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August 26, 2014

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1613-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

**Re: File code CMS-1613-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; physician-owned hospitals: data sources for expansion exception; physician certification of inpatient hospital services; Medicare Advantage organizations and Part D sponsors: appeals process for overpayments associated with submitted data" [CMS-1613-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 classifications (APCs). 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 APCs as the product of the relative weights and a conversion factor. The ASC payment system largely uses the APCs 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 APCs and proposes changes to the relative weights based on analysis of claims and cost report data. The rule also estimates the calendar year 2015 update to the conversion factors in the OPPS and the ASC payment system.

This rule also proposes to:

- Complete development and implementation of comprehensive APCs (C-APCs), as indicated by CMS in the 2014 final rule. Payment for C-APCs will be based on all charges on applicable claims, excluding only charges for items that are not payable under the OPPS; brachytherapy seeds, pass-through drugs, and pass-through devices, all of which

must be paid separately under the OPPS; and self-administered drugs, which are not covered under Medicare Part B.

- Package the cost of ancillary services into the payment rate of the primary services they are provided with if the ancillary services have a geometric mean cost of \$100 or less.
- Package the cost of prosthetic supplies into the payment of primary services that they are provided with.
- Continue to adjust payment rates for sole-community hospitals (SCHs) by 7.1 percent for all OPPS-covered services except for separately payable drugs and biologicals, pass-through devices, and items paid at charges reduced to cost.
- Create a HCPCS modifier that providers must report with every code for physicians' services and hospital outpatient services that are furnished in off-campus provider-based departments of hospitals.
- Remove three current quality measures and add one new quality measure to the Hospital Outpatient Quality Reporting (OQR) Program for payment determination in CY 2017.
- Change the definition of device-intensive APCs, which will increase the number of device-intensive APCs in the ASC payment system. Increasing the number of device-intensive APCs will likely make more surgical procedures that involve a device being implanted attractive to ASCs.
- Add one new quality measure to the ASC Quality Reporting Program for payment determination in CY 2017.

We focus our comments on the updates to the OPPS and ASC conversion factors and the eight topics listed above. We also discuss an additional issue: Consideration should be given to packaging all policy-packaged drugs and biologicals rather than allowing some initially to have pass-through status, then moving them to packaged status when their pass-through status expires.

### **Proposed 2015 update to OPPS conversion factor**

CMS has proposed to update the OPPS conversion factor by 2.1 percent in 2015. CMS obtained this result starting with the estimated increase in the hospital market basket of 2.7 percent and subtracting an estimate of productivity of 0.4 percentage points plus an additional deduction of 0.2 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 2015 update to the OPPS conversion factor as stated in PPACA and commend CMS for their work. We note that in our March 2014 Report to the Congress we recommended that the Congress provide an update of 3.25 percent in 2015 along with reducing or eliminating differences in payment rates between HOPDs and physician offices for selected APCs. We estimate that the net of effect of an update of 3.25 percent and aligning payment rates in HOPDs and physician offices for select APCs would be an increase

in hospitals' outpatient revenue of 0.55 percent, which differs from the requirement in the PPACA.<sup>1</sup>

### **Establishing comprehensive APCs**

In the 2014 OPPS/ASC proposed rule, CMS proposed to establish a new payment unit, comprehensive APCs (C-APCs). CMS proposed to create 29 C-APCs to replace 29 "device-dependent" APCs, defined as usually requiring a device to be implanted or used to perform the service. Under this proposal, nearly all charges on each claim that contains a HCPCS code that is in one of the 29 device-dependent APCs would be combined into a single payment, including those items that have revenue center codes that are not packaged under current rules. The only exclusions would be charges for items that cannot be covered under Medicare Part B or that are not payable under the OPPS.

In the 2014 OPPS/ASC final rule, CMS stated that it would delay implementation of the comprehensive APCs until CY 2015, citing concerns that this is a complex change to the OPPS and that hospitals need time to prepare for that change.

CMS now proposes that it will implement C-APCs in CY 2015. However, CMS has proposed modifications to the C-APCs discussed in the 2014 OPPS/ASC proposed and final rules. First, CMS has proposed that the only costs on a claim with a HCPCS code that maps to a C-APC that will not be packaged into the payment of the C-APC include:

- services not payable under the OPPS, such as certain mammography and ambulance services;
- brachytherapy seeds, pass-through drugs and biologicals, and pass-through devices, all of which must be paid separately under statute; and
- self-administered drugs that are not otherwise packaged as supplies because they are not covered under Medicare Part B.

Second, CMS has proposed to expand APCs that will become C-APCs. CMS initially indicated the C-APCs would be limited to 29 of the 39 device-dependent APCs. In this rule, CMS proposes to pay all 39 of the device-dependent APCs as C-APCs. However, CMS also proposes to reorganize, combine, and restructure the 39 device-dependent APCs into 26 C-APCs. Finally, CMS has proposed to add two APCs that are not device-dependent: APC 0067 (single session cranial stereotactic radiosurgery) and APC 0351 (level V intraocular surgery). Consequently, CMS is proposing 28 C-APCs, 26 that would be derived from the 39 device-dependent APCs plus APCs 0067 and 0351.

### *Comments*

MedPAC has long supported CMS' efforts to expand the size of payment units in the OPPS, and

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<sup>1</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

we support the proposal on C-APCs, which 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. We are pleased that CMS is proposing in this rule to redefine more standard APCs to C-APC status than what CMS proposed in the 2014 OPSS/ASC rule. We also encourage CMS to continue to investigate whether other APCs can reasonably become C-APCs.

### **Expanded packaging**

CMS has previously expanded the extent to which services and items are packaged together to create larger payment units in the OPSS. Expanded packaging increases incentives for hospitals to furnish care in the most efficient manner while still providing high-quality care. Also, CMS is able to identify more claims that can be used in the process for setting OPSS payment rates, which results in more reliable and more stable rates.

In this rule, CMS has proposed to add two categories to the list of dependent services and items that are packaged with a primary service into a single payment unit:

- Ancillary services that have geometric mean costs that are less than or equal to \$100. This includes a wide range of services. Examples include some plain film imaging, some eye tests and treatments, and electrocardiograms.
- Prosthetic supplies currently covered under the durable medical equipment, prosthetics, orthotics, and supplies fee schedule.

### *Comments*

As we mentioned earlier in regard to the proposal to establish C-APCs, MedPAC has long supported CMS' efforts to expand the size of payment units in the OPSS, and we support the proposals to expand packaging of secondary services and items. We believe packaging the services and items in the two categories discussed above also will improve efficiency and efficacy.

### **Continue to adjust upward OPSS payment rates for most services provided in sole-community hospitals above the payment rates for other hospitals**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to study whether rural hospitals incur greater costs than urban hospitals under the OPSS. If the Secretary found a cost discrepancy, the MMA directed the Secretary to adjust OPSS payment rates to reflect the higher costs of rural hospitals.

When CMS investigated this issue, the agency found that costs among rural hospitals were only marginally higher than among urban hospitals. However, CMS also found that rural SCHs incur higher costs under the OPSS than do urban hospitals. Based on those results, CMS adjusted OPSS payments to rural SCHs upward by 7.1 percent for all OPSS services except separately paid drugs and biologicals, pass-through devices, and items paid at charges adjusted to cost.

CMS implemented this policy in CY 2006 and has largely maintained the same payment rate adjustments for the same hospitals since then and proposes to continue the 7.1 percent adjustment to OPPS payment rates for rural SCHs for 2015. This policy is made budget neutral by reducing OPPS payment rates for all other hospitals.

*Comments*

If CMS finalizes this proposed adjustment, this will be the tenth year that rural SCHs will be receiving the same proportional adjustment to their OPPS payment rates. Since CMS implemented this policy in 2006, the OPPS has undergone substantial changes such as increased packaging of secondary services and use of composite APCs. Moreover, our analysis indicates that cost growth for services provided in hospital outpatient departments has differed among hospital categories. For example, cost growth among proprietary hospitals has been well below the average for all hospitals. Therefore, we encourage CMS to at least investigate whether the magnitude of cost differences between rural SCHs and urban hospitals has changed since CMS implemented this policy.

However, we also expressed reservations about implementing this policy in our comment letter to the 2006 proposed rule. We summarize these reservations here, but for a more complete discussion, see our comment letter to the 2006 rule.<sup>2</sup>

- CMS found that being in a rural location had only a marginal significance on a hospital's costs. CMS pursued an additional analysis that separated rural hospitals into several groups, including rural SCHs. CMS found that rural SCHs do have higher OPPS costs than urban hospitals. However, we believe this analysis excluded some important variables that would have more completely identified whether being a rural SCH has a significant effect on hospital costs.
- Hospitals should not receive additional payments for having relatively high costs if those high costs are due to inefficiency. It is plausible that the high costs experienced by SCHs are due to inefficiencies that result from special payment status under both the inpatient PPS (IPPS) and OPPS.
- The central objective of any payment policy should be to ensure beneficiaries' access to care. However, many rural SCHs are near other hospitals, so it is questionable whether these rural SCHs are needed to ensure access to care.

We acknowledge that CMS is legally required to make this payment adjustment based on whether a hospital has a rural location. However, we believe a more appropriate policy would adjust payments to hospitals with relatively high costs for factors beyond the hospital's control, such as a relatively small scale of operation. Consequently, we encourage the Secretary to offer a legislative proposal to the Congress that would allow adjustments to OPPS payments to small-scale hospitals.

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<sup>2</sup> Medicare Payment Advisory Commission. 2005. Comment letter on 2006 proposed rule for the outpatient prospective payment system. [www.medpac.gov/documents/091605\\_OPSS\\_comment.pdf](http://www.medpac.gov/documents/091605_OPSS_comment.pdf).

## **HCPCS modifier for services provided in off-campus provider-based departments of hospitals**

There has been a trend in recent years for hospitals to acquire physician practices, which has resulted in the billing of services shifting from freestanding physician offices to HOPDs. MedPAC has discussed this issue in three recent reports and recommended ways to align payment rates across ambulatory settings for certain services.<sup>3,4,5</sup>

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 OPDS. For most services, the combined payment from the PFS and the OPDS is greater than the single payment Medicare 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 conversion of these practices to off-campus provider-based departments, CMS proposes to collect data to analyze the type and frequency of services provided in off-campus provider-based departments. Specifically, CMS proposes to create a HCPCS modifier that would be reported with every claim for physicians' services and hospital outpatient services furnished in off-campus provider-based departments.

### *Comments*

The proposal to collect data on services provided in off-campus provider-based departments through the claims process may have some value in helping policymakers understand the growing trend of hospitals acquiring physician practices. The information may also help CMS verify that PFS claims include the correct site of service. However, the proposal does not address the fundamental problem of unjustified payment differences between settings. The PFS payment rate is usually higher when a service is provided in a nonfacility setting (such as a freestanding office) than a facility setting (such as an HOPD). PFS claims for services furnished in provider-based departments should indicate that the service was provided in a facility and should therefore receive the lower facility amount. However, there may be cases where the claim incorrectly indicates that the service was provided in a nonfacility setting. If this occurs, CMS could use the proposed modifier to check whether the service was furnished in a provider-based department and pay the appropriate rate.

A greater concern is that the billing of many services has been migrating from physicians' offices to the usually higher-paid HOPD setting. This migration has resulted in higher spending for the

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<sup>3</sup> Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>4</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>5</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

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. Although it is reasonable to pay higher rates in HOPDs for certain services, we have developed criteria to identify services for which payment rates should be equal across settings or the differences should be narrowed.<sup>6</sup> We encourage CMS to seek legislative authority to implement our recommendations to set equal payment rates for evaluation and management (E&M) office visits across settings and to align payment rates across settings for additional, select groups of services.

### **Eliminate pass-through payment for policy-packaged drugs**

As part of its effort to expand the extent to which the cost of secondary services are packaged into the payment of primary services, CMS has over time added to the list of “policy-packaged” drugs. These drugs now include contrast agents; diagnostic radiopharmaceuticals; anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure.

Despite being packaged items, these drugs are paid separately when they have pass-through status, which occurs when a drug was not being paid as an HOPD service as of December 31, 1996 and whose cost is not insignificant in relation to the OPPS payments for the procedures or services associated with the new drug. Pass-through payments can be made for at least 2 years but not more than 3 years. Policy-packaged drugs that have pass-through status become packaged items as soon as their pass-through status expires.

#### *Comments*

The primary arguments for pass-through payments for new drugs are twofold. First, they are needed to ensure the diffusion and use of new drugs. Second, they facilitate the collection of claims-based data that CMS can use to determine the cost of new drugs for future rate setting in the OPSS.

We do not believe pass-through payments are needed to address either issue. First, pass-through payments are not needed to ensure diffusion and use of new drugs because health care providers can (and should) make the appropriate clinical decisions for their patients whether a new drug has pass-through status or is separately paid. Second, pass-through payments are not needed for CMS to collect cost data for future rate setting. CMS requests that hospitals record the use and charges for all drugs on their claims—whether the drugs are packaged or paid separately—so that they can be used to appropriately set OPSS payment rates.

We believe that pass-through status should not be allowed for policy-packaged drugs. We understand that CMS may be legally required to provide pass-through status for new drugs that

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<sup>6</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

would otherwise fall into the policy-packaged category, so we encourage CMS to seek legislative authority to package all drugs that fit into the policy-packaged category.

### **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 OPSS 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 hospitals to report on seven quality measures in order to receive the full OPSS payment update in 2009. In 2014, the program consists of 26 measures, 15 of which require hospitals to extract and report data from samples of patient medical records. The other measures are reported by hospitals through a web-based reporting tool or calculated by CMS from Medicare claims data.

For 2015, CMS proposes to remove three medical chart-based process measures; add one claims-based outcome measure; and change one current chart-based outcome measure from required reporting to voluntary reporting. The new measure would use Medicare claims to calculate a risk-standardized rate of all-cause, unplanned hospital visits (admissions, observation stays, and emergency department visits) that occur within seven days of a colonoscopy performed in a HOPD. CMS also proposes to adopt this measure for the ASC Quality Reporting Program. Taken together, the proposed changes to the Hospital OQR Program would slightly reduce the number of measures required for 2015 from 26 to 24, with 11 of the measures still requiring hospitals to collect and report data from a sample of patients' medical charts.

#### *Comments*

The Commission supports any steps that will simplify and reduce the administrative burden of FFS Medicare's quality reporting programs. Therefore, we support the proposed elimination of the three chart-based measures. CMS's proposed new claims-based measure (facility seven-day hospital visit rate after outpatient colonoscopy) moves in the right direction of tracking adverse outcomes following a procedure performed in an HOPD. Although we have concerns about how the measure is defined and calculated, we support it conceptually.

One technical concern is that the proposed measure specifications appear to include all unplanned hospital visits within seven days of an outpatient colonoscopy, even visits that could be unrelated to an adverse event from the colonoscopy. For example, the measure would include hospital visits for HIV infection, upper limb fractures, and influenza, even though these diagnoses are unlikely to be related to a complication from a colonoscopy.<sup>7</sup> CMS should consider focusing the measure on diagnoses that could reasonably be related to an adverse event from a colonoscopy.

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<sup>7</sup> Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation. 2014. *Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy: Measure technical report*. Subtask 3.3, deliverable #63a. Submitted to Centers for Medicare & Medicaid Services. January 31.

Another technical concern is that the measure numerator would be the number of hospital visits within seven days of the colonoscopy that the HOPD is predicted to have, based on its case mix. The denominator is the number of hospital visits the HOPD is expected to have based on the nation's performance given the HOPD's case mix. CMS's description of the numerator does not adequately describe the method as represented in the contractor report cited in the proposed rule. CMS should clarify the description of the numerator in the final rule.

### **Proposed update to the lists of Ambulatory Surgical Center (ASC) covered surgical procedures and covered ancillary services**

CMS currently defines device-intensive procedures as OPPS services for which the cost of an implantable device is packaged into the procedure payment and the cost of the device (such as a spine infusion pump) accounts for more than 50 percent of the APC's total cost under the OPPS. When these procedures are provided in ASCs, CMS divides the payment for these services into a device portion (which includes the cost of the device) and a non-device portion. CMS pays ASCs the same amount it would pay under the OPPS for the device portion of the service but pays the lower ASC amount for the non-device portion. The rationale for this policy is that the cost of implantable devices is unlikely to vary significantly across settings.

CMS proposes to change the definition of device-intensive procedures by including APCs for which the cost of the device accounts for more than 40 percent (instead of more than 50 percent) of the APC's total cost. This would increase the number of device-intensive APCs. The purpose for this change is to align the definition of device-intensive procedures with the OPPS device credit policy, which applies to APCs that have device costs that exceed 40 percent of the APC's total cost. CMS's proposed change would increase the number of device-intensive APCs in the ASC payment system from 75 to 135.

#### *Comments*

We support CMS's proposal to expand the number of device-intensive procedures by including APCs for which the cost of the device accounts for more than 40 percent of the APC's total cost. Paying ASCs and OPDs the same amount for a greater number of implantable devices should make it more feasible for ASCs to provide procedures that include these devices. Because CMS pays ASCs less than OPDs for the non-device portion of the payment rate for these services, Medicare and beneficiaries would save money when these procedures are performed in ASCs. CMS should monitor, however, whether making device-intensive procedures more attractive to ASCs results in substantial increases in volume of these services. In addition, CMS should explore the implications of further expanding the list of device-intensive procedures.

### **Calculation of the proposed ASC conversion factor and the proposed ASC payment rates**

CMS proposes to increase the conversion factor in the ASC payment system in 2015 by 1.2 percent. This proposed update is based on CMS's estimate of a 1.7 percent increase in the consumer price index for all urban consumers (CPI-U) minus a 0.5 percent deduction for multifactor productivity growth mandated by PPACA.

*Comments*

In the Commission's March 2014 report, we recommended that the Congress eliminate the update to ASC payment rates for 2015. This recommendation was based on our indicators of payment adequacy for ASCs, which are positive, and the importance of maintaining financial pressure on providers to constrain costs.

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.<sup>8</sup> 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 cost 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. 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.<sup>9</sup> 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

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<sup>8</sup> Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC

<sup>9</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

specified set of measures have their annual payment update reduced by 2.0 percentage points. 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 currently report the following patient safety, outcome, and process measures:

- 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;
- prophylactic intravenous (IV) antibiotic timing;
- use of a safe surgery checklist;
- facility volume for six types of procedures;
- influenza vaccination coverage among health care personnel;
- appropriate follow-up interval for normal colonoscopy in average risk patients; and
- colonoscopy interval for patients with a history of adenomatous polyps.

In this proposed rule, CMS proposes criteria for removing measures that are “topped-out” from the ASC Quality Reporting Program. A measure is topped out when performance among ASCs is so high and unvarying that meaningful distinctions among ASCs and improvement in performance can no longer be made. CMS believes that such measures should be considered for removal from the Quality Reporting Program because their reporting burden may outweigh the value of the information they provide.

CMS also proposes to adopt a new quality measure: facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy. Colonoscopies are associated with a range of potentially preventable adverse events that can lead to hospital visits, such as perforation and gastrointestinal bleeding. The literature suggests that the majority of these visits occur within the first seven days after the colonoscopy. CMS believes that this measure would encourage ASCs to lower the rates of adverse events leading to hospital visits after colonoscopies and provide quality information to patients. CMS would use Medicare claims to calculate a risk-standardized rate of all-cause, unplanned hospital visits (admissions, observation stays, and emergency department visits) that occur within seven days of a colonoscopy performed in an ASC. CMS also proposes to adopt this measure for the Hospital Outpatient OQR program.

### *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.<sup>10</sup> 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 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 support CMS's proposal to remove topped-out measures but we are concerned that the two existing colonoscopy measures 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.

CMS's proposed new measure of facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy moves in the right direction of tracking adverse outcomes that occur after the patient is discharged from an ASC. However, the technical issues we raised regarding this proposed new measure in the HOPD setting also apply to use of this measure in the ASC setting (see page 8).

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.<sup>11</sup> 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

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<sup>10</sup> Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

<sup>11</sup> 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.

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

We support CMS's proposal to remove measures that are topped-out from the ASC Quality Reporting Program. Removing such measures would reduce the burden on ASCs and focus the program on meaningful quality indicators. We encourage CMS to examine whether the measure of prophylactic IV antibiotic timing is topped-out. CMS proposes to drop this measure from the Hospital OQR program because it is topped-out in the HOPD setting.

We are concerned that the two existing colonoscopy measures (appropriate follow-up interval for normal colonoscopy in average risk patients and colonoscopy interval for patients with a history of adenomatous polyps) may impose an unreasonable burden on ASCs because they require facilities to abstract data from the medical records of their patients. 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.

Finally, 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 website 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 began submitting data in October 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**

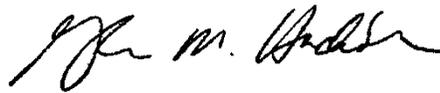
MedPAC appreciates the opportunity to comment on the important policy proposals from CMS.

Marilyn Tavenner  
Administrator  
Page 14

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,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a prominent initial "G" and "H".

Glenn M. Hackbarth, J.D.  
Chairman

GMH/dz/wc