September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1772-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

Dear Administrator Brooks-LaSure:

The undersigned state ambulatory surgery center associations appreciate the opportunity to comment on the proposals found in the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule ("Proposed Rule") (88 Fed. Reg. 145, July 31, 2023). While there are some positive policy proposals in the rule, there is much work to be done to ensure that all Medicare beneficiaries have access to the high-quality lower-cost surgery center setting.

Research[1] shows that ASCs reduced costs to the Medicare program by $28.7 billion in the period between 2011 and 2018. This study, which provides an update to ASC cost savings research released several years ago,[2] indicates an increase in annual savings from $3.1 billion in 2011 to $4.1 billion in 2018. Adopting policies that encourage further migration will generate even greater savings than those projected.

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 2023, there were 6,223 Medicare-certified ASCs, and approximately 54 percent have only one or two operating rooms.[3] These facilities must purchase the same equipment, devices and implants as hospitals to perform surgery. In fact, smaller ASCs often pay more for supplies since they lack the purchasing power of a hospital or large health system.

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[1] *Reducing Medicare Costs by Migrating Volume from Hospital Outpatient Departments to Ambulatory Surgery Centers*, KNG Health Consulting, LLC, September 2020. https://www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/reducing-medicare-costs

[2] *Medicare Cost Savings Tied to Ambulatory Surgery Centers*, University of California-Berkeley Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, September 2013, and the US Department of Health and Human Services. Office of Inspector General. Washington: Government Printing Office, April 2014. (A-05-1200020).

[3] CMS staff provided the current number of CMS-certified ASCs. Provider of Services Current Files, available at https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities/data is being updated, so OR data represents the latest update available (May 2022).

The past few years have been particularly challenging, beginning with COVID-19 restrictions starting in early 2020 and supply chain issues and increased costs that persist today. ASCs compete with hospitals and other health care providers for the same short supply of nurses and other staff, with shortages projected to grow over the next several years.[4] Anesthesia costs are skyrocketing due to many factors,[5] including declining physician reimbursement 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.[6]

The Ambulatory Surgery Center Association (ASCA) will submit more detailed comments on the proposals in the rule, but below are high-level comments on ASC payment policy proposals in the rule. We respectfully ask CMS to act to encourage the clinically appropriate migration of services into the lower-priced ASC setting, which will provide the Medicare program and its beneficiaries with savings while ensuring continued access to the high-quality care that ASCs provide, and beneficiaries deserve.

Annual Payment Update Policies

We support CMS' extended use of the hospital market basket as the annual update mechanism for ASC payments.

Since 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,[7] the ASC community has urged CMS to adopt the same update factor for both the ASC and OPPS payments. We appreciate that CMS took this first, necessary step toward better alignment of the payment systems. We support the alignment of OPPS and ASC update factors and using the hospital market basket (HMB) for updating ASC rates.

The COVID-19 pandemic arose during the second year of CMS' five-year pilot for aligning the ASC and OPPS update factors which has limited both ASCA and the Agency's ability to fully assess the success of the policy. Medicare fee-for-service (FFS) volume in 2020 was significantly lower than 2019 volume, and while there was a rebound in 2021, it is still below 2019 figures.[8] As such, we appreciate that CMS has proposed to extend the five-year trial for an additional two years.

We encourage CMS to discontinue the ASC weight scalar.

While the alignment of update factors was a positive first step, the lack of alignment on other policies leads to ASC reimbursement rates that are less than 50 percent on average of the hospital outpatient department (HOPD) rate for the same procedures. In too many markets, surgeries that

[4] https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage
[5] https://vmghealth.com/thought-leadership/blog/understanding-solving-the-new-reality-for-anesthesia-services/
[6] https://www.beckersasc.com/asc-coding-billing-and-collections/this-trend-could-reduce-the-number-of-ascs.html
[7] 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)
[8] Based on CMS PSPS Data for 2019 through 2021.

could be performed in surgery centers continue to be provided predominantly in hospitals, which we attribute to Medicare's failure to pay competitive rates to ASCs. Lack of alignment for policies such as the ASC (secondary) weight scalar threatens outpatient access to care, particularly in rural communities 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.

Under the statute implementing the current ASC payment system in 2008, CMS was only required to apply budget neutrality in the first year of implementation of the payment system.[9] Since CMS maintains budget neutrality in silos, if the Agency continues to apply budget neutrality adjustments looking at the ASC payment system alone, any increase in volume would lead to stagnation or a decrease in reimbursement rates. The Agency is needlessly increasing Medicare program costs by making it financially untenable for ASCs to perform procedures that are clinically appropriate and instead driving those procedures to the more expensive HOPD setting. To ensure ASCs remain a viable alternative for Medicare beneficiaries in need of outpatient surgical care, CMS must discontinue use of the ASC weight scalar.

Proposed Addition to the List of ASC Covered Surgical Procedures

While we support in theory the addition of dental codes to the ASC Covered Procedures List (ASC-CPL), the language regarding eligibility – that the procedure must be ""inextricably linked to the clinical success of an otherwise covered medical service, and therefore, are instead substantially related and integral to that primary medical service," is extremely limiting. It is unclear whether any dental procedures will be able to be performed in the ASC setting.

In addition, we are extremely disappointed that no other surgical codes were proposed for addition. The lack of transparency in this section of the rule is concerning. In addition to the Agency's failure to even mention codes that were requested by the industry, there was no mention of the Pre-Proposed Rule CPL Recommendation Process that is to go into effect on January 1, 2024, with a deadline for submissions of March 1, 2024.

Currently, CMS is not required to disclose a rationale for excluding a procedure and may ignore requests, as seen in this rule. As such, we view this new process as a much-needed avenue through which CMS must show its work and respond to requests for additions to the ASC-CPL presented to the Agency. The lack of implementation details in this rule is extremely troubling.

CMS indicates that additions to the ASC-CPL should be considered "in a carefully calibrated fashion to ensure that the procedure is safe to be performed in the ASC setting for a typical Medicare beneficiary." However, no guidance has been provided as to who this "typical" Medicare beneficiary looks like.

[9] 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.

Medicare beneficiaries – like our country's population at large – are not a monolith. When CMS added total knee arthroplasty (TKA) to the ASC-CPL in 2020, the Agency acknowledged that there is a "small subset of Medicare beneficiaries who may be suitable candidates to receive TKA procedures in an ASC setting based on their clinical characteristics." Presumably, TKA and total hip arthroplasty (THA) would not be added under the new criteria being used, which would be a huge loss to Medicare beneficiaries and taxpayers. In 2021, there were more than 20,000 TKAs and more than 9,000 THAs performed on Medicare FFS beneficiaries. It is unclear why CMS does not believe other joint replacement codes, such as total shoulder arthroplasty, are safe for the ASC setting.

Key Comments on ASC Quality and Proposed Reporting Program Changes

The ASC community has long-embraced quality reporting. In 2006, the ASC Quality Collaboration (ASC QC) was established to develop, test and publicly report quality measures specific to the ASC setting. We proactively requested an ASC Quality Reporting (ASCQR) Program and began submitting data more than a decade ago and support the collection and submission of publicly available data that can guide patients to the appropriate healthcare setting. However, the ASCQR Program has been foundering in recent years, and burdens are being imposed on facilities without any benefit to patients.

We are concerned that CMS fails to adequately consider the cost burden on facilities when establishing new quality measures. ASCs will be required to contract with a third-party vendor to administer the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery (OAS CAHPS) beginning in 2025. CMS maintains a list of approved vendors, but it is not clear that CMS knows how much their approved vendors charge. When ASCA surveyed the vendors, prices varied significantly, including one quote for $20,000 per year. At some point, an ASC may make the business decision to decline to participate in the ASCQR Program and accept the two percent penalty. This does not mean the facility will be any less safe – or that it will not be collecting quality metrics. But if the burden outweighs the benefit to patients and the facility, we may see ASCQR Program participation decline. We ask CMS to work with the ASC community to include measures in the ASCQR Program that provide useful data to consumers and encourage ASC participation.

We continue to request that ASC-11 be removed from the ASCQR Program.

CMS' recognition in 2023 that implementing *ASC-11 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* would represent an undue burden due to the continued impact of COVID-19 on facilities was the correct decision, however, this measure would place an undue burden on our facilities regardless of the presence of a public health emergency (PHE) in this country.

This measure was developed, tested and previously endorsed by the National Quality Forum (NQF) as a clinician-level measure (NQF #1536), and was never intended to measure facility performance. *ASC-11* relies on data obtained by the physician and recorded in the medical records housed in the physician office at two key points in time: (1) the patient's visit(s) with the physician during which the evaluation, examination and decision regarding surgery was made,

and (2) the patient's visit(s) with the physician after surgery and during the post-operative 90-day global period. ASCs do not have access to these records. Asking ASCs to report this measure is administratively burdensome and not reflective of the attributes of the ASC facility or the actions of its staff during the patient's time in the facility.

We support CMS' decision to maintain *ASC-11* as a voluntary measure and once again request that it simply be removed from the dataset altogether as it is not actionable by the facility and therefore of limited to no value to the patients served.

We support changes to OAS CAHPS implementation that will reduce the administrative and financial burden on our facilities.

We appreciate the longer implementation period ASCs were given but continue to advocate for an electronic-only option to make the survey easier for our patients to complete and to decrease the financial burden on facilities.

ASC-20 should be removed from the ASCQR Program.

As 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.

The COVID-19 public health emergency ended on May 11, 2023. On May 31, CMS released a final rule that withdrew the regulations that had mandated COVID-19 vaccination for healthcare personnel (HCP). It has never been a requirement that facilities collect vaccination status of their patients and guests, and many healthcare facilities no longer require patients and guests entering facilities to even wear masks anymore. And yet, surgery centers and other healthcare facilities must continue to report on HCP vaccination status monthly to avoid penalties. It is difficult to claim it is a matter of epidemiology when we do not know the vaccination status for a sizable number of the individuals coming through the facility daily – including the patients undergoing surgery.

We respectfully request that this measure be removed from the ASCQR Program.

In the absence of complete removal from the program, CMS should move to an annual reporting requirement. This would at least reduce the burden of having to collect data monthly, especially when vaccination status is not changing as rapidly as it was previously.

Closing Summary

We appreciate the opportunity to provide feedback on the Agency's latest proposal to reimburse and regulate surgery centers. As is clear from these comments, it is imperative that CMS improve its coordination with the healthcare community to improve the Medicare program. We welcome the opportunity to collaborate with CMS on the recommendations in this comment letter that ensure our facilities can continue to provide outstanding care to Medicare beneficiaries at a fair cost to the Medicare program.