Ambulatory Surgery Center Association

August 31, 2026

The Honorable Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1850-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Via online submission at www.regulations.gov**

**Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; etc.**

Dear Administrator Oz:

The Ambulatory Surgery Center Association (ASCA) submits these comments in response to the calendar year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule ("Proposed Rule") (91 Fed. Reg. 41734, July 7, 2026).

This administration has rightly prioritized reducing the cost of healthcare.[1] Medicare spending grew 7.8% to $1,118.0 billion in 2024, or 21% of total National Health Expenditures.[2] **ASCs that same year saved the Medicare program *5.1 billion* simply by existing as an alternative to hospitals.[3]** CMS should adopt policies that encourage migration of more procedures to the surgery center setting to generate even greater savings. Unfortunately, an unsustainable decline in reimbursement rates for most of the highest volume ASC procedures threatens the increased savings research projects.[4]

Most ASCs are small businesses and must run efficiently to remain viable and continue to provide savings for Medicare and needed care for its beneficiaries. As of June 2026, there are 6,640[5] Medicare-certified ASCs, and more than 50% of those have two or fewer operating rooms.[6] These facilities must purchase the same equipment, devices and implants as hospitals to perform surgery. Smaller ASCs often pay more for supplies since they lack the purchasing power of a hospital or a large health system.

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[1] https://www.whitehouse.gov/greathealthcare/
[2] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet
[3] *Medicare Savings from Use of Ambulatory Surgery Centers, 2019-2024* (https://www.ascassociation.org/asca/about-ascs/savings/medicare-savings-from-use-of-ambulatory-surgery-centers)
[4] *Id.*
[5] Provider of Services Current Files, available at https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-internet-quality-improvement-and-evaluation-system-home-health-agency-ambulatory-surgical-center-and-hospice-providers/data (Q2 2026 data).
[6] *Id.*

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ASCs compete with hospitals and other healthcare providers for the same surgeons, nurses and other staff. While new surgeons are being trained using robotics for many common procedures, these devices are often cost-prohibitive for ASCs. Anesthesia costs for ASCs continue to increase substantially due to many factors, including declining anesthesia reimbursement, provider shortages and the administrative and financial burden imposed by inconsistent payer compliance with the No Surprises Act's Independent Dispute Resolution process, including payment delays that persist even when anesthesia providers succeed in arbitration. The threat these challenges have to the economic viability of the ASC community cannot be overstated.

ASCs must comply with state and federal regulations[7] comparable to those required of hospital outpatient departments (HOPD), along with extensive Medicare quality reporting, yet under this proposed rule, the disparity in reimbursement between the two settings is slated to widen greatly. While ASCs are reimbursed this year on average 53% of the HOPD rate for our top one hundred procedures by volume, that percentage is slated to drop to an alarming 44% in 2027. This is unsustainable.

CMS has been receptive to ASCA proposals in the past and we welcome the chance to work with the agency on the payment policy proposals outlined in this letter that would encourage the migration of clinically appropriate services into the ASC setting. This, in turn, will provide the Medicare program and its beneficiaries with substantial savings while ensuring continued access to the high-quality care that surgery centers provide and beneficiaries deserve.

Specifically, we make the following requests:

- **Conversion Factor.** CMS must continue to use the hospital market basket as the annual update mechanism for ASC payments. Research shows that this alignment with the HOPD update factor has increased annual savings to the Medicare program, and projects even greater future savings.[8]

- **ASC Weight Scalar Adjustment**. CMS must discontinue the ASC weight scalar. When CMS aligned the ASC and HOPD update factors in 2019, it became even clearer that this secondary scaling adjustment must be eliminated to truly align the payment systems and motivate increased migration of surgery to the ASC setting.

## Annual Payment Update Policies

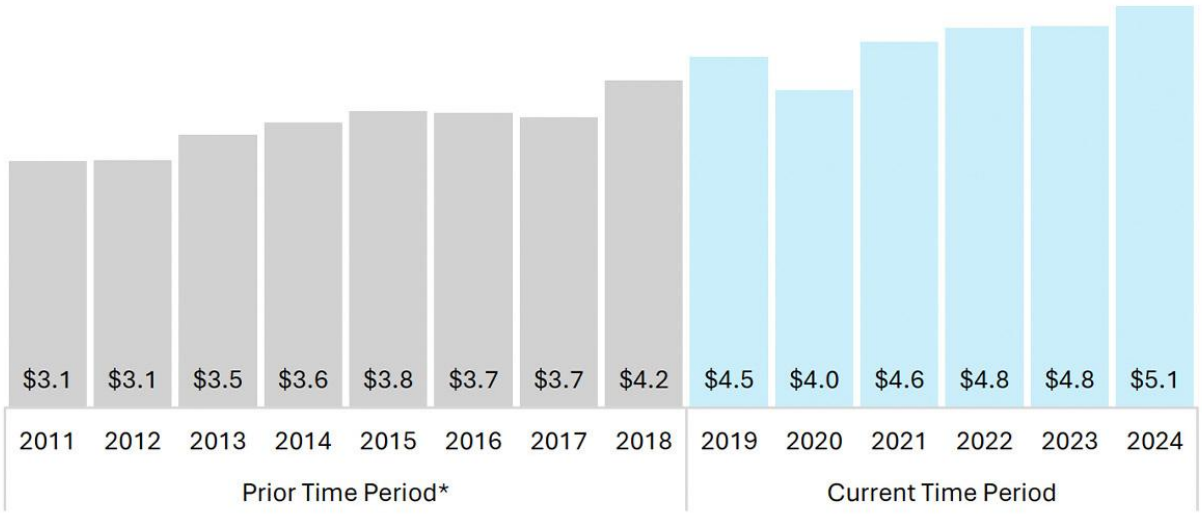
**ASCA supports CMS' continued use of the hospital market basket as the annual update mechanism for ASC payments.**

CMS aligned the ASC payment system to the OPPS in 2008 to encourage high-quality, efficient care in the most appropriate outpatient setting and align payment policies to eliminate payment incentives favoring one care setting over another.[9] However, siloed payment policies have led to increasingly disparate reimbursements. The ASC community has long urged CMS to adopt the

[7] https://www.ascassociation.org/asca/about-ascs/quality-and-safety/federal-requirements (Accessed August 2024)
[8] *Medicare Savings from Use of Ambulatory Surgery Centers, 2019-2024*
[9] CY 2007 OPPS/ASC Proposed Rule (https://www.cms.gov/newsroom/press-releases/cms-revises-payment-structure-ambulatory-surgical-centers-and-proposes-policy-and-payment-changes)

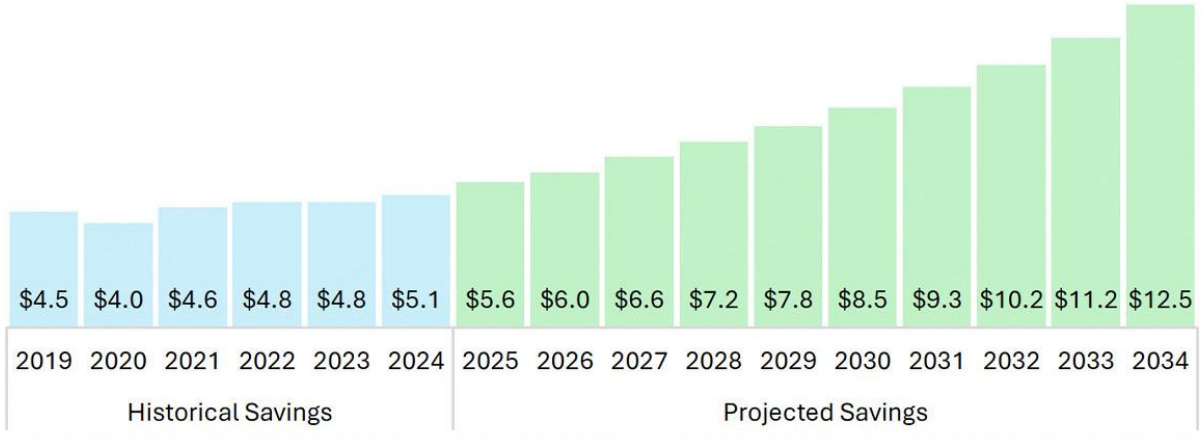
same update factor for both the ASC and OPPS payments, and we were gratified that the first Trump administration took this necessary step toward better alignment of the payment systems by piloting the use of the hospital market basket for ASCs beginning in 2019. Recent research indicates that this policy change has proved successful. Figure 1 below indicates an increase in savings over the initial five-year trial period, allowing for a slight dip in 2020 due to the COVID-19 pandemic which generally impacted elective surgery volume.

**Figure 1: Total Historical Savings in FFS (2011 – 2024), in billions**




Even more impressively, Figure 2 below demonstrates that projected annual savings have the potential to more than double over the next decade.

**Figure 2: Total Historical and Projected Cost Sharing Savings in FFS (2019 – 2034), in billions**




KNG Health states in their report discussing these findings that "CMS could permanently align the updated indices of ASCs to HOPDs to prevent further widening of reimbursement

differences."[10] We agree with KNG and contend that if the hospital market basket is deemed the appropriate update for HOPDs, it should be used for ASCs as well. ASCA is disappointed that CMS is only proposing to extend this policy for one more year. We appreciate feedback as to what additional evidence would be necessary to align the update factors indefinitely.

**ASCA implores CMS to discontinue the ASC weight scalar.**

While the alignment of update factors is a positive first step, the lack of alignment on other policies continues to exacerbate the difference between ASC and HOPD reimbursement rates. Currently, for the top 100 codes by volume, which represent 87% of Medicare fee-for-service ASC volume, ASCs are reimbursed 53% of what HOPDs are reimbursed. Alarmingly, in 2027, this ratio is projected to drop to 44%. There is no evidence of a growing difference in capital or operating costs in the two outpatient settings to support this growing payment differential. The positive impact of the conversion factor alignment is negated by the application of a secondary weight scalar to the ASC payment system. The savings that ASCs can generate for the Medicare program will be needlessly constrained until the secondary weight scalar is eliminated.

Since the payment systems were aligned, CMS has taken the relative weights in the OPPS, which have already been scaled, and then applied a secondary weight scalar, known as the ASC weight scalar, before arriving at the ASC payment weights. CMS' antiquated and reductive cost containment mechanisms, which maintain budget neutrality in silos for each payment system, penalize migration to a lower-cost setting because that shift ultimately leads to reductions in reimbursement rates for those providing the care.

In too many markets, surgeries that could be performed in less expensive surgery centers continue to be provided predominantly in hospitals, which we attribute to Medicare's refusal to pay rates to ASCs that would incentivize migration. Lack of alignment for the ASC (secondary) weight scalar threatens outpatient access to care and stifles the ability of our facilities to perform all the Medicare cases that potentially could be absorbed. This lack of migration comes at a high price to the Medicare program and the taxpayers who fund it.

As CMS tries to maintain the same level of spending year over year, only accounting for a small update for inflation, any increase in volume leads to stagnation or a decrease in reimbursement rates within the ASC silo. The consequences of this are particularly glaring in the proposed rule.

Of the top 100 codes by volume in the ASC setting, ***85*** are proposed to have their reimbursement decreased in 2027. This is due at least in part to the ASC weight scalar, which is by far the largest projected cut to ASC weights since the payment system was aligned with the OPPS in 2008. CMS stands to lose all positive momentum that has been accomplished with procedures shifting to ASCs if the agency fails to address the ASC weight scalar.

Under the 2008 statute that implemented the current ASC payment system, CMS was required to apply the budget neutrality adjustment only in the first year of implementation of the new

[10] *Medicare Savings from Use of Ambulatory Surgery Centers, 2019-2024*

payment system.[11] CMS continued the scalar after the initial year of the new ASC payment system pursuant to its own perceived authority and not pursuant to any identified statutory requirement. As such, CMS has the clear authority to discontinue the scalar at its discretion under the same rationale. ASCA implores CMS to encourage additional savings and greater access to surgery centers for Medicare beneficiaries by eliminating the ASC weight scalar.

Although the elimination of the ASC weight scalar would require a modest initial start-up increase in cost to the Medicare program, it would take little time or procedure volume shift for cost savings to be achieved. In addition, the start-up costs will only grow each year CMS delays addressing this problem that suppresses ASC rates and traps volume in the higher-cost setting.

While this would be both the right thing to do and save billions of dollars for the Medicare program, we also propose an alternative: CMS could combine the OPPS and ASC utilization and mixes of services to establish a single weight scalar. In other words, CMS could apply a single budget neutrality calculation to the OPPS and ASC payment systems. By incorporating the ASC volume into the OPPS weight scalar calculations, CMS would further the alignment of the payment systems and more accurately scale for outpatient volume across both sites of service.

ASCA asserts that one of these options is critical for ASCs to provide care to all the Medicare beneficiaries who could and should receive care in this highly efficient, lower-cost setting.

## Wage Index Considerations

**ASCA supports policies that mitigate the impact of inadequate wage indices on rural ASCs.**

A lack of alignment between ASC and HOPD reimbursement methodology also is evident with wage indices. Hospitals can request geographic reclassifications that raise the hospital wage index depending on the distance between the hospital and the county line of the area to which it seeks reclassification. Unfairly, ASCs cannot seek reclassification.

Hospitals in frontier states receive payment based on a wage index floor at 1.0. A frontier state is defined as a state in which "at least 50% of counties located within the State have a reported population density less than 6 persons per square mile,"[12] excluding Alaska and Hawaii. For example, South Dakota is a frontier state. While the state rural wage index for surgery centers in the state is projected at 0.7979 in 2027, hospitals in South Dakota receive the "floor" wage index of 1.0.

We request that CMS apply these policies for ASCs—geographic reclassifications and wage index floors—to allow for further alignment between the ASC payments and the OPPS.

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[11] See Social Security Act 1833(i)(D)(ii): ***In the year the system described in clause (i) is implemented***, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

[12] 42 CFR 412.64 (m)(i).

## Proposed Addition to the List of ASC Covered Surgical Procedures

**ASCA supports broad expansion of the ASC-CPL, but migration will be dependent upon addressing the secondary weight scalar.**

ASCA supports the emphasis this proposed rule places on clinical discretion to select the appropriate site of service by use of a physician's medical training. This proposed rule would add 618 codes to the ASC Covered Procedures List (ASC-CPL) for 2027.

We support the expansion of the ASC-CPL and were happy to see the hernia codes that we requested in the Pre-Proposed Rule CPL Recommendation Process were included in this proposal. In 2023, coding for hernia procedures changed dramatically, moving away from the surgical approach to the size of the hernia. Unfortunately, the following procedures, once allowed in both HOPDs and ASCs, are currently on the inpatient-only (IPO) list:

- 49596 (Rpr aa hrn 1st > 10 ncr/strn)
- 49616 (Rpr aa hrn rcr 3-10 ncr/strn)
- 49617 (Rpr aa hrn rcr > 10 rdc)
- 49618 (Rpr aa hrn rcr > 10 ncr/strn)

For all codes being considered for addition to the ASC-CPL, CMS will not achieve the shift in procedures to the lower-cost ASC setting that his policy is meant to promote if the payment policy issues raised above are not addressed.

In addition, while CMS made positive changes to the criteria CMS uses to determine which codes should be considered for addition to the ASC-CPL in 2026, one problematic exclusion remains - the automatic denial of all unlisted codes.

**CMS should allow ASCs to bill for unlisted codes.**

The Code of Federal Regulations *§416.166 - Covered surgical procedures* states that "covered surgical procedures do not include those surgical procedures that … can only be reported using a CPT unlisted surgical procedure code."

One unlisted code requested for addition to the ASC-CPL by an ASCA member is CPT 27299 (Unlisted px pelvis/hip joint). It is in the same ambulatory payment classification (APC) group, 5111, as 100 other musculoskeletal codes that are currently on the ASC-CPL. In fact, the only codes within APC 5111 that are not payable in ASCs are unlisted codes.

There is no identified safety rationale for this provision and commercial payers commonly provide ASCs with the flexibility to use unlisted CPT codes to report procedures. Facilities must document why they need to use the unlisted code and receive approval from the payer to be reimbursed. This also is a practice that CMS permits for HOPDs and physician offices but not for ASCs. ASCA requests that CMS revise the Code of Regulations to eliminate this restriction.

## Proposal to Eliminate the Inpatient-Only (IPO) List

**ASCA supports this proposal in theory but has concerns about implementation.**

For the second year of CMS' multi-year transition away from an inpatient-only (IPO) list, CMS is proposing to make 637 additional procedures payable in the HOPD setting for 2027, with 618 of those also being proposed for addition to the ASC-CPL. While it is refreshing to see CMS providing additional discretion to clinical decision-making, there are unintended consequences to removing the IPO list entirely.

The complete elimination of the IPO list means that every code must be assigned to an ambulatory payment classification (APC) group, regardless of whether there will be any volume in the outpatient setting. ASCA is concerned that even projecting a small amount of volume for procedures that will not actually be performed in our setting will negatively impact procedures currently on the ASC-CPL.

## ASC Payment for Combinations of Primary and Add-On Procedures Eligible for Complexity Adjustments under the OPPS

**ASCA supports further evaluation of the complexity adjustment policy to ensure all appropriate code combinations are contemplated.**

ASCA supports complexity adjustments in the ASC setting. As CMS notes in this rule, while add-on codes (N1) do not come with additional reimbursement (packaged into primary code), the addition of the add-on codes to a primary procedure code often change the complexity of the procedure, making it more costly to perform due to labor, implants and supply costs.

However, ASCA has concerns that the policy is not currently working as intended. The number of complexity-adjusted codes has decreased every year since the policy was installed.

We question whether the volume of cases with the N1 payment indicator are truly being captured. We have heard anecdotally that it is common for facilities to leave these codes off claims even when they are being performed in conjunction with other surgical codes.

We understand that claims may be denied by Medicare Administrative Contractors (MAC) when add-on codes with the payment indicator of N1 appear with the primary code, even though the primary code is payable. CMS must clarify in the billing claims processing manual that the entire claim will not be denied by the MACs when an add-on code is billed that may not be deemed payable.

## Payment for Non-Opioid Pain Management Treatments

ASCA supports the separate payment for the cost of non-opioid pain management drugs and devices that reduce the prescription and use of opioids after surgery. The NOPAIN Act took a critical step in expanding access to these products.

Unfortunately, during the first year and a half of implementation of the NOPAIN Act, facilities are struggling to get reimbursed for the applicable products, particularly devices. Medicare Administrative Contractors (MACs) require facilities to submit the Paperwork (PWK) form, an operative note and device invoice for payments yet still deny claims once all the paperwork has been submitted. Congress intended for these products to be readily available to Medicare beneficiaries. Accordingly, CMS must clearly communicate with the MACs as to how they should facilitate implementation of the NOPAIN Act.

## Codes Subject to a Multiple Procedure Discount

While not specifically addressed in the text of the proposed rule, ASCA is concerned by changes reflected in the proposed CY 2027 ASC Addendum AA that would subject certain device-intensive ASC procedures to multiple procedure discounting when such discounting did not previously apply. The addendum includes changes from "No" to "Yes" in the column identifying whether individual procedures are subject to the multiple procedure reduction. For many of these procedures, the device alone represents more than 50% of the reimbursement rate, so the facility would lose money on these procedures.

One such example is a two-lead peripheral nerve stimulation (PNS), for which 64555 is billed twice. The national reimbursement rate for 64555 in the proposed rule is $6,338.90, so the ASC would be reimbursed at $3,169.45 for the second use of the code. and CMS published a device offset of $5,225.24 for this code, meaning the facility would lose at least $2,000 for performing this case.

The proposed rule does not mention a potential change in status from CY 2026, so it is unclear whether this is an error or whether CMS has assessed these procedures to determine that payment reductions should be proposed. Whether intentional or not, ASCA urges CMS not to finalize the addendum as proposed, given the lack of rationale offered in the proposed rule and considering the fixed costs associated with the affected procedures.

## Key Comments on ASC Quality and Proposed Reporting Program Changes

ASCA supports meaningful quality reporting that can improve transparency and patient care. Twenty years ago, the ASC community established the ASC Quality Collaboration (ASC QC) to develop, test and publicly report quality measures specific to the ASC setting. The ASC community supported the creation of the ASCQR Program and has generated extremely high participation rates over the past 14 years. However, the ASCQR Program has lost direction in recent years and burdens are being imposed on facilities without any benefit to patients or facilities.

The ASC QC will submit detailed comments on the aspects of the rule proposal pertaining to the ASCQR Program, and ASCA supports the ASC QC's comments. In addition, we wish to highlight below our position on select policies.

**ASCA supports the removal of *ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients* from the ASC Quality Reporting Program.**

As indicated by CMS, this measure assesses "documentation of recommended follow-up intervals rather than patient outcomes." As such, removal of the measure falls within ASCA's desire for the ASCQR Program to focus on measures that provide benefit to patients and facilities, and we support its removal.

**ASCA requests a reprieve from penalty for those facilities that encountered issues achieving 200 completed OAS CAHPS surveys.**

Beginning in 2025, ASCs were required to contract with a third-party vendor to administer the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery (OAS CAHPS) Survey. This survey has imposed a huge time and cost burden on our facilities. This unfunded mandate is costing ASCs thousands of dollars a year and supplants much less-expensive patient satisfaction surveys that produced much higher return rates.

ASCA is extremely concerned that facilities will do everything they are supposed to do—contracting with a vendor early enough to begin survey administration by January—and still not meet the requirement of 200 completed surveys. Mailing out surveys or calling individuals on the phone does not guarantee completion. As CMS knows through various mode testing, some survey modes might see lower than 20% return rates.

Anecdotally, we are hearing even worse return rates from many of our members. This is likely due to the length of the survey. When patients are responding, much of the negative feedback received is about the survey itself. Patients are frustrated with the length of the survey, and question why they need to provide demographic information. They believe the facility is requiring them to complete the survey, not understanding it is a government mandate.

While ASCA still has many concerns with the survey itself (which we have detailed to CMS in many previous comment letters), at the very least ASCA requests that if a facility is operational with the OAS CAHPS survey—meaning they contract with an authorized vendor that is sending out the surveys in line with CMS specifications—they should not be penalized if fewer than 200 patients complete the survey.

**ASCA requests the delay of *ASC-21: THA/TKA PRO-PM* implementation.**

In 2024 rulemaking, CMS adopted *ASC-21: Risk-Standardized Patient Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)* beginning with voluntary reporting for the CY 2025 and 2026 reporting periods followed by mandatory reporting beginning with the CY 2027 reporting period. This measure includes pre-operative data collected from 0-90 days before the procedure and post-operative data collected between 300-425 days after the procedure.

CMS assumes that ASCs will use electronic health record (EHR) technology to facilitate compliance. While the Office of the National Coordinator for Health Information Technology (ONC) estimates that at least 86% of office-based physicians and 96% of acute care hospitals are currently using an EHR, at most 76% of ASCs are using an EHR.[13] ASCs did not receive any federal funding for EHR adoption in the *Health Information Technology for Economic and Clinical Health Act of 2009* and are not currently contemplated by federal efforts. We should not be penalized for slower adoption of EHR technology.

This measure will be burdensome even for facilities that use EHR technology. The amount of data ASCs would be required to collect and submit for this measure is substantial: a total of 44 to 47 data elements for each THA patient and a total of 46 to 49 data elements for each TKA patient when complete patient-reported outcome data is provided by the patient.

Yet, the agency proposes ASCs be required to submit complete and match preoperative and postoperative PRO data for at least 45% of their eligible elective primary THA/TKA procedures[14] to avoid future payment penalties. ASCs will be accountable for obtaining information that is ultimately dependent on patients' participation, which we cannot control. The OAS CAHPS survey sees much lower response rates, as seen in the OAS CAHPS 2019 mode. The highest return rate was 39% for web plus mail follow-up for a much less onerous survey.

With *ASC-21*, if a patient does not respond to all the items on each of the instruments requiring their input (the preoperative and postoperative HOOS, JR or KOOS, JR, the mental health items from the PROMIS-Global or VR-12, the Health Literacy SILS2, the "Total Painful Joint Count" and the Oswestry Index Question), the patient PRO data submission would be considered incomplete. As such, data collection for this measure requires repeated patient engagement and multiple staff touchpoints.

The Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) is a private payer initiative that requires the collection of much of the same data CMS will require under *ASC-21.* Facilities that participate in MARCQI are incentivized by the payor for their participation, which is necessary since data abstraction can exceed more than $100,000. Since CMS will not be increasing reimbursement for facilities nationwide to cover this additional cost, as collection expectations increase, the ASC must redirect clinical and administrative labor away from direct patient care and operational functions to achieve compliance.

CMS ***must*** test this proposed measure in the ASC setting before implementation. A THA/TKA PRO-PM was only recently mandated for inpatient hospitals that have been working toward implementation for years. In fact, data for this measure will not become public until 2027. It would be prudent to evaluate whether the measure produces useful data in the inpatient setting before mandating it in other settings. As such, mandatory reporting for HOPDs and ASCs in 2027 should be delayed.

[13] https://archive.ascfocus.org/ascfocusarchive/content2/articles-content/articles/2025/digital-debut/asca-survey-shows-continued-growth-of-ehr-usage-by-ascs

[14] We see a statement that a 50% minimum is proposed for ASCs at 88 FR 49883 but have elected to reference the 45% minimum as stated elsewhere. Clarification would be welcome.

**ASCA does not support stratification of *ASC-4: All-Cause Hospital Transfer/Admission* at this time.**

The ASC QC is the measure developer and steward for this measure, and members have often expressed interest in stratifying the measure data and have discussed feasible and reliable approaches to doing so. The ASC QC is currently exploring an approach based on pre-, intra- and post-procedure categories. Members started collecting and submitting stratified data to the ASC QC internal dataset last year. Currently, over 1000 centers are participating. The results for millions of admissions suggest that approximately 20% of transfers occur pre-operatively, approximately 10% are initiated in the intraoperative period, and approximately 70% occur post-operatively. These rates represent aggregated totals across all facility types, including both single-specialty and multi-specialty centers performing the full spectrum of ASC services.

The ASC QC's aggregated phase-based totals contrast greatly with those reported in the literature by one single-specialty ophthalmology ASC. This center, reporting on approximately 25,000 admissions, found that approximately 75% of transfers were for issues noted prior to the induction of anesthesia, while approximately 25% were for issues temporally related to anesthesia or surgery.[15] There is significant variance in these facility-specific rates from those the ASC QC has observed in the aggregate. Although the same categories were not used, the differences still raise questions about CMS's suggestion that stratification "would improve attribution and interpretability across the diverse range of ASCs services" and that a "phase of care stratification may also provide more comprehensive information to support beneficiary decision-making and patient safety monitoring."

The disparities in the phase-related rates of transfers/admissions seen in these two datasets suggest that stratification by phase of care alone would not be meaningful, as it appears that other factors may have a significant impact on the outcomes. Actionable data may require further levels of stratification, such as by single specialty/multi-specialty, case type, and characteristics of the patient population typically cared for by the ASC.

Keeping in mind that CMS appears to be planning to retain all phases of care in the measure, we question whether the new burdens that would be imposed by any future stratification of measure data by phase-of-care based approach would add information that is sufficiently useful and valuable to warrant the additional effort involved.

**Closing Summary**

While the expansion of the ASC Covered Procedures List signifies that CMS values the role that ASCs play in providing safe and high-quality care to Medicare beneficiaries, a failure to address the urgent payment issues we have identified in this and previous comment letters will needlessly increase overall costs to the program and trap patient volume in more expensive settings. The solutions we offer in this comment letter will ensure ASCs can continue to serve Medicare

[15] Stange, N. R., & Rauen, M. P. (2025). Evaluating ASC-4 transfer rates in cataract surgery: insights into timing and causes of hospital transfers. *Journal of cataract and refractive surgery*, *51*(5), 376–381.https://doi.org/10.1097/j.jcrs.0000000000001613.

beneficiaries while generating even more savings for the Medicare program and taxpayers. We welcome the opportunity to further discuss our recommendations with CMS, as it is in the best interest of the Medicare program, beneficiaries, and taxpayers, that our facilities remain able to continue providing outstanding care at a fair cost to the Medicare program.

Please contact Kara Newbury at knewbury@ascassociation.org or (703) 836-8808 if you have any questions or need additional information.

Sincerely,

William Prentice
Chief Executive Officer