Section 1 - Short Title – Ambulatory Surgical Center Quality and Access Act of 2011

Section 2 - Requires the Center for Medicare and Medicaid Services (CMS) to use the hospital market basket as the update factor when determining the update for payments for services performed in ambulatory surgery centers (ASCs). Currently, the ASCs do not have a market basket update and the default update mechanism is CPI-U, which does not appropriately measure the costs of an ASC. The provision does not affect the productivity adjusters mandated for all providers by the Patient Protection and Affordable Care Act (PPACA) or the secondary rescaling required for budget neutrality in the ASC pool.

Section 3 - Requires CMS to implementa voluntary system for reporting quality measures in ASCs no later than January 1, 2013. The provision defines the process that measures must go through in order to be approved for use in the reporting system. The process is modeled after the system designed for all other providers/settings in PPACA. This would include independent third party validation and multi-stakeholder input into the design of the measures. CMS could begin penalizing ASCs that do not report quality data to CMS after 2014. Under current law, the Secretary could immediately impose penalties of up to 2% of ASC's Medicare payments for failure to report quality data. This provision would align the new ASC reporting system with the systems that were introduced for hospitals, physicians, and other providers in which penalties were delayed while the systems were developed and providers became familiar with the reporting systems.

Requires the development of a value-based purchasing (VBP) program for ASCs by January 1st, 2015. The system would be established as follows:

- Each reporting facility would be assigned a score based ontheir performance on the quality measurements;
- Facilities would not be required to report on those measures that were inappropriate for their facility, i.e. shaving of surgical site in ASCs that perform ophthalmic procedures;
- CMS would develop an estimate of the total amount that Medicare is expected to spend hospital outpatient department (HOPD) and ASC procedures for the coming year for procedures that are eligible to be performed in an ASC. The estimate would be based on spending in the three prior years and would be adjusted for beneficiarydemographics, eligible procedures, and other factors, such as changes in the proportion of beneficiaries enrolled in Medicare Advantage plans;
- Each year, CMS would compare the actual spending to their estimated spending for procedures eligible to be performed in an ASC that were performed in either an HOPD or and ASC. If the actual spending for these procedures is less than the estimated spending, the difference would create the shared savings or bonus pool. This system is similar to the VBP system designed for the home health demonstration mentioned in the Secretary's report to Congress on VBP for ASCs;
- The shared savings pool would be divided, with 50% of the pool being retained by CMS and returned as savings to the Medicare program. The other 50% of the pool would be used to provide bonuses to high quality ASCs;
- The creation of the mechanism to provide bonuses to individual ASCs is left to the discretion of the Secretary with instruction to reward providers for both improvement and attainment; however, the Secretary is required to spend 50% of the savings pool on ASC bonuses.

Section 4 - Directs CMS to add a representative from the ASC community to the membership of the Advisory Panel for Ambulatory Payment Classifications Group (APC) since decisions made by the panel affect both HOPD and ASC facility fees and eligible procedures.

Section 5 - Permits patients who wish to receive care sooner, to do so by allowing an ASC physician to provide disclosure notifications to patients on the same day that their procedure is to be performed. Currently, ASC physicians must perform the notification at least 24 hours in advance of performing a procedure in an ASC unless it is an emergency and the patient's health would be jeopardized by the delay. The provision would provide the same notification standards as are applied to the HOPD.