Ambulatory Surgery Center Association

September 15, 2025

The Honorable Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1834-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at www.regulations.gov

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz:

The Ambulatory Surgery Center Association (ASCA) submits these comments in response to the calendar year (CY) 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule ("Proposed Rule") (90 Fed. Reg. 33476, July 17, 2025). While we appreciate the administration's recognition of the important role ambulatory surgical centers (ASCs) play in the US healthcare system, much work still needs to be done to ensure that all Medicare beneficiaries have access to the high-quality lower-cost surgery center setting.

This administration has rightly prioritized reducing the cost of healthcare. **ASCs already save Medicare more than *$5.6 billion* on an annual basis simply by existing as an alternative to hospitals.**[1] CMS should adopt policies that encourage migration of more procedures to the surgery center setting to generate even greater savings.

Most ASCs operate as small businesses and must run efficiently to remain viable and continue to provide savings to Medicare and needed care to its beneficiaries. As of June 2025, there were 6,502[2] Medicare-certified ASCs, and more than 50 percent of those have two or fewer operating rooms.[3] 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.

[1] State Cost Savings (2023) analysis file based on the CMS ASC LDS 2023 claims data that was used for the 2025 final rule.
[2] 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 2025 data).
[3] *Id.*

277 S Washington St Ste 375
Alexandria VA 22314-3646
Phone: 703.836.8808

asc@ascassociation.org
ascassociation.org

ASCs compete with hospitals and other healthcare providers for the same short supply of nurses and other staff, with shortages projected to grow over the next several years.[4] Anesthesia costs for ASCs continue to increase substantially due to many factors, including declining anesthesia reimbursement, provider shortages and the inordinate impact of the *No Surprises Act* on anesthesia providers. The threat these challenges have to the economic viability of the ASC community cannot be overstated.

ASCs must comply with state and federal regulations[5] comparable to those required of hospital outpatient departments (HOPD), along with extensive Medicare quality reporting, yet surgery center reimbursement rates continue to languish under CMS payment policies.

We appreciate recent opportunities to discuss collaboration with CMS and welcome the chance to work with the agency on the payment policy proposals outlined in this letter that would encourage the clinically appropriate migration of services into the ASC setting. This, in turn, will provide the Medicare program and its beneficiaries with a substantial savings opportunity 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. This will ensure better alignment with the HOPD payment system.

- **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.

- **Procedures Permitted in ASCs.** ASCA supports the changes proposed for the ASC covered procedures list (ASC-CPL) and encourages further policy changes to ensure that the appropriate site of care is determined by healthcare providers.

- **Quality Reporting.** ASCA supports CMS' proposal to remove *ASC-20, ASC-22, ASC-23 and ASC-24* from the ASC Quality Reporting (ASCQR) Program. In addition, CMS should delay implementation of the new Information Transfer Patient Reported Outcome-Based Performance Measure (PRO-PM) until it has been tested in, and deemed appropriate for, 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.

[4] https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage
[5] https://www.ascassociation.org/asca/about-ascs/quality-and-safety/federal-requirements (Accessed August 2024)

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.[6] However, siloed payment policies have led to increasingly disparate reimbursements. The ASC community has long urged CMS to adopt the 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.

Further research is needed, but there are promising signs of migration from the higher-cost HOPD setting to ASCs. When analyzing surgical volume across three outpatient settings—HOPDs, ASCs and physician offices—ASCs increased their fee-for-service (FFS) market share 0.3 percent between 2021 and 2023, while at the same time HOPD volume declined a commensurate 0.3 percent.

That said, further payment policy reform, such as the elimination of the ASC weight scalar and expansion of the ASC-CPL, is necessary to hasten migration of appropriate procedures to the lower-cost surgery center setting.

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 leads to ASC reimbursement rates to be less than 50 percent on average of the HOPD rate for the same procedures. In too many markets, surgeries that could be performed in 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.

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—in an attempt to 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.

However, since 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. 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 generate for the Medicare program will remain limited until this oversight is rectified.

[6] 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)

Looking again at our highest-volume code, a cataract code (CPT 66984), CMS proposes to ***decrease*** the reimbursement rate by 4.74 percent in 2026. This is due at least in part to the ASC weight scalar, which is 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 cataract procedures migrating to the ASC away from the higher-cost HOPDs 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 payment system.[7] 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 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.

While the elimination of the ASC weight scalar would represent an initial start-up increase in cost to the Medicare program, it would take very little time or procedure volume shift for cost savings to be achieved. In addition, the start-up costs will 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.

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 percent of counties located within the State have a reported population density less than 6 persons per square mile,"[8] 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 0.8203, hospitals in South Dakota receive the "floor" wage index of 1.0.

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[7] 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.
[8] 42 CFR 412.64 (m)(i).

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.

Proposed Addition to the List of ASC Covered Surgical Procedures

ASCA supports broad expansion of the ASC-CPL.

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 276 codes currently reimbursed in the HOPD setting to the ASC-CPL for 2026. We support the expansion of the ASC-CPL and were happy to see many of the codes that we requested in the Pre-Proposed Rule CPL Recommendation Process were included in this proposal. We highlight those below:

Spine Codes

ASCA supports the addition of CPT codes 22630 (lumbar interbody fusion) and 22633 (combined interbody fusion with a posterior fusion) to the ASC-CPL for calendar year 2025. Doing so will provide Medicare beneficiaries with the freedom to select an ASC for their outpatient spine surgery procedure if their surgeon determines it to be the most medically appropriate option. For at least 15 years, commercially insured patients have had the option to select an ASC for their lumbar interbody fusion surgery (either 22630 or 22633).

Numerous peer reviewed published studies have confirmed the safety and efficacy of outpatient lumbar spine interbody fusion surgery. Legacy Surgery Center in Little Rock, AR, enrolled as a temporary hospital through the Hospital Without Walls program in May of 2020 during the public health emergency (PHE) and was able to compile objective medical safety and outcome data from lumbar interbody fusions in the Medicare age group. Patients were 65 years old and above with a mean age of 73 years old. The facility's surgeons published data on their Medicare patients during the PHE, confirming this same advantage in Medicare aged patients undergoing ASC lumbar interbody fusion surgery.[9]

Cardiology Codes

ASCA also requested several cardiology codes through the Pre-Proposed Rule CPL Recommendation Process. We were happy to see several of these codes proposed for addition.

- Electrophysiology Studies and Ablations: 93650, 93653, 93654 and 93656
- Percutaneous Coronary Intervention (PCI): C9602, C9604 and C9607

However, there are several other cardiology codes that were requested by ASCA, the Heart Rhythm Society (HRS) and the American College of Cardiology that were not included in the proposed rule. ASCA requests that these codes be added to the ASC-CPL for 2026:

[9] Int J Spine Surg 2024, 18 (2) 199-206, https://www.ijssurgery.com/content/ijss/18/2/199.full.pdf

- Electrophysiology Studies and Ablations: 93619, 93620, and 93642
- Cardioversion and Transesophageal Echocardiogram (TEE): 92960, 93312 and 93318

We have seen an increase in outpatient cardiovascular care in recent years, largely influenced by CMS' decision to expand the number of cardiovascular procedures that are eligible for the ASC setting, especially percutaneous coronary interventions (PCI).

Recent data presented to CMS by HRS supports the continued expansion of the ASC-CPL with cardiovascular codes, including cardiac ablation services on the ASC-CPL. Of note, electrophysiologists recently conducted a large, multicenter safety and feasibility study[10] of more than 4,000 cardiac electrophysiology procedures performed across six ASCs during the COVID-19 pandemic under the Hospitals Without Walls program. Findings from the study demonstrated that catheter ablations performed in ASCs and HOPDs both had very low rates of acute complications with complication rates even lower than other comparable cardiac procedures already covered in the ASC-CPL (i.e., pacemakers/ICD implants and elective PCI procedures). Catheter ablation procedures performed in the ASC setting demonstrated lower rates of urgent hospital admissions than at HOPDs and very low rates of 30-day admissions.

ASCA respectfully requests that CMS listen to the cardiovascular groups advocating for these procedures and add these cardiology codes to the ASC-CPL for 2026.

CMS should eliminate the exclusionary criteria.

CMS proposes to revise the exclusionary criteria under *42 CFR 416.166 (c)* by eliminating *42 CFR 416.166 (c)(1) – (5); (1) generally result in extensive blood loss; (2) require major or prolonged invasion of body cavities; (3) directly involve major blood vessels; (4) are generally emergent or life threatening in nature; (5) commonly require systemic thrombolytic therapy*.

ASCA recommends that CMS remove all the exclusionary criteria. The criteria in the Code of Federal Regulations (CFR) are imprecise and subjective. Many states that look to the CMS regulations when determining what to allow in their jurisdictions misinterpret the exclusionary criteria for the Conditions for Coverage (CfCs) and impose onerous limitations on ASCs based on this misinterpretation. The CfCs that are in place already ensure that *all* ASC patients receive care in a highly regulated, quality environment regardless of payer.

That said, CMS should evaluate codes for safety before adding them to the ASC-CPL. If CMS deems a particular procedure to be unsafe for the outpatient setting, the agency can use the parameters proposed in the nomination process to decline to add the said procedure instead of the exclusionary criteria currently found in *42 CFR 416.166 (b) and (c*).

Two criteria proposed to remain in the CFR that are particularly problematic are those that require "active medical monitoring and care at midnight following the procedure" and the automatic denial of all unlisted codes.

[10] Aryana A, Thihalolipavan S, Willcox ME, et al. Safety and Feasibility of Cardiac Electrophysiology Procedures In Ambulatory Surgery Centers. *Heart Rhythm* (2024), https://doi.org/10.1016/j.hrthm.2024.07.123

Active Medical Monitoring and Care Past Midnight

CMS-certified ASCs are facilities for patients "not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission." However, for Medicare beneficiaries, CMS seems to be interpreting "hospitalization" as equivalent to "active medical monitoring and care at midnight following the procedure." If non-Medicare beneficiaries are permitted to stay in an ASC for up to 24 hours, it should be clear that the same standard applies to Medicare beneficiaries. A procedure can be extremely safe, but a beneficiary might be best served by staying overnight or would feel more comfortable spending the night. It also is unclear what is meant by "medical monitoring and care." If the patient is stable and could be discharged but is simply being monitored at an ASC instead of at home by a family member or caregiver, it is irrational, from a safety perspective, why that should not be permitted.

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." There is no clear 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.

In addition to CMS' proposal to eliminate the inpatient-only (IPO) list over the next three years, CMS also is proposing to move 271 procedures directly from the IPO list onto the ASC-CPL. It is refreshing to see CMS providing additional discretion to clinical decision-making. However, there might be certain unintended consequences of 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 strongly supports complexity adjustments in the ASC setting and commends CMS for implementing a policy that provides an opportunity for better access to Medicare beneficiaries and significant cost savings to the Medicare program.

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 volume of cases with the N1 payment indicator are not 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.

Key Comments on ASC Quality and Proposed Reporting Program Changes

ASCA supports meaningful quality reporting that can improve transparency and patient care. In 2006, 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 13 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 four measures proposed for removal are prime examples. 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-20: COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)* from the ASCQR Program.

As ASCA feared when this measure was first proposed back in 2022 rulemaking, *ASC-20: COVID-19 Vaccination Coverage Among HCP* has placed an undue burden on our facilities and the implementation has been confusing, with definitions constantly changing midstream. In response to the 2022 proposal, we wrote, "when a new measure is proposed for addition, particularly with such a short turnaround time for compliance, it must be clear that the benefits of the measure will outweigh the burden. This does not seem to be the case here." Four years later, the benefits are even less clear. We wholeheartedly support CMS' proposal to remove this measure from the ASCQR Program.

ASCA supports the removal of the Health Equity Measures (*ASC-22* through *ASC-24*) from the ASCQR Program.

ASCA supports access to care for all patients. However, 2025 rulemaking was unclear as to how *ASC-22* through *ASC-24* would address disparities that exist or how CMS would support the facilities required to collect this information. In addition, none of these measures have been tested in the ASC setting. ASCA supports CMS' proposal to remove these measures from the ASCQR Program.

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 percent return rates. Anecdotally, we are hearing even worse return rates from many of our members. ASCA requests that if a facility is operational with the OAS CAHPS survey, meaning their authorized vendor can survey beginning the first quarter of 2025, they should not be penalized if fewer than 200 patients complete the survey.

ASCA does not support the addition of the new *Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure* (Information Transfer PRO–PM) to the ASC Quality Reporting Program.

ASCA has serious concerns that this survey lacks sufficient clinical support and that the burden will far outweigh any perceived benefits.

No Evidence to Support a Need for this Measure in the ASC Setting

The Methodology Report for this measure indicates that HOPDs and "ASCs fail to provide patients with critical information about recovery at a much higher rate than inpatient hospitals." It is extremely misleading to include ASCs in this statement, when the Methodology Report provides absolutely no research indicating this is a problem in the ASC setting. One study was cited, based on a review of a mere 233 patient visits in 20 hospitals. It is presumptive to apply this small study to ASCs when only hospitals—inpatient and HOPDs—were evaluated.

In fact, when it comes to postoperative outcomes, which the Methodology Report uses as a rationale for the survey, ASCs routinely fare better than hospitals. According to a National Institutes of Health (NIH) study,[11] ASCs were significantly better than hospitals, particularly

[11] Carey, Kathleen, et al. "Patient Outcomes Following Total Joint Replacement Surgery: A Comparison of Hospitals and Ambulatory Surgery Centers." The Journal of Arthroplasty, U.S. National Library of

when comparing 30- and 90-day readmission rates and postsurgical complications for inpatient and outpatient procedures.

No Pilot-Testing in the ASC Setting

While it is the stated intent of the measure developers that this measure will apply to ASCs, the measure was not tested in our site of service. The survey should not be finalized for use in the ASC setting until it is adequately tested in the ASC setting.

Lack of Clarity on Survey Implementation

Although CMS indicates that a third-party vendor is not required to conduct this survey, the specifications "require that the survey be administered anonymously to patients." CMS needs to provide further guidance as to how facilities can administer this anonymously in-house to avoid the additional costs that would be associated with working with an outside vendor.

Survey fatigue

This survey would only contribute to more fatigue and potentially cannibalize other CMS-mandated surveys, such as OAS CAHPS for which facilities are already having trouble getting responses.

Accordingly, CMS should delay or eliminate implementation of this measure.

Request for Information: Adjusting Payment Under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings

On its face, the phrase "site neutrality" has been construed as a catch-all to include policy proposals that our community of healthcare providers and patients could support. However, ASCA has concerns that Congressional proposals to date focus only on the cost of care and do not contemplate unintended clinical impacts that could limit access to care.

ASCA welcomes the opportunity to discuss the important topics of cost, transparency, competition and patient safety and the important role that ASCs can play as an increasing number of patients seek outpatient surgical services.

Below are brief answers to some of the questions in the RFI, but we strongly recommend that the agency extensively research the ramifications of site neutrality on access to care and safety concerns before any policies be implemented.

2. Should we limit OPPS payment for certain services to the payment made for that service under the ASC payment system or the Medicare Physician Fee Schedule—depending on the setting where the service is performed most frequently?

Medicine, Jan. 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6910922/.

Any policy should be aimed to incentivize moving appropriate care to the ASC but should not penalize HOPDs when seeing patients that belong in that setting. A foundational element of the surgery center model is that ASCs are the proper setting for appropriate patients—that subset of the Medicare population without the comorbidities that would dictate they receive care in a hospital.

Similarly, there are beneficiaries who benefit from receiving care in the highly regulated ASC environment over that of a physician's office. Using payment policy to drive patient care to a lower-cost, unregulated environment presents risks to patients that are not currently being considered by policymakers.

3. If we were to adjust payment based on the setting-specific volume of ambulatory services, should we pay the ASC payment amount if the service is predominantly performed in the ASC setting; and if the service is predominantly performed in the physician office setting, should we continue to calculate the PFS-equivalent rate using a PFS relativity adjuster that we would periodically update?

Both suggestions risk having patients with multiple comorbidities being seen in the wrong setting or losing access to the HOPD.

4. In determining the setting in which a service is performed most frequently, should we use the most recent data available or should we use data that is 5 or even 10 years prior to the rate-setting year? Should we use solely Medicare FFS data for our analysis or should we explore and potentially incorporate Medicare Advantage data into our work (to the extent feasible and practicable)?

More data is typically better. It is our understanding that Medicare Advantage data is not readily available. If that is not true, it would benefit CMS and the healthcare community to better incorporate Medicare Advantage data into a wide range of policy decisions.

5. How could we account for the availability of HOPDs, ASCs and physician offices in a geographic area when determining the setting in which a service is most frequently performed? If there is a shortage of one of these settings of care in a geographic area, would it be appropriate to tie payment for a service to a setting of care that may not be readily available to a beneficiary?

This has long been one of ASCA's largest concerns with site neutral policies—CMS should not promote any policies that will create barriers to access.

8. Should we apply OPPS site-neutral policies more broadly to all HOPDs or should we instead consider applying this payment adjustment to only certain HOPDs, such as excepted off-campus HOPDs?

ASCA does not support any of the site-neutral policy proposals we have seen to date and does not support disparate policies for off-campus versus on-campus HOPDs.

Closing Summary

We appreciate the opportunity to provide feedback on the agency's latest policy proposals. It is clear in this rule that CMS values the role that ASCs play in the US healthcare system, but more needs to be done to ensure ASCs can better serve Medicare beneficiaries while generating even more savings to the Medicare program and taxpayers. We welcome the opportunity to continue to collaborate with CMS on the recommendations in this comment letter to ensure our facilities can continue to provide outstanding care to Medicare beneficiaries 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