ASCs get pay hike, reprieve on quality reporting

On November 1, 2011, in posting the final 2012 outpatient payment rule, Medicare gave the ambulatory surgery center (ASC) industry a reprieve in its quality reporting deadline and an unexpected pay hike.

While industry experts are pleased with what they see as the cooperation of federal regulators, they remain concerned about the details and frustrated with what they still believe is an unfair payment formula.

First, the good news:

• ASCs need not begin reporting on the initial new quality measures until October 1, 2012, rather than January 1, 2012, the original start date.
• The number of measures ASCs will need to track and report initially is 5, down from the proposed 7. Eliminated were hair removal method and antibiotic selection. Three additional measures will be reported in future years (sidebar, p 21).
• Reporting of the 5 measures will be on Part B claim forms, a method with which ASC staff already are familiar.
• In 2012, ASCs will receive an overall payment increase of 1.6%, rather than the 0.9% originally proposed by CMS. That figure is based on a projected 2012 inflation rate of 2.7% minus a productivity adjustment of 1.1%.

CMS will begin paying for 6 additional outpatient procedures in 2012.

One immediate deadline is looming for a future measure. Starting January 1, 2012, for the entire calendar year, ASCs need to be using a surgical safety checklist—even though data on checklist use will not be reported until 2013 and will not affect Medicare payment until 2015.

In announcing the final rule, CMS projects that it will pay $3.5 billion in 2012 to the 5,000 ASCs that participate in Medicare.

Discussions with CMS

David Shapiro, MD, Ambulatory Surgery Association (ASCA) board chair, says those modifications are largely due to discussions CMS held during the summer with ASC representatives.

“I am very gratified that CMS paid attention to a lot of the issues that we brought to the table,” he says. “There were a lot of issues with the proposed rule. I really felt the time frame of January 1 was too short a notice for any industry but certainly for the ASC industry. That was the number one thing.”

Uncertainty remains

Tempering the mood of satisfaction immediately following the release of the rule was uncertainty about exactly how the quality measures will be tracked and reported and implications for noncompliance. Answers are still emerging.

According to CMS spokeswoman Charlotte Thompson, the codes for reporting quality measures will be released during the 9 months leading up to the October 1, 2012, start date, and CMS is planning to conduct educational programs to help ASC staff meet the new requirements.
As for what CMS plans to do with the resulting data, the rule states that failure to report on at least half of the 5 measures will reduce an ASC’s 2014 payment update by 2%. Thompson stresses that the payment penalty will be based only on reporting: If an ASC reports, for example, on the number of patient burns it experienced during the year, it will meet the standard.

“For 2014, it will simply be whether you comply with reporting,” she says. “Did you or did you not report? There will not be an impact based on the quality of care.”

The initial measures were chosen for their impact on patient outcomes, CMS states in the final rule. Future measures will attempt to bring ASC quality reporting more in line with that required of hospitals, CMS says.

In the final rule, CMS explains it considered a variety of reporting methods, such as independent databases, but decided to rely on claim forms.

The agency plans to issue quality data codes (QDCs) to be entered on the Part B claim forms.

Future measures
Future quality measures will be reported in other ways, however. Beginning in 2013, ASCs will report their use of a safe surgery checklist during 2012 and the volume for specified procedures using the internet.

Regarding the checklist, ASCs will need to report during a 45-day period from July 1, 2013, to August 31, 2013, that they used a checklist during all of calendar year 2012. ASCs would submit their responses at www.qualitynet.org. They will also report on their ASC’s facility volume for 6 specialties: gastrointestinal, eye, nervous system, musculoskeletal, skin, and genitourinary. Those reports will affect payments beginning in 2015.

ASCs will report on another measure, the rate of influenza vaccination for health care personnel, through the National Healthcare Safety Network (NHSN) administered by the Centers for Disease Control and Prevention (CDC). Reporting of that measure will be required starting in 2014 and will affect payments starting in 2016.

Surgical safety checklist
CMS says it decided to adopt use of a safe surgery checklist as a quality measure because checklists have been credited with “dramatic decreases in preventable harm, complications, and postsurgical mortality.”

The agency says the purpose of this measure is to assess whether ASCs are using a checklist that covers effective communication and safe practices during 3 critical perioperative periods: prior to anesthesia administration, prior to incision, and prior to the patient leaving the OR. One example is the World Health Organization’s Surgical Safety Checklist (www.who.int/patientsafety/safesurgery/ss_checklist/en/).

The measure would assess whether the ASC uses a safe surgery checklist in general, CMS says, not whether it uses a checklist for any individual procedures.

Mixed response to pay news
The ASCA cheered at the news that pay rates will rise more than expected but criticized the way payments are calculated. In a statement following the rule’s release, ASCA said, “While we are disappointed that, despite ASCA’s objections, CMS continues to use a flawed measurement (CPI-U) in setting the ASC rates, we are pleased that the anemic 0.9% that had been initially proposed has grown to 1.6% in the final rule.”

Dr Shapiro explains: “The underlying problem is the formula. The thing we asked CMS to reconsider is the update factor as applied to HOPDs [hospital outpatient de-
ASC quality measures

Measures for CY 2014 payment determination:

- ASC-1: Patient burn
- ASC-2: Patient fall
- ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant
- ASC-4: Hospital transfer/admission
- ASC-5: Prophylactic IV antibiotic timing

New measure for CY 2015 payment determination:

- ASC-6: Safe surgery checklist use*

New measures for CY 2016 payment determination:

- ASC-7: ASC facility volume data on selected ASC surgical procedures
  (selected codes)
  - Gastrointestinal
  - Eye
  - Nervous system
  - Musculoskeletal
  - Skin
  - Genitourinary
- ASC-11: Influenza vaccination coverage among health care personnel

*ASCs would report during July 1, 2013, and August 15, 2013, that the checklist was in use from January 1, 2012, through December 31, 2012.

Source: Centers for Medicare and Medicaid Services, 2011.

For hospitals, rate factors include health care-specific costs such as professional salaries, medical equipment and supplies, and drugs. While ASCs have similar expenses, their payments are based on the national consumer price index for urban areas (CPI-U).

“We have always felt it was inappropriate for us to be updated according to the CPI,” Dr Shapiro says, adding that he believes CMS has the statutory authority to make such a change without going back to Congress.

Another criticism of the final rule, he says, is that while CMS added 6 new procedures for which ASCs will be paid by Medicare, “they are low paying and infrequent, so the impact will be minimal.”

For surveyors, business as usual

ASCs have in general welcomed the decision by CMS to monitor quality, saying they already track many of the new measures, and official recognition of that will increase public confidence.

The Accreditation Association for Ambulatory Health Care (AAAHC) already reviews practices that are addressed in the quality measures, such as tracking serious reportable events and following national infection control and prevention guidelines, whether inspecting for Medicare deemed status or accreditation status.
based on compliance with state and federal law.

“These are things the AAAHC will continue to look at,” says Naomi Kuznets PhD, senior director of the AAAHC Institute for Quality Improvement. “What [ASCs] will do differently is report the measures to CMS.”

However, she adds, “We have not been informed by CMS that accrediting organizations will be required to ensure ASCs are reporting data on the measures.”

Like Dr Shapiro, Kuznets says she was pleasantly surprised by the reporting deadline extension and the decision to simplify reporting via claim forms.

“ASCs are familiar with billing, so we’re happy to see that’s where they’re beginning.” She also notes that the number of initial measures—5—is small and will give ASCs a chance to get used to the reporting system.

“Relatively, this is a small number,” Kuznets says, noting that hospitals now report on about 90 measures, while physicians may have up to 200, depending on the specialty.

Additional good news, Kuznets says, is the fact that, unlike with some other programs, there is no administrative requirement to sign up or gain access to a system to participate. ASCs may simply start entering the codes when the time comes.

“CMS has acknowledged that, after all, ASCs are small businesses,” she says. They need not even report on all 5 measures; 50% compliance on applicable measures will earn them the 2% payment increase.

“I think CMS is trying, with this, to be understanding of the industry.”

They listened

Shapiro agrees. “I think they really listened,” he says. “Almost everything changed. The payment increase was better than we thought.”

The question now is whether the codes will be developed in time for ASCs to implement the program before the October 2012 deadline, and Dr Shapiro says ASCA will be keeping an eye on that and any other new developments.

“We are very committed at ASCA to keeping our members informed,” he says. “This is a very complicated thing. We want to be sure as many ASCs as possible are participating.”

For now, however, the good news outweighs the bad, he says. “Overall, I think the industry is very pleased.”

—Paula DeJohn

The final 2012 outpatient payment rule is available at www.ofr.gov/(X(1)S(rhobxacskl5wogotn3fkpwc3n))/inspection.aspx?AspxAutoDetectCookieSupport=1