We are proposing to continue the Electronic Reporting Pilot for the 2013 payment year as finalized for the 2012 payment year. We are proposing to revise our regulations at § 495.8(b)(2)(vi) to reflect the continuation of the Electronic Reporting Pilot for 2013, and also to remove the reference to § 495.6(f)(9) in order to conform with the proposed changes to § 495.6(f) that were included in the EHR Incentive Program - Stage 2 proposed rule (77 FR 13817). We invite public comments on these proposals.

We note that we finalized reporting clinical quality measures for the Medicare EHR Incentive Program by attestation of clinical quality measure results in the CY 2012 OPPS/ASC final rule with comment period for 2012 and subsequent years, such as 2013 (76 FR 74489). Thus, eligible hospitals and CAHs may continue to report clinical quality measure results as calculated by certified EHR technology by attestation for 2013, as they did for 2011 and 2012. We also note the intent of CMS to move to electronic reporting. In the Stage 2 Medicare EHR Incentive Program proposed rule, we proposed that the Medicare EHR Incentive Program would require electronic reporting of clinical quality measures beginning in 2014 for eligible hospitals and CAHs that are beyond the first year of Stage 1 of meaningful use (77 FR 13764).

XVI. Requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

A. Background

1. Overview

We refer readers to section XV.A.1. of this proposed rule for a general overview of our quality reporting programs.

2. Statutory History of the ASC Quality Reporting (ASCQR) Program

We refer readers to section XIV.K.1. of the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74493) for a detailed discussion of the statutory history of the ASCQR Program.

3. History of the ASCQR Program

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780), the CY 2010 OPPS/ASC final rule with comment period (74 FR 60656), and the CY 2011 OPPS/ASC final rule with comment period (75 FR 72109), we did not implement a quality data reporting program for ASCs. We determined that it would be more appropriate to allow ASCs to acquire some experience with the revised ASC payment system, which was implemented for CY 2008, before implementing new quality reporting requirements. However, in these rules, we indicated that we intended to implement a quality reporting program for ASCs in the future.

In preparation for proposing a quality reporting program for ASCs, in the CY 2011 OPPS/ASC proposed rule (75 FR 46383), we solicited public comments on 10 measures. In addition to preparing to propose implementation of a quality reporting program for ASCs, HHS developed a plan to implement a value-based purchasing (VBP) program for payments under title XVIII of the Act for ASCs as required by section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act. We also submitted a report to Congress, as required by section 3006(f)(4) of the Affordable Care Act, entitled "Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan" that details this plan. This report is found on the CMS

Web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/Downloads/C_ASC_RTC-2011.pdf. Currently, we do not have express statutory authority to implement an ASC VBP program. If and when legislation is enacted that authorizes CMS to implement an ASC VBP program, we will develop the program and propose it through rulemaking.

In the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74517), we finalized our proposal to implement the ASCQR Program beginning with the CY 2014 payment determination. We adopted quality measures for the CY 2014, CY 2015, and CY 2016 payment determination years and finalized some data collection and reporting timeframes for these measures. We also adopted policies with respect to the maintenance of technical specifications and updating of measures, publication of ASCQR Program data, and, for the CY 2014 payment determination, data collection and submission requirements for the claims-based measures. For a discussion of these final policies, we refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74517).

In the CY 2012 OPPS/ASC final rule with comment period (76 FR 74515), we indicated our intent to issue proposals for administrative requirements, data validation and completeness requirements, and reconsideration and appeals processes in the FY 2013 IPPS/LTCH PPS proposed rule, rather than in the CY 2013 OPPS/ASC proposed rule, because the FY 2013 IPPS/LTCH PPS proposed rule is scheduled to be finalized earlier and prior to data collection for the CY 2014 payment determination, which is to begin with services furnished on October 1, 2012. In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28101 through 28105), we issued proposals for

administrative requirements, data completeness requirements, extraordinary circumstances waiver or extension requests, and a reconsideration process. For a complete discussion of these proposals, we refer readers to the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28101 through 28105).

Because we have included proposals in the FY 2013 IPPS/LTCH PPS proposed rule for the ASCQR Program, we are limiting the number of proposals in this proposed rule. In addition, in an effort to prevent confusion regarding what we are proposing in this proposed rule and what we have proposed in the FY 2013 IPPS/LTCH PPS proposed rule, in this proposed rule, we are limiting our discussion of the proposals contained in the FY 2013 IPPS/LTCH PPS proposed rule primarily to background related to the proposals being made in this proposed rule.

B. ASCQR Program Quality Measures

1. Proposed Considerations in the Selection of ASCQR Program Quality Measures

Section 1833(i)(7)(B) of the Act states that section 1833(t)(17)(C) of the Act shall apply with respect to ASC services in a similar manner in which they apply to hospitals for the Hospital OQR Program, "except as the Secretary may otherwise provide." The requirements under section 1833(t)(17)(C)(i) of the Act state that measures developed shall "be appropriate for the measurement of quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities."

In addition to following the statutory requirements, in selecting measures for the ASCQR Program and other quality reporting programs, we have focused on measures

that have a high impact on and support HHS and CMS priorities for improved health care outcomes, quality, safety, efficiency, and satisfaction for patients. Our goal for the future is to expand any measure set adopted for the ASCQR Program to address these priorities more fully and to align ASC quality measure requirements with those of other reporting programs as appropriate, including the Hospital OQR Program, so that the burden for reporting will be reduced.

In general, we prefer to adopt measures that have been endorsed by the NQF because it is a national multi-stakeholder organization with a well-documented and rigorous approach to consensus development. However, as discussed above, the Hospital OQR Program statute only requires that we adopt measures that are appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, reflect consensus among affected parties, and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities. Therefore, measures are not required to be endorsed by the NQF or any other national consensus building entity and, as we have noted in a previous rulemaking for the Hospital OQR Program (75 FR 72065), the requirement that measures reflect consensus among affected parties can be achieved in other ways, including through the measure development process, through broad acceptance and use of the measure(s), and through public comment. Further, the Secretary has broader authority under the ASCQR Program statute, as discussed above, to adopt nonendorsed measures or measures that do not reflect consensus for the ASCQR Program because, under the ASCQR Program statute, these Hospital OQR Program provisions apply "except as the Secretary may otherwise provide."

In developing the ASCQR Program, we applied the principles set forth in the CY 2011 OPPS/ASC proposed rule and final rule with comment period (76 FR 42337 through 42338 and 74494 through 74495, respectively). Although we are not proposing any new measures for the ASCQR Program in this proposed rule as discussed below, we plan to apply the following principles in future measure selection and development for the ASCQR Program. These principles were applied in developing other quality reporting programs and many are the same principles applied in developing the ASCQR Program last year.

- Our overarching goal is to support the National Quality Strategy's three-part aim of better health care for individuals, better health for populations, and lower costs for health care. The ASCQR Program will help achieve this three-part aim by creating transparency around the quality of care at ASCs to support patient decision-making and quality improvement. More information regarding the National Quality Strategy can be found at: http://www.hhs.gov/secretary/about/priorities/priorities.html and http://www.ahrq.gov/workingforquality/. HHS engaged a wide range of stakeholders to develop the National Quality Strategy, as required by the Affordable Care Act.

- Pay-for-reporting and public reporting programs should rely on a mix of standards, process, outcomes, and patient experience of care measures. Across all programs, we seek to move as quickly as possible to the use of primarily outcome and patient experience measures. To the extent practicable and appropriate, outcome and patient experience measures should be adjusted for risk or other appropriate patient population or provider/supplier characteristics.

- To the extent possible and recognizing differences in payment system maturity and statutory authorities, measures should be aligned across public reporting and payment systems under Medicare and Medicaid. The measure sets should evolve so that they include a focused core set of measures appropriate to the specific provider/supplier category that reflects the level of care and the most important areas of service and measures for that provider/supplier.

- We weigh the relevance and the utility of measures compared to the burden on ASCs in submitting data under the ASCQR Program. The collection of information burden on providers and suppliers should be minimized to the extent possible. To this end, we continuously seek to adopt electronic-specified measures so that data can be calculated and submitted via certified EHR technology with minimal burden. We also seek to use measures based on alternative sources of data that do not require chart abstraction or that use data already being reported by ASCs.

- We take into account the views of the Measure Application Partnership (MAP). The MAP is a public-private partnership convened by the NQF for the primary purpose of providing input to HHS on selecting performance measures for quality reporting programs and pay-for-reporting programs. The MAP views patient safety as a high priority area and it strongly supports the use of NQF-endorsed safety measures. Accordingly, we consider the MAP's recommendations in selecting quality and efficiency measures (we refer readers to the Web sites at: http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx, and http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69885).

- Measures should be developed with the input of providers/suppliers, purchasers/payers and other stakeholders. Measures should be aligned with best practices among other payers and the needs of the end users of the measures. We take into account widely accepted criteria established in medical literature.

- HHS Strategic Plan and Initiatives. HHS is the U.S. government's principal agency for protecting the health of all Americans. HHS accomplishes its mission through programs and initiatives. Every 4 years HHS updates its Strategic Plan and measures its progress in addressing specific national problems, needs, or mission-related challenges. The current goals of the HHS Strategic Plan can be located at http://www.hhs.gov/about/FY2012budget/strategicplandetail.pdf.

- CMS Strategic Plan. We strive to ensure that measures for different Medicare and Medicaid programs are aligned with priority quality goals, that measure specifications are aligned across settings, that outcome measures are used whenever possible, and that quality measures are collected from EHRs as appropriate.

We believe that ASCs are similar to HOPDs, insofar as the delivery of surgical and related nonsurgical services. Similar standards and guidelines can be applied between HOPDs and ASCs with respect to surgical care improvement, because many of the same surgical procedures are provided in both settings. Measure harmonization assures that comparable care in these settings can be evaluated in similar ways, which further assures that quality measurement can focus more on the needs of a patient with a particular condition rather than on the specific program or policy attributes of the setting in which the care is provided.

We invite public comment on this approach in future measure selection and development for the ASCQR Program.

2. ASCQR Program Quality Measures

In the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74517), we finalized our proposal to implement the ASCQR Program beginning with the CY 2014 payment determination and adopted measures for the CY 2014, CY 2015, and CY 2016 payment determinations. We also finalized our policy to retain measures from one calendar year payment determination to the next so that measures adopted for a previous payment determination year would be retained for subsequent payment determination years (76 FR 74504, 74509, and 74510).

We adopted the following five claims-based measures for the CY 2014 payment determination for services furnished between October 1, 2012 and December 31, 2012: (1) Patient Burns (NQF #0263); (2) Patient Fall (NQF #0266); (3) Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267); (4) Hospital Transfer/Admission (NQF #0265); and (5) Prophylactic Intravenous (IV) Antibiotic Timing (NQF #0264).

For the CY 2015 payment determination, we retained the five claims-based measures we adopted for the CY 2014 payment determination and adopted the following two structural measures: (1) Safe Surgery Checklist Use; and (2) ASC Facility Volume Data on Selected ASC Surgical Procedures. We specified that reporting for the structural measures would be between July 1, 2013 and August 15, 2013, for services furnished between January 1, 2012 and December 31, 2012, using an online measure submission Web page available at: https://www.QualityNet.org. We did not specify the data

collection period for the five claims-based measures for the CY 2015 payment determination.

For the CY 2016 payment determination, we finalized the retention of the seven measures from the CY 2015 payment determination (five claims-based measures and two structural measures) and adopted Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), a process of care, healthcare-associated infection measure. We specified that data collection for the influenza vaccination measure would be via the National Healthcare Safety Network from October 1, 2014 through March 31, 2015. We did not specify the data collection period for the claims-based or structural measures.

We stated that, to the extent we finalize some or all of the measures for future payment determination years, we would not be precluded from adopting additional measures or changing the list of measures for future payment determination years through annual rulemaking cycles so that we may address changes in program needs arising from new legislation or from changes in HHS and CMS priorities.

Considering the time and effort required for us to develop, align, and implement the infrastructure necessary to collect data on the ASCQR Program measures and make payment determinations, and likewise the time and effort required on the part of ASCs to plan and prepare for quality reporting, at this time we are not proposing to delete or add any quality measures for the ASCQR Program for the CY 2014, CY 2015, and CY 2016 payment determination years or to adopt quality measures for subsequent payment determination years. For readers' reference, the following table lists the ASCQR Program quality measures we previously finalized in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74504 through 74511).

ASC Program Measurement Set Adopted in Previous Rulemaking	
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 Intravenous (IV) Antibiotic Timing*	
ASC-6: Safe Surgery Checklist Use**	
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures**	
Procedure Category	Corresponding HCPCS Codes
Gastrointestinal	40000 through 49999, G0104, G0105,G0121,C9716, C9724, C9725, and 0170T
Eye	65000 through 68999, G0186, 0124T, 0099T, 0017T, 0016T, 0123T, 0100T, 0176T, 0177T, 0186T, 0190T, 0191T, 0192T, 76510, and 0099T
Nervous System	61000 through 64999, G0260, 0027T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, and 0062T
Musculoskeletal	20000 through 29999, 0101T, 0102T, 0062T, 0200T, and 0201T
Skin	10000 through 19999, G0247, 0046T, 0268T, G0127, C9726, and C9727
Genitourinary	50000 through 58999, 0193T, and 58805
ASC- 8: Influenza Vaccination Coverage among Healthcare Personnel ***	

*New measure for the CY 2014 payment determination.
** New measure for the CY 2015 payment determination.
***New measure for the CY 2016 payment determination.

3. ASC Measure Topics for Future Consideration

We seek to develop a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the ASC setting. Therefore, through future rulemaking, we intend to propose new measures consistent with the principles discussed in section XVI.B.1. of this proposed rule, in order to select measures that address clinical quality of care, patient safety, and patient and

caregiver experience of care. We invite public comment specifically on the inclusion of procedure-specific measures for cataract surgery, colonoscopy, endoscopy, and for anesthesia-related complications in the ASCQR Program measure set.

4. Clarification Regarding the Process for Updating ASCQR Program Quality Measures

In the CY 2012 OPPS/ASC final rule with comment period, we finalized our proposal to follow the same process for updating the ASCQR Program measures that we adopted for the Hospital OQR Program measures (76 FR 74513 through 74514). This process includes the same subregulatory process for the ASCQR Program as used for the Hospital OQR Program for updating measures, including issuing regular manual releases at 6-month intervals, providing addenda as necessary, and providing at least 3 months of advance notice for nonsubstantive changes such as changes to ICD-9-CM, CPT, NUBC, and HCPCS codes, and at least 6 months' notice for substantive changes to data elements that would require significant systems changes. We provided a citation to the CY 2009 OPPS/ASC final rule with comment period where the final Hospital OQR Program policies are discussed (73 FR 68766 through 68767).

In examining last year's finalized policy for the ASCQR Program, we recognize that we may need to provide additional clarification of the ASCQR Program policy in the context of the previously finalized Hospital OQR Program policy in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766 through 68767). Therefore, in this proposed rule, we seek to more clearly articulate the policy that we adopted for the ASCQR Program, which is the same policy that has been adopted for the Hospital OQR Program.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766 through 68767), we established a subregulatory process for making updates to the measures we have adopted for the Hospital OQR Program. This process is necessary so that the Hospital OQR measures are calculated based on the most up-to-date scientific evidence and consensus standards. Under this process, when a national consensus building entity updates the specifications for a measure that we have adopted for the Hospital OQR Program, we update our specifications for that measure accordingly and provide notice as described above and in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74514). An example of such an entity is the NQF. For measures that are not endorsed by a national consensus building entity, the subregulatory process is based on scientific advances as determined necessary by CMS, in part, through our measure maintenance process involving Technical Expert Panels (73 FR 68767). We invite public comment on this clarification of the finalized ASCQR Program policy of using a subregulatory process to update measures.

C. Proposed Requirements for Reporting of ASC Quality Data

1. Form, Manner, and Timing for Claims-Based Measures for the CY 2014 Payment Determination and Subsequent Payment Determination Years

a. Background

In the CY 2012 OPPS/ASC final rule with comment period, we adopted claims-based measures for the CY 2014, CY 2015, and CY 2016 payment determination years (76 FR 74504 through 74511). We also finalized that, to be eligible for the full CY 2014 ASC annual payment update, an ASC must submit complete data on individual quality measures through a claims-based reporting mechanism by submitting the

appropriate QDCs on the ASC's Medicare claims (76 FR 74515 through 74516). As stated in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74516), ASCs will add the appropriate QDCs on their Medicare Part B claims forms, the Form CMS-1500s submitted for payment, to submit the applicable quality data. A listing of the QDCs with long and short descriptors is available in Transmittal 2425, Change Request 7754 released March 16, 2012 (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Transmittals-Items/ASC-CR7754-R2425CP.html). Details on how to use these codes for submitting numerators and denominator information are available in the ASCQR Program Specifications Manual located on the QualityNet Web site (https://www.QualityNet.org). We also finalized the data collection period for the CY 2014 payment determination, as the Medicare fee-for-service ASC claims submitted for services furnished between October 1, 2012 and December 31, 2012. We did not finalize a date by which claims would be processed to be considered for the CY 2014 payment determination.

In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28104), we proposed that claims for services furnished between October 1, 2012 and December 31, 2012, would have to be paid by the administrative contractor by April 30, 2013 to be included in the data used for the CY 2014 payment determination. We believe that this claim paid date would allow ASCs sufficient time to submit claims while allowing sufficient time for CMS to complete required data analysis and processing to make payment determinations and to supply this information to administrative contractors. We did not finalize a data collection and processing period for the CY 2015 payment determination, but stated our intention to do so in this proposed rule (77 FR 28104).

b. Proposals Regarding Form, Manner, and Timing for Claims-Based Measures for the CY 2015 Payment Determination and Subsequent Payment Determination Years

We are proposing that, for the CY 2015 payment determination and subsequent payment determination years, an ASC must submit complete data on individual quality claims-based measures through a claims-based reporting mechanism by submitting the appropriate QDCs on the ASC's Medicare claims. We are proposing that the data collection period for such claims-based measures will be for the calendar year 2 years prior to a payment determination. We also are proposing that the claims for services furnished in each calendar year would have to be paid by the administrative contractor by April 30 of the following year of the ending data collection time period to be included in the data used for the payment determination. Thus, for example, for the CY 2015 payment determination, we are proposing the data collection period to be claims for services furnished in CY 2013 (January 1, 2013 through December 31, 2013) which are paid by the administrative contractor by April 30, 2014. We believe that this claim paid date would allow ASCs sufficient time to submit claims while allowing sufficient time for CMS to complete required data analysis and processing to make payment determinations and to supply this information to administrative contractors. We invite public comment on these proposals.

2. Data Completeness and Minimum Threshold for Claims-Based Measures Using QDCs

a. Background

In the CY 2012 OPPS/ASC final rule with comment period (76 FR 74516), we finalized our proposal that data completeness for claims-based measures for the CY 2014 payment determination be determined by comparing the number of claims meeting

measure specifications that contain the appropriate QDCs with the number of claims that would meet measure specifications but did not have the appropriate QDCs on the submitted claims. In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28104), we proposed, for the CY 2014 and CY 2015 payment determination years, that the minimum threshold for successful reporting be that at least 50 percent of claims meeting measure specifications contain QDCs. We believe 50 percent is a reasonable minimum threshold based upon the considerations discussed above for the initial implementation years of the ASCQR Program. We stated in the proposed rule that we intend to propose to increase this percentage for subsequent payment determination years as ASCs become more familiar with reporting requirements for this quality data reporting program.

b. Proposed Data Completeness Requirements for the CY 2015 Payment Determination and Subsequent Payment Determination Years

After publication of the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28101 through 28105), we realized that we did not propose a methodology for determining data completeness for the CY 2015 payment determination and subsequent payment determination years. Therefore, we are proposing that data completeness for claims-based measures for the CY 2015 payment determination and subsequent payment determination years be determined by comparing the number of Medicare claims (where Medicare is the primary or secondary payer) meeting measure specifications that contain the appropriate QDCs with the number of Medicare claims (where Medicare is the primary or secondary payer) that would meet measure specifications, but did not have the appropriate QDCs on the submitted claims for the CY 2015 payment determination and subsequent payment determination years. This is the same method for determining data

completeness for claims-based measures that was finalized in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74516) for the CY 2014 payment determination. We note that the claims we use include claims where Medicare is either the primary or secondary payor. We invite public comment on this proposal.

D. Proposed Payment Reduction for ASCs That Fail to Meet the ASCQR Program Requirements

1. Statutory Background

Section 1833(i)(2)(D)(iv) of the Act states that the Secretary may implement the revised ASC payment system "in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7)." Paragraph (7) contains subparagraphs (A) and (B). Subparagraph (A) of paragraph (7) states the Secretary may provide that an ASC that does not submit "data required to be submitted on measures selected under this paragraph with respect to a year" to the Secretary in accordance with this paragraph will incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. It also specifies that this reduction applies only with respect to the year involved and will not be taken into account in computing any annual increase factor for a subsequent year. Subparagraph (B) of paragraph (7) makes many of the provisions of the Hospital OQR Program applicable to the ASCQR Program "[e]xcept as the Secretary may otherwise provide." Finally, section 1833(i)(2)(D)(v) of the Act states that, in implementing the revised ASC payment system for 2011 and each subsequent year, "any annual update under such system for the year, after application of clause (iv) [regarding the reduction in the annual update for failure to report on quality measures] shall be reduced by the

productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."

Section 1833(i)(2)(D)(v) of the Act also states that the "application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the [revised ASC payment system] for a year being less than such payment rates for the preceding year."

2. Proposed Reduction to the ASC Payment Rates for ASCs That Fail to Meet the ASCQR Program Requirements for the CY 2014 Payment Determination and Subsequent Payment Determination Years

The national unadjusted payment rates for many services paid under the ASC payment system equal the product of the ASC conversion factor and the scaled relative payment weight for the APC to which the service is assigned. Currently, the ASC conversion factor is equal to the conversion factor calculated for the previous year updated by the MFP-adjusted CPI-U update factor, which is the adjustment set forth in section 1833(i)(2)(D)(v) of the Act. The MFP-adjusted CPI-U update factor is the Consumer Price Index for all urban consumers (CPI-U), which currently is the annual update for the ASC payment system, minus the MFP adjustment. As discussed in the CY 2011 MPFS final rule with comment period (75 FR 73397), if the CPI-U is a negative number, the CPI-U would be held to zero. Under the ASCQR Program, any annual update would be reduced by 2.0 percentage points for ASCs that fail to meet the reporting requirements of the ASCQR Program. This reduction would apply beginning with the CY 2014 payment rates. For a complete discussion of the calculation of the ASC conversion factor, we refer readers to section XIV.H. of this proposed rule.

To implement the requirement to reduce the annual update for ASCs that fail to meet the ASCQR Program requirements, we are proposing that we would calculate two conversion factors: a full update conversion factor and an ASCQR Program reduced update conversion factor. We are proposing to calculate the reduced national unadjusted payment rates using the ASCQR Program reduced update conversion factor that would apply to ASCs that fail to meet their quality reporting requirements for that calendar year payment determination. We are proposing that application of the 2.0 percentage point reduction to the annual update may result in the update to the ASC payment system being less than zero prior to the application of the MFP adjustment.

The ASC conversion factor is used to calculate the ASC payment rate for services with the following payment indicators (listed in Addenda AA and BB to this proposed rule, which are available via the Internet on the CMS Web site): "A2," "G2," "P2," "R2," "Z2," as well as the service portion of device intensive procedures identified by "J8." We are proposing that payment for all services assigned the payment indicators listed above would be subject to the reduction of the national unadjusted payment rates for applicable ASCs using the ASCQR Program reduced update conversion factor.

The conversion factor is not used to calculate the ASC payment rates for separately payable services that are assigned status indicators other than payment indicators "A2," "G2," "J8," "P2," "R2," and "Z2." These services include separately payable drugs and biologicals, pass-through devices that are contractor-priced, brachytherapy sources that are paid based on the OPPS payment rates, and certain office-based procedures and radiology services where payment is based on the MPFS PE RVU amount and a few other specific services that receive cost-based payment. As a result,

we also are proposing that the ASC payment rates for these services would not be reduced for failure to meet the ASCQR Program requirements because the payment rates for these services are not calculated using the ASC conversion factor and, therefore, not affected by reductions to the annual update.

Office-based surgical procedures (performed more than 50 percent of the time in physicians' offices) and separately paid radiology services (excluding covered ancillary radiology services involving certain nuclear medicine procedures or involving the use of contrast agents, as discussed in section XIV.D.2.b. of this proposed rule) are paid at the lesser of the MPFS non-facility PE RVU-based amounts and the standard ASC ratesetting methodology. We are proposing that the standard ASC ratesetting methodology for this comparison would use the ASC conversion factor that has been calculated using the full ASC update adjusted for productivity. This is necessary so that the resulting ASC payment indicator, based on the comparison, assigned to an office-based or radiology procedure is consistent for each HCPCS code regardless of whether payment is based on the full update conversion factor or the reduced update conversion factor.

For ASCs that receive the reduced ASC payment for failure to meet the ASCQR Program requirements, we believe that it is both equitable and appropriate that a reduction in the payment for a service should result in proportionately reduced copayment liability for beneficiaries. Therefore, we are proposing that the Medicare beneficiary's national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would be based on the reduced national unadjusted payment rate.

We are proposing that all other applicable adjustments to the ASC national unadjusted payment rates would apply in those cases when the annual update is reduced for ASCs that fail to meet the requirements of the ASCQR Program. For example, the following standard adjustments would apply to the reduced national unadjusted payment rates: the wage index adjustment, the multiple procedure adjustment, the interrupted procedure adjustment, and the adjustment for devices furnished with full or partial credit or without cost. We believe that these adjustments continue to be equally applicable to payment for ASCs that do not meet the ASCQR Program requirements.

We invite public comment on these proposals.

XVII. Proposed Inpatient Rehabilitation Facility (IRF) Quality Reporting Program Updates

A. Overview

In accordance with section 1886(j)(7) of the Act, as added by section 3004 of the Affordable Care Act, the Secretary established a quality reporting program (QRP) for Inpatient Rehabilitation Facilities (IRFs). The IRF Quality Reporting Program (IRF QRP) was implemented in the FY 2012 IRF PPS final rule (76 FR 47836). We refer readers to the FY 2012 IRF PPS final rule (76 FR 47873 through 47883) for a detailed discussion on the background and statutory authority for the IRF QRP.

In this proposed rule, we are proposing to: (1) adopt updates on a previously adopted measure for the IRF QRP that will affect annual prospective payment amounts in FY 2014; (2) adopt a policy that would provide that any measure that has been adopted for use in the IRF QRP will remain in effect until the measure is actively removed,