MEDPAC Medicare Payment Advisory Commission

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Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: File code CMS-1601-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit comments on CMS's proposed rule entitled: "Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; hospital value-based purchasing program; organ procurement organizations; quality improvement organizations; electronic health records (EHR) incentive program; provider reimbursement determinations and appeals" [CMS-1601-P]. We appreciate your staff's ongoing efforts to administer and improve the payment system for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs), particularly considering the agency's competing demands.

As you know, the outpatient prospective payment system (OPPS) classifies services provided in outpatient departments into ambulatory payment classification (APC) groups. Each APC group has a relative weight, which is an indexed measure of the resources needed to furnish a service. The OPPS determines payment rates for APC groups as the product of the relative weights and a conversion factor. The ASC payment system largely uses the APC groups and relative weights from the OPPS, but uses a different conversion factor to obtain payment rates. This proposed rule is similar to its predecessors in the sense that it documents changes in the composition of some APC groups and proposes changes to the relative weights based on analysis of claims and cost report data. The rule also estimates the calendar year 2014 update to the conversion factors in the OPPS and ASC payment system.

This rule also proposes to:

- Create a new payment unit called comprehensive APC groups. Payment for comprehensive APC groups would be based on all charges on applicable claims, excluding only charges that cannot be covered under Medicare Part B or are not payable under the

OPPS. CMS proposes to create comprehensive APC groups for the 29 most costly device-dependent APC groups.

- Expand the extent to which interrelated services and items are packaged into a single payment unit.
- Create a single HCPCS code and APC group for clinic visits, a single HCPCS code and APC group for Type A emergency department (ED) visits, and a single HCPCS code and APC group for Type B ED visits. Currently, the OPPS has 10 HCPCS codes and 5 APC groups for clinic visits, 5 HCPCS codes and 5 APC groups for Type A ED visits, and 5 HCPCS codes and 5 APC groups for Type B ED visits.
- Use cost-to-charge ratios (CCRs) from newly created standard cost centers on hospitals' cost reports for computed tomography (CT), magnetic resonance imaging (MRI), and cardiac catheterization. Use of these new standard cost centers in place of the old standard cost centers would substantially reduce payment rates for CT, MRI, and cardiac catheterization and increase rates for other types of imaging such as ultrasound.
- Allow an instruction regarding direct supervision of therapeutic services provided in critical access hospitals (CAHs) and other rural hospitals with 100 or fewer beds to expire at the end of calendar year (CY) 2013. This would result in a requirement that all outpatient therapeutic services furnished in hospitals and CAHs would require a minimum of direct supervision unless the service is on the list of services that may be furnished under direct supervision or is designated as a nonsurgical extended duration therapeutic service.
- To better understand the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based departments, CMS is considering collecting information that would allow analysis of the frequency, type, and payment for services provided in off-campus provider-based departments.
- Remove two current quality measures and add five new quality measures to the hospital outpatient quality reporting (OQR) program for payment determination in CY 2016.
- Add four new quality measures to the ASC quality reporting program for payment determination in CY 2016.

We focus our comments on the updates to the OPPS and ASC conversion factors and the 8 topics listed above.

Proposed 2014 update to OPPS conversion factor

CMS has proposed to update the OPPS conversion factor by 1.8 percent in 2014. CMS obtained this result starting with the estimated increase in the hospital market basket of 2.5 percent and subtracting an estimate of productivity of 0.4 percentage points plus an additional deduction of 0.3 percentage points required by the Patient Protection and Affordable Care Act of 2010 (PPACA).

Comments

We understand that CMS is required by law to implement the 2014 update to the OPPS conversion factor as stated in PPACA and commend CMS for their work. We note that in our March 2013

Report to the Congress we recommended that the Congress provide an update of 1.0 percent in 2014, which differs from the requirement in the PPACA.[1]

Expanded packaging

CMS has previously expanded the extent to which services and items are packaged together to create larger payment units in the OPPS. In this rule, CMS has proposed two ways of increasing the size of payment units, both of which are budget neutral: comprehensive APC groups and greater packaging of subordinate services and items with a primary service.

The advantages CMS cites for these larger payment units are that they

- improve CMS' ability to accurately set payment rates in the OPPS because CMS will be able to use more claims in setting the payment rates and
- improve hospitals' flexibility to tailor treatment to meet the specific needs of each beneficiary, which will improve the efficacy of the care and how efficiently it is provided.

Comprehensive APC groups

CMS has proposed to create 29 comprehensive APC groups to replace 29 current APC groups that usually require a device to be implanted or used to perform the service, called device-dependent APC groups. Currently, the unit of payment for device-dependent APC groups includes the device, the service that uses the device, and other items that have HCPCS codes or revenue center codes that are packaged under current packaging rules. Under comprehensive APC groups, all charges on each claim containing a HCPCS code that is in these 29 device-dependent APC groups would be combined into single payment unit, including items that have revenue center codes that are not packaged under current rules, such as room and board. The only exclusions are charges for items that cannot be covered under Medicare Part B or that are not payable under the OPPS. Examples of items that would be packaged in comprehensive APC groups include:

- services and supplies that are already packaged in the OPPS;
- other services that are typically integral, ancillary, supportive, dependent, or adjunctive to a primary service;
- devices, durable medical equipment, prosthetics, orthotics, and supplies;
- outpatient services reported as therapy codes;
- room, board, and nursing services; and
- hospital-administered drugs, except for pass-through drugs

Expanded packaging of dependent services and items

CMS has proposed to expand the list of dependent services and items that are packaged with a

[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

primary service into a single payment unit to include:

- Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure. Product categories that would become packaged under this proposal include stress agents such as adenosine and hexaminolevulinate hydrochloride, which is used in the diagnosis of bladder cancer.
- Drugs and biologicals that function as supplies or devices when used in a surgical procedure. A category of products that would become packaged is skin substitutes, which are wound dressings that stimulate the patient to regenerate lost tissue and replace a wound with functional skin.
- Clinical diagnostic laboratory tests when provided on the same date as a primary service and ordered by the same practitioner who ordered the primary service. When provided in HOPDs, these services have been paid under the clinical laboratory fee schedule (CLFS). CMS is also proposing to exclude molecular pathology tests from packaging and continue to have them paid under the CLFS.
- Procedures described by add-on codes. An example is additional time infusing chemotherapy drugs.
- Ancillary services identified by status indicator of "X". Under the OPPS, these services are currently paid separately. CMS proposes to package them conditionally: When they are provided on the same date as a service that has status indicator = S (significant procedure, multiple procedure discount does not apply), T (significant procedure, multiple procedure discount applies), or V (clinic or emergency department visit), they would be packaged. Otherwise, they would be paid separately.
- Diagnostic tests on bypass list. The bypass list consists of HCPCS codes that represent services that are separately paid in the OPPS and generally have relatively low levels of items packaged with it. CMS proposes to package diagnostic tests on the bypass list if they are provided on the same date as a service that has status indicator of S, T, or V.
- Device removal procedures. These procedures are often performed with procedures to repair or replace devices. CMS proposes to conditionally package these procedures when they are billed with other surgical procedures involving repair or replacement.

Comments

MedPAC has long supported CMS' efforts to expand the size of payment units in the OPPS, and we support the proposals in this rule. The comprehensive APC groups have similarities to the diagnosis related groups used in the inpatient prospective payment system (IPPS). We believe this payment structure encourages hospitals to identify the most efficient and efficacious methods to provide care for each patient, which will help reduce costs. We also believe packaging the services and items in the seven categories discussed above also will improve efficiency and efficacy.

Create single HCPCS codes and APC groups for clinic visits, Type A ED visits, and Type B ED visits

The OPPS currently has 10 HCPCS codes for physician clinic visits (99201–99215), 5 HCPCS

codes for Type A ED visits (99281–99285), and 5 HCPCS codes for Type B ED visits (G0380–G0384).[2] The OPPS also has 5 APC groups each for clinic visits, Type A ED visits, and Type B ED visits. The different HCPCS codes and APC groups for clinic visits and the two ED visit categories represent differences in resources needed to treat patients. OPPS payment rates are higher for HCPCS codes and APC groups that indicate relatively high resource needs.

For 2014, CMS proposes to replace the 10 HCPCS codes for clinic visits with one HCPCS code and the 5 HCPCS codes in both of the ED visit categories with one HCPCS code each. CMS also proposes one APC group each for clinic visits, Type A ED visits, and Type B ED visits. Consequently, there would be only one payment rate each for all clinic visits, all Type A ED visits, and all Type B ED visits.

CMS cites four reasons for this proposal. First, it would reduce incentives for hospitals to expend unnecessary resources to obtain a higher level payment. Second, it would reduce hospitals' administrative burden. Third, there would be a large number of claims available for calculating the payment rates for each of the new APC groups. This will result in more accurate and more stable payment rates. Fourth, it will eliminate incentives for hospitals to 'upcode' patients whose visits do not clearly fall into any one category.

Comments

We do not deny the validity of any of the rationales CMS cites for this proposal. Nevertheless, we strongly oppose this proposal. We believe that the proposed APC groups are overly broad and encompass an excessively wide range of beneficiaries. Hospitals would be paid the same rate for all clinic visits or all ED visits, irrespective of the patients' clinical condition. Hospitals that serve a disproportionately healthy Medicare population would benefit financially, while those that serve a population that is sicker than average would be hurt financially. Moreover, a primary purpose of replacing the old diagnosis-related groups (DRGs) with Medicare severity DRGs (MS-DRGs) in the IPPS was to account for differences in costs due to differences in patient severity. This proposal for one APC group for clinic visits, Type A ED visits, and Type B ED visits is inconsistent with that purpose. Consequently, MedPAC strongly opposes this proposal.

Use CCRs from new standard cost centers for CT, MRI, and cardiac catheterization

The method CMS uses to set payment rates for the APC groups in the OPPS involves calculating a geometric mean of the estimated cost of each unit of service that hospitals provide in each APC group. CMS estimates a cost for each unit of service by multiplying the hospital charges for each input to the service by a hospital-level cost-to-charge ratio (CCR) from the applicable cost center on the hospital's cost report. To obtain an estimated cost for each unit of service, CMS sums the estimated costs from all the inputs to that service.

[2] A Type A ED is defined as an "organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." A Type B ED has less stringent criteria, as it does not have to be available 24 hours a day, but it does have to be available for urgent care.

Some cost centers encompass services, supplies, or other inputs that have a wide range of costs. Within a single cost center, hospitals tend to mark-up charges for lower-cost items by a greater proportion than they mark-up higher-cost items. This results in costs being overestimated for lower-cost items and underestimated for higher-cost items, an effect termed "charge compression."

RTI International investigated the issue of charge compression in the methods CMS uses to set payment rates in the OPPS and IPPS.[3] In response to RTI International's results, CMS created new standard cost centers for CT, MRI, and cardiac catheterization and required that hospitals report the costs and charges for these services in these new cost centers. For 2014, CMS has proposed for the first time OPPS payment rates that result from using these new cost centers. The result would be much lower OPPS payment rates for CT, MRI, and cardiac catheterization services. Conversely, other imaging APC groups such as ultrasound and cardiac imaging would have much higher payment rates. The lower payment rates for MRI, CT, and cardiac imaging APC groups must result in higher payment rates in other APC groups to maintain budget neutrality in the OPPS.

Comments

We support CMS' proposal to use the new standard cost centers in the setting of payment rates for 2014. Many have asserted that charge compression has resulted in inaccurate payments in the OPPS since its inception in August 2000. We believe this is an important step in mitigating the effects of charge compression and should result in more accurate payments. We also encourage CMS to continue to investigate alternatives for further reducing the effects of charge compression.

Supervision of hospital outpatient therapeutic services

Over the past several years, CMS has been addressing issues regarding supervision of therapeutic services provided in outpatient departments of hospitals and CAHs. Currently, there is an instruction to all Medicare contractors not to evaluate or enforce supervision requirements for therapeutic services provided to outpatients in CAHs and other small rural hospitals (100 or fewer beds). In this proposed rule, CMS proposes to allow this instruction to expire at the end of CY 2013.

The expiration of this nonenforcement instruction would result in all hospitals, including CAHs and small rural hospitals being required to provide direct supervision of all outpatient therapeutic services unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service (NSEDTS).

CMS has made updates to the definition of direct supervision, the most recent being January 1, 2011, that have resulted in more flexible guidelines. Currently, direct supervision means that the supervising practitioner must be immediately available to furnish assistance and direction

[3] RTI International. 2008. *Refining cost to charge ratios for calculating APC and MS-DRG relative payment weights.* RTI Project Number 0209853.008. Research Triangle Park, NC: RTI International.

throughout the performance of the procedure.[4,5] The supervising provider is not required to be present in the room where the procedure is performed or within any other physical boundary as long as he or she is immediately available. Immediate availability requires the immediate physical presence of the supervisory provider. Direct supervision may be furnished from a providers' office or other nonhospital space that is not officially part of the hospital or CAH campus where the service is being furnished as long as the supervising provider is immediately available.

The rules are less burdensome for general supervision than for direct supervision. General supervision requires that a procedure be furnished under the supervisory physician's overall direction and control, but the physician's present is not required during the performance of the procedure.

Comments

A major factor in CMS' decision to the implement the nonenforcement instruction regarding supervision requirements was concerns raised by CAHs and small rural hospitals. These providers said that they would have difficulty meeting standards for direct supervision of therapeutic services that CMS had established in the 2010 final rule. In response, CMS established the nonenforcement instruction, which has been in place since March 15, 2010. Since then, CMS has made adjustments to the definition of direct supervision and expanded the list of outpatient therapeutic services for which direct supervision is not required. CMS made these changes in response to concerns and requests made by CAHs and other stakeholders.

It is important to strike a balance between assuring quality and allowing staffing flexibility for hospitals—particularly for small, isolated rural hospitals. It is also important to maximize the productivity of all members of health care delivery teams (physicians, other professionals, nurses). In light of the decision to enforce the supervision instructions, we advocate that CMS continue working with the Hospital Outpatient Payment Panel to define services that are appropriate for general supervision. Similarly, we encourage CMS to review Conditions of Participation (CoPs) for CAHs to ensure that the CoPs are consistent with regulations.

Collecting data on services furnished in off-campus provider-based departments

There has been a trend in recent years for hospitals to acquire physician practices, which has resulted in a shift of many services being billed in freestanding physician offices to HOPDs. MedPAC has discussed this issue in two chapters in recent reports that investigate options to align payment rates for ambulatory services across settings.[6,7] Issues related to this purchase of physician practices by hospitals also have been discussed by researchers and in the popular press.

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[4] Nonphysician practitioners that can provide supervisory services include licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives.
[5] Centers for Medicare & Medicaid Services. 2013. *Medicare benefit policy manual, chapter 6*. Pub. 100-02. Baltimore, MD: Centers for Medicare & Medicaid Services.
[6] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

When hospitals acquire physician practices, they often treat the practices as off-campus provider-based departments of the hospitals. Under this construct, hospitals can bill Medicare for the physicians' services under the Medicare physician fee schedule (PFS) and also bill Medicare for hospital facility expenses under the OPPS. For most services, the combined payment from the PFS and the OPPS are greater than the single payment Medicare care would make under the PFS if the same service had been provided in a freestanding physician's office.

To better understand the trend toward hospital acquisition of physician practices and the treatment of them as off-campus provider-based departments, CMS is considering collecting data they could use to analyze the frequency, type, and payment for services provided in off-campus provider-based hospital departments. CMS indicates they have considered several methods for collecting these data. In this proposed rule, CMS mentions two general methods:

- Claims-based approaches that could include creating a HCPCS modifier that could be reported with every code for services furnished in off-campus provider-based departments on claims for physician services and for HOPD services.
- Ask hospitals to break out the costs and charges for their provider-based departments as outpatient service cost centers on hospital cost reports.

CMS is inviting public comments on the best means for collecting these data.

Comments

As described above, we have found that the billing of many services has been migrating from physicians' offices to the usually higher paid HOPD setting, which has resulted in higher spending for the Medicare program and higher cost sharing for Medicare beneficiaries without significant changes in patient care. Therefore, payment variations across ambulatory settings should be immediately addressed. However, CMS's proposal to collect data on services provided in off-campus provider-based departments is insufficient to address the central issue: payment rates for many services are higher in HOPDs than freestanding offices and ASCs for most services, which encourages the migration of services to HOPDs. Although it is reasonable to pay higher rates in HOPDs for certain services, we have developed criteria to identify services for which payment rates could be equal across settings or the differences could be narrowed.[8]

We encourage CMS to seek legislative authority to implement our recommendation of equal total payment rates for E&M office visits across settings.[9] CMS also should examine options to reduce differences in payment rates across settings for other services using the principles and criteria described in our June 2013 report.

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[7] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Regarding the proposal to collect data on services provided in off-campus provider-based departments, there may be some limited value in collecting these data to validate the accuracy of site-of-service reporting in circumstances where physician offices are off-campus but billing as HOPDs. However, it would have been more valuable if CMS had tracked the growth of off-campus provider-based departments for the last several years because this could have provided an early indication that hospitals were purchasing physician practices and converting them to HOPDs. In any case, collecting these data should not prevent CMS from developing policies to align payment rates across settings.

In addition, Medicare's rules for provider-based status have not slowed the migration of ambulatory services to HOPDs. These rules are not particularly stringent, and CMS does not require hospitals to attest that they are complying with them. Moreover, rules for establishing provider-based departments do not address the problem that Medicare pays higher rates for many services in HOPDs than in other ambulatory settings.

Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting (OQR) Program requires hospitals to report data on a set of quality measures specified by CMS or their OPPS payment update factor will be reduced by two percentage points in the following year. The payment update determination is not based on a hospital's performance on the set of measures required for that year, only on whether the hospital successfully reported the measures that CMS required. In the first year of the OQR program in 2008, CMS required reporting on seven measures in order for a hospital to receive a full OPPS payment update in 2009 (and 2010). The 2011 payment update was based on 11 measures; there were 15 measures for the 2012 payment update determination; 23 measures for the 2013 update; and 25 measures currently for the 2014 and 2015 updates. Twelve of the current measures require hospitals to report data obtained from patients' medical charts; the others are reported by hospitals using a CMS Internet-based tool or are calculated by CMS directly from Medicare claims data.

In this year's proposed rule, CMS proposes to remove two chart-abstracted measures and add five new measures for the CY 2016 OPPS payment determination and subsequent years. One proposed measure would report the rate of influenza vaccination coverage among the facility's health care personnel, which hospitals would report through the CDC's Internet-based National Healthcare Safety Network. The other four proposed measures—two related to cataract surgery outcomes and two related to appropriate use of colonoscopy—would require hospitals to report using patient chart-abstracted data. If adopted, the proposed changes would bring the total number of measures to 28, of which 16 would require hospitals to collect data from patient medical charts.[10]

Comments

We are concerned that adding four new chart-abstracted measures to an already large and complex quality reporting program could increase the administrative burden on hospitals to an unreasonable

[10] One measure, "Use of brain computed tomography in the emergency department for atraumatic headache" is deferred at this time.

degree. We encourage CMS to consider whether it could use claims data rather than requiring hospitals to collect the needed information from patient medical records. For example, for the new proposed measure of the rate of complications following cataract surgery, CMS could analyze claims for beneficiaries who received cataract surgery in an outpatient department to identify if they received a procedure for a complication related to the surgery (such as endophthalmitis) within 30 days of the surgery. CMS could also use claims data to identify patients who should be excluded from the measure because of certain pre-operative conditions and comorbidities.

We also continue to be concerned about the "volume of selected surgical procedures" measure that CMS requires for both the OQR and ASC quality reporting programs. As we noted in our comment letter on the CY 2013 proposed rule, the research that finds a correlation between higher volume of surgical procedures and better patient outcomes is based on analyses of the outcomes of high-risk surgical procedures, such as esophageal resection and abdominal aortic aneurysm repair. These procedures typically are not performed in outpatient departments and ASCs. Moreover, adoption of this measure could lead hospitals to increase their volume of outpatient surgeries to improve their performance on this measure. We suggest again that CMS eliminate this measure from the program, or, at a minimum, refine it to include only high-risk surgical procedures.

Lastly, we note that this year's proposed rule does not mention another important outcome measure discussed in previous years, the rate of surgical site infections (SSIs). CMS proposed adding a SSI measure for the Hospital OQR and ASC quality reporting programs in the CY 2012 proposed rule, but decided not to do so in the CY 2012 final rule (CMS-1525-FC). In that final rule, CMS stated that "we intend to re-propose the surgical site infection measure through future rulemaking once measurement and operational issues for HOPDs are resolved." We request that CMS provide an update on the status of its efforts to develop a SSI measure for HOPDs and ASCs in the 2014 final rule issued later this year.

Proposed updates to the Ambulatory Surgical Center (ASC) payment system

CMS proposes to increase the conversion factor in the ASC payment system in 2014 by 0.9 percent. This proposed update is based on CMS's estimate of a 1.4 percent increase in the consumer price index for all urban consumers (CPI–U) minus a 0.5 percent deduction for multifactor productivity growth (PPACA requires that the update be reduced by a productivity adjustment).

Comments

In the Commission's March 2013 report, we recommended that the Congress eliminate the update to ASC payment rates for 2014. This recommendation was based on our indicators of payment adequacy for ASCs, which are positive; the importance of maintaining financial pressure on providers to constrain costs; and the lack of ASC cost and quality data.

CMS believes that it has statutory discretion to select the basis for updating ASC payments and has decided to base annual updates on the CPI–U for the last several years. However, in the proposed rule for CY 2013, CMS noted that the CPI-U may not be an ideal index for the cost of providing

ASC services because the CPI-U is highly weighted for housing and transportation. CMS considered alternatives to the CPI-U for updating ASC payment rates, such as the hospital market basket. However, CMS believes that the hospital market basket does not align with the cost structure of ASCs because hospitals provide a much wider range of services than ASCs, such as room and board. Therefore, CMS concluded that it needs data on the cost inputs of ASCs to determine whether there is a better alternative than the CPI-U to measure changes in ASC input costs. In the proposed rule for CY 2013, CMS asked for public comment on the feasibility of collecting cost information from ASCs but has not proposed a plan to collect this information.

We agree with CMS that the CPI-U may not reflect ASCs' cost structure. As described in our March 2010 report, we used data from a Government Accountability Office (GAO) survey of ASC costs and found that ASCs have a different cost structure than do hospitals and physicians' offices.[11] However, the GAO data are from 2004 and do not contain information on several types of costs. Therefore, CMS should collect new cost data and use that information to examine whether an existing Medicare price index is an appropriate proxy for the costs of these facilities or an ASC-specific market basket should be developed.

We understand the concern expressed by CMS in prior rules that requiring ASCs to submit cost data may impose a burden on these providers. However, we believe it is feasible for ASCs to provide a limited amount of cost information. Although ASCs are generally small facilities, such businesses typically keep records of their costs for filing taxes and other purposes. Moreover, other small providers submit cost data to CMS, including home health agencies and hospices. To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit a limited amount of cost data.[12] One such mechanism could be annual surveys of a random sample of ASCs with mandatory response. Another approach would be to require all ASCs to submit streamlined cost reports on an annual basis.

Proposed requirements for the Ambulatory Surgical Center Quality Reporting Program

In the final rule for CY 2012, CMS established a Quality Reporting Program for ASCs that requires them to submit quality data beginning in 2012; ASCs that do not submit data on a specified set of measures will have their annual payment update reduced by 2.0 percentage points in 2014. However, Medicare payments to ASCs will not be adjusted based on their actual performance on these quality measures, only on whether the facilities successfully reported them. Although the Secretary submitted a plan to the Congress in 2011 to implement a value-based purchasing program (VBP) for ASCs that would reward high-performing facilities, the agency lacks the statutory authority to establish such a program.

Under the Quality Reporting Program, ASCs began reporting the following patient safety, outcome, and process measures on claims in October 2012:

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[11] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare Payment Policy.* Washington, DC: MedPAC

[12] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare Payment Policy.* Washington, DC: MedPAC.

- patient fall in the ASC;
- patient burn;
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;
- hospital transfer or admission after an ASC procedure; and
- prophylactic intravenous antibiotic timing.

ASCs began reporting data on two additional measures in 2013 for the 2015 payment determination: use of a safe surgery checklist and facility volume for six types of procedures. They will begin reporting data on another measure—influenza vaccination coverage among health care personnel—in 2014 for the 2016 payment determination.

In this proposed rule, CMS proposes four new quality measures for the 2016 payment determination (ASCs would begin reporting data on these measures in 2014):

- Complications within 30 days following cataract surgery requiring additional surgical procedures
- Endoscopy/poly surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients
- Endoscopy/poly surveillance: colonoscopy interval for patients with a history of adenomatous polyps — avoidance of inappropriate use
- Cataracts: improvement in patient's visual function within 90 days following cataract surgery

CMS proposes to collect data on all ASC patients for these four chart-abstracted measures via an online tool. CMS is also proposing to adopt these four new measures for the Hospital OQR program, which would contribute to harmonizing measures across similar settings.

Comments

The Commission supports the ASC Quality Reporting Program but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system. In our March 2012 report, we recommended that the Congress direct the Secretary to implement a VBP program for ASC services no later than 2016.[13] The current quality reporting program could lay the foundation for such a VBP program. The VBP program should reward ASCs for improving their prior year performance on providing care and for exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services.

Consistent with the Commission's overall position on pay-for-performance programs in Medicare, an ASC VBP program should include a relatively small set of measures to reduce the administrative burden on ASCs and CMS, and the measure set should focus on clinical outcomes, as Medicare's central concern should be improving outcomes across all ASCs. The program also

[13] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

should minimize the use of measures that require providers to extract data from patients' medical records.

Several of the measures that are used in the ASC Quality Reporting Program could be used for an ASC VBP program. However, the measure on hospital transfer or admission after a procedure should be expanded, a measure on surgical site infections (SSIs) should be developed, and the measure of ASC facility volume should be eliminated. In addition, we are concerned that the four new measures proposed by CMS for collection in 2014 could impose an unreasonable burden on ASCs.

The ASC Quality Reporting Program currently includes a measure on hospital transfer or admission after a procedure, which tracks whether patients are transferred or admitted directly to a hospital (including a hospital emergency room) upon discharge from an ASC. Such an event can indicate a potentially preventable complication or serious medical error. As we have stated in prior comment letters, this measure should be expanded to include patients who return home after the ASC procedure but are admitted to a hospital shortly thereafter because of a problem related to the procedure. Including these patients in the measure would enable CMS to more comprehensively track patients who experience serious complications or medical errors related to an ASC procedure.

Another important outcome measure is the rate of SSIs in ASCs. Researchers have found that lapses in infection control practices were common among a sample of ASCs in three states.[14] Problems with infection control could increase the rate of SSIs. Therefore, CMS should develop an SSI measure that applies to common ASC procedures. To harmonize quality measurement across settings, CMS should consider using the same measure to track infection rates for ambulatory surgeries in both HOPDs and ASCs. Because SSIs often do not appear until after a patient has been discharged from an ASC, CMS could instruct ASCs to conduct follow-up phone calls with patients, their caregivers, or their physicians after the procedure to identify patients who have developed SSIs.

Although the ASC Quality Reporting Program does not yet include an SSI measure, CMS stated in the final rule for CY 2012 that it will consider proposing one in the future after the agency has identified an appropriate set of outpatient procedures for an SSI measure and developed a protocol for facilities to track and report SSIs. We request that CMS provide an update on the status of its efforts to develop an SSI measure in this year's final rule.

In the final rule for CY 2012, CMS adopted the following structural measure for ASCs to begin reporting in 2013: ASC facility volume for six broad categories of procedures (e.g., gastrointestinal, eye, nervous system). The research finding a correlation between higher volume of surgical procedures and better patient outcomes is based on analyses of high-risk procedures, such as esophageal resection. These procedures are typically not performed in ASCs. Moreover,

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14 Schaefer, M. K., M. Jhung, M. Dahl, et al. 2010. Infection control assessment of ambulatory surgical centers. *Journal of the American Medical Association* 303, no. 22 (June 9): 2273-2279.

adoption of this measure could lead ASCs to increase their volume to improve their performance on this measure. Therefore, we reiterate our suggestion that CMS eliminate this measure from the ASC Quality Reporting Program.

Finally, we are concerned that the four new measures proposed by CMS for data collection in 2014 could impose an unreasonable burden on ASCs because they would require facilities to abstract data from the medical records of their patients who had cataract surgery or colonoscopy. We are also concerned that having too many quality indicators would increase the administrative burden on ASCs. We encourage CMS to consider whether it could use claims data to calculate these measures rather than requiring ASCs to collect the information from medical records. For example, for the proposed measure of the rate of complications within 30 days following cataract surgery, CMS could analyze claims for beneficiaries who received cataract surgery in an ASC to identify if they received a procedure for a complication related to the surgery (such as endophthalmitis).

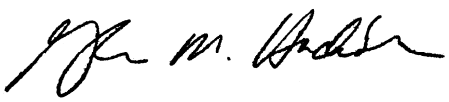
In the final rule for CY 2012, CMS announced that it would make data submitted by ASCs to the ASC Quality Reporting Program available on a public web site after giving ASCs an opportunity to preview the data. CMS said that it would provide more detail on the publication of data in a future rule. However, the agency has not announced when it would begin releasing this information. ASCs submitted data on the first five measures between October 1, 2012, and December 31, 2012. CMS should begin the process of making these data publicly available as soon as possible to help patients and researchers compare quality among facilities.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/dz/wc