ASC Quality Collaboration

December 22, 2023

RE: MUC 2023-175
Facility Commitment to Health Equity

This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity. Facilities will receive one point for attesting to each of five different domains of commitment to advancing health equity for a total of five points.

This measure was developed for use in hospitals and, according to the information provided with the measure, is being presented "as is" for use in ambulatory surgical centers. It is clear the measure has never been tested in an ASC because the specifications are not appropriate to this setting. Important differences between hospitals and ASCs should be, but have not been, considered.

For example, the measure assumes all ASCs have EHRs. Most of ASCs do not have an EHR. While the HITECH Act of 2009 authorized financial incentives for hospitals and clinicians to adopt and meaningfully use certified EHR technology, ASCs were not included in the provisions of the Act and were subsequently ineligible for financial incentives under the Promoting Interoperability Program. This has perpetuated cost barriers to EHR implementation in ASCs. As a result, many of the analyses required by the measure would not be possible.

The measure also assumes that ASCs are led by CEOs and have a board of trustees, which is not the case. ASCs are overseen by a governing body (which may be a small as one individual if the ASC has one owner). This governing body has direct oversight of the ASC's mandatory quality program, but strategic planning is not a required activity under Medicare's ASC Conditions for Coverage.

The measure also assumes that ASCs have personnel and other resources that could be directed to all the activities required to achieve a full score on the measure. However, as CMS itself has indicated, approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data indicating a median of two operating/procedure rooms per facility (mean = 2.5). The average ASC employs 33 clinical and non-clinical full-time equivalents, significantly fewer individuals than the average hospital.

Further, Federal regulations dictate that ASCs operate "exclusively for the provision of surgical services not requiring hospitalization". As a result of the Medicare Conditions for Coverage, ASC services are limited to the immediate preoperative, intraoperative and postoperative period. ASCs may not perform preoperative or postoperative clinic visits. As a result, staff expertise is focused on providing surgical services. Without social workers, case managers and other related professionals on staff, ASCs may find it difficult to perform all the stipulated activities and develop expertise (such as culturally sensitive collection of demographics and/or social determinant of health information) in matters outside the scope of surgery.

Achieving a 5/5 score on this measure would be challenging for the substantial majority of ASCs which are not owned by hospitals, and impossible for those that do not have an EHR. Yet, this would not necessarily reflect a lack of commitment to equity. The measure should be adapted for a small organization providing surgical care, so the measure score is not biased in favor of large facilities with greater resources, such as hospitals, including their outpatient departments (HOPDs).

An alternative approach to the topic of commitment to equity in ASCs would be to develop and test a measure assessing whether an ASC's quality program addresses equitable care and outcomes for the surgical services provided at the center. Placing the focus on actual quality improvement efforts around equitable care would measure commitment in a way that could be applied to all facilities, regardless of size and resources.