



June 9, 2026

Dr. Mehmet Oz, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
CMS-1849-P  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Via online submission at <https://www.regulations.gov/document/CMS-2026-1256-0002>

**Re: CMS-1849-P – Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes**

Dear Administrator Oz,

The Ambulatory Surgery Center Association (ASCA) submits the following comments in response to the Centers for Medicare & Medicaid Services' Ambulatory Surgical Center (ASC) Episode Request for Information (RFI) published in the FY 2027 inpatient prospective payment system proposed rule.

ASCA represents the interests of the more than 6,600 Medicare-certified ASCs nationwide. ASCs offer a high-quality, convenient and low-cost choice for Medicare beneficiaries who do not require hospitalization after surgical or diagnostic procedures. A recent analysis of Medicare claims by KNG Health Consulting found that surgery centers save the Medicare program more than \$5 billion per year, including more than \$1.3 billion in annual savings for beneficiaries<sup>1</sup>. Thanks to recent policy changes by CMS, this number is expected to grow significantly, with ASCs projected to save Medicare \$12.5 billion annually by 2034. We appreciate the opportunity to comment on proposed policies that affect ASC clinicians and the Medicare patients they serve.

**Ambulatory Surgical Center Episode Request for Information**

ASCA is pleased to submit comments on CMS' RFI regarding ASC inclusion in the Transforming Episode Accountability Model (TEAM) and similar future models. While ASCA supports CMS'

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<sup>1</sup><https://www.ascassociation.org/assessing-medicare-savings>

efforts to improve value-based care delivery, ASCA does not believe that surgery centers are well positioned for inclusion in TEAM or other similar episode-based payment models.

The core problems that TEAM is designed to address—fragmented care coordination, poor transitions and communication between providers, a complicated patient experience—are fundamental advantages of choosing an ASC as the surgical site of service. Even for complex procedures such as total joint replacements, surgery centers are seeing patients who are carefully selected as those least likely to need intricate recovery protocols and/or post-discharge maintenance. While unexpected circumstances can always arise, most patients who would require the extensive care coordination services included in TEAM’s 30-day episodes would likely be unfit for surgery in an ASC in the first place.

Additionally, ASCA has serious concerns with any model design that mandates participation for facilities. Surgery centers have not been the focus of any prior CMS value-based payment model and have not accrued the same experience that hospitals have from models like Bundled Payments for Care Improvement or Comprehensive Care for Joint Replacement. This creates fundamental issues with CMS’ method for selecting facilities to participate in TEAM, as past exposure to bundled payment models is one of the criteria used for stratification and sampling. Other criteria such as historical spending and safety net designation would also be inapplicable to the ASC space. ASCA strongly recommends that any future payment model featuring ASCs be implemented with voluntary participation, giving surgery centers time to develop familiarity and best practices.

ASCA provides the following responses to selected questions within the TEAM RFI and looks forward to continuing discussions about the appropriate metrics and levers that can deliver Medicare beneficiaries the highest-quality, most cost-effective care.

***What operational challenges would ASCs face participating in an episode-based payment model such as TEAM? Are there any unique challenges to treating patients in an ASC compared to IP/OP hospital settings? How might these challenges impact model participation?***

While some ASCs perform one of the anchor procedures that initiate a TEAM episode, the surgery center does not typically coordinate patient management for all transitions of care or with providers in the 30-day period post-discharge. In fact, the decision to have a procedure performed in a surgery center will always originate from outside the ASC by a physician or team of physicians operating out of an office or a hospital. While the hospitals currently participating in TEAM have large staffs and connections to post-acute care providers, ASCs are typically small, streamlined facilities with limited outreach beyond their procedural purpose. As previously mentioned, ASCs treat patients with a narrower band of health risks compared to hospitals in order to achieve the greatest possible efficiency and cost savings. While an ASC follows strict discharge criteria, facilities often recommend that patients contact their surgeon/physician’s office rather

than the surgery center if complications arise post-discharge. For these reasons, ASCs are not the appropriate convening entity for a 30-day episode of care.

***What steps could CMS take to support ASC readiness to participate in episode-based payment models such as TEAM?***

Although TEAM does not currently require certified electronic health record technology (CEHRT), hospitals that use CEHRT have access to more participation tracks and thus more flexibility within the model. ASCs were not included in Meaningful Use and did not receive any EHR stimulus funds from the *HITECH Act*. Because of this, surgery center adoption of EHRs has proceeded much more slowly than in hospitals and physician offices. CMS could support ASC readiness for TEAM and other advanced payment models by dedicating resources to support EHR uptake and usage in the ASC space.

While ASCs represent the leading edge of outpatient surgical techniques, EHR adoption has proceeded incrementally. As recently as 2020, estimates from vendors put EHR penetration in surgery centers at 15% to 20%. While the proportion has increased in recent years, ASCA continues to estimate that, at most, 50% of surgery centers use an EHR. Additionally, some facilities using an EHR are likely using a product ill-suited to their clinical needs and processes. For comparison, data from the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT shows that hospitals achieved 90% EHR adoption and physician offices achieved 74% EHR adoption by 2014<sup>2</sup>.

Because of their small size and streamlined operational structure, many surgery centers experience significant difficulty when introducing EHRs into their operations. ASCA surveyed its members in July 2025 and found that among facilities that reported using an EHR, 43% stated concern regarding their ability to connect to external programs and 40% stated concern regarding their ability to send and receive patient information<sup>3</sup>. An August 2024 ASCA survey found that only 54% of ASCs were using an EHR to facilitate reporting for Medicare's ASC Quality Reporting (ASCQR) Program. Additional time and investment is necessary before CMS can rely on health IT to provide an accurate depiction of clinical decision-making and patient care in surgery centers.

In the past, ASCA has enjoyed a collaborative relationship with the Office of the National Coordinator. CMS could leverage agency relationships to ensure that industry standards are clear and well designed for the ASC space. This would in turn ensure broader usage of EHRs within the ASC community and ease future participation in TEAM or other episode-based payment models.

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<sup>2</sup> <https://www.healthit.gov/data/quickstats/national-trends-hospital-and-physician-adoption-electronic-health-records>

<sup>3</sup> ASCA 60-Second Survey, July 2025

***Could including ASCs in TEAM create barriers to care for any Medicare beneficiaries? What could CMS do to mitigate this?***

ASCs are already paid significantly less per procedure than hospitals. For example, an ASC receives roughly 30% less in facility reimbursement than a hospital outpatient department for a total knee replacement. This payment differential allows surgery centers to generate significant savings for Medicare and its beneficiaries but also creates an environment wherein ASCs operate with tight margins and high sensitivity to regulatory burden.

ASCA has been supportive of CMS policy changes in recent years that have added new surgeries to the ASC Covered Procedures List (ASC-CPL). In particular, the addition of total knee arthroplasty (TKA) and total hip arthroplasty (THA) to the ASC-CPL has created an incredible opportunity for Medicare beneficiaries to experience the high-quality, efficient care that surgery centers provide. Swift migration of these joint replacement procedures to the ASC space reflects both surgeon and beneficiary appreciation of the benefits of surgery centers.

As of 2024, ASCs are performing more than 42,000 TKAs and more than 24,000 THAs annually. KNG Health Consulting's recent analysis found that ASC performance of TKA alone saved Medicare \$624 million from 2020 to 2024. Based on the current procedure growth rate, KNG Health estimates that ASC performance of TKA could save Medicare Fee-for-Service \$2.8 billion over the next 10 years. However, incorporating ASCs into an episode-based payment model could stifle the current environment of growth and outpatient migration. Some ASCs that are currently performing total joint replacements may choose to remove their Medicare service lines rather than assume the responsibility of managing 30-day episodes of care. The ensuing reduction to access of care and increase in spending by shifting procedures to the higher-cost hospital setting would offset any marginal gains in efficiency achieved by the model.

ASCA would also like to reiterate the lack of a beneficiary copay cap in the ASC space, which paradoxically makes high-cost surgeries more expensive for beneficiaries when performed in a surgery center. For example, a total knee replacement in a hospital outpatient department costs a Medicare Fee-for-Service beneficiary \$1,736 (the inpatient deductible amount). The same procedure performed in a surgery center costs a beneficiary \$1,878 (the full 20% coinsurance) due to the lack of a copay cap. Until this issue is resolved, ASCA cannot recommend any payment model that incorporates high-cost procedures.

***What quality measures would reasonably capture performance and outcomes of TEAM ASC episodes?***

ASCA strongly recommends that any quality measure be appropriately introduced and tested as part of the ASCQR Program before being implemented in an episode-based payment model. This would ensure that measures properly reflect quality of care and patient experience before tying

them to reimbursement for specific procedures. CMS explicitly used existing hospital quality measures in TEAM with the goal of reducing provider burden, and the same efforts should be applied when considering ASCs in any episode-based payment model.

Some of the measures included in TEAM may have similar analogues in the ASCQR Program. For example, *ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures* and *ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers* measure similar outcomes to the *Hybrid Hospital-Wide All-Cause Readmission Measure* currently included in TEAM performance year (PY) 1. However, it should be noted that the ASC measures only contemplate a seven-day window post-discharge rather than the 30-day window in the hospital measure. The ASC measures would require refinement if tied to reimbursement for a longer episode of care.

One measure to note is *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)*, which is analogous to the inpatient LEJR measure currently included in TEAM PY1. However, *ASC-21* is voluntary until the CY 2028 reporting period, with limited reporting available to confirm the efficacy of the measure in the ASC space. ASCA reiterates comments submitted as part of its [CY 2026 OPPS/ASC payment system proposed rule comment letter](#). The comment letter elaborates fully on why this measure, as currently constructed, is not appropriate for inclusion in the ASCQR Program. Issues include, but are not limited to, lack of clinical support that outweighs facility burden, lack of pilot testing and lack of clarity on the need for ASCs to procure vendors. Until this measure is refined, tested and proven in the ASC space, it should not be implemented as a core element for reimbursement as part of any bundled payment model.

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ASCA appreciates CMS' acknowledgement that all settings of care and practices of all sizes are essential to providing high-quality, efficient care to Medicare beneficiaries. We value the agency's willingness to listen to our concerns as we strive to support our members in providing high-quality patient care and look forward to continuing to work with you and your staff. If you have any questions, please contact Kara Newbury at [knewbury@ascassociation.org](mailto:knewbury@ascassociation.org) or 703.636.0705.

Sincerely,



William Prentice  
Chief Executive Officer