinicians and clinician performance using MIPS measures. While certain MIPS measure topics might be reasonably developed into facility-specific measures helpful for understanding facility performance, having facilities report on clinician measures that are already being reported by the clinicians themselves is ultimately duplicative. This "clinician" focus does not address the actual data deficit: consumers need information that can help them understand how well surgical facilities are performing the myriad tasks involved in creating and maintaining a well-run facility that promotes excellent outcomes. We urge CMS to measure quality in facilities in a way that adds to the depth and breadth of the quality data landscape rather than revisiting the same clinician measures under a different guise.

We have reviewed the tables of measures that CMS believes could be appropriate to include in a potential future specialty-specific approach to quality measurement, and don't see much that would be useful and worthwhile. A review of the measures presented in Table 74: Example Ophthalmology ASCQR Program MVP Measures shows the following:

- Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery and Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery: retinal surgery is uncommon in ASCs and these measures are unlikely to be impactful
- Cataract Surgery: Difference Between Planned and Final Refraction: a surgical facility has no role in developing the planned refraction
- Cataracts: Improvement in Visual Function Within 90 Days Following Cataract Surgery: this measure is already included in the ASCQR Program as ASC-11, with the attendant problems described elsewhere in this letter
- Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery: this measure would be preferable to ASC-11 since it does not require a survey, making the data somewhat more easily obtained
- Cataracts: Patient Satisfaction Within 90 Days Following Cataract Surgery: this measure requires completion of the CAHPS Surgical Care Survey, an entirely different CAHPS

survey, which would be prohibitively expensive since this also has to be administered by a third party

The measures presented in Table 75: Example Gastroenterology ASCQR MVP Measures are as follows:

- Age Appropriate Screening Colonoscopy: clinicians already have very high performance levels on this measure, and we don't see a significant opportunity for improvement
- Anastomotic Leak Intervention: the denominator for this measure is defined by a list of CPT codes, none of which are on the List of ASC Covered Surgical Procedures, leading to a denominator of zero
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients: this measure is already included in the ASCQR Program
- Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use: this measure was, in the past, part of the ASCQR Program measure set (as ASC-10) and has already been removed from the Program
- Photodocumentation of Cecal Intubation: this is the only measure suggested that might be adapted to a new facility-level measure

The MIPS measures CMS has already adopted in the ASCQR Program have been among the most difficult to operationalize because they have required data that is not created or available as part of the patient's episode of care in the ASC. As you know, Federal regulations governing ASCs intentionally limit the scope of ASC services and the time frame ASCs are permitted to be involved in patient care - and also intentionally isolate the operations of ASCs from other providers. This makes the acquisition of data that is not generated in the process of providing care during the patient's time-limited stay in the ASC challenging. It requires the investment of significant additional resources to get this information from other providers and/or their contractors. ASC-11, described above, is an example of this.

C. Managing Burden for Multispecialty Centers Under a Potential Specialty-Specific Approach

In addition to the question of appropriate and feasible measures, we have no sense of how CMS would propose to balance reporting burden across single-specialty and multispecialty centers using a specialty-specific approach. For consumers to have equally informative quality data for a given specialty, regardless of whether the surgery or procedure is offered in a single-specialty or a multispecialty setting, all facilities performing the service would need to report on the designated panel of specialty measures. Otherwise, consumers would not be able to make apples-to-apples comparisons. Yet this would mean that multispecialty centers would have to shoulder a significantly greater reporting burden due to the need to report on a full set of specialty-specific measures for each service line.

IV. CMS Request for Comment: Potential Future Reimplementation of ASC Facility Volume Data on Selected ASC Surgical Procedures (ASC–7) Measure or Other Volume Indicator

In past rulemaking, CMS adopted ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures for inclusion in the ASCQR Program. After several years, the agency removed the measure, believing that outcome measures on specific types of procedures such as ASC-17 (Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures), ASC-18 (Hospital Visits after Urology Ambulatory Surgical Center Procedures) and ASC-19 (Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers) would provide patients with more valuable ASC quality of care information.

In this proposed rule, CMS indicates it is considering reimplementing ASC–7 or proposing another volume measure in the future. The agency now believes 1) volume is an important component of quality, 2) tracking the volume of outpatient surgical procedures is important, 3) volume is an indicator for patients of which facilities are experienced with certain outpatient procedures, and 4) 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.

A. ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures Was Not Useful to Consumers

ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures was a structural measure that collected surgical procedure volume data in six very broad categories: Gastrointestinal, Eye, Nervous System, Musculoskeletal, Skin, and Genitourinary services. At the time of its adoption, CMS stated its belief that the measure "would provide patients with beneficial information to use when selecting a care provider" (76 FR 74507).

At the time ASC-7 was proposed, and after it was finalized, the ASC QC continually pointed out that the categories of services CMS had established were too large and diverse to provide meaningful consumer information. In our comments to CMS, we posed the following questions to illustrate the limitations of the data from each of the six categories:

- How would a consumer needing a hernia repair use the data in the "Gastrointestinal" category to distinguish a facility that performs a high volume of gastrointestinal endoscopies from a facility that performs a high volume of general surgery?

- How would a consumer planning a corneal transplant determine if a facility performed a high or low volume of that operation by reviewing the data in the "Eye" category?

- How would a consumer needing carpal tunnel surgery distinguish a facility with a high volume of carpal tunnel repairs from a facility with a high volume of pain management injections by looking the data in the "Nervous System" category?

- How would a consumer requiring a bunionectomy determine the relative volume (if any) of podiatric surgery as compared to arthroscopic surgery in a facility with high volume in the "Musculoskeletal" category?

- How would a consumer planning breast surgery determine what volume of breast surgery a facility performed by looking at the "Skin" category data? Would the consumer even realize that breast procedures were included in this category?

- How would a consumer needing prostate surgery determine whether a facility with high volume in the "Genitourinary" category performed a high volume of prostate surgery as compared to a high volume of hysteroscopies and laparoscopic gynecologic surgeries, which would be irrelevant to his decision?

These few examples from past comments demonstrate that aggregate volume data from very broad procedure categories is not helpful. We do not believe there is any meaningful consumer information to be derived from this type of data, nor do we think it can be used to advance quality of care. We do not support the reimplementation of ASC-7.

B. Volume Measures Are Less Useful Than Outcome Measures

Volume can indicate the level of experience a facility has with certain procedures. However, although there can be an association between high volume and better outcomes, studies have also shown significant variation in outcomes regardless of volume. Low-volume providers can have excellent outcomes and high-volume providers can have poor outcomes. In light of this, we believe it is more meaningful to measure outcomes directly, rather than to allow consumers to believe that more volume always means better outcomes and low volume always means poorer outcomes. CMS made the right decision when it removed ASC-7 from the ASCQR Program, and the agency should remain focused on outcome measures going forward.

V. CMS Request for Comment: Interoperability Initiatives in Ambulatory Surgical Centers

In this proposed rule, CMS indicates it is considering a future shift in reporting to electronic clinical quality measures, or eCQMs. Electronic clinical quality measures are generated by a provider's electronic health record (EHR). CMS believes transitioning to eCQMs would increase alignment across quality reporting programs such as the ASCQR and Hospital OQR Program.

The history of Federal incentives for the adoption of EHRs is important to understanding the current situation in ASCs. In the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, financial incentives were authorized for hospitals and clinicians to adopt and meaningfully use certified electronic health record (EHR) technology. CMS implemented these financial incentives by establishing the Medicare and Medicaid EHR Incentive Program (now known as the Promoting Interoperability Program), to encourage health care providers to adopt and meaningfully use certified EHR technology (CEHRT).

However, ASCs were not included in the HITECH Act and were ineligible for the financial incentives under the Promoting Interoperability Program. The lack of ASC incentives has perpetuated the cost barriers to implementation of EHRs in this setting.

CMS cites an EHR utilization survey conducted by the Ambulatory Surgical Center Association (ASCA), which indicated that 54.6 percent of ASCs use an EHR in their facility. While this may reflect the use of EHRs in the pool of survey respondents, we do not believe this figure accurately reflects the use of EHRs in the ASC industry as a whole. It is likely that the percentage of ASCs that use an EHR in their facility is lower. Past environmental scans have shown the use of EHRs in the ASC industry to be more limited than in other healthcare settings.

We agree moving toward eCQMs is a desirable long-term goal. As a first step, we believe it would be prudent for the agency to formally assess the current capabilities of the ASC industry through a detailed environmental scan prior to any additional action. Having a clear sense of current information technology resources and interoperability capabilities in the ASC setting would provide a solid foundation to underpin a sound approach to the adoption of eCQMs in ASCs.

VI. Public Reporting of ASCQR Program Data

The ASC QC has offered many comments to CMS in the past on ways to improve the public reporting of ASCQR Program data. We are pleased to see that a Facility Compare Dashboard has been created. This dashboard displays facility and state specific data published as part of the HOQR and ASCQR Programs. This represents a very positive step forward and we are appreciative of the work that went into constructing the dashboard. Thank you.

This data should not be displayed exclusively on the qualityreportingcenter.com website.

While we know that providers are interested in the quality measure data generated by the ASCQR and HOQR Programs, we believe healthcare consumers should be the primary beneficiaries of this information. This data should also presented be on CMS Care Compare, which is the portion of the Medicare.gov website that allows consumers to find and compare providers, including results of measures of quality of patient care. We believe the Facility Compare Dashboard should be incorporated into the Care Compare website as this is the CMS site that consumers are most likely to visit in the search for information about healthcare providers and related quality data.

There is one link to ASC data on the current Care Compare website, but it is challenging to find. On the landing page, there are numerous ways to locate provider types, but none direct the consumer to ASCs. For example, near the top of the page, a link titled “Learn more about the types of providers listed here” opens a page that includes information about various provider types but does not list ASCs. The landing page also includes a search box with a dropdown menu for provider type, but ASCs are not listed here either. Another option on the landing page is to click on a button for a specific provider type, yet there is no button for ASCs. It is only when one clicks on the “Hospitals” button and reads through a pop-up window that one sees the

question, “Or want to learn more about ambulatory surgical centers (ASC)?” with a link titled “Visit the ASC data on CMS.gov”.

We are disappointed that ASCs are still not among the providers included in the CMS Care Compare site. We urge the agency to make the addition of ASCs a priority. Until then, we ask CMS to make it easier for consumers to locate the link to ASC data. We suggest that the current “Hospitals” button on the landing page be relabeled to read “Hospitals including Ambulatory Surgery Centers”. This is not because we think data for ASCs belongs with data for hospitals, but rather because it is a way to help consumers find the link to ASC data more readily within the current site.

ASC quality measure data is available on the data.cms.gov site, but finding ASC information on this site is not easy or user friendly. On the Home page, there is no button for ASCs. On the Datasets page, there is no Ambulatory Surgical Center Topic listed. On the Topics page, there is no Ambulatory Surgical Center dataset link. Again, we find ASC data is included in the datasets for “Hospitals” although ASCs are not hospitals. We think it is unlikely consumers would intuitively search for ASC information under the Hospital heading.

For those who do manage to find the links to the ASCQR Program data, the display of the data is not as helpful as it should be. It is difficult to understand the measure data being presented and what it means. Measure scores are listed under column titles such as “ASC-9 Rate”. Clicking on the column title does not provide any additional information. It is also hard to find a specific facility without downloading the entire dataset and there is no easy way to compare measure data from various centers.

The current method of displaying ASCQR Program data for consumers needs improvement. As you know, ASCs are the most common providers of outpatient surgery in the United States, making it is very important for CMS be more effective in sharing quality measure data for ASCs with the public. Among the many improvements needed to support consumers, including ASCs on CMS Care Compare is essential. We hope CMS will take timely steps to include the Facility Compare Dashboard on this central site and develop direct paths to ASC quality data.

VII. The Measure Applications Partnership (MAP)

The ASC QC appreciates the work of the Measure Applications Partnership (MAP) and of those individuals serving on the numerous committees and workgroups of the MAP. Unfortunately, a serious gap in the expertise of the MAP Hospital Workgroup, which is charged with developing recommendations regarding the ASCQR Program, has been allowed to persist for seven years. ASC organizational or subject matter expert presence on the MAP Hospital Workgroup is important to ensuring well-informed decisions regarding the ASCQR Program. We bring this issue to your attention again because CMS is responsible for convening the MAP. We urge the agency to work with the National Quality Forum to ensure the absence of appropriate expertise is corrected with the next cycle of appointments in 2023.

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Thank you for considering these comments. We look forward to continuing our dialogue with CMS regarding the ASCQR Program and would be happy to assist with questions or provide additional information at your request.

Sincerely,

Kathy Wilson

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ASC Quality Collaboration