

# The Leapfrog ASC Public Reporting Program Scoring Algorithms

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Scoring Details for the  
2026 Leapfrog ASC Public Reporting Program



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# Scoring and Public Reporting Overview

There are three components to the [Leapfrog ASC public reporting program](#). This document describes the scoring algorithms used for each measure in [public reporting](#).

1. **CMS ASCQR Measures** are scored and publicly reported for ALL ASCs included in the CMS provider data catalog, except those missing data for all four of the ASC 1-4 measures, for the following 13 measures:
  - ASC-1: Patient Burn
  - ASC-2: Patient Fall
  - ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant
  - ASC-4: All Cause Transfer/Admission
  - ASC-12: Facility 7-Day Risk-Standardized Hospital Rate after Outpatient Colonoscopy
  - ASC-14: Unplanned Anterior Vitrectomy
  - 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 Performed at Ambulatory Surgical Centers
  - OAS CAHPS Top Box Scores for the following domains:
    - Facilities and Staff
    - Communication About Your Procedure
    - Patients' Rating of the Facility
    - Patients Recommending the Facility
  
2. **Accreditation Standards** are scored and publicly reported as Achieved the Standard (best score) for ASCs that provide basic demographic information and upload proof of AAAHC or JC's accreditation on Leapfrog's ASC Dashboard for the following 5 measures:
  - Clinicians Certified in Adult Advanced Life Support Always Present
  - Use of a Safe Surgery Checklist
  - Medication and Allergy Documentation
  - Effective Leadership to Prevent Errors
  - Identification and Mitigation of Risks and Hazards
  
3. **The Leapfrog ASC Survey 2.0 Measures** are scored and publicly reported for ASCs that submit a completed Leapfrog ASC Survey 2.0 through the online survey tool for the following 8 measures:
  - Patients' Rights and Ethics**
    - Billing Ethics
    - Health Care Equity
    - Informed Consent
    - Taking Responsibility for Never Events
  - Patient Safety Practices**
    - Infection Surveillance following Breast Surgeries, Laminectomies, Herniorrhaphies, or Knee Prosthesis Procedures
    - Hand Hygiene
    - Culture of Safety
  - Volume of Procedures**
    - National Volume Standards for Total Knee Replacement, Total Hip Replacement, and Bariatric Surgery for Weight Loss
    - Facility Volume for Select Procedures (Optional; not scored but publicly reported)

**Public Reporting Schedule**

All results are publicly reported on Leapfrog’s Hospital and Surgery Center Ratings website at <https://ratings.leapfroggroup.org>.

Review key dates and deadlines at <https://www.leapfroggroup.org/asc-program/key-dates-and-deadlines>

| Program Component       | Details  | Updates   |
|-------------------------|--|---|
| CMS ASCQR Measures      | Facilities in the CMS Provider Data Catalog on Leapfrog’s first download date of June 30 <sup>th</sup> will have results scored and publicly reported on July 25 <sup>th</sup>   | Updated on June 30 <sup>th</sup> , August 31 <sup>st</sup> , and November 30 <sup>th</sup> based on updates to the CMS Provider Data Catalog  |
| Accreditation Standards | Facilities that upload proof of accreditation on the ASC Dashboard by June 30 <sup>th</sup> will have results publicly reported on July 25 <sup>th</sup>   | Facilities can continue to upload proof of accreditation until November 30 <sup>th</sup>  |
| ASC Survey 2.0          | Facilities that submit the Leapfrog ASC Survey 2.0 by June 30 <sup>th</sup> will have results confidentially available on the ASC Details Page on July 12 <sup>th</sup> and then publicly reported on July 25 <sup>th</sup> Submission deadline. | <p>Facilities can continue to (re)submit the Survey until November 30<sup>th</sup>. Results will be updated within the first 7 business days of the month following (re)submission.</p> <p>Facilities can make corrections to previously submitted Surveys until January 31<sup>st</sup>. Results will be updated within the first 7 business day of the months following resubmission.</p> |

*Results on Leapfrog’s Hospital and Surgery Center Ratings website are frozen from February to July.*

## Leapfrog's Hospital and Surgery Center Ratings Website

For the purposes of [public reporting](#), performance on each measure included in the Leapfrog ASC Public Reporting Program is scored using the algorithms detailed in this document and then placed into one of four performance categories:

- **Achieved the Standard** (displayed as four filled bars)
- **Considerable Achievement** (displayed as three filled bars)
- **Some Achievement** (displayed as two filled bars)
- **Limited Achievement** (displayed as one filled bar)





Additional scoring terms include:

- **Does Not Apply:** This term is used for facilities that report not performing a particular procedure or not having applicable patients for a particular measure.
- **Not Available:** This term is used for facilities that are not included in the CMS dataset (i.e., Military Treatment Facilities, Pediatric Facilities, etc.) or did not submit proof of accreditation.
- **Unable to Calculate:** This term is used when the number of cases/patients is too few to report.
- **Declined to Report:** This term is used for facilities that did not submit an ASC Survey 2.0.
- **Pending Leapfrog Verification:** This term is used for facilities that have Survey responses that are undergoing Leapfrog's standard verification process.

Additionally, for ASCs that have obtained approval from Leapfrog to participate in the 2026 Leapfrog ASC Survey 2.0 using limited data due to a cybersecurity event or natural disaster or have Extraordinary Circumstances Exception approved by CMS (i.e., CMS Footnote 28), the following footnote will be included alongside impacted Survey Results: "Results are based on limited data due to a reported cybersecurity event, natural disaster, or a CMS Extraordinary Circumstance." For more information, please visit our [webpage](#).

Figure 1: Legend from Leapfrog's public reporting [website](#).

**Progress towards meeting Leapfrog standards:**

|  |   |
|--|---|
|   | Achieved the Standard   |
|   | Considerable Achievement  |
|   | Some Achievement  |
|   | Limited Achievement   |
|  | Did not submit a Leapfrog Survey  |
| <b>DOES NOT APPLY</b>  | This measure is not applicable to this facility   |
| <b>DID NOT MEASURE</b>   | Facility reported not collecting data on this measure   |
| <b>UNABLE TO CALCULATE</b>   | Sample size too small to calculate score  |
| <b>NOT AVAILABLE</b>   | CMS measure or surgery center accreditation status is not available for the reported facility |
| <b>PENDING LEAPFROG VERIFICATION</b>   | This facility's responses are undergoing Leapfrog's standard data verification process        |

For the purposes of [public reporting](#), measures are organized into eight groups. The following measures are included in each group:

| Group Name                              | Program Component              | Measure Name   | Shown on public reporting website as:   |
|---|--------------------------------|--|---|
| <b>Patient Rights and Ethics</b>        | Leapfrog ASC Survey Section 2A | Billing Ethics   | <i>Billing Ethics</i>   |
|   | Leapfrog ASC Survey Section 2B | Health Care Equity   | <i>Health Care Equity</i>   |
|   | Leapfrog ASC Survey Section 2C | Informed Consent   | <i>Informed Consent</i>   |
|   | Leapfrog ASC Survey Section 2D | Taking Responsibility for Never Events   | <i>Responding to Never Events</i>   |
| <b>Preventing Patient Harm</b>          | Accreditation Standards        | Effective Leadership to Prevent Errors   | <i>Leadership Structures and Systems to Support Patient Safety</i>                              |
|   | Leapfrog ASC Survey Section 3C | NQF Safe Practice #2 - Culture Measurement, Feedback, and Intervention   | <i>Staff Work Together to Prevent Errors</i>  |
|   | Accreditation Standards        | Identification and Mitigation of Risks and Hazards   | <i>Identification and Mitigation of Patient Safety Risks</i>                                    |
|   | Leapfrog ASC Survey Section 3B | Hand Hygiene   | <i>Handwashing</i>  |
|   | CMS ASCQR Measures             | ASC-1: Patient Burn  | <i>Percentage of Patients Who Experience a Burn Prior to Discharge from the ASC</i>             |
|   | CMS ASCQR Measures             | ASC-2: Patient Fall  | <i>Percentage of Patients Who Experience a Fall Within the ASC</i>                              |
|   | CMS ASCQR Measures             | ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant                                  | <i>Percentage of Patients Who Experience a Wrong Site, Side, Patient, Procedure, or Implant</i> |
| <b>Healthcare-Associated Infections</b> | Leapfrog ASC Survey Section 3A | Infection Surveillance following Breast Surgeries, Laminectomies, Herniorrhaphies, or Knee Prosthesis Procedures | <i>Infection Tracking and Reporting</i>   |
| <b>Medication Safety</b>                | Accreditation Standards        | Medication and Allergy Documentation   | <i>Medication and Allergy Documentation</i>   |
|   | Leapfrog ASC Survey Section 4A | Bariatric Surgery for Weight Loss Volume   | <i>Bariatric Surgery for Weight Loss</i>  |
|   |                                | Bariatric Surgery for Weight Loss Privileging  |   |

|  |                                 |   |   |
|--|---------------------------------|---|---|
| <b>Complex Adult Surgery</b>                         | Leapfrog ASC Survey Section 4A  | Total Knee Replacement Surgery Volume   | <i>Total Knee Replacement Surgery</i>   |
|  |                                 | Total Knee Replacement Surgery Privileging  |   |
|  | Leapfrog ASC Survey Section 4A  | Total Hip Replacement Surgery Volume  | <i>Total Hip Replacement Surgery</i>  |
|  |                                 | Total Hip Replacement Surgery Privileging   |   |
| <b>Elective Outpatient Surgery – Adult*</b>          | Leapfrog ASC Survey Section 4B* | Gastroenterology  | <i>Gastroenterology (Stomach and Digestive)</i>   |
|  | Leapfrog ASC Survey Section 4B* | General Surgery   | <i>General Surgery</i>  |
|  | Leapfrog ASC Survey Section 4B* | Ophthalmology   | <i>Ophthalmology (Eyes)</i>   |
|  | Leapfrog ASC Survey Section 4B* | Orthopedic  | <i>Orthopedic (Bones and Joints)</i>  |
|  | Leapfrog ASC Survey Section 4B* | Otolaryngology  | <i>Otolaryngology (Ear, Nose, Mouth, and Throat)</i>                                      |
|  | Leapfrog ASC Survey Section 4B* | Urology   | <i>Urology (Urinary Tract, Male Reproductive)</i>   |
|  | Leapfrog ASC Survey Section 4B* | Neurological Surgery  | <i>Neurosurgery</i>   |
|  | Leapfrog ASC Survey Section 4B* | Obstetrics and Gynecology   | <i>Obstetrics and Gynecology</i>  |
|  | Leapfrog ASC Survey Section 4B* | Plastic and Reconstructive Surgery  | <i>Plastic and Reconstructive Surgery</i>   |
| <b>Elective Outpatient Surgery - Pediatric*</b>      | Leapfrog ASC Survey Section 4B* | Ophthalmology   | <i>Ophthalmology (Eyes)</i>   |
|  | Leapfrog ASC Survey Section 4B* | Orthopedic  | <i>Orthopedic (Bones and Joints)</i>  |
|  | Leapfrog ASC Survey Section 4B* | Otolaryngology  | <i>Otolaryngology (Ear, Nose, Mouth, and Throat)</i>                                      |
| <b>Care for Elective Outpatient Surgery Patients</b> | Accreditation Standards         | Clinicians Certified in Adult Advanced Life Support Always Present                        | <i>Clinicians Certified in Adult Advanced Life Support Always Present</i>                 |
|  | Accreditation Standards         | Use of a Safe Surgery Checklist   | <i>Use of a Safe Surgery Checklist</i>  |
|  | CMS ASCQR Measures              | ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy | <i>Rate of Unplanned Hospital Visits within 7 days of an Outpatient Colonoscopy</i>       |
|  | CMS ASCQR Measures              | ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures            | <i>Rate of Unplanned Hospital Visits within 7 Days of an Orthopedic Surgery at an ASC</i> |

**ASC Public Reporting Program**

**Scoring Algorithms**

|  |                    |  |   |
|--|--------------------|--|---|
|  | CMS ASCQR Measures | ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures  | <i>Rate of Unplanned Hospital Visits Within 7 Days of a Urology Surgery at an ASC</i>                           |
|  | CMS ASCQR Measures | ASC-19: Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers | <i>Rate of Unplanned Hospital Visits Within 7 Days of General Surgery at an ASC</i>                             |
|  | CMS ASCQR Measures | ASC-14: Unplanned Anterior Vitrectomy  | <i>Percentage of Cataract Surgery Patients Who Had a Unplanned Additional Eye Surgery (Anterior Vitrectomy)</i> |
|  | CMS ASCQR Measures | ASC-4: All Cause Transfer/Admission  | <i>Percentage of Patients Who Are Transferred or Admitted to a Hospital Upon Discharge from the ASC</i>         |
|  | CMS ASCQR Measures | Patient Experience (OAS CAHPS)   | <i>Experience of Patients Undergoing Elective Outpatient Surgery</i>  |

\*Note: These data are not scored but are displayed on Leapfrog's public reporting website for facilities that submit this section of the Leapfrog ASC Survey 2.0.

## Change Summary Since Release

This section will be updated if changes are made to scoring after this document's initial release on April 1, 2026.

**April 29, 2025:** Leapfrog updated the scoring algorithms for the CMS measures to remove the "Declined to Report" category. ASCs without data in the CMS Provider Data Catalog for the applicable measures will be publicly reported as "Not Available."

# CMS ASCQR MEASURES

## Outcome Measures

All ASCs that report to CMS and have data publicly available for at least one of the ASC 1-4 measures during the 01/01/2024-12/31/2024 reporting period (the most current reporting period available from CMS on April 1, 2026) will be eligible to have their data scored and publicly reported.

Facilities are scored based on their performance on nine outcome measures collected and published by the Centers for Medicare and Medicaid Services (CMS):

- ASC-1: Patient Burn,
- ASC-2: Patient Fall,
- ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant,
- ASC-4: All Cause Transfer/Admission,
- ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy,
- ASC-14: Unplanned Anterior Vitrectomy,
- ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures,
- ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures, and
- ASC-19: Facility-Level-7-Day Hospital Visits after General Surgery Procedures at Ambulatory Surgical Centers.

Leapfrog will download the CMS data from the [CMS provider data catalog](#) on the dates indicated in the public reporting schedule above for ASC measures 1-4,12,14,17-19.

The scoring algorithms used for each of the CMS measures listed above are described in detail in pages 12 to 20.

**ASC-1: Patient Burn**

ASCs' performance is based on scores [published by CMS](#) on April 1, 2026, for this measure. This scoring algorithm will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

| Patient Burn Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>                 | The facility did not have any patients that experienced a burn prior to discharge.                                       |
| <b>Considerable Achievement</b>              | The facility reported data for this measure to CMS.  |
| <b>Unable to Calculate Score</b>             | The number of cases is too few to report (CMS footnote 1).   |
| <b>Does Not Apply</b>                        | The facility is a pediatric facility.  |
| <b>Not Available</b>                         | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5). |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-2: Patient Fall**

ASCs' performance is based on scores [published by CMS](#) on April 1, 2026, for this measure. This scoring algorithm will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

| Patient Fall Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>                 | The facility did not have any patients that experienced a fall prior to discharge.                                       |
| <b>Considerable Achievement</b>              | The facility reported data for this measure to CMS.  |
| <b>Unable to Calculate Score</b>             | The number of cases is too few to report (CMS footnote 1).   |
| <b>Does Not Apply</b>                        | The facility is a pediatric facility.  |
| <b>Not Available</b>                         | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5). |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant**

ASCs' performance is based on scores [published by CMS](#) on April 1, 2026, for this measure. This scoring algorithm will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

| Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>   | The facility did not have any patients that experienced a wrong site, side, patient, procedure, or implant prior to discharge. |
| <b>Considerable Achievement</b>  | The facility reported data for this measure to CMS.  |
| <b>Unable to Calculate Score</b>   | The number of cases is too few to report (CMS footnote 1).   |
| <b>Does Not Apply</b>  | The facility is a pediatric facility.  |
| <b>Not Available</b>   | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).       |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-4:** All Cause Transfer/Admission

ASCs’ performance is compared to top quartile based on the distribution of ASC performance among all ASCs with scores [published by CMS](#) on April 1, 2026, for this measure. These cut-points will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|                                   | 2026 Cut-points for All Cause Transfer/Admission |
|-----------------------------------|--|
| <b>Minimum</b>                    | 0  |
| <b>Top quartile</b>               | 0.28   |
| <b>99<sup>th</sup> Percentile</b> | 0.75   |

| All Cause Transfer/Admission Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>                                 | The facility is in the top quartile of performance.  |
| <b>Considerable Achievement</b>                              | The facility is not in the top quartile of performance.  |
| <b>Unable to Calculate Score</b>                             | The number of cases is too few to report (CMS footnote 1).   |
| <b>Does Not Apply</b>  | The facility is a pediatric facility.  |
| <b>Not Available</b>   | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5). |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-12:** Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (per 1,000 colonoscopies)

ASCs' performance is compared to quartiles based on the distribution of rates among all ASCs and hospitals with scores [published by CMS](#) on April 1, 2026, for this measure. These cut-points will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|                 | 2026 Cut-points for Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy |
|-----------------|---|
| Minimum         | 7.3   |
| Top quartile    | 10.1  |
| Second quartile | 12.4  |
| Third quartile  | 13.1  |
| Maximum         | 17.0  |

| Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Score (Performance Category) | Meaning that...  |
|--|--|
| Achieved the Standard  | The facility is in the top quartile of performance (where lower scores are better).  |
| Considerable Achievement   | The facility is in the second quartile of performance.   |
| Some Achievement   | The facility is in the third quartile of performance.  |
| Limited Achievement  | The facility is in the bottom quartile of performance.   |
| Does Not Apply   | The facility is a pediatric facility or the facility did not have any cases that met the criteria for this measure (CMS footnote 7). |
| Unable to Calculate Score  | The number of cases is too few to report (CMS footnote 1).   |
| Not Available  | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).             |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-14: Unplanned Anterior Vitrectomy**

ASCs’ performance is compared to the mean based on all ASCs with scores [published by CMS](#) on April 1, 2026, for this measure. This cut-point will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|                                   | 2026 Cut-points for Unplanned Anterior Vitrectomy |
|-----------------------------------|---|
| <b>Minimum</b>                    | 0.0   |
| <b>50<sup>th</sup> Percentile</b> | 0.227   |
| <b>Maximum</b>                    | 9.5   |

| Unplanned Anterior Vitrectomy Score (Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>                               | The facility is at or below the 50 <sup>th</sup> percentile (where lower scores are better).   |
| <b>Considerable Achievement</b>                            | The facility has a score published by CMS but is above the 50 <sup>th</sup> percentile score (where lower scores are better).        |
| <b>Does Not Apply</b>                                      | The facility is a pediatric facility or the facility did not have any cases that met the criteria for this measure (CMS footnote 7). |
| <b>Unable to Calculate Score</b>                           | The number of cases is too few to report (CMS footnote 1).   |
| <b>Not Available</b>                                       | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).             |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-17:** Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures (per 100 procedures)

ASCs’ performance is compared to top quartile based on the distribution of ASC performance among all ASCs with scores [published by CMS](#) on April 1, 2026, for this measure. These cut-points will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|                     | 2026 Cut-points for Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures |
|---------------------|--|
| <b>Minimum</b>      | 1.2  |
| <b>Top quartile</b> | 2.3  |
| <b>Maximum</b>      | 4.3  |

| Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>   | The facility is in the top quartile of performance (where lower scores are better).  |
| <b>Considerable Achievement</b>  | The facility has a score published by CMS but is not in the top quartile of performance.   |
| <b>Does Not Apply</b>  | The facility is a pediatric facility or the facility did not have any cases that met the criteria for this measure (CMS footnote 7). |
| <b>Unable to Calculate Score</b>   | The number of cases is too few to report (CMS footnote 1).   |
| <b>Not Available</b>   | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).             |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-18:** Hospital Visits after Urology Ambulatory Surgical Center Procedures (per 100 procedures)

ASCs’ performance is compared to top quartile based on the distribution of ASC performance among all ASCs with scores [published by CMS](#) on April 1, 2026, for this measure. These cut-points will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|                     | 2026 Cut-points for Hospital Visits after Urology Ambulatory Surgical Center Procedures |
|---------------------|---|
| <b>Minimum</b>      | 3.1   |
| <b>Top quartile</b> | 4.8   |
| <b>Maximum</b>      | 9.2   |

| Hospital Visits after Urology Ambulatory Surgical Center Procedures Score<br>(Performance Category) | Meaning that...  |
|---|--|
| <b>Achieved the Standard</b>  | The facility is in the top quartile of performance (where lower scores are better).  |
| <b>Considerable Achievement</b>   | The facility has a score published by CMS but is not in the top quartile of performance.   |
| <b>Does Not Apply</b>   | The facility is a pediatric facility or the facility did not have any cases that met the criteria for this measure (CMS footnote 7). |
| <b>Unable to Calculate Score</b>  | The number of cases is too few to report (CMS footnote 1).   |
| <b>Not Available</b>  | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).             |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

**ASC-19:** Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers (per 100 procedures)

ASCs' performance is compared to top quartile based on the distribution of ASC performance among all ASCs with scores [published by CMS](#) on April 1, 2026, for this measure. These cut-points will remain in place for the entire 2026 program cycle, unless it is determined that there are compelling reasons to make revisions.

|              | 2026 Cut-points for Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers |
|--------------|--|
| Minimum      | 0.6  |
| Top quartile | 0.9  |
| Maximum      | 2.0  |

| Facility-Level-7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers Score (Performance Category) | Meaning that...  |
|---|--|
| <b>Achieved the Standard</b>  | The facility is in the top quartile of performance (where lower scores are better).  |
| <b>Considerable Achievement</b>   | The facility has a score published by CMS but is not in the top quartile of performance.   |
| <b>Does Not Apply</b>   | The facility is a pediatric facility or the facility did not have any cases that met the criteria for this measure (CMS footnote 7). |
| <b>Unable to Calculate Score</b>  | The number of cases is too few to report (CMS footnote 1).   |
| <b>Not Available</b>  | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).             |

Note: See [Appendix I](#) for explanation of CMS footnotes that may be displayed

## Patient Experience (OAS CAHPS)

Facilities are scored based on Top Box Scores from four domains included in the Outpatient and Ambulatory Surgery (OAS) CAHPS Survey:

- Facilities and Staff
- Communication About Your Procedure
- Patients' Rating of the Facility
- Patients Recommending the Facility

Facilities are scored based on the number of domains where the facility is performing in the top quartile. The top quartiles will be calculated using results published by CMS for both Ambulatory Surgery Centers (ASCs) and hospitals on June 30, 2026. The scoring algorithm will be re-posted with an announcement once the cut points become available.

| Top Quartile for OAS CAHPS Domains (Quartiles) | Facilities and Staff (%) | Communication About Your Procedure (%) | Patients' Rating of the Facility (%) | Patients Recommending the Facility (%) |
|--|--------------------------|--|--------------------------------------|--|
| <b>Top Quartile (&gt;= Q3)</b>                 | TBD                      | TBD                                    | TBD                                  | TBD                                    |

| Patient Experience (OAS CAHPS) Score (Performance Category) | Meaning that the facility...   |
|---|--|
| <b>Achieved the Standard</b>                                | Scored in top quartile of facilities on <b>4 out of 4</b> OAS CAHPS domains.   |
| <b>Considerable Achievement</b>                             | Scored in top quartile of facilities on <b>3 out of 4</b> OAS CAHPS domains.   |
| <b>Some Achievement</b>                                     | Scored in top quartile of facilities on <b>2 out of 4</b> OAS CAHPS domains.   |
| <b>Limited Achievement</b>                                  | Scored in top quartile of facilities on <b>1 or fewer</b> OAS CAHPS domains.   |
| <b>Unable to Calculate Score</b>                            | The facility did not meet the minimum reporting requirements for the measure (<100 returned OAS CAHPS Surveys) or had too few cases/patients to report (CMS footnote 1, 6, or 10). |
| <b>Does Not Apply</b>                                       | The facility is a pediatric facility.  |
| <b>Not Available</b>  | The facility is not included in the CMS dataset or results are not available for this reporting period (CMS footnote 5).   |

Note: Data for the OAS CAHPS measures will be downloaded from the CMS provider catalog at <https://data.cms.gov/provider-data/dataset/48nr-hqxx>.

See [Appendix I](#) for explanation of CMS footnotes that may be displayed.

# ACCREDITATION STANDARDS

ASCs with active accreditation through the Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission’s (JC) accreditation programs are scored and publicly reported as Achieved the Standard (best score) for five (5) measures that were formerly collected via the Leapfrog ASC Survey and currently collected on the Leapfrog Hospital Survey:

- Clinicians Certified in Adult Advanced Life Support Always Present
- Use of a Safe Surgery Checklist
- Medication and Allergy Documentation
- Effective Leadership to Prevent Errors
- Identification and Mitigation of Risks and Hazards

ASCs are required to upload proof on AAACH or JC’s accreditation on the ASC Dashboard. Visitors to our [website](#) will be able to see achievement of these important patient safety standards that ASCs have earned through their rigorous accreditation process.

| Accreditation Standards<br>(Performance Category) | Meaning that...  |
|---|--|
| <b>Achieved the Standard</b>                      | The facility has uploaded proof of AAAHC or JC accreditation via Leapfrog’s ASC Dashboard and the documentation was reviewed and accepted. |
| <b>Not Available</b>                              | The facility has not uploaded proof of AAAHC or JC accreditation or the facility is accredited by another organization.                    |
| <b>Pending Leapfrog Verification</b>              | The facility’s documentation is undergoing Leapfrog’s standard verification process.   |

ASCs that do not upload proof of accreditation and ASCs that are accredited by another organization will be reported as “Not Available” for the five measures.

# LEAPFROG ASC SURVEY 2.0 MEASURES

## Summary of Scoring Changes to Leapfrog ASC Survey 2.0 Measures

- **Section 2A Billing Ethics**
  - Leapfrog has updated the response option in question #5, asking if facilities take legal action against patients for late or insufficient payments to include state laws similar to Military Treatment Facilities that require transferring unpaid medical bills to the Department of Treasury.
- **Section 3A NHSN Outpatient Procedure Component Module**
  - Leapfrog is no longer asking ASCs for the number of monthly SSI reporting plans they have in place in NHSN OPC for applicable procedures or to select the reporting period end date. Instead, Leapfrog standardized the reporting period and will score applicable ASCs based directly on their participation with NHSN and the SSI monthly reporting plans they entered within NHSN OPC.
- **Section 3B Hand Hygiene**
  - In question #3, Leapfrog removed the requirement that hand hygiene training include a topic concerning “when gloves should be used in addition to hand washing”. This element was removed because it is specific to bedside care, instead of typical outpatient procedures.
  - Questions #4, #6, and #7, concerning audits of dispensers and audits of the volume of hand sanitizer, were removed. Many ASCs do not have enough dispensers for regular statistically sampled audits to be necessary.
- **Section 3C Culture of Safety**
  - Three questions were removed from this section so each practice element is now worth more points when scoring this measure.
- **Section 4B Facility Volume for Select Procedures (Optional)**
  - Leapfrog no longer requires ASCs to report on their facility volume of procedures. Instead, this section is optional, and ASCs will be able to submit responses to the Leapfrog ASC Measures of the ASC Survey 2.0 without using the CPT Code Workbook to track the volumes of procedures performed in CY2026.

## Section 1 Basic Facility Information

This section will not be scored in 2026. However, some responses will be shown on Leapfrog's public reporting [website](#). For example, Leapfrog will display the number of operating and/or procedure rooms.

## Section 2 Patient Rights and Ethics

### 2A: Billing Ethics

Facilities are scored on four aspects of their billing practices, including whether they provide payer-specific negotiated charges or cash prices on their website, the quality and timeliness of the billing statement or master itemized bill, the availability of a billing representative to negotiate a patient’s bill within 10 business days, and whether or not the facility takes legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service or is required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action.

| Billing Ethics Score<br>(Performance Category) | Meaning that...   |
|--|---|
| <p><b>Achieved the Standard</b></p>            | <ul style="list-style-type: none"> <li>• The facility provides <b>either</b> payer-specific negotiated charges or cash prices on their website for commonly performed procedures,</li> <li>• Provides <b>every</b> patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3,</li> <li>• Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #4 within 10 business days, <b>and</b></li> <li>• Does <b>not</b> take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical services or the ASC does <b>not</b> take legal action against patients, but is required by state law to transfer delinquent payments to a state agency (e.g., Department of Treasury, Attorney General, etc.) for action.</li> </ul> <p>OR (applies to Military Treatment Facilities only)</p> <ul style="list-style-type: none"> <li>• The facility provides Department of Defense medical and dental reimbursement rates on their website for commonly performed procedures,</li> <li>• Provides <b>every</b> patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3,</li> <li>• Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #4 within 10 business days, <b>and</b></li> <li>• Does <b>not</b> take legal action against patients but is required by federal law to transfer delinquent payments to a federal agency (e.g., Department of Treasury, Attorney General, etc.) for action.</li> </ul> |

| Billing Ethics Score<br>(Performance Category)       | Meaning that...  |
|--|--|
| <p><b>Considerable Achievement</b></p>               | <ul style="list-style-type: none"> <li>• The facility does <b>not</b> provide either payer-specific negotiated charges or cash prices or Department of Defense medical and dental reimbursement rates on their website for commonly performed procedures, <b>but</b></li> <li>• Provides <b>every</b> patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3,</li> <li>• Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #4 within 10 business days, and</li> <li>• Does <b>not</b> take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service or the facility does <b>not</b> take legal action against patients but is required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action.</li> </ul>    |
| <p><b>Considerable Achievement (Alternative)</b></p> | <ul style="list-style-type: none"> <li>• The facility provides <b>either</b> payer-specific negotiated charges or cash Prices or Department of Defense medical and dental reimbursement rates on their website for commonly performed procedures,</li> <li>• <b>Upon request</b>, provides patients with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3,</li> <li>• Gives patients instructions for contacting a billing representative who has access to an interpretation service and has the authority to do all three required elements in question #4 within 10 business days, <b>and</b></li> <li>• Does <b>not</b> take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service or the facility does <b>not</b> take legal action against patients but is required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action.</li> </ul>       |
| <p><b>Some Achievement</b></p>                       | <ul style="list-style-type: none"> <li>• The facility does <b>not</b> provide either payer-specific negotiated charges or cash prices or Department of Defense medical and dental reimbursement rates on their website for commonly performed procedures,</li> <li>• <b>Upon request</b>, provides patients with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3,</li> <li>• Gives patients instructions for contacting a billing representative who has access to interpretation services and has the authority to do all three required elements in question #4 within 10 business days, <b>and</b></li> <li>• Does <b>not</b> take legal action against patients for late or insufficient payment of a medical bill in cases where the facility did not have a written agreement in place specifying a good faith estimate for a medical service or the facility does <b>not</b> take legal action against patients but is required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action.</li> </ul> |
| <p><b>Limited Achievement</b></p>                    | <p>The facility responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.</p>  |

|                                      |   |
|--------------------------------------|---|
| <b>Declined to Report</b>            | The facility did not submit a Survey.   |
| <b>Pending Leapfrog Verification</b> | The facility's responses are undergoing Leapfrog's standard verification process. |

## 2B: Health Care Equity

Facilities are scored on whether they meet the requirements for collecting patient self-reported demographic data, training staff responsible for collecting demographic data, stratifying at least one quality measure, and additional steps the facility takes once this data is collected and analyzed.

| Health Care Equity Score<br>(Performance Category) | Meaning that...   |
|--|---|
| <p><b>Achieved the Standard</b></p>                | <ul style="list-style-type: none"> <li>• The facility collects, at a minimum, patient self-identified <b>race, ethnicity, and preferred written or spoken language</b> data as described in question #1,</li> <li>• Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2,</li> <li>• Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3,</li> <li>• And has done at least <b>two</b> of the three remaining elements:                             <ul style="list-style-type: none"> <li>○ Has updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5 (if disparities were identified in question #4), OR</li> <li>○ Shares information about efforts to identify and reduce health care disparities on its public website as described in question #6, OR</li> <li>○ Reports out and discusses efforts to identify and address health care disparities with the facility’s leadership and governance as described in question #7.</li> </ul> </li> </ul> <p><i>Question #5 is not used in scoring for facilities that responded “No, disparities were not identified” or “Inadequate data available to determine if disparities exist” to question #4.</i></p> |
| <p><b>Considerable Achievement</b></p>             | <ul style="list-style-type: none"> <li>• The facility collects, at a minimum, patient self-identified <b>race, ethnicity, and preferred written or spoken language</b> data as described in question #1,</li> <li>• Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2,</li> <li>• Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3,</li> <li>• And has done <b>one</b> of the three remaining elements:                             <ul style="list-style-type: none"> <li>○ Has updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5 (if disparities were identified in question #4), OR</li> <li>○ Shares information about efforts to identify and reduce health care disparities on its public website as described in question #6, OR</li> <li>○ Reports out and discusses efforts to identify and address health care disparities with the facility’s leadership and governance as described in question #7.</li> </ul> </li> </ul> <p><i>Question #5 is not used in scoring for facilities that responded “No, disparities were not identified” or “Inadequate data available to determine if disparities exist” to question #4.</i></p>          |

| <b>Health Care Equity Score</b><br>(Performance Category) | <b>Meaning that...</b>   |
|---|--|
| <b>Some Achievement</b>                                   | <ul style="list-style-type: none"> <li>• The facility collects, at a minimum, patient self-identified <b>race, ethnicity, and preferred written or spoken language</b> data as described in question #1,</li> <li>• Trains staff responsible for collecting the self-identified demographic data from patients as described in question #2,</li> <li>• Uses the patient self-identified demographic data to stratify at least one quality measure as described in question #3,</li> <li>• But has not yet done any of the remaining elements:                             <ul style="list-style-type: none"> <li>○ Updated or revised a policy or procedure to address the disparity or developed a written action plan as described in question #5 (if disparities were identified in question #4), OR</li> <li>○ Shared information about efforts to identify and reduce health care disparities on its public website as described in question #6, OR</li> <li>○ Reported out and discusses efforts to identify and address health care disparities with the facility’s leadership and governance as described in question #7.</li> </ul> </li> </ul> <p><i>Question #5 is not used in scoring for facilities that responded “No, disparities were not identified” or “Inadequate data available to determine if disparities exist” to question #4.</i></p> |
| <b>Limited Achievement</b>                                | The facility responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.   |
| <b>Declined to Report</b>                                 | The facility did not submit a Survey.  |
| <b>Pending Leapfrog Verification</b>                      | The facility’s responses are undergoing Leapfrog’s standard verification process.  |

## 2C: Informed Consent

Facilities are scored on whether they meet the requirements for their informed consent training, the content of their informed consent forms, and their processes for gaining informed consent for all procedures where general and regional anesthesia are used, or where monitored anesthesia care is administered.

| Informed Consent Score<br>(Performance Category) | Meaning that...  |
|--|--|
| Achieved the Standard                            | <ul style="list-style-type: none"> <li>• The facility responded “yes, <b>all</b> applicable forms are written at a 6<sup>th</sup> grade reading level or lower” to question #4, <b>and</b></li> <li>• The facility responded “yes” to the remaining <b>five</b> questions in                             <ul style="list-style-type: none"> <li>○ Training on Informed Consent (question #1),</li> <li>○ Content of Informed Consent Forms (questions #2-3), and</li> <li>○ Process for Gaining Informed Consent (questions #5-6).</li> </ul> </li> </ul>  |
| Considerable Achievement                         | <ul style="list-style-type: none"> <li>• The facility responded “yes, <b>all</b> applicable forms are written at a 6<sup>th</sup> grade reading level or lower” to question #4 <b>and</b></li> <li>• The facility responded “yes” to at least <b>four</b> additional questions in                             <ul style="list-style-type: none"> <li>○ Training on Informed Consent (question #1),</li> <li>○ Content of Informed Consent Forms (questions #2-3), and</li> <li>○ Process for Gaining Informed Consent (questions #5-6).</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• The facility responded that “no, but at least <b>one</b> form is written at a 6<sup>th</sup> grade reading level or lower” <b>OR</b> “no, all applicable forms are written at a 9<sup>th</sup> grade reading level or lower” to question #4 <b>and</b></li> <li>• The facility responded “yes” to the <b>five remaining</b> questions in                             <ul style="list-style-type: none"> <li>○ Training on Informed Consent (question #1),</li> <li>○ Content of Informed Consent Forms (questions #2-3), and</li> <li>○ Process for Gaining Informed Consent (questions #5-6).</li> </ul> </li> </ul>   |
| Some Achievement                                 | <ul style="list-style-type: none"> <li>• The facility responded “yes, <b>all</b> applicable forms are written at a 6<sup>th</sup> grade reading level or lower” <b>OR</b> “no, but at least <b>one</b> form is written at a 6<sup>th</sup> grade reading level or lower” <b>OR</b> “no, all applicable forms are written at a 9<sup>th</sup> grade reading level or lower” to question #4 <b>and</b></li> <li>• The facility responded “yes” to at least <b>three</b> additional questions in                             <ul style="list-style-type: none"> <li>○ Training on Informed Consent (question #1),</li> <li>○ Content of Informed Consent Forms (questions #2-3), and</li> <li>○ Process for Gaining Informed Consent (questions #5-6).</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• The facility responded “no forms are written at a 6<sup>th</sup> grade reading level or lower” to question #4 <b>and</b></li> <li>• The facility responded “yes” to <b>at least four</b> additional questions in                             <ul style="list-style-type: none"> <li>○ Training on Informed Consent (question #1),</li> <li>○ Content of Informed Consent Forms (questions #2-3), and</li> <li>○ Process for Gaining Informed Consent (questions #5-6).</li> </ul> </li> </ul> |
| Limited Achievement                              | <p>The facility responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.</p>  |
| Declined to Report                               | <p>The facility did not submit a Survey.</p>   |
| Pending Leapfrog Verification                    | <p>The facility’s responses are undergoing Leapfrog’s standard verification process.</p>   |

## 2D: Taking Responsibility for Never Events

Facilities are scored based on their adoption of the nine principles of The Leapfrog Group’s Never Events Policy.

| Taking Responsibility for Never Events Score<br>(Performance Category) | Meaning that...  |
|--|--|
| <b>Achieved the Standard</b>   | The facility has implemented a policy that adheres to <b><u>all nine principles</u></b> of The Leapfrog Group’s Never Events Policy.   |
| <b>Considerable Achievement</b>  | The facility has implemented a policy that adheres to all the <b><u>original five principles</u></b> * of The Leapfrog Group’s Never Events Policy, as well as <b>at least two additional principles</b> . |
| <b>Some Achievement</b>  | The facility has implemented a policy that adheres to all the <b><u>original five principles</u></b> * of The Leapfrog Group’s Never Events Policy.  |
| <b>Limited Achievement</b>   | The facility responded to all questions in this section, but it does not yet meet the criteria for Some Achievement.   |
| <b>Declined to Report</b>  | The facility did not submit a Survey.  |
| <b>Pending Leapfrog Verification</b>                                   | The facility’s responses are undergoing Leapfrog’s standard verification process.  |

\*The Leapfrog Group’s original five principles include: apologizing to the patient, performing a root cause analysis, reporting to an external agency within 15 days, waiving all associated costs, and making a copy of the policy available to patients and payors upon request. More information is available at <https://ratings.leapfroggroup.org/measure/asc/2026/responding-never-events>.

## Section 3 Patient Safety Practices

### 3A: Infection Surveillance following Breast Surgeries, Laminectomies, Herniorrhaphies, or Knee Prosthesis Procedures

Data from the NHSN Outpatient Procedure Component Module is downloaded by Leapfrog for all facilities who 1) [join Leapfrog’s NHSN Group for ASCs](#), 2) enter a valid NHSN ID in the ASC Profile, and 3) submit a 2026 Leapfrog ASC Survey.

Leapfrog downloads available data from NHSN for each facility for the following:

- 2025 Outpatient Procedure Component - Annual Facility Survey (available January 1, 2026)
- Breast Surgery (BRST) Procedure SSI Outcome Measure
- Herniorrhaphy (HER) Procedure SSI Outcome Measure
- Knee Prosthesis (KPRO) Procedure SSI Outcome Measure
- Laminectomy (LAM) Procedure SSI Outcome Measure

Facilities are scored based on their enrollment in the NHSN OPC Module and having 1) completed the 2025 OPC Annual Facility Survey, 2) had a Monthly Reporting Plan in place for all applicable Surgical Site Infection Measures, as follows:

| Infection Surveillance following Breast Surgeries, Laminectomies, Herniorrhaphies, or Knee Prosthesis Procedures Score (Performance Category) | Meaning that...   |
|---|---|
| <b>Achieved the Standard</b>  | Facility is enrolled in the NHSN OPC Module, completed the 2025 OPC Annual Facility Survey, and has a Monthly Reporting Plan in place for each month of the reporting period (12 months) for all applicable Surgical Site Infection Measures.                                     |
| <b>Considerable Achievement</b>   | Facility is enrolled in the NHSN OPC Module, completed the 2025 OPC Annual Facility Survey, and has a Monthly Reporting Plan in place for 6 to 11 months of the reporting period for all applicable Surgical Site Infection Measures.   |
| <b>Some Achievement</b>   | Facility is enrolled in the NHSN OPC Module, completed the 2025 OPC Annual Facility Survey, and has a Monthly Reporting Plan in place for less than 6 months for all applicable Surgical Site Infection Measures.   |
| <b>Limited Achievement</b>  | Facility has not enrolled in the NHSN OPC Module, has not completed the 2025 OPC Annual Facility Survey, has not had a Monthly Reporting plan in place for applicable Surgical Site Infection Measures, has not joined Leapfrog’s NHSN Group, or did not provide a valid NHSN ID. |
| <b>Does Not Apply</b>   | The facility does not perform any breast surgeries, herniorrhaphies, knee replacements, or laminectomies.   |
| <b>Declined to Report</b>   | The facility did not submit a Survey.   |
| <b>Pending Leapfrog Verification</b>  | The facility’s responses are undergoing Leapfrog’s standard verification process.   |

### 3B: Hand Hygiene

Facilities are scored based on their performance in five domains of hand hygiene. To meet the requirements of each domain, the facility must respond in the affirmative to all applicable questions.

1. Monitoring: questions #5-8
  - a. Electronic: questions #9-10
  - b. Direct Observation: questions #11-12
2. Feedback\*: questions #13-16
3. Training and Education: questions #1-3
4. Infrastructure: question #4
5. Culture: questions #17-18

\*Facilities must respond “yes” to question #5, #6, or #7 in the Monitoring Domain to access the questions in the Feedback Domain.

| Hand Hygiene Score<br>(Performance Category) | Meaning that...   |
|--|---|
| <b>Achieved the Standard</b>                 | <p>The facility responded “yes” to <b>all</b> applicable questions in the Monitoring and Feedback Domains and meets the <b>monthly</b> sample size of <b>200</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 1 (measure specifications, Section 4 of the <a href="#">ASC Survey 2.0</a>), <b>each month</b> for monitoring hand hygiene opportunities:</p> <ul style="list-style-type: none"> <li>• <b>Monitoring Domain:</b> <ul style="list-style-type: none"> <li>○ Question #5:<br/>Facility collects hand hygiene compliance data on at least <b>200</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 1 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), <b>each month</b>.</li> <li>○ Question #8:<br/>Facility uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene.</li> <li>○ The facility responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #5):                             <ul style="list-style-type: none"> <li>▪ <i>Electronic Compliance Monitoring:</i> questions #9-10</li> <li>▪ <i>Direct Observation:</i> questions #11-12</li> </ul> </li> </ul> </li> <li>• <b>Feedback Domain:</b> questions #13-16</li> </ul> <p style="text-align: center;"><b><u>AND</u></b></p> <p>The facility responded “yes” to <b>all</b> questions in any <b>two</b> of the following domains:</p> <ul style="list-style-type: none"> <li>• <b>Training and Education Domain:</b> questions #1-3</li> <li>• <b>Infrastructure Domain:</b> question #4</li> <li>• <b>Culture Domain:</b> questions #17-18</li> </ul> |
| <b>Achieved the Standard (Alternative)</b>   | <p>Facilities that collect hand hygiene compliance data on a <b>monthly</b> sample size of <b>100</b> hand hygiene opportunities per <b>month</b>, or at least the number of hand hygiene opportunities outlined in Table 2 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), can Achieve the Standard if they meet the following:</p>  |

| Hand Hygiene Score<br>(Performance Category)                       | Meaning that...   |
|--|---|
|  | <ul style="list-style-type: none"> <li>• <b>Monitoring Domain:</b> <ul style="list-style-type: none"> <li>○ Question #6<br/>Facility collects hand hygiene compliance data on at least <b>100</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), <b>each month</b>.</li> <li>○ Question #8:<br/>Facility uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene.</li> <li>○ The facility responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #6):                             <ul style="list-style-type: none"> <li>▪ <i>Electronic Compliance Monitoring:</i> questions #9-10</li> <li>▪ <i>Direct Observation:</i> questions #11-12</li> </ul> </li> </ul> </li> </ul> <p style="text-align: center;"><b><u>AND</u></b></p> <p>The facility responded “yes” to <b>all</b> questions in the other four domains:</p> <ul style="list-style-type: none"> <li>• <b>Feedback Domain:</b> questions #13-16</li> <li>• <b>Training and Education Domain:</b> questions #1-3</li> <li>• <b>Infrastructure Domain:</b> question #4</li> <li>• <b>Culture Domain:</b> questions #17-18</li> </ul>   |
| <p style="text-align: center;"><b>Considerable Achievement</b></p> | <p>The facility responded “yes” to <b>all</b> applicable questions in the Monitoring and Feedback Domains and meets the <b>monthly or quarterly</b> sample size of <b>100</b> for monitoring hand hygiene opportunities:</p> <ul style="list-style-type: none"> <li>• <b>Monitoring Domain:</b> <ul style="list-style-type: none"> <li>○ Question #6 or #7:                             <ul style="list-style-type: none"> <li>▪ Facility collects hand hygiene compliance data on at least <b>100</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), <b>each month</b>.</li> <li>▪ Facility collects hand hygiene compliance data on at least <b>100</b> hand hygiene opportunities <b>each quarter</b>.</li> </ul> </li> <li>○ Question #8:<br/>Facility uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene.</li> <li>○ The facility responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #6 or #7):                             <ul style="list-style-type: none"> <li>▪ <i>Electronic Compliance Monitoring:</i> questions #9-10</li> <li>▪ <i>Direct Observation:</i> questions #11-12</li> </ul> </li> </ul> </li> <li>• <b>Feedback Domain:</b> questions #13-16</li> </ul> <p style="text-align: center;"><b><u>AND</u></b></p> <p>The facility responded “yes” to <b>all</b> questions in any <b>two</b> of the following domains:</p> |

|                                |   |
|--------------------------------|---|
|                                | <ul style="list-style-type: none"> <li>• <b>Training and Education Domain:</b> questions #1-3</li> <li>• <b>Infrastructure Domain:</b> question #4</li> <li>• <b>Culture Domain:</b> questions #17-18</li> </ul>  |
| <p><b>Some Achievement</b></p> | <p>The facility responded “yes” to all applicable questions in any two of the following domains:</p> <ul style="list-style-type: none"> <li>• <b>Monitoring Domain:</b> <ul style="list-style-type: none"> <li>○ Question #5, #6, or #7:                             <ul style="list-style-type: none"> <li>▪ Facility collects hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 1 (measure specifications, Section 3B of the ASC Survey), each month.</li> <li>▪ Facility collects hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2 (measure specifications, Section 3B of the ASC Survey), each month.</li> <li>▪ Facility collects hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter.</li> </ul> </li> <li>○ Question #8:                             <p>Facility uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene.</p> </li> <li>○ The facility responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #5, #6, or #7):                             <ul style="list-style-type: none"> <li>▪ Electronic Compliance Monitoring: questions #9-10</li> <li>▪ Direct Observation: questions #11-12</li> </ul> </li> </ul> </li> <li>• <b>Feedback Domain:</b> questions #13-16</li> <li>• <b>Training and Education Domain:</b> questions #1-3</li> <li>• <b>Infrastructure Domain:</b> question #4</li> <li>• <b>Culture Domain:</b> questions #17-18</li> </ul> |

|   |   |
|---|---|
| <p style="text-align: center;"><b>Limited Achievement</b></p>           | <p>The facility responded “yes” to <b>all</b> applicable questions in any <b>one</b> of the following domains:</p> <ul style="list-style-type: none"> <li>• <b>Monitoring Domain:</b> <ul style="list-style-type: none"> <li>○ Question #5, #6, or #7:                             <ul style="list-style-type: none"> <li>▪ Facility collects hand hygiene compliance data on at least <b>200</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 1 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), <b>each month</b>.</li> <li>▪ Facility collects hand hygiene compliance data on at least <b>100</b> hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on Table 2 (measure specifications, Section 3B of the <a href="#">ASC Survey 2.0</a>), each <b>month</b>.</li> <li>▪ Facility collects hand hygiene compliance data on at least <b>100</b> hand hygiene opportunities <b>each quarter</b>.</li> </ul> </li> <li>○ Question #8:                             <p>Facility uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene.</p> </li> <li>○ The facility responded “yes” to all questions pertaining to the monitoring method used (as indicated in question #5, #6, or #7):                             <ul style="list-style-type: none"> <li>▪ <i>Electronic Compliance Monitoring:</i> questions #9-10</li> <li>▪ <i>Direct Observation:</i> questions #11-12</li> </ul> </li> </ul> </li> <li>• <b>Feedback Domain:</b> questions #13-16</li> <li>• <b>Training and Education Domain:</b> questions #1-3</li> <li>• <b>Infrastructure Domain:</b> question #4</li> <li>• <b>Culture Domain:</b> questions #17-18</li> </ul> <p style="text-align: center;"><b><u>OR</u></b></p> <p style="text-align: center;">The facility met <b>0</b> domains.</p> |
| <p style="text-align: center;"><b>Declined to Report</b></p>            | <p style="text-align: center;">The facility did not submit a Survey.</p>  |
| <p style="text-align: center;"><b>Pending Leapfrog Verification</b></p> | <p style="text-align: center;">The facility’s responses are undergoing Leapfrog’s standard verification process.</p>  |

### 3C: Culture of Safety

Facilities are scored based on their progress in implementing elements of the National Quality Forum’s (NQF) Safe Practice #2 – Culture Measurement, Feedback, and Intervention.

| NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention Score (Performance Category) | Meaning that the facility earned...   |
|---|---|
| Achieved the Standard   | 100% of Points  |
| Considerable Achievement  | 80% to 99% of Points  |
| Some Achievement  | 50% to 79% of Points  |
| Limited Achievement   | 0% to 49% of Points   |
| Does Not Apply  | The facility had too few employees (<20).   |
| Declined to Report  | The facility did not submit a Survey.   |
| Pending Leapfrog Verification   | The facility’s responses are undergoing Leapfrog’s standard verification process. |

Scoring details are described below.

1. **Maximum Points:** NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention has a maximum number of points of 120.
1. **Point Values per Safe Practice Element:** Each question has an equal point value, computed as the Maximum Points for this NQF Safe Practice divided by the number of elements within this NQF Safe Practice (n=6).
2. **Points Earned:** Total points earned for this NQF Safe Practice is the sum of the elements for which the facility responded “yes” for this NQF Safe Practice.
3. **Performance Category Cut Points** are based on a percentage of the Maximum Points achievable for this NQF Safe Practice. The distribution of scores, including new or updated Survey Results, will be reviewed periodically to determine if there are compelling reasons to revise these performance category cut points further. However, there are no current plans or commitments to change the cut-points during the 2026 Survey Cycle.
4. **Updated Submissions:** Facilities may update and resubmit their Surveys as often as needed to reflect actual progress achieved or additional commitments undertaken in these patient safety areas up until **November 30**. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

## Section 4: Volume of Procedures

### 4A: National Volume Standards for Total Knee Replacement, Total Hip Replacement, and Bariatric Surgery for Weight Loss

Facilities are scored on whether they met the minimum facility volume standards and whether the facility’s process for privileging its surgeons includes meeting or exceeding the minimum annual surgeon volume standards in the table below.

| Procedure                         | Facility Volume | Surgeon Volume |
|-----------------------------------|-----------------|----------------|
| Total knee replacement surgery    | 50              | 25             |
| Total hip replacement surgery     | 50              | 25             |
| Bariatric surgery for weight loss | 50              | 20             |

Performance categories are assigned for each procedure as follows:

| Facility and Surgeon Volume Score (Performance Category) | Meaning that for each of the procedures performed...  |
|--|---|
| <b>Achieved the Standard</b>                             | <ul style="list-style-type: none"> <li>The facility <b>met</b> the minimum facility volume standard for the procedure, <b>and</b></li> <li>The facility’s process for privileging surgeons <b>does</b> include meeting or exceeding the minimum annual surgeon volume standard.</li> </ul>          |
| <b>Considerable Achievement</b>                          | <ul style="list-style-type: none"> <li>The facility <b>met</b> the minimum facility volume standard for the procedure, <b>but</b></li> <li>The facility’s process for privileging surgeons <b>does not</b> include meeting or exceeding the minimum annual surgeon volume standard.</li> </ul>      |
| <b>Some Achievement</b>                                  | <ul style="list-style-type: none"> <li>The facility <b>did not</b> meet the minimum facility volume standard for the procedure, <b>but</b></li> <li>The facility’s process for privileging surgeons <b>does</b> include meeting or exceeding the minimum annual surgeon volume standard.</li> </ul> |
| <b>Limited Achievement</b>                               | <ul style="list-style-type: none"> <li>The facility <b>did not</b> meet the minimum facility volume standard for the procedure, <b>and</b></li> <li>The facility <b>does not</b> include the minimum annual surgeon volume standard in its privileging process.</li> </ul>                          |
| <b>Does Not Apply</b>                                    | The facility does not perform the procedure.  |
| <b>Declined to Report</b>                                | The facility did not submit a Survey.   |
| <b>Pending Leapfrog Verification</b>                     | The facility’s responses are undergoing Leapfrog’s standard verification process.   |

## **4B: Facility Volume for Select Procedures (Optional)**

Responses to the annual volume of each procedure performed are optional and not scored. However, if submitted, responses are publicly reported to inform purchasers and consumers about the facility's experience with the procedure.

**Appendix I: CMS Footnote Table**

See the table below for a list of CMS footnotes and definitions used in scoring and public reporting for the CMS ASCQR Measures ASC 1-4,12,14,17-19 and Patient Experience (OAS CAHPS).

*CMS Footnote Definitions*

| Footnote Number | CMS Definition  |
|-----------------|---|
| 1               | The number of cases/patients is too few to report.  |
| 3               | Results are based on a shorter time period than required.   |
| 5               | Results are not available for this reporting period because: <ul style="list-style-type: none"> <li>• The facility elected not to submit data for the entire reporting period; or</li> <li>• The facility had no claims data for a particular measure; or</li> <li>• The facility elected to suppress a measure from being publicly reported</li> </ul> |
| 6               | Fewer than 100 patients completed the CAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess facility performance.   |
| 7               | No cases met the criteria for this measure.   |
| 10              | Very few patients were eligible for the CAHPS survey. The scores shown reflect fewer than 50 complete surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess facility performance.  |

For more information about Leapfrog’s new ASC Public Reporting Program, please click [here](#).



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