



ASC Quality Collaboration

September 6, 2016

VIA ELECTRONIC SUBMISSION

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1656-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program

Dear Acting Administrator Slavitt:

On behalf of the ASC Quality Collaboration (ASC QC), please accept the following comments regarding CMS-1656-P (81 FR 45604, July 14, 2016), Section XIV. Requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. The ASC QC is a non-profit organization that has spent the last decade advancing quality measurement and public reporting in the ambulatory surgery center (ASC) industry through a progressive and collaborative effort involving a diverse group of ASC stakeholders. These stakeholders include leaders from the ASC industry, accreditation organizations, and professional physician and nursing associations. Current members of the ASC QC include the following: Accreditation Association for Ambulatory Health Care; Ambulatory Surgery Foundation; Ambulatory Surgical Centers of America; AmSurg; ASD Management; Association of periOperative Registered Nurses; Covenant Surgical Partners; Hospital Corporation of America, Ambulatory Surgery Division; Kaiser Permanente; Merritt Healthcare; Outpatient Ophthalmic Surgery Society; Physicians Endoscopy; Practice Partners in Healthcare, Inc.; Regent Surgical Health; Surgical Care Affiliates; Surgery Partners; The Joint Commission; United Surgical Partners, Inc.; and Visionary Enterprises, Inc. Collectively, these organizations represent over 1,500 ASCs.

The ASC QC's commitment to quality is reflected in our ongoing efforts to facilitate meaningful quality reporting by ASCs. This includes the development of fully tested facility-level quality measures appropriate to the ASC setting, participation in Federal projects pertaining to

ASC quality measurement, and our publication of a quarterly public report of ASC quality data that is freely available online. These quarterly reports are made possible through the voluntary efforts of participants in the ASC QC and may be accessed at the ASC QC's website at: <http://www.ascquality.org/qualityreport.cfm>.

We appreciate the ongoing effort the agency devotes to the ASC Quality Reporting (ASCQR) Program and are pleased to have this opportunity to offer input regarding the agency's recent proposals for the ASCQR Program and matters related to the Program.

I. Proposed ASCQR Program Quality Measures for the CY 2020 Payment Determination and Subsequent Years: Normothermia Outcome and Unplanned Anterior Vitrectomy

The ASC QC is the measure developer and steward for the Normothermia Outcome and Unplanned Anterior Vitrectomy measures. We are pleased to see them proposed for inclusion in the ASCQR Program. Both have been fully tested in the ASC setting and are currently in use as part of our online public report of ASC quality data. We support the adoption of these measures and submission of aggregate data for each via QualityNet.

II. Proposed ASCQR Program Quality Measures for the CY 2020 Payment Determination and Subsequent Years: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measures

We appreciate the investment CMS has made in developing and obtaining CAHPS accreditation for the OAS CAHPS survey. We fully support use of a standardized instrument focusing on the patient's experience of care and are pleased the survey addresses the experience of surgical care received in both hospital-based outpatient surgical departments (HOSDs) and ASCs, thereby increasing opportunities for consumers to make meaningful comparisons across outpatient surgical facilities. The ASC QC would like to see the highest possible levels of ASC usage of the OAS CAHPS survey.

It is in light of this desire for strong participation that we harbor significant concerns regarding the current instrument. While the survey's respondents are patients, ASCs are expected to pay for its administration. We believe that the survey will prove unduly expensive for many ASCs and that this burden may lead centers to opt out. In the past, CMS has acknowledged that ASCs are predominantly small providers; approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data indicating a median of two operating/procedure rooms per facility (mean = 2.5). As we have stated in our remarks to CMS and the Office of Management and Budget, it is imperative to keep the administrative and financial burden associated with this survey as low as possible. We also have a new concern regarding the proposal to publicly report OAS CAHPS survey measure scores by CCN.

A. The Length of the OAS CAHPS Imposes Undue Burden

In our previous comments, we have urged limiting the number of items included in the survey to ensure high response rates and to control the cost of administration. Despite the reduction of the number of items from the original 49 to current 37, the survey remains *much too*

long. As the agency knows, the Hospital CAHPS survey includes only 32 items. Given the potential complexity and length of patient stays at acute inpatient hospitals, it is difficult to reconcile the idea that a longer survey is appropriate to the ASC setting, where patients are being seen for elective surgery and have stays of less than 24 hours.

Our collective, real-world experience has repeatedly shown that brief surveys have a better response rate in the ambulatory surgical patient population. ASC management companies have learned to keep their surveys short in order to maximize patient response rates and to minimize cost. We urge you to take immediate steps to remove additional items from the survey. In particular we draw your attention to the inclusion of a question regarding a requirement under the ASC Conditions for Coverage (item 13), the opportunity to consolidate questions (items 15, 17, 19 and 21), the inclusion of items that are not actionable (items 16, 18, 20, and 22), and the inclusion of optional items in the patient demographic questions (items 26, 34, 35, and 37).

The first survey question that should be removed is item 13: “Discharge instructions include things like symptoms you should watch for after your procedure, instructions about medicines, and home care. Before you left the facility, did you receive written discharge instructions?” As CMS is aware, written discharge instructions are required by the ASC Conditions for Coverage at §416.52(c)(1), which state that “[e]ach patient, or the adult who accompanies the patient upon discharge, must be provided with written discharge instructions.” There is little to be gained from including this question in the survey.

There is also an opportunity for consolidation in the section titled “Your Recovery”. Items 15, 17, 19 and 21 ask whether the patient received information about what to do regarding pain control, nausea or vomiting, bleeding, or signs of infection. While these topics reflect some of the problems that can arise after ASC services, they are not tailored to the patient but rather to a generic list of outcomes that may or may not be pertinent. For example, cataract surgery is the most commonly performed procedure in ASCs; for this surgery worsening vision would be a very important problem. For other patients, inability to void would be a key issue. In effect, the survey has decided what the focus of patient discharge information should be *for every patient*, ignoring important procedure-specific concerns (and completely disregarding the tenet of patient-centeredness in quality of care). In truth, it is not feasible to address every significant sign or symptom that might indicate a complication after discharge in a general survey of this nature. However, it is possible to pose a single question that addresses the topic at the core of each of these items - the patient’s need for information about what to do in the event a problem arises after their procedure. This topic is most efficiently addressed with a question such as, “Before you left, did your doctor or anyone from the facility give you information about what to do if you had problems as a result of your procedure or anesthesia?” A single question of this type should be substituted for items 15, 17, 19, and 21. This consolidation would reduce the length of the survey without sacrificing essential feedback on a key aspect of patient experience.

In addition, we note that several of the items in this section of the survey are not useful. These include items 16 (At any time after leaving the facility, did you have pain as a result of your procedure?), 18 (At any time after leaving the facility, did you have nausea or vomiting as a result of either your procedure or the anesthesia?), 20 (At any time after leaving the facility, did you have bleeding as a result of your procedure?), and 22 (At any time after leaving the facility, did you have any signs of infection?). The patient’s responses to these items cannot be used to

improve performance without other relevant clinical information. As CMS is aware, ASCs offer a mix of surgical services across many subspecialties, from which a very broad range of outcomes is possible. Items 16, 18, 20 and 22 ask the patient if they experienced selected potential post-procedure signs and symptoms, yet the answers do not provide actionable data. Whether pain (item 16) is an expected or unexpected outcome after an ASC visit depends on the service. We wonder what ASCs, especially multi-specialty centers, are supposed to do with the responses without knowing their relation to the service performed. If a patient reports nausea or vomiting, how is the ASC to determine if it was related to the procedure, the anesthesia, or perhaps a medication prescribed for pain management? If the patient reports bleeding, how does the ASC determine if this was expected (bloody nasal discharge after sinus surgery, blood in the urine after urinary tract surgery) or unexpected? If the patient reports “signs of infection”, how is the ASC to determine if an affirmative response is an indication of an actual infection, or of something that does not require action (e.g., redness at the wound margin)? In the absence of other key information, the survey results for these items cannot be understood or used for performance improvement purposes.

Further, items 16, 18, 20 and 22 do not figure in the calculation of top box scores for proposed measure ASC-15c: OAS CAHPS – Preparation for Discharge and Recovery. The fact that the patient responses to these items will not figure in measure scores further highlights their dispensability.

Item 16, a question regarding pain management, is also of concern for other reasons. In rulemaking elsewhere, CMS has proposed to remove the three pain management questions of the HCAHPS Survey from the total Hospital VBP Program performance score due to confusion about the intent of these questions and the public health concern about the ongoing prescription opioid overdose epidemic. The OAS CAHPS Survey contains two questions regarding pain management (items 15 and 16), which CMS states “are very different from those contained in the HCAHPS Survey because they focus on communication regarding pain management rather than pain control.” While it is true that item 15 focuses on communication regarding pain control, item 16 is clearly focused on the experience of pain (as above, “At any time after leaving the facility, did you have pain as a result of your procedure?”). This question, which values a “No” response over a “Yes” response, implies that CMS believes patients should not experience pain after discharge. Is this a signal the agency should be sending to healthcare providers?

Finally with respect to the length of the OAS CAHPS, we continue to believe that the inclusion of 13 demographic questions in the “About You” section of the survey is excessive. *Only those items that are required by law or that would actually be used in patient-mix adjustment for public reporting purposes should be included.* Based on our review of the factors used in the patient-mix adjustment for CAHPS® surveys, only the items that identify self-reported health status (item 25), age (item 27), education (item 29), primary language other than English (item 33) and a proxy respondent (item 36) should be retained. Federal data collection requirements regarding sex, race, ethnicity, and primary language can be met with items 28, 30, 31, 32 and 33. The other four items (26, 34, 35 and 37) are not required. In fact, the US Office of Minority Health clearly identifies items 34 and 35 as optional in its implementation guidance. It is not reasonable to ask ASCs to shoulder the additional cost of items that are discretionary. Optional, non-essential items in this section should be removed.

In summary, the survey must be significantly shortened by focusing sharply on critical, actionable aspects of patient experience and demographic data essential to either patient-mix adjustment or compliance with the law.

B. Information Technology Should Be Utilized to Minimize Burden

As we have repeatedly stated in our comments regarding this survey, information technology should be employed to the fullest extent possible to keep burden low. In addition to the currently available survey modes, options that utilize this technology should be available, including the ability to send survey invitations via email as well as via text message (SMS), and the use of a web-based survey administration mode.

In the past CMS has stated, “[a]ny additional forms of information technology, such as web surveys, would be less feasible with OAS CAHPS patients, as patient e-mail address information is not readily available through HOPDs and ASCs.” *This statement is manifestly untrue!* Patient email addresses can be, *and are*, as readily collected as the patient’s address and phone number. ASCs that do not routinely collect email addresses now would certainly have an incentive to do so if the option to use them were available as a means to realize lower survey costs.

CMS has also expressed reluctance to offer information technology solutions because of its impression that Medicare beneficiaries or poor households would be unlikely to respond online. However, data from other government agencies indicates that the use of enabling technology is not only prevalent, but also expanding rapidly amongst all Americans regardless of age, sex, educational attainment, household income, and employment status. We encourage the review of the most recent data from the US Census Bureau regarding Internet use, which is included in its dataset titled [Computer and Internet Use in the United States: 2013](#), released in November 2014. (Note particularly that the number of individuals age 65 years and older living in a house with a computer has increased to 71.0 percent from 61.8 percent just two years earlier. Also of interest is that while in 2011 45.5 percent of individuals age 65 and older accessed the Internet from some location, the number living in a house with Internet use had grown to 64.3 percent in 2013.) The National Telecommunications & Information Administration of the US Department of Commerce has recently issued two pertinent items pointing to significant growth in the use of the Internet over time in all age groups. Both, [Exploring the Digital Nation: America’s Emerging Online Experience](#) and [Exploring the Digital Nation: Embracing the Mobile Internet](#), are available online. The latter report states, “some form of broadband, whether fixed or mobile, *is now available to almost 99 percent of the U.S. population* [emphasis added].”

Our members consistently report achieving significant cost savings by incorporating the use of electronic distribution of survey invitations and web-based survey administration into their patient survey methodologies. Most centers have seen savings of 50%, and some have seen savings of up to 75% from third-party survey vendors. These savings opportunities are substantial and should not be ignored. As an added benefit to an electronic approach, our members report substantially higher survey responses rates of up to 60%.

Steps must be taken as soon as possible to ensure the use of information technology is incorporated in the administration of the OAS CAHPS. Failing to incorporate email and text message invitations and a web-based survey in the modes available to ASCs during the

implementation of these measures *cannot be justified* in the light of current information technology adoption in the United States. Limiting survey administration options to mail, telephone and mixed mail/telephone leaves ASCs in the position of having to shoulder avoidable costs.

C. The Minimum Number of Completed Surveys Affects Small ASCs Disproportionately

CMS has stated elsewhere that, “[a] minimum of 300 completed surveys annually is the target for each participating outpatient facility. If a facility patient volume is too small to yield 300 completed surveys per year, a census will be surveyed. The 300 completed surveys needed for analysis is derived from the formula for the precision of a proportion with the estimate at 0.5, the confidence interval of about +/- 0.05, and a confidence level of 95%.”

The sample size needed to assure 300 respondents using CMS’s assumed response rate of 32% for mail only or telephone only surveys is 938 patients annually. A significant minority of ASCs treats less than 938 patients each year. A review of volume data from surgery centers in Florida, Georgia and Tennessee suggests that the number of facilities in each of these states that would *not meet* the 938 patient volume threshold ranges from approximately 20 to 33 percent. Presumably some of these small centers would then be required to default to the more expensive mail and telephone mixed mode. ASCs whose patient volumes are too small to yield 300 completed surveys per year using the mixed mode would be expected to survey *all their patients*. The result of these proposed policies is that a significant minority of ASCs – those with the lowest patient volumes - would face the steepest burdens associated with the use of the survey. This strikes us as inherently unfair.

CMS has allowed lower minimums elsewhere. A minimum of 200 completed surveys has been established for the In-Center Hemodialysis CAHPS Survey. The 300-survey threshold is also three times higher than that required during the initial years of survey implementation in other CMS programs. For example, CMS set a threshold of 100 completed surveys for hospital participation in its HCAPHS Star Ratings initiative under the Hospital Inpatient Quality Reporting Program. The same standard was used in the Hospital Value-Based Purchasing Program.

We encourage CMS to consider options to address the disproportionate survey costs low volume ASCs would face if current proposals were implemented and finalize a more even-handed approach in recognition that ASCs would have to finance the collection of survey data.

D. Additional Implementation Costs for the OAS CAHPS Survey Are Significant

A number of our members have taken the first steps toward using the OAS CAHPS survey during its voluntary phase and have encountered issues we believe CMS should be aware of. The first of these is making provision for the patient populations excluded from the measure, namely patients who cannot be surveyed because of state regulations, patients whose address is not a U.S. domestic address, patients who request that the ASC not release their name and contact information to anyone other than facility personnel (“no-publicity” patients), prisoners, nursing home residents, patients discharged to hospice, and deceased patients. Presently, the ASC billing systems that would be used to develop the files of eligible patient data are not capable of

identifying these patient populations. Adding this capability to the functionality of those systems is proving complicated, time-consuming and costly. In addition, ASCs must pay to for the creation of an electronic interface between their billing systems and their survey vendor to communicate patient information. There is significant expense – thousands of dollars of additional charges – associated with these steps in implementation. Most of the ASC QC’s members are fortunate to have rich IT resources at their disposal, but we are concerned many ASCs without this luxury will find these issues very challenging, time-consuming, and expensive to address.

In short, we find several aspects of this survey – its excessive length, its limited modes of administration, the expectations regarding the number of completed surveys regardless of facility volume, and the implementation costs to be borne – very troublesome. They represent obstacles to maximizing the use of the survey, and although most can be rectified, they have not been. For many ASCs, the costs related to use of the OAS CAHPS survey would prove to be in excess of the 2% payment update penalty for failing to meet ASCQR Program requirements.

E. Proposed Exemption from OAS CAHPS Reporting

CMS has proposed that ASCs treating fewer than 60 survey-eligible patients during the eligibility period (which is the calendar year before the data collection period) may submit a request to be exempted from the OAS CAHPS Survey-based measures. We are confused by this threshold because existing ASCQR Program policy states that ASCs with fewer than 240 Medicare claims 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 (42 CFR 416.305(c)).

We have not been able to envision a scenario in which an ASC meeting the requirements for a Program-level exemption would not automatically be exempt from OAS CAHPS reporting. We are concerned that, if the proposed policy is finalized, these low volume ASCs might conclude that there is a need to file a request for exemption from OAS CAHPS reporting when, in fact, there may be no need to do so. We request clarification from the agency on this proposal. The agency may also wish to consider that it may be less confusing to avoid setting a separate, lower threshold for OAS CAHPS reporting.

F. OAS CAHPS Public Reporting Should Be by NPI

CMS has proposed “ASCs that share the same CCN must combine data for collection and submission for the OAS CAHPS Survey across their multiple facilities. These results would then be publicly reported on the Hospital Compare Web site as if they apply to a single ASC.” The agency intends to note instances where publicly reported measures combine results from two or more ASCs “to increase transparency in public reporting and improve the usefulness of the Hospital Compare Web site.”

As we have stated in the past, CMS should report quality measure data by NPI, as this method would uniquely identify each individual ASC. We believe the primary aim of public reporting of quality data is to ensure that consumers can distinguish performance at the individual facility level. In cases where multiple facilities share the same CCN, combining results makes it all but impossible for consumers to understand the performance of the particular facility they may

be interested in using as a setting for the delivery of their health care.

Currently, ASCs report almost all their ASCQR Program quality measure data to CMS using their NPI. Only one measure is currently reported by CCN: ASC-8, Influenza Vaccination Coverage among Healthcare Personnel. As we have mentioned in past comments to CMS, the Centers for Disease Control and Prevention (CDC), the agency responsible for the National Healthcare Safety Network (NHSN), has indicated their willingness to consider changing their data collection from one that is CCN-based to an NPI-based approach. Making this change soon would be particularly beneficial in light of the potential for the future use of NHSN for collection of data for an ASC SSI measure that is under consideration for endorsement by the National Quality Forum. CMS should work with CDC to implement data collection under the NPI in NHSN, and then move quickly to consolidate reporting around the NPI for all future measures.

We do not think CMS should stray further from using NPI-based reporting by finalizing a CCN-based approach for the collection, submission and public reporting of the OAS CAHPS survey measures. Instead we advocate for the most transparent and user-centric approach for the healthcare consumer. For us, that is clearly a strategy that allows the public to directly correlate quality measure data with an individual facility.

III. Existing ASCQR Program Quality Measures: Ongoing Concerns Regarding ASC-12 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

We were pleased to learn that, upon further consideration, CMS no longer intends to compare data from OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy and ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. We applaud this decision because the results of the two measures cannot help but reflect fundamental claim and billing policy differences between the two settings that preclude valid comparisons. This is due to several factors, including the following:

- Medicare's three-day payment window policy results in major challenges to identifying index HOPD visits, and therefore subsequent hospital visits related to HOPD care, creating a systematic undercounting bias in the HOPD 7-day hospital visit rates.
- ASC-12 identifies ASC facility claims *directly*, using ASC facility claims. HOPD claims for OP-32 during the three-day payment window are identified *indirectly, using physician claims* for colonoscopy in the HOPD setting with an inpatient admission within 3 days and lacking a corresponding HOPD facility claim. Place of service (POS) coding on the physician claim is used to establish the HOPD site of service. However, the Department of Health and Human Services Office of Inspector General has performed repeated audits of physician POS coding that consistently demonstrate high error rates, so this indirect methodology is flawed.
- OP-32 has exclusions for colonoscopies that are billed on the same hospital outpatient claim as an observation stay or an ED visit, as well as colonoscopies that are billed on a separate claim on the same day and at the same facility as an ED visit. This is because the sequence of events in these cases is not clear. However, a similar adjustment is not made when an ASC visit and an ED visit are billed on the same day even though the sequence of events in this case is also unclear.

- HOPDs submit claims using the UB-04; ASCs submit claims using the CMS-1500. Among their differences, the two forms vary in the total number of fields available for the submission of diagnosis codes and in the types of fields associated with diagnosis coding. For example, the CMS-1500 requires a pairing of each procedure code with a diagnosis code supporting its medical necessity; there is no method for coding underlying comorbidities that may impact the measure's risk adjustment methodology.

Although careful analysis makes it clear that the results for the two measures cannot be compared, we are concerned that a casual observer might not be aware of this fact. Because ASC-12 and OP-32 have the same title, and because CMS has not explicitly stated that the results from the two measures are not comparable, the public could understandably come to the conclusion that comparisons are appropriate. Individual consumers will be making healthcare choices and decisions based on the data CMS presents so we believe it is critical that these two measures be clearly distinguished as different. CMS should take immediate action to differentiate the measures. Possible steps include revising the names of the measures and adding interpretive guidance that makes it clear that the measure results cannot be compared across the two settings.

In addition to the above concern, we continue to take issue with the reliability of the scores for this measure. We have shared this issue with CMS in the past, and still consider it unresolved.

The measure developer has acknowledged that the number of outcome events for this measure is low. To compensate for this, the measure has been specified in ways that generate large case volumes through the inclusion of physician office claims for colonoscopy in the measure denominator. Even with this approach, the results of reliability testing were quite low. With two years of data, the intra-class correlation coefficient (ICC) was, on average, 0.335, which according to conventional interpretation is only "fair."

The reliability data presented to NQF demonstrates that this measure requires three years of data to achieve even modestly reliable measure scores for *high volume* facilities. The reliability of the measure was "fair" for two years of data and therefore the one-year measure reliability score would be even lower due to the significantly smaller number of observations. In fact, the measure developer has recommended use of three years of data. We note the "dry run" was performed using three years of data, yet CMS has implemented the measure using only one year of claims data, which is not enough to develop sufficiently reliable performance data. The agency should extend the data collection period to three years to fulfill its obligation to ensure reliable data is reported to the public.

It should also be noted that the "fair" ICC for this measure was only obtained *after excluding low volume facilities* from the calculation. As the measure developer explained to NQF, "[b]ecause we expect facilities with relatively few cases to have less reliable estimates, we only included scores for facilities with at least 400 cases in the reliability calculation (i.e., with 200 cases in each of the split samples, about 100 cases/year). This approach is consistent with a reporting strategy that includes smaller facilities in the measure calculation but does not publicly release the measure score for smaller facilities." However, in the "dry run" for this measure, CMS lowered the threshold for the number of colonoscopies to fewer than 30, which is about equivalent to 10 cases/year because the dry run incorporates three years of claims data. This is a significant

change and one that further impacts the reliability of measure scores. CMS should not degrade the measure results further by lowering the threshold to 10 cases/year from 100 cases/year.

In our opinion, the reliability of measure data intended for public reporting and accountability purposes is of paramount concern. We reiterate our position that CMS should extend the data collection period to three years and set the low volume threshold at 100 cases/year in order to ensure some semblance of reliability in the measure scores reported to the public.

IV. ASCQR Program Quality Measures for Future Consideration

CMS has invited public comment regarding future consideration of the Toxic Anterior Segment Syndrome (TASS) measure for inclusion in the ASCQR Program. Developed by the ASC QC, this outcome measure assesses the number of patients diagnosed with TASS within 2 days of undergoing anterior segment surgery in the ASC. The measure is fully developed and has been specifically tested in the ASC setting. The measure was reviewed by the Measure Applications Partnership (MAP) last year and received conditional support pending endorsement by the National Quality Forum (NQF).

We would support the inclusion of this measure in the ASCQR Program in the future. We note that, in spite of the MAP's recommendation, NQF endorsement is not necessary. The requirement that measures reflect consensus among affected parties has been met through our collaboration within the ASC industry, as well as our inclusion of the American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, and the Outpatient Ophthalmic Surgery Society in the review of the measure early in the development process.

V. Deadline for Data Submitted Via QualityNet

Currently, data for quality measures reported via QualityNet must be submitted during the period from January 1 to August 15 in the year prior to the affected payment determination year. CMS established a different time period – January 1 through May 15 - for data submission for ASC-8: Influenza Vaccination Coverage among Healthcare Personnel, which is submitted via the CDC's NHSN. These deadlines were finalized and codified in previous rulemaking. The agency is now proposing to change the deadline for data submission for all data reported via QualityNet, shortening the submission period to between January 1 and May 15 in the year prior to the affected payment determination year. If adopted, this policy would reduce the data submission period currently allowed for the following ASCQR Program measures *by three months*:

- ASC-6: Safe Surgery Checklist Use;
- ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures;
- ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients;
- ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use; and
- ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (voluntary).

In addition, this proposal would apply to other measures CMS has proposed should they be finalized, namely ASC-13: Normothermia Outcome and ASC-14: Unplanned Anterior Vitrectomy.

CMS is proposing this change in the belief that aligning all Web-based data submission deadlines to May 15 would allow for earlier public reporting of measure data and reduce the administrative burden of tracking multiple submission deadlines. While we appreciate the effort to streamline program requirements and agree that selecting one data submission timeframe is desirable, we do not agree with electing to give ASCs less time to submit their data. We again urge CMS to consider the cumulative impact of the many conditions the agency places on ASCs seeking a full Medicare payment update. The requirements of the ASCQR Program are already complicated and demanding, and growing more so with time. Shortening the data submission time period would add to, rather than reduce, ASC administrative burden.

ASCs have used an August deadline for QualityNet reporting since data submission began on ASC-6 and ASC-7 in 2013. We believe that changing the deadline after having finalized and codified August 15 for web-based quality data submission will create a great deal of confusion in the industry. We are concerned that many ASCs, who are already challenged by all the various and sundry demands of the ASCQR Program, will inadvertently miss the earlier deadline and unwittingly forfeit their full payment update.

CMS should retain the data submission timeframe of January 1 through August 15 in the year prior to the affected payment determination year. If the agency desires a consistent data submission deadline across settings, it should allow the August 15 deadline for its other quality reporting programs.

VI. CMS Should Take Steps to Simplify the ASCQR Program

Although the ASCQR Program is less than 5 years old, the ASC industry is already finding Program requirements quite complex. At this time, measures are being reported via Medicare claims using quality data codes, through the QualityNet website, through the CDC's NHSN website, and through extraction of Medicare claims data by a CMS contractor. The proposals surrounding the OAS CAHPS measures would add yet another reporting method to this list. The ASC QC suggests CMS explore options to streamline data submission methods and issue proposals for change in next year's rulemaking.

We believe CMS should change the method of reporting ASC-1 through ASC-5. These measures are currently reported using quality data codes on ASC Medicare claims, but we assert it would be more beneficial to all stakeholders to submit this data on QualityNet. The major advantage of making this change is that, rather than having data limited to Medicare patients, CMS and the public would have access to aggregate data for all the patients served by an ASC, considerably expanding the scope and transparency of public reporting as well as the accountability related to these measures. The ASC QC is the measure developer and steward for all five measures and we can attest that, as originally developed, they are suitable for the type of aggregate data collection and submission in use at the QualityNet site.

Our second suggestion would facilitate reporting for those ASCs affiliated with a management company. In these cases, quality data originates at the individual ASC level, but it is extracted, compiled, and validated at the corporate office. This corporate support allows the staff at the center to focus on patient care. However, at the moment, all reporting mechanisms are at the individual ASC level. As a result, management companies then have to return the data to the center and instruct or re-instruct personnel at the ASC on how the data is to be reported for their location. These companies spend many hours updating and correcting accounts within QualityNet, and also training and re-training center staff regarding the registration and security processes. To help streamline the reporting process in these cases, we suggest CMS develop a batch submission option for QualityNet, similar to the “Group” function CDC has in place for the NHSN website. This would allow management companies to report quality data in one batch for many centers.

VII. Public Reporting of ASCQR Program Data

A. Public Display of Program Data

The agency is proposing to publicly display ASC quality data on the Hospital Compare website, or other CMS website, as soon as possible after measure data have been submitted to CMS. We agree that prompt display of quality data is desirable, but think the current method of displaying data on Hospital Compare is not ideal. The current link to ASCQR Program data on Hospital Compare is not prominent, being but one of many in a list of quality program links. This is not user-friendly for consumers trying to find ASC information. We would like to see CMS establish a website that is dedicated to ASCs, as it has done already for nursing homes, dialysis facilities and home health care.

B. Preview Reports

CMS is required to give ASCs an opportunity to preview their data before it is made public. Historically, the preview for the April data release typically occurs in January, the preview for the July data release typically occurs in April, the preview for the October data release typically occurs in July, and the preview for the December data release typically occurs in October. To date, ASCs have generally had approximately 30 days to preview their data. The agency is proposing to formalize this period of approximately 30 days.

We believe CMS should allow a preview period of 60 days for ASCs. ASCs are generally small providers whose staff does not include a team member dedicated solely to managing quality reporting requirements. For those ASCs who are affiliated with a management company, a corporate team member often provides support by examining preview reports on behalf of many, sometimes hundreds, of centers. In either scenario, a more generous 60-day preview period would allow a more appropriate amount of time for review and any necessary action, particularly if a center encounters issues with maintenance of their QualityNet account or security administrator credentials.

VIII. Extraordinary Circumstances Extensions or Exemptions for the CY 2019 Payment Determination and Subsequent Years

CMS is proposing to modify the ASCQR Program’s extraordinary circumstances

extensions or exemptions policy for the CY 2019 payment determination and subsequent years. This proposal would extend the time to submit a request from within 45 days of the date that the extraordinary circumstance occurred to within 90 days of the date that the extraordinary circumstance occurred. We agree that it may be difficult for ASCs to evaluate the impact of an extraordinary event within 45 calendar days. Extending the deadline to 90 calendar days will allow ASCs more time to determine whether it is appropriate to submit a request and to determine whether to request an extension or an exemption based on the nature and severity of the event. Further, the proposed 90-day timeframe also aligns with existing timelines for other programs such as the Hospital VBP Program, the HAC Reduction Program, and the Hospital Readmissions Reduction Program. A 90-day period has also been proposed for the Hospital IQR Program, the LTCH QRP Program and the Hospital OQR Program.

We support revising current regulation to allow ASCs to request an extension or exemption within 90 days of the date that the extraordinary circumstance occurred.

XI. Opportunities for Additional Comparative Quality Measures Across Settings

As noted above, the ASC QC is the measure developer for several of the ASCQR Program measures, including ASC-1 Patient Burn, ASC-2 Patient Fall, ASC-3 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant, and ASC-4 Hospital Transfer/Admission. These facility-level measures have not been tested for use in other outpatient surgical settings, but we believe CMS should consider doing so. If testing yields satisfactory results, we would encourage CMS to implement these measures for other facility providers of outpatient surgical services, such as HOPDs. Applying the same facility-level quality measures to all settings offering outpatient surgery would expand the comparative data available to consumers.

X. Measure Applications Partnership (MAP) Improvements Are Necessary

CMS relies on the recommendations of the MAP when issuing proposals for measures for future inclusion in the ASCQR Program. We appreciate the work of the individuals serving on the MAP Coordinating Committee and its various workgroups, and applaud the improvements in the MAP process that have been made over time, but continue to be concerned about two issues: public comments on the Coordinating Committee draft report and the practice of submitting measure concepts for consideration.

MAP procedures for the consideration of public comment at critical junctures have improved but remain unsatisfactory. While the public is given the opportunity to comment on the draft Pre-Rulemaking Report issued by the MAP, these comments are not considered by the Coordinating Committee and therefore do not result in any revisions to the recommendations in the final report. Public comments are merely summarized by NQF staff and then appended to the report. This lack of consideration should be corrected. The MAP Coordinating Committee should be required to formally consider and respond to public comments regarding its draft report, and to then make any appropriate revisions to its recommendations prior to issuing a final report.

In addition, we are troubled by CMS's practice of asking the MAP to make recommendations regarding measure concepts and/or drafts. The agency and its contractors have developed a habit of including incomplete measures to the Measures Under Consideration List,

getting a stamp of approval from the MAP, and then pointing to conditional recommendations regarding measure topics and drafts as evidence of consensus. Not all concepts and drafts are successfully developed. The MAP should not issue recommendations based on measure concepts or measure drafts. Further, the inclusion of incomplete measures creates an unreasonably large number of items for the MAP to review. As a result, thoughtful consideration of each is very difficult in the brief timeframe allocated. We urge CMS to take steps to promote a pre-rulemaking process in which due consideration of fully developed measures becomes the standard.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Donna Slosburg". The signature is written in a cursive style with a large, looping flourish at the end.

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