**Proposed New Measure for HEDIS® MY 2025:**

**Acute Hospitalization Following Outpatient Surgery (HFO)**

NCQA seeks comments on a proposed new measure for inclusion in HEDIS MY 2025: *Acute Hospitalization Following Outpatient Surgery (HFO):* For Medicare Advantage beneficiaries 65 years of age and older, the percentage of select outpatient procedures that were followed by an unplanned acute hospitalization (inpatient and observation stays) for any diagnosis within 15 days, and the predicted probability of an acute hospitalization. Four rates are reported:

- Colonoscopy.
- General Surgery.
- Orthopedic Procedures.
- Urology Procedures.

The measure excludes persons in hospice or using hospice services during the measurement period. Each measure rate excludes hospitalizations with a principal diagnosis of pregnancy, perinatal conditions or hospitalizations considered planned. For the Colonoscopy rate, visits with a principal diagnosis of any type of cancer following a colonoscopy are also excluded.

Outpatient or ambulatory surgeries are planned procedures where the patient is not expected to be admitted to an inpatient setting. Most (over 70%) of all surgeries that occur annually, including some that are complex and invasive, now take place in an outpatient setting.² While outpatient surgery is generally considered safe, adverse patient outcomes have been documented. However, the occurrence of adverse outcomes varies widely and is based on several factors, including procedure type and patient characteristics.

There are currently no health plan-level measures that assess outpatient surgery quality. Existing measures focus primarily on assessing outpatient surgery quality at the facility level. Given the same-day nature of most outpatient procedures, surgical facility staff may be somewhat limited in their ability to provide direct oversight of patients following surgery. Health plans can provide important services to their members to ensure proper care coordination during the critical post-surgical period. NCQA sees this as a quality measurement gap to fill and developed this new measure to assess the quality of care provided by health plans in the period after surgery. NCQA’s approach aligns with measures in CMS’s Ambulatory Surgery Center Quality Reporting (ASCQR) Program that are specified for Medicare fee-for-service members 65 and older.³

NCQA tested the proposed measure using 2021–2022 administrative claims data. The measure was tested for the Medicare 18-64, Medicare 65+ and commercial 18+ populations. Testing demonstrated that the measure can be feasibly reported by health plans with a sufficient denominator size for HEDIS reporting. Based on technical considerations (i.e., low event rates, suboptimal risk model performance) in the Medicare 18-64 and commercial 18+ populations, and with support from advisory panels and other experts, NCQA chose to move forward with the Medicare 65+ population, only. This approach also aligns HFO with the population measured in CMS’ facility measures.

Among the Medicare 65+ population, observed rates of acute hospitalizations within 15 days of an outpatient surgery varied by procedure type and across health plans. The overall rate of 15-day

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³ ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy; ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures; ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures; ASC-19: Facility-Level-7-Day Hospital Visits after General Surgery Procedures —includes abdominal, alimentary tract, breast, skin/soft tissue, wound and varicose vein procedures.

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hospitalizations following outpatient colonoscopy, general surgery, urology and orthopedic surgery was 0.66%, 1.37%, 1.69% and 3.02%, respectively.

NCQA used logistic regression to predict the probability a member would experience a hospitalization within 15 days of surgery. The measure adjusts for variables such as age, gender and clinical conditions (using the CMS Hierarchical Condition Categories [HCC]). An adjustor for procedure subtype was also included due to the heterogeneity of procedures within the four larger categories (colonoscopy, general surgery, orthopedic, urology). Testing demonstrated that the risk adjustment models for the Medicare 65 and older population performed adequately and was calibrated well. Refer to Table 1 for distribution of observed-to-expected (O/E) ratios for the four procedure types among the Medicare 65 and older population.

The mean plan-level O/E ratio for the colonoscopy rate was 1.14. Poor-performing plans in the 90th percentile had 73% more hospitalizations than expected (O/E ratio: 1.73); high-performing plans in the 10th percentile had 35% fewer hospitalizations than expected (O/E ratio: 0.65). The mean plan-level O/E ratio for the general surgery rate was 1.07, with variation between the 90th percentile (O/E ratio: 1.49) and the 10th percentile (O/E ratio: 0.66). The mean plan-level O/E ratio for the orthopedic rate was 1.00 (90th percentile O/E: 1.47; 10th percentile O/E: 0.68). Lastly, the mean plan-level O/E ratio for the urology rate was 0.98 (90th percentile O/E: 1.29; 10th percentile O/E: 0.64).

Table 1. Distribution of Health Plan-Level O/E Ratios for the HFO Measure

<table>
<thead>
<tr>
<th>Product Line &amp; Age</th>
<th>Measure Rate</th>
<th>N of Plans*</th>
<th>Mean</th>
<th>Percentile O/E Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare 65+</td>
<td>Colonoscopy</td>
<td>48</td>
<td>1.14</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>General Surgery</td>
<td>41</td>
<td>1.07</td>
<td>0.41</td>
</tr>
<tr>
<td></td>
<td>Orthopedic</td>
<td>40</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>Urology</td>
<td>36</td>
<td>0.98</td>
<td>0.52</td>
</tr>
</tbody>
</table>

*Includes plans that met the minimum denominator size of 150 members.

O/E interpretation: 1 = as expected, <1 = better than expected, >1 = worse than expected.

Advisory panels and surgical experts expressed overall support for this measure for the Medicare 65 and older population, and agreed that assessing the quality of care after a member undergoes surgery is important at the health plan level. Some panel members suggested stratifying by dual eligibility status and examining its impact on reporting feasibility and performance. Preliminary testing revealed that stratification may not be feasible for this measure, given low event numbers among each procedure type, as fewer health plans will be able to meet the minimum denominator threshold of 150 index outpatient surgery events. However, NCQA intends to explore this further in testing prior to publishing the final measure.

NCQA seeks general feedback on the proposed measure and specific feedback on the following questions:

1. Do you support publishing this measure for the Medicare ages 65 and older population?
2. Do you support stratification by dual eligibility? If not, what are your concerns?

Supporting documents include the measure specification and evidence workup.

**NCQA acknowledges the contributions of the Geriatric, Technical and Utilization Measurement Advisory Panels.**
Acute Hospitalization Following Outpatient Surgery (HFO)

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description

For members 65 years of age and older, the percentage of select outpatient procedures that were followed by an unplanned acute hospitalization (inpatient and observation stays) for any diagnosis within 15 days, and the predicted probability of an acute hospitalization. Four rates are reported:

- Colonoscopy.
- General Surgery.
- Orthopedic Procedures.
- Urology Procedures.

Definitions

Outpatient surgery episode
A qualifying outpatient surgery or procedure that occurs on or between January 1 and December 16 of the measurement period, as identified in each denominator.

Planned hospital stay
A hospital stay that meets criteria in step 3 of each numerator.

Classification period
365 days prior to and including the outpatient surgery episode date.

Eligible Population

Product line
Medicare.

Ages
65 years and older as of the last day in the outpatient surgery episode.

Continuous enrollment
365 days prior to the outpatient surgery episode through 15 days after the outpatient surgery episode.

Allowable gap
No more than one gap in enrollment of up to 45 days during the 365 days prior to the outpatient surgery episode and no gap during the outpatient surgery episode or during the 15 days following the last day of the outpatient surgery episode.

Anchor date
Last day of the outpatient surgery episode.

Benefit
Medical.

Event/diagnosis
Select outpatient surgery episodes on between January 1 and December 16 of the measurement year. The denominator for this measure is based on outpatient surgery episodes, not members. Include all outpatient surgery episodes for members on or between January 1 and December 16 of the measurement year.
Follow the steps below to identify eligible outpatient surgery episodes.

**Note:** Multiple procedures that occur on the same date may be captured in multiple measure denominators. For example, if a person has an orthopedic procedure and a general surgery procedure on the same date, that event may be included in the denominator for both the orthopedic rate and the general surgery rate.

**Required exclusion**

Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

**Administrative Specification**

Report each rate separately.

**Rate 1: Colonoscopy**

**Denominator 1**

The eligible population.

**Step 1** Identify outpatient colonoscopy procedures on or between January 1 and December 16 of the measurement year:

1. Identify all outpatient colonoscopy procedures using a colonoscopy procedure code (Routine Colonoscopy Value Set) with an outpatient surgery place of service code (Ambulatory Surgery POS Value Set). Both codes must be on the same claim line.
2. Identify the outpatient colonoscopy episode date. For episodes that span more than one calendar day, use the last service date as the episode date.

**Step 2** Exclude colonoscopy episode dates that occur the day before an inpatient stay (Inpatient Stay Value Set) or observation stay (Observation Stay Value Set) or at any time during an inpatient or observation stay.

**Step 3** Exclude outpatient colonoscopy episodes that meet the following criteria:

- A principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.
- Occurs concurrently (on the same claim) with a high-risk GI endoscopy procedure (High Risk Upper GI Endoscopy Value Set), followed by a subsequent outpatient colonoscopy (Routine Colonoscopy Value Set) with an outpatient surgery place of service code (Ambulatory Surgery POS Value Set) within 15 days following the episode date. Both codes for the subsequent outpatient colonoscopy (procedure code for colonoscopy, outpatient place-of-service code) must be on the same claim line.
• History or current diagnosis of irritable bowel diseases (Irritable Bowel Diseases Value Set) in the 365 days preceding the episode date through 15 days after the episode date.

Rate 2: General Surgery

Denominator 2 The eligible population.

Step 1 Identify outpatient general surgery procedures on or between January 1 and December 16 of the measurement year:

1. Identify all outpatient general surgery procedures using a general surgery procedure code (Routine Colonoscopy Value Set) with an outpatient surgery place of service code (Ambulatory Surgery POS Value Set). Both codes must be on the same claim line.

2. Identify the outpatient general surgery episode date.
   For episodes that span more than 1 calendar day, use the last service date as the episode date.

Step 2 Exclude outpatient general surgery episode dates that occur the day before an inpatient stay (Inpatient Stay Value Set) or observation stay (Observation Stay Value Set) or at any time during an inpatient or observation stay.

Step 3 Exclude outpatient general surgery episodes that meet the following criteria:

• A principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

Rate 3: Orthopedic Procedures

Denominator 3 The eligible population.

Step 1 Identify outpatient orthopedic procedures on or between January 1 and December 16 of the measurement year:

1. Identify all outpatient orthopedic procedures using an orthopedic procedure code (Orthopedic Surgery Value Set) with an outpatient surgery place of service code (Ambulatory Surgery POS Value Set). Both codes must be on the same claim line.

2. Identify the outpatient orthopedic episode date.
   For episodes that span more than one calendar day, use the last service date as the episode date.

Step 2 Exclude outpatient orthopedic episode dates that occur the day before an inpatient stay (Inpatient Stay Value Set) or observation stay (Observation Stay Value Set) or at any time during an inpatient or observation stay.

Step 3 Exclude outpatient orthopedic episodes that met the following criteria:

• A principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
• A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

**Rate 4: Urology Procedures**

**Denominator 4**  The eligible population.

**Step 1** Identify outpatient urology procedures on or between January 1 and December 16 of the measurement year:

1. Identify all outpatient colonoscopy procedures using a urology procedure code (Urologic Surgery Value Set) with an outpatient surgery place of service code (Ambulatory Surgery POS Value Set). Both codes must be on the same claim line.

2. Identify the outpatient urology episode date.
   
   For episodes that span more than one calendar day, use the last service date as the episode date.

**Step 2** Exclude outpatient urology episode dates that occur the day before an inpatient stay (Inpatient Stay Value Set) or observation stay (Observation Stay Value Set) or at any time during an inpatient or observation stay.

**Step 3** Exclude outpatient urology episodes that met the following criteria:

• A principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

• A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

**Risk Adjustment Procedure Subtype Determination**

For each outpatient surgery episode, use the following steps to identify risk adjustment procedure subtype categories.

**Step 1** Identify all CPT codes associated with each outpatient surgery episode date. Some episode dates will be associated with more than one CPT code.

**Step 2** Assign each CPT code to a procedure subtype using Table Proc—Mapping in the Risk Adjustment Shared Tables.

**Example:** Assume an episode date has CPT 10160 and CPT 20520 codes.

• CPT 10160 maps to CCS 170 (Excision of skin lesion).

• CPT 20520 maps to CCS 160 (Other therapeutic procedures on muscles and tendons).

The final procedure subtypes for this episode date are CCS 170 and CCS 160.

**Table Proc—Mapping**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
<th>CCS</th>
<th>CCS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10160</td>
<td>Aspiration of abscess, blood, or cyst</td>
<td>170</td>
<td>Excision of skin lesion</td>
</tr>
<tr>
<td>20520</td>
<td>Removal of foreign body in muscle or tendon</td>
<td>160</td>
<td>Other therapeutic procedures on muscles and tendons</td>
</tr>
</tbody>
</table>
Risk Adjustment Determination

For each outpatient surgery episode use the following to identify risk adjustment categories based on age, gender, comorbidity and procedure subtype. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

<table>
<thead>
<tr>
<th>Procedure subtype</th>
<th>Refer to Risk Adjustment Procedure Subtype Determination, above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comorbidities</td>
<td>Refer to Risk Adjustment Comorbidity Category Determination in the Guidelines for Risk Adjusted Utilization Measures.</td>
</tr>
</tbody>
</table>

Risk Adjustment Weighting

For each outpatient surgery episode, use the following steps to identify the 15-day hospitalization risk adjustment weights based on procedure subtype, comorbidity, age and gender. Weights are specific to reporting rate (colonoscopy, general surgery, orthopedic, urology). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

**Step 1**
For each outpatient surgery episode with a procedure subtype, link the subtype weights.

**Step 2**
For each outpatient surgery episode with a Comorbidity HCC category, link the comorbidity weights.

**Step 3**
Link the age and gender weights for each outpatient surgery episode.

**Step 4**
Sum all weights (procedure subtype, comorbidities, age and gender) associated with each outpatient surgery episode for each rate (colonoscopy, general surgery, orthopedic, urology).

**Step 5**
Calculate the count of expected hospitalizations for each age, for each rate (colonoscopy, general surgery, orthopedic, urology). The count of expected hospitalizations is the sum of the estimated hospitalizations risk calculated in step 4 for each outpatient surgery episode for each age, for each rate.

\[
\text{Count of Expected Hospitalizations} = \sum (\text{Estimated Hospitalization Risk})
\]

Use the formula below and the estimated hospitalization risk calculated in step 5 to calculate the variance for each outpatient surgery episode, for each rate.

\[
\text{Variance} = \text{Estimated Hospitalization Risk} \times (1 - \text{Estimated Hospitalization Risk})
\]

Truncate the variance for each outpatient surgery episode to 10 decimal places.

**Example:** If the Estimated Hospitalization Risk is 0.1518450741 for an outpatient surgery episode, then the hospitalization variance for this outpatient surgery episode is 0.1518450741 \times 0.8481549259 = 0.1287881475.

**Note:** Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.
**Numerator 1**  
At least one acute hospitalization (inpatient or observation stay) for any diagnosis within 15 days after the outpatient surgery episodes identified in Denominator 1 (Colonoscopy).

**Step 1** For each outpatient episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient surgery episode.

To identify acute inpatient and observation admissions:
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

**Step 2** *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

**Step 3** Exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:
- Members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- A principal diagnosis of a malignant neoplasm (Malignant Neoplasms Value Set, Other Malignant Neoplasm of Skin).
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

**Note:** For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

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**Note**

Only one inpatient admission or observation stay hospitalization may be included in the numerator for each unique outpatient surgery denominator event. If there are multiple numerator events that meet criteria for a singular single denominator event, only count the numerator event closest to the outpatient surgery. For example, consider the following events:
- **Outpatient surgery episode:** May 10.
- **Observation stay:** May 13–14.
- **Acute inpatient stay:** May 16–May 20.
Both the observation stay of May 13–14 and the acute inpatient stay of May 16–May 20 are within 15 days of the outpatient surgery episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient surgery episode.

**Numerators 2–4**

At least one acute hospitalization (inpatient or observation stay) for any diagnosis within 15 days of the outpatient surgery episodes identified in denominators 2 (General Surgery), 3 (Orthopedic Procedures) or 4 (Urology Procedures).

**Step 1**

For each outpatient episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient surgery episode.

To identify acute inpatient and observation admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

**Step 2**

*Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures*.

**Step 3**

Exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:

- Members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

**Note:** For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

**Note**

- Only one inpatient admission or observation stay hospitalization may be included in the numerators for each unique outpatient surgery denominator event. If there are multiple numerator events that meet criteria for a singular single denominator event, only count the numerator event closest to the outpatient surgery. For example, consider the following events:
  - Outpatient surgery episode: May 10.
  - Observation stay: May 13–14.
– Acute inpatient stay: May 16–May 20.

Both the observation stay of May 13–14 and the acute inpatient stay of May 16–May 20 are within 15 days of the outpatient surgery episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient surgery episode.

- Count each unique acute inpatient admission or observation stay hospitalization only once toward the numerator for the last denominator event. If a single numerator event meets criteria for multiple denominator events, only attribute the numerator event to the last denominator event. For example, consider the following events:
  – Outpatient surgery episode 1: May 10.
  – Outpatient surgery episode 2: May 15.
  – Acute inpatient stay: May 18.

  The outpatient surgery episodes of May 10 and May 15 are included as denominator events. The acute inpatient stay counts as a numerator event only toward the last denominator event (episode 2, May 15).

**Reporting: Denominator**

The number of outpatient surgery episodes for each rate (colonoscopy, general surgery, orthopedic, urology), reported as the Denominator.

**Reporting: Numerator**

The number of observed acute inpatient admission or observation stay hospitalizations for each rate (colonoscopy, general surgery, orthopedic, urology), reported as the ObservedCount.

**Calculated: Observed Hospitalization Rate**

The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of outpatient surgery episodes (Denominator) for each rate (colonoscopy, general surgery, orthopedic, urology). Calculated by IDSS as the ObservedRate.

**Reporting: Count of Expected Hospitalizations**

**Step 1** Calculate the number of expected inpatient admission or observation stay hospitalizations for each rate (colonoscopy, general surgery, orthopedic, urology).

**Step 2** Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.

**Calculated: Expected Hospitalization Rate**

The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of outpatient surgery episodes (Denominator) for each rate (colonoscopy, general surgery, orthopedic, urology). Calculated by IDSS as the ExpectedRate.

**Reporting: Variance**

**Step 1** Calculate the variance (from Risk Adjustment Calculation, Variance) for each rate (colonoscopy, general surgery, orthopedic, urology).

**Step 2** Round to 4 decimal places using the .5 rule and report these values as the CountVariance.
**Calculated: O/E Ratio**

The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admissions or observation stay hospitalizations (ExpectedCount) for each rate (colonoscopy, general surgery, orthopedic, urology). Calculated by IDSS as the OE.

**Note**

- Supplemental data may not be used for this measure, except for required exclusions.

**Data Elements for Reporting**

Organizations that submit HEDIS data to NCQA must provide the following data elements.

*Table HFO-3: Data Elements for Acute Hospitalization Following Outpatient Surgery*

<table>
<thead>
<tr>
<th>Metric</th>
<th>Data Element</th>
<th>Reporting Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>Denominator</td>
<td>For each Metric</td>
</tr>
<tr>
<td>GeneralSurgery</td>
<td>ObservedCount</td>
<td>For each Metric</td>
</tr>
<tr>
<td>OrthoProcedures</td>
<td>ObservedRate</td>
<td>ObservedCount / Denominator (Percent)</td>
</tr>
<tr>
<td>UrologyProcedures</td>
<td>ExpectedCount</td>
<td>For each Metric</td>
</tr>
<tr>
<td></td>
<td>ExpectedRate</td>
<td>ExpectedCount / Denominator (Percent)</td>
</tr>
<tr>
<td></td>
<td>CountVariance</td>
<td>For each Metric</td>
</tr>
<tr>
<td></td>
<td>OE</td>
<td>ObservedCount / ExpectedCount</td>
</tr>
</tbody>
</table>
Acute Hospitalization Following Outpatient Surgery
Measure Workup

Topic Overview

Background and Importance

Outpatient, or ambulatory, surgeries are planned surgeries where the patient is not expected to be admitted to an inpatient setting. Though most facilities primarily offer same-day surgeries, some provide extended stay services to patients who need additional recovery time or monitoring (Steiner et al. 2020). Surgical procedures are increasingly moving from the inpatient to the outpatient setting, with over 50 million procedures (translating to about 70% of all surgeries) now performed in ambulatory settings each year (Gabriel et al. 2021; Hollenbeck et al. 2014).

There are two main types of outpatient settings in which surgeries occur; each provide similar services but differ based on ownership and regulations:

- **Hospital outpatient departments (HOPD)** can be located on or off the hospital campus, and are financially and clinically integrated with a parent hospital.
- **Ambulatory surgery centers (ASC)** are typically free-standing facilities and are usually not affiliated or financially integrated with a parent hospital. However, with the financial risk and potential loss of investment involved with independent, physician-owned ASCs, some have converted to HOPD centers, allowing more predictable, albeit often smaller, payments (Tanaka 2019).

Surgeries performed in outpatient surgery centers typically take less time than those performed in hospitals (MEDPAC, 2021). ASCs and HOPDs are not routinely interrupted for emergency surgeries and can therefore focus on providing efficient and convenient patient care. Many outpatient surgery centers specialize in specific clinical areas, such as orthopedics or cardiology, to enhance efficiency and productivity (Bates, Blohm, and Kelly 2022). In 2019, the most common surgery performed among Medicare beneficiaries was lens and cataract procedures for both HOPDs (17.0%) and ASCs (18.5%) (McDermott and Liang 2021; MEDPAC 2021). The top 5 most frequent Medicare procedures performed in HOPDs and ASCs in 2019 are listed in Table 1.

Table 1. Top 5 Outpatient Surgical Procedures Among Medicare Beneficiaries by Setting Type, 2019

<table>
<thead>
<tr>
<th>2019 Ranking</th>
<th>HOPDs (McDermott and Liang, 2021)</th>
<th>ASCs (MEDPAC, 2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
<td>% of Total</td>
<td>Procedure</td>
</tr>
<tr>
<td>1</td>
<td>Lens and cataract procedures</td>
<td>17.0</td>
</tr>
<tr>
<td>2</td>
<td>Therapeutic muscle &amp; tendon procedures</td>
<td>6.9</td>
</tr>
<tr>
<td>3</td>
<td>Cardiac pacemaker or defibrillator</td>
<td>4.6</td>
</tr>
<tr>
<td>4</td>
<td>Select vascular procedures (not head or neck)</td>
<td>3.7</td>
</tr>
<tr>
<td>5</td>
<td>Knee arthroplasty</td>
<td>3.7</td>
</tr>
</tbody>
</table>

1 Unless otherwise stated, the term ‘outpatient surgery center’ refers to both HOPDs and ASCs collectively.
Available evidence suggests sociodemographic disparities in outpatient surgery access and utilization (Rabbitts and Groenewald 2020). Studies have shown that patients who are Black or Hispanic are less likely to receive the same outpatient surgery than their White counterparts (Amen et al. 2022; Janeway et al. 2020). A study of data from New York and Florida also found that patients with Medicare and Medicaid were less likely to receive surgery in an ASC than those with private insurance (Janeway et al. 2020). One reason for this may be differential referral patterns, based on evidence that physicians who own and have financial stake in ASCs are more likely to refer under- or uninsured individuals to HOPDs, which typically charge more than ASCs for the same procedures (Hollingsworth et al. 2011). This has raised concerns that structural barriers may limit outpatient surgery access among more disadvantaged and vulnerable populations (Chatterjee, Amen, and Khormaee 2022).

The same study examined unplanned hospital visits (i.e., emergency care or inpatient admission) after a surgery in an ASC and found a significantly higher likelihood of an unplanned hospital visit among Black patients in both New York and Florida, and among Hispanic patients in New York, than among White patients. In addition, patients with Medicaid or Medicare and those with lower income had higher rates of a 30-day unplanned hospital visit, post-surgery, and were more likely to require acute care after surgery (Janeway et al. 2020). There is also procedure-specific evidence of disparity. For example, one study showed that Black patients and patients with Medicaid were associated with increased odds of an unplanned hospital visit within 30 days of an outpatient urethral sling placement, compared to those who were White or privately insured (Dallas et al. 2017).

There is marked variation in outpatient surgery based on geographic location. Most studies examine trends by setting type (HOPDs or ASCs), making it difficult to estimate outpatient surgery volume and geographic variation for all outpatient settings combined. Most ASCs (93.8%) are located in urban or suburban areas; HOPDs are more likely to be located in medium to small metropolitan or rural areas (McDermott and Liang 2021). In 2019, Maryland had the most ASCs per Medicare beneficiary (38 ASCs per 100,000 beneficiaries), followed by Georgia, Alaska and New Jersey. Vermont had the fewest ASCs per Medicare beneficiary Vermont (2 ASCs per 100,000 beneficiaries) (MEDPAC 2021).

Variation has even been observed within states. For example, among the 10 largest counties in California, there was a 2-fold difference in ambulatory surgery case volume per capita (O’Neill, Frencher, and Maggard-Gibbons 2017). In addition, a study based on ASCs in New York state found that higher-income counties had more ASCs per capita than lower-income counties (Chatterjee, Amen, and Khormaee 2022).

The proliferation of outpatient surgery centers has occurred alongside an increase in overall surgical utilization. This raises concerns about whether opening new facilities satisfies unmet clinical need, or is a byproduct of physician-induced demand, particularly for ASCs, since they are mostly physician owned. A study in Florida found that, in markets where an ASC opened in the last 4 years, there was a 117% increase in gastrointestinal endoscopy rates compared to areas without ASC facilities (Hollingsworth et al. 2011). However, a study of national rates found a more modest impact, about 11% across all procedure types (Hollenbeck et al. 2014). These data suggest a markedly varied impact of outpatient surgery availability on utilization patterns.
Payment arrangements and financial incentives have been a major driver in the transition to outpatient surgery. As of 2020 there were 5,930 ASCs in the U.S. that were certified by CMS to receive full reimbursement for services provided to Medicare beneficiaries. In 2020, Medicare spent $4.9B on treatment and procedures at ASCs (MEDPAC 2021). There has been growth in the number of ASC facilities and in the number of procedures performed in these settings. Between 2015 and 2019, the number of ASCs increased each year by an average of 2.1%. The majority were for-profit, physician-owned facilities. During the same period, there was an average increase of 6.7% in payments for ASC services for Medicare fee-for-service members (MEDPAC 2021).

The total cost for surgeries performed in an HOPD is statistically higher than the same surgeries performed in an ASC (Robinson et al. 2015; Higgins, Veselovskiy, and Schinkel 2016). For example, the median price for a knee arthroscopy for patients enrolled in the California Public Employees Retirement System was $5,668 in an HOPD, compared to $3,083 when performed in an ASC (Robinson et al., 2015).

Studies have found that cost savings for payers for outpatient procedures compared to similar inpatient procedures are significant, ranging from around 15%–60% depending on procedure type (Crawford et al. 2015; Richter and Diduch 2017; Tanaka 2019). For example, a study found that outpatient unicompartmental knee arthroplasties were, on average, about $20,000 less per patient than those performed in an inpatient setting (Richter and Diduch 2017).

A growing list of surgeries are performed outside the hospital, due to significant advancements in surgical and anesthesia techniques. However, not all procedures are deemed safe or appropriate for outpatient settings. The Centers for Medicare & Medicaid Services (CMS) maintains a list of Inpatient Only (IPO) procedures that are reimbursed only if performed in an inpatient setting. Procedures on this list are chosen based on how invasive they are, whether outpatient settings have the necessary equipment and whether the surgery requires extended postoperative recovery time/monitoring. CMS reviews the IPO list annually, removing procedures only after rigorous criteria are met (CMS 2022d). For Calendar Year 2023, CMS removed an additional 10 procedures, including certain facial reconstruction, arthrodesis and escharotomy procedures, from the IPO list (CMS 2022d).

Prior to surgery, clinicians typically evaluate whether each patient is suitable for an outpatient procedure by considering several factors, including patient age, extent and duration of the procedure, the surgical team’s skillset and level of expected postoperative care (Doyle, Goyal, and Garmon 2022). In the last decade, there has been a paradigm shift in the approach to preoperative assessment, particularly in ambulatory surgery settings. Rather than order a large number of routine tests and laboratory panels, a practice that has demonstrated minimal benefit and higher costs, there is now a focus on more targeted risk assessment based on a patient’s comorbidity burden and management (Fong and Sweitzer 2014; Okocha, Gerlach, and Sweitzer 2019; Kataria, Cutter, and Apfelbaum 2013).

Many assessments, risk calculators and guidelines in use today are targeted to specific procedures or to patients with certain comorbidities such as obesity, obstructive sleep apnea, heart disease and diabetes (Fong and Sweitzer 2014). There are also universal methods of evaluating operative suitability across all surgical procedures and populations, including the Surgical Risk Preoperative
Assessment System and American College of Surgeons Surgical Risk Calculator (American College of Surgeons n.d.; Ra et al. 2016).

The American Society of Anesthesiologists (ASA) Physical Status Classification System is widely used during inpatient and outpatient preoperative assessment to evaluate a patient’s pre-anesthesia medical comorbidities (American Society of Anesthesiologists 2020). The ASA system classifies patients into levels based on comorbidity burden and presence of risk factors such as smoking or drinking alcohol, starting at level 1 (i.e., a normal, healthy patient). A study of over 9 million outpatient surgeries showed that the majority (64.2%) of cases were classified as having a low (level 1 or 2) ASA Physical Status score. However, there was wide variability between outpatient facilities in how patients were classified, suggesting inconsistency in preoperative assessment for surgeries performed in an outpatient setting (Gabriel et al. 2021).

Care coordination

The same-day nature of most ambulatory procedures limits the opportunity for direct oversight of patients in the hours and days after surgery, which makes patient surveillance and management of potential complications difficult (Theissen et al. 2019). Care coordination is therefore critical for capturing problems early and ensuring positive patient outcomes. This is true for all outpatient surgery settings, but particularly for independent, free-standing ASCs that are not integrated with a larger health system.

There are few studies examining care coordination quality after an outpatient surgery. One found wide variation (4.5%–61.8%) across outpatient surgical facilities in how frequently patients were given discharge instructions (Downey and Olds 2021). The same study also found a lower completion rate for medication lists and documentation of pending diagnostic results in ambulatory settings compared to inpatient settings. Another study of outpatient thyroidectomy procedures showed that 54% of patients contacted the surgeon’s office within 30 days after surgery, with common concerns about medications, lab results and surgical wounds, suggesting an opportunity for improvement in post-procedure communication with patients (Brekke et al. 2016).

Outpatient surgery outcomes

The potential for cost savings and higher patient satisfaction associated with outpatient surgery (compared to inpatient surgery) is negated when followed by adverse health outcomes such as emergency department (ED) visits or hospital admissions. The following section describes evidence for medical errors, complications and acute care visits after outpatient surgery procedures.

Medical errors, complications

Studies are mixed about the incidence of medical errors and complications in outpatient surgery settings. A study of orthopedic surgeries in ASCs found the rate of complications varies by procedure, and that between 0.05% and 20% are associated with a complication, most commonly pain, nausea, infection, impaired healing and bleeding (Goldfarb, Bansal, and Brophy 2017). Reported complications following individual procedures are also mixed. One study showed the rate of complications following outpatient total knee arthroplasty (TKA) is 3.7% (DeMik et al. 2021). Another study, comparing outcomes between TKA procedures performed inpatient vs. outpatient, found higher odds of perioperative complications (including deep vein thrombosis, surgical site infection and acute renal failure) after outpatient procedures (Arshi et al. 2017). However, others have found no difference in complication rates following a TKA, when comparing inpatient to outpatient procedures (Courtney et al. 2018). Patient characteristics and risk factors can increase the chances of complications following outpatient surgical procedures. A study of over 400,000
elective outpatient procedures showed that the risk of complications is higher among patients with frailty (Rothenberg et al. 2019). A study of 170,000 patients who had outpatient total joint arthroplasty showed an overall complication rate of 8%, with significantly increased risk of complications among patients over age 70 and those with malnutrition, a history of cardiac problems or smoking, diabetes mellitus (Courtney, Boniello, and Berger 2017). Increased risk of adverse events among individuals with obstructive sleep apnea and obesity has also been demonstrated, though this finding was mixed across studies (Kent, Metzner, and Bollag 2014). While certain risk factors are not independently associated with outpatient surgery complications, studies documented a higher risk of complications when multiple risk factors are present.

Rates of acute care visits following outpatient surgery vary based on a variety of factors including geographic location, procedure type and patient characteristics. One study showed the adjusted odds of a revisit within 30 days of a surgery is 2.23 times greater for ambulatory otolaryngologic surgery, compared to inpatient surgery across all procedures examined (Gadkaree et al. 2022). Another study showed that 3.7% of outpatient urological surgeries resulted in a hospital admission within 30 days of the procedure, ranging from 0.85% for sling surgery for urinary incontinence and 4.97% for resection of bladder tumor (Rambachan et al. 2014). Predictors of readmission in this study included a history of cancer, bleeding disorder, male gender, hypertension, diabetes, age and ASA classification level 3 or 4 due to the presence of comorbidities. Differences have also been observed between outcomes in HOPDs and ASCs. Compared to HOPDs, one study found that ASCs had significantly higher odds of a 30-day unplanned hospital visit for central venous catheterization (OR=2.26), debridement of skin and tissues (OR=1.47), cholecystectomy (OR=1.33) and liver biopsy (OR=1.22); however, lower odds were observed for arthroscopy (OR=0.71), cataract surgery (OR=0.50), colonoscopy (OR=0.67) and upper gastrointestinal endoscopy (OR=0.97) (Janeway et al. 2020).

A study of over 3.8 million patients treated at 1,295 ASCs across California, Florida and Nebraska showed that overall, 1.1 per 1,000 procedures resulted in a direct hospital transfer, a common metric used to evaluate ASC quality. However, the adjusted rate of hospital-based acute care (defined as either an ED visit or hospitalization within 7 days) following ASC discharge was 30-fold higher (about 28.0 per 1,000) than the direct transfer rate (Fox et al. 2014). Acute visit rates range from 9.7 per 1,000 discharges, for lens and cataract procedures, to 81.9 per 1,000 discharges following diagnostic cardiac catheterization. The same study showed similar results among older adults, with an adjusted rate of 31 hospital-based acute care visits per 1,000 ASC discharges (Fox et al. 2014). The most common reasons for 7-day acute care visits were surgical site complications (i.e., bleeding, infections) and pain or discomfort.

There are effective ways to reduce adverse outcomes after an outpatient surgical procedure. Quality improvement initiatives aimed at improving communication and engagement with patients and their caregivers about what to expect after outpatient surgery, coordinating effectively with a patient’s primary care doctor and appropriate medication and symptom management can reduce ED visits and hospitalizations after surgery. Health plans are uniquely positioned to ensure proper care coordination for patients undergoing an outpatient procedure, particularly when a patient has a surgery at an independent ASC or other facility that is not affiliated with their health system or primary care.

Evidence for reducing adverse surgical outcomes

Unplanned acute ED visits, hospitalizations

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provider. Payers can provide broad oversight and bridge the communication gap, so patients have the right resources and information.

Pain management is one of the most effective ways of avoiding adverse outpatient surgical outcomes. Some outpatient surgery centers are starting to employ designated Ambulatory Surgery Pain Specialists to implement a multimodal approach to pain management (Vadivelu et al. 2016). This approach entails a variety of analgesic options, such as over the counter medications, gabapentinoids, corticosteroids, local anesthetics and alpha-2 agonists, to reduce perioperative opioid requirements and improve patient recovery (Prabhakar et al. 2017). Care coordination is also important before, during and after outpatient surgery. In the Perioperative Surgical Home (PSH) model, an interdisciplinary team of clinicians coordinates a patient’s care experience from preoperative consultations to recovery (American Society of Anesthesiologists n.d.). One study by Kaiser showed that ambulatory cholecystectomy patients who participated in the PSH program experienced significantly lower unplanned hospital admission rates compared to non-PSH patients (1.7% vs. 8.5%, respectively) (Qiu et al. 2017).

Quality Measurement in Outpatient Surgery Centers

The measures and programs that exist evaluate quality at the facility level for HOPDs and ASCs separately. CMS has made some efforts to align measures for both settings across their programs, though MEDPAC recently advocated for further alignment to facilitate comparison between HOPDs and ASCs (CMS 2014; MEDPAC 2021). The existing measures and programs that evaluate outpatient surgery centers are summarized below, and additional details are available in the Appendix.

<table>
<thead>
<tr>
<th>Existing measures and programs</th>
<th>HOPDs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital Outpatient Quality Reporting (OQR) Program. Includes measures that assess quality in hospital outpatient settings. Two measures focus on outcomes following outpatient surgery (Appendix, Table A1). Hospitals are required to report data every year to receive full payment under the Outpatient Prospective Payment System (CMS 2022a).</td>
</tr>
<tr>
<td></td>
<td>Patient-Reported Outcome Performance Measures (PRO-PM). With funding from CMS, Yale New Haven Health Services Corporation's Center for Outcomes Research and Evaluation is developing a patient-reported measure that assesses a patient’s understanding of key information received regarding recovery after an outpatient procedure (CMS 2022c).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASCs</th>
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<tbody>
<tr>
<td>Ambulatory Surgical Center Quality Reporting (ASCQR) Program. CMS established the program in response to the 2008 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule. The ASCQR is a pay-for-reporting program that all eligible2 CMS-approved ASCs must participate in to receive payment for services furnished to Medicare beneficiaries. There are 13 facility-level measures (Appendix, Table A2) (CMS 2022b). Four measures assess outcomes for Medicare FFS beneficiaries, but only one outcome measure (Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy) was required to be reported by ASCs in 2021. Two outcome measures (Hospital Visits After Orthopedic ASC Procedures, Hospital Visits After Urology ASC Procedures) were activated for 2022; Hospital</td>
</tr>
</tbody>
</table>

2ASCs with fewer than 240 Medicare claims in any calendar year are not required to participate in the ASCQR program.
Visits After General Surgery ASC Procedures will be activated in 2024 (MEDPAC 2021, 5). In addition, CMS has proposed the addition of 5 patient experience survey measures (Appendix, Table A3) to the ASCQR program for calendar year 2025 (CMS 2022d).

- Ambulatory Health Care Accreditation. The Joint Commission established this program in 1975 to recognize and encourage high-quality patient care in free-standing ambulatory care facilities. The program accredits over 2,200 organizations across multiple settings, including ASCs, community health centers, free-standing emergency rooms, Federally Qualified Health Care Centers and pain clinics (The Joint Commission 2022).

Transfer directly to a hospital from an outpatient surgery center has been a marker for poor quality in the past. However, studies have shown direct transfer is rare, with little to no variation across outpatient surgery centers, suggesting that it is not the best indicator for assessing health care quality. Instead, experts suggest incidence of hospital-based acute care (i.e., ED visits or inpatient admissions) may be a better measure of quality, as it is variable across outpatient surgery facilities and illuminates complications in the days following a procedure (Fox et al. 2014).

Gaps in current measurement

There are no known health plan-level measures or programs assessing outpatient surgery outcomes. Some experts have criticized the focus of current quality measures on a narrow set of procedures, highlighting the potential for adverse outcomes regardless of surgery type. Instead, a more comprehensive list of procedures will capture all possible quality issues, such as lack of communication related to pain management or medication adherence upon discharge. MEDPAC has also called for CMS to create a value-based purchasing program for the outpatient surgery sector, to incentivize quality over quantity and develop more claims-based outcome measures, such as rates of surgical site infection (MEDPAC 2021; Petersen 2014).

Identifying outpatient surgeries for quality measurement

A consistent definition of an event or outcome is essential for accurate assessment of health quality and to facilitate comparison across organizations. However, this has been a challenge for outpatient surgeries because there are several ways of identifying these events. Procedures in outpatient settings are heterogeneous, ranging from minor (i.e., routine venipuncture) to major (i.e., hip replacement). Some quality measures use narrow definitions based on procedure invasiveness, category (i.e., orthopedic), risk of complications or surgery setting (i.e., free-standing ambulatory surgery center vs. hospital outpatient department) (CMS 2022a; 2022b). Other measures use broad definitions; for example, California’s Align. Measure. Perform. Program captures all visits to an outpatient surgery center in its Encounter Rate by Service Type measure (Integrated Healthcare Association 2021).

The issue of multiple methods for identifying and defining outpatient surgeries has been documented. A study of the Veterans Health Administration (VA) compared the number of surgeries captured using definitions from two national healthcare organizations. The Health Care Cost Institute (HCCI) Outpatient Surgery list captures encounters based on a broad list of procedure codes, with no restriction on surgery setting. Conversely, the Agency for Healthcare Research and Quality (AHRQ) Surgery Flag software uses a narrower definition, including only surgeries that are invasive, require an operating room and regional or general anesthesia or sedation. Both definitions are commonly used for public reporting and utilization measurement; however, the study found that the HCCI definition identified
approximately six times as many surgeries as the AHRQ definition (6.5 million vs. 1.1 million) (Mull et al. 2017).

Wide variations in methodology create challenges for comparing and benchmarking outpatient surgery center quality and performance across organizations. Using a narrow definition is beneficial for targeted quality improvement efforts, but can result in high adverse event rates for reporting entities. A broad definition dilutes rates of adverse events, but may give the impression that complications are rarer than they truly are, and may result in a lack of focus on quality improvement and patient safety (Mull et al. 2017). What may be most appropriate is a definition that balances sensitivity and specificity.

References


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## Appendix:

### Quality Measures Related to Outpatient Surgical Procedures

**Table A1. Select Hospital Outpatient Quality Reporting (OQR) Program Measures for Calendar Year 2023**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-32</td>
<td>Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy</td>
<td>The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.</td>
</tr>
<tr>
<td>OP-36</td>
<td>Hospital Visits after Hospital Outpatient Surgery</td>
<td>Facility-level, post-surgical risk-standardized hospital visit ratio of the predicted to expected number of all-cause, unplanned hospital visits within 7 days of a same-day surgery at a hospital outpatient department (HOPD) among Medicare fee-for-service (FFS) patients aged 65 years and older.</td>
</tr>
</tbody>
</table>

**Table A2. Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures for Calendar Year 2023**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC-1</td>
<td>Patient Burn</td>
<td>The number of admissions (patients) who experience a burn prior to discharge from the ASC.</td>
</tr>
<tr>
<td>ASC-2</td>
<td>Patient Fall</td>
<td>The number of admissions (patients) who experience a fall within the ASC.</td>
</tr>
<tr>
<td>ASC-3</td>
<td>Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant</td>
<td>The number of admissions (patients) who experience a wrong site, side, patient, procedure, or implant.</td>
</tr>
<tr>
<td>ASC-4</td>
<td>All-Cause Hospital Transfer/Admission</td>
<td>The percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC.</td>
</tr>
<tr>
<td>ASC-9</td>
<td>Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients</td>
<td>Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.</td>
</tr>
<tr>
<td>ASC-11</td>
<td>Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery</td>
<td>Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.</td>
</tr>
<tr>
<td>ASC-12</td>
<td>Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy</td>
<td>The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.</td>
</tr>
<tr>
<td>ASC-13</td>
<td>Normothermia Outcome</td>
<td>This measure is used to assess the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in post-anesthesia care unit (PACU).</td>
</tr>
<tr>
<td>ASC-14</td>
<td>Unplanned Anterior Vitrectomy</td>
<td>This measure is used to assess the percentage of cataract surgery patients who have an unplanned anterior vitrectomy.</td>
</tr>
<tr>
<td>ASC-17</td>
<td>Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures</td>
<td>The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an orthopedic surgery.</td>
</tr>
<tr>
<td>Measure ID</td>
<td>Measure Title</td>
<td>Description</td>
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<tr>
<td>ASC-18</td>
<td>Hospital Visits after Urology Ambulatory Surgical Center Procedures</td>
<td>The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a urology surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older</td>
</tr>
<tr>
<td>ASC-19</td>
<td>Facility-Level-7-Day Hospital Visits after General Surgery Procedures</td>
<td>The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a general surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older</td>
</tr>
<tr>
<td>ASC-20</td>
<td>COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination)</td>
<td>Percentage of All Core Healthcare Personnel (HCP) eligible to work at the ASC for at least one day of the self-selected week, in each month of quarterly data reporting, who received a complete primary series of COVID–19 vaccine</td>
</tr>
</tbody>
</table>

Table A3. Proposed Measures* for the Outpatient and Ambulatory Surgery Consumer Assessment (OAS CAHPS) Initiative for Calendar Year 2025

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Title</th>
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</thead>
<tbody>
<tr>
<td>ASC-15a</td>
<td>About Facilities and Staff</td>
</tr>
<tr>
<td>ASC-15b</td>
<td>Communication About Procedure</td>
</tr>
<tr>
<td>ASC-15c</td>
<td>Preparation for Discharge and Recovery</td>
</tr>
<tr>
<td>ASC-15d</td>
<td>Overall Rating of Facility</td>
</tr>
<tr>
<td>ASC-15e</td>
<td>Recommendation of Facility</td>
</tr>
</tbody>
</table>

*These measures will be added to the CMS ASCQR Program.