August 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: CMS-1772-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals; Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating.

Dear Administrator Brooks-LaSure,

MarsdenAdvisors (MA) is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2023 Ambulatory Surgical Center Quality Reporting Program (ASCQR). MA is an EHR consulting and software company that helps small to medium sized specialty practices implement and manage EHR technology and comply with quality reporting requirements. We support over 1,000 clinicians in quality compliance and reporting nationwide.

Provided below is a summary of the key points from our comments on the ASCQR portion of the proposed rule. These comments are more fully developed in the body of this letter along with other issues and comments not highlighted in our summary.

Ambulatory Surgical Center Quality Reporting Program Executive Summary

We appreciate the thought and time that went into the development of this proposed rule. We focus our comments on the proposed changes and requests for comment related to the ASCQR.

Changes to 2025 ASCQR Measures

MA urges CMS to finalize the proposal to make ASC-11 Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery voluntary for 2025. This is a burdensome and inappropriate measure for ASCs to complete. We also ask CMS to finalize this proposal for all future years.

Requests for Comment:

Potential Future Specialty-Centered Approach for the ASCQR Program

MA asks CMS to not further complicate compliance with federal quality programs. ASCs continue to experience staffing and resource shortages and physicians are already measured in a more specialty-centered capacity under the Merit-based Incentive Payment System (MIPS) and many of the measures discussed in the request would require the ASC to report on data that is inaccessible by the ASC.

Interoperability Initiatives in ASCs

MA agrees that increased EHR use is an important goal, but we ask CMS to phase in this requirement gradually to allow ASCs with limited staffing and financial resources to come into compliance without jeopardizing their ability to remain solvent.

Detailed Comments of MarsdenAdvisors: Contents

Specific Issues on the Ambulatory Surgical Center Quality Reporting Program

SPECIFIC ISSUES ON THE ASC QUALITY REPORTING PROGRAM

A. 2025 Reporting

i. ASC-11: Cataracts – Improvement in Patient's Visual Function

MA strongly encourages CMS to finalize the proposal to make ASC-11 voluntary not just for 2025, but for all future years as well. This measure requires the ASC to report on data that is located in the surgeon's office and, thus, inaccessible by the ASC as, per Medicare ASC Conditions for Coverage, the two entities must be physically, administratively, and financially separate from one another.

ASC-11 has had problems before it was even implemented, with the Ambulatory Surgery Center Association (ASCA), the American Society of Cataract and Refractive Surgeons (ASCRS), and the American Academy of Ophthalmology (AAO) strongly advocating against its use from its inception. This measure has ill-defined logic as an evaluation of individual physicians and is a high burden for facilities to complete.

Moreover, any improvement in visual function is attributable to the individual surgeon, not to the facility in which the procedure was performed. ASCs are neither licensed nor qualified to evaluate the cataract patient and make these assessments. ASCs should not be involved in the professional decision-making intended by this measure. This measure will not result in improved patient outcomes and is inappropriate for facility measurement as facilities do not contribute to the skill of the cataract surgeon.

B. Request for Comment: Potential Future Specialty-Centered Approach for the ASCQR Program

MA asks CMS to not further complicate compliance with federal quality programs with this potential future approach to the ASCQR. ASCs continue to experience staffing and resource shortages. Moreover, physicians are already measured in a more specialty-centered capacity under the Merit-based Incentive Payment System (MIPS), the results of which are publicly reported.

In CMS' discussion of a potential ophthalmology-specific ASCQR measure set (Table 1), CMS includes measures that would demonstrate the same problems as ASC-11. Specifically, the presented measures would require the ASC to report on data that is located in the surgeon's office and is, thus, inaccessible by the ASC as, per Medicare ASC Conditions for Coverage, the two entities must be physically, administratively, and financially separate from one another.

In comparison, Example Gastroenterology ASCQR Program MVP Measures (Table 2), contains both process and claims measures that are both more accessible to the ASC and appropriately within the scope of the ASC to address.

Table 1. ASC Control Over Example ASCQR Ophthalmology MVP Measures

Example Ophthalmology ASCQR Program MVP Measures	**Accessibility of Information to ASC**	**Level of Impact ASC could have on this measure**
Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	YES	LOW
Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	NO	NONE
Cataract Surgery: Difference Between Planned and Final Refraction	NO	NONE
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	NO	NONE
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	NO	NONE
Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	NO	LOW

Table 2. ASC Control Over Example ASCQR Gastroenterology MVP Measures

Example Gastroenterology ASCQR Program MVP Measures	**Accessibility of Information to ASC**	**Level of Impact ASC could have on this measure**
Age Appropriate Screening Colonoscopy	YES	MEDIUM
Anastomotic Leak Intervention	NO	MEDIUM
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	YES	LOW
Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	YES	MEDIUM
Photodocumentation of Cecal Intubation	YES	HIGH

Based on feedback from our clients, in most cases, clinicians do not work directly for ASCs, but rather gain surgical privileges at ASCs. Therefore, it is inappropriate to measure ASCs for outcomes that are outside of their control. Additionally, patients choose the clinician they want to receive care from, not the ASC itself (i.e., choosing the ASC is not in the steps of care coordination that patients undertake). More appropriate measures for ASCs would reflect this separation and distinguish between the responsibilities and expectations of the ASC vs. the responsibilities and expectations of the physician.

When scheduling a surgery at an ASC, the patient has already chosen the clinician, making this burdensome to collect information irrelevant as the patient has access to the clinician's quality metrics.

Any measure included in ASC quality measurement should provide insight into factors within an ASC's control. For example, a more appropriate ophthalmology-specific measure that should be included in the ASCQR is one that CMS considered adding in the 2018 Proposed Rule: Toxic Anterior Segment Syndrome (TASS). This measure is broadly supported by both ophthalmic specialty societies and ASC associations as the incidence of TASS is measurable, attributable to the ASC, and prevention is actionable by the ASC. In addition, as TASS is a sight-threatening condition that is largely preventable using published guidelines regarding the cleaning and

sterilization of intraocular surgical instruments,[1] this measure would provide valuable insight into an important outcome that an ASC can address independently.

Finally, MA strongly urges CMS not to include the OAS CAHPS Survey in any required future model. This measure places substantial burdens on ASCs and burdens their patients as well. Many facilities struggle to convince patients to answer any questionnaires, let alone a survey that ranges from 37 to 52 questions. This issue is even more pronounced with ophthalmology-specific ASCs as many ophthalmology patients are unable to regularly check their email due to their limited vision. Ophthalmology-specific ASCs represent approximately 22 percent of all ASCs.[2] In this context, it is easy to understand why many patients refuse to complete surveys. **MA strongly encourages CMS to allow OAS CAHPS to remain optional in all future years and in all future models.**

C. Request for Comment: Interoperability Initiatives in ASCs

MA agrees that increased EHR use is an important goal, but we ask CMS to phase in this requirement gradually to allow ASCs with limited staffing and financial resources to come into compliance without jeopardizing their ability to remain solvent.

As noted in this proposed rule, ASCs were ineligible for the financial incentives for EHR adoption that were available in other healthcare sectors under HITECH Act of 2009. This factor is a major contributor to the slow rate of EHR adoption in ASCs (54.6%) as compared to other healthcare sectors.

In addition, there are few EHR vendors that offer solutions tailored to the unique needs of ASCs.[3] EHRs are expensive investments for ASCs, both in terms of financial cost and staff hours. Given the relative paucity of ASC-focused EHR solutions, EHR adoption often yields little benefit to resource-limited ASCs.

Finally, there also is no federal requirement for ASCs to adopt an EHR. Given the significant hurdles impeding meaningful ASC EHR adoption, the potentially prohibitive cost of an EHR go-live, and the lack of federal requirements for ASCs to adopt EHRs, we ask CMS to phase any

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[1] Chang, David F., and Nick Mamalis. "Guidelines for the Cleaning and Sterilization of Intraocular Surgical Instruments." Journal of Cataract and Refractive Surgery, vol. 44, no. 6, 2018, pp. 765–773., https://doi.org/10.1016/j.jcrs.2018.05.001.

[2] MedPAC analysis of Medicare carrier file claims, 2015.

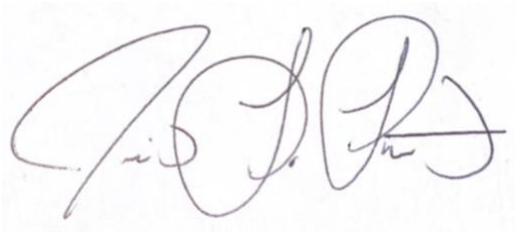
[3] Nelson, H. EHR Usability, User Satisfaction High in Ambulatory Surgery Centers. September 2021. Available at: https://ehrintelligence.com/news/ehr-usability-user-satisfaction-high-in-ambulatory-surgery-centers.

EHR-based requirements for ASCs slowly and to create timelines for adoption in coordination with ASC stakeholders to ensure their feasibility.

Conclusion

We appreciate the opportunity to work with CMS to improve the Ambulatory Surgical Center Quality Reporting Program. If you have questions or need any additional information regarding any portion of these comments, please contact Dr. Jessica Peterson, VP of Health Policy at MarsdenAdvisors at jessica@marsdenadvisors.com.

Sincerely,



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