September 10, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010

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 (CMS-1834-P)

Dear Administrator Oz:

On behalf of the over 90,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2026 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule published in the *Federal Register* on July 17, 2025.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of surgical care is furnished in hospital outpatient departments (HOPDs) and ASCs, the College has a vested interest in CMS' coverage, reimbursement, and quality reporting requirements applicable to these settings. With our more than 100-year history in developing policy recommendations to optimize the delivery of surgical services, lower costs, improve program integrity, and make the U.S. healthcare system more effective and accessible, we believe that we can offer insight to the Agency's proposed modifications to the hospital outpatient and ASC payment systems for CY 2026. Our comments below are presented in the order in which they appear in the rule.

## SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES

### CY 2026 Proposal to Eliminate the Inpatient Only (IPO) List

CMS proposes to eliminate the IPO list—which identifies services for which Medicare will make payment only when furnished in the inpatient hospital setting due to the invasive nature of the procedures, the underlying physical condition of the Medicare patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged—over a three-year transitional period, with

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the list being completely phased out by CY 2029. The Agency would begin with the removal of nearly 300 procedures in CY 2026, making these services eligible for Medicare payment in the hospital outpatient setting in addition to the inpatient setting.

**The ACS strongly opposes the elimination of the IPO list.** As stated in our previous comments to CMS, we agree with the removal of certain services from the IPO list for which there is evidence that they can safely be furnished in the outpatient setting. However, we are extremely concerned by the Agency's proposed removal of various IPO procedures that do not have sufficient data to support the appropriateness of their performance on an outpatient basis. **CMS' proposal is riddled with inaccurate clinical assumptions and fails to address a number of underlying implementation issues—we note that the Agency does not provide any discernible rationale or description of efforts undertaken by CMS to thoroughly examine each service on the IPO list and provide evidence that all such services can safely be performed in the outpatient setting.** We question if, in the absence of such evidence to substantiate elimination of the IPO list in this rule, CMS has considered the potential negative consequences of its proposal, several of which are outlined below, for Medicare beneficiaries, as well as for the physicians and hospitals participating in the Medicare program.

***Patient Safety, Quality, and Access to Surgical Care***

Elimination of the IPO list would make major and complex procedures that typically require extensive inpatient treatment payable in outpatient sites of service. This policy change raises concerns about the safety and quality of care—even with advancements in medical practice and technology, certain care is too complex to be provided safely in the outpatient setting. Cost and feasibility should not be the only considerations when determining which procedures can be done in outpatient settings. Surgical patients may face more risk in the post-operative period or have comorbidities that require the resources and capabilities of an inpatient setting to prevent or manage complications, including the ability to render timely and necessary interventions to prevent patient death. Evaluating risk with clinical outcomes data to examine pre- and post-operative morbidity and mortality outcomes is critical for making site of service determinations. Analysis of procedures on the IPO list using risk-adjusted clinical data, such as those from ACS National Surgical Quality Improvement Program (NSQIP) registry, can provide insights into safety and appropriateness to determine which procedures can be safely and effectively done in outpatient settings.

Additionally, the next generation of quality measures for the outpatient setting should be patient-centered and tied to the condition(s) and surgical procedure(s) under consideration. They must also track patients across the full episode of care and should not only focus on the care managed within an outpatient setting. Currently, quality mechanisms available for the outpatient setting differ greatly from those in inpatient settings. To date, the majority of efforts to measure quality, especially in surgery, have focused on the inpatient setting. To optimally care for patients in inpatient settings, we have developed capabilities to track outcomes, processes, structures, and patient experience delivered by care teams. This multi-faceted approach to quality is lacking in the outpatient setting, making it difficult to truly understand how complications are managed during and after outpatient procedures, how care teams function, if care met patient goals, and so on. As CMS looks to transition more care to outpatient settings, it is important that it works with clinical experts and relevant specialty societies to build out meaningful and effective quality standards that focus on the patient and equip care teams to deliver optimal care and meet patient goals and expectations.

Furthermore, the elimination of the IPO list may result in unintended consequences that shift care to urban areas. This may result in unequal access to outpatient procedures for Medicare beneficiaries. When hip replacements were removed from the IPO list in 2020, there was a nearly ten-fold difference



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in the proportion of White Medicare beneficiaries undergoing outpatient hip replacements compared to Black Medicare beneficiaries.[1] More than 88 percent of rural US counties have no ASCs and more than 46 percent of rural US counties have neither an ASC nor an HOPD[2]). Especially for Medicare Advantage beneficiaries for which health plans may default to covering only outpatient or ASC procedures, elimination of the IPO list at this time may potentially reduce access to necessary inpatient surgical procedures for rural Medicare beneficiaries. CMS should consider ongoing assessment of the consequences of elimination of the IPO list on patient safety and quality for all Medicare beneficiaries and on access to surgical procedures especially for rural Medicare beneficiaries.

***Healthcare Business Model***

The elimination of the IPO list may have a significant impact on hospital business models and may contribute to unintended downstream consequences for cross-functional community health services, such as behavioral health, maternity care, etc. It is common for hospitals to support service lines that deliver higher rates of uncovered services by sharing revenue from other covered services lines, such as surgery. It is important that CMS is aware of how the removal of the IPO list may impact the business model in healthcare, and it should continue to assess how this policy might impact access and availability of all a patient's healthcare needs, not only those procedures on the IPO list.

***Out-of-Pocket Costs***

We are concerned by the implications that the inevitable mass shift of procedures to the outpatient setting will have on the accessibility and affordability of care for Medicare beneficiaries. Per CMS rules, the copayment for a single outpatient hospital service cannot be more than the inpatient hospital deductible; however, a patient's total copayment for the cumulative cost of all outpatient services related to a single procedure may be equal to an amount greater than the inpatient hospital deductible.[3] Therefore, patients treated in the outpatient setting may be subject to increased out-of-pocket costs that exceed the costs incurred had they been treated in the inpatient setting. The ACS does not support any policies, such as the elimination of the IPO list, that will inappropriately shift costs onto patients and therefore discourage beneficiaries from seeking necessary care.

***Administrative Burden***

The elimination of the IPO list would create increased documentation and audit burden for physicians and hospitals, and we question how CMS would begin implementing the IPO list phase-out in CY 2026 without first publishing specific program integrity and reporting guidelines to support provider education and compliance. The Agency does not specify how utilization reviews will occur for procedures performed on an inpatient basis once they are removed from the IPO list, and it remains unclear how physicians must indicate that the provision of a service in the inpatient setting is reasonable and necessary, if obtaining prior authorization is required, and when organization determinations will be made by CMS or its contractors. We do not understand why CMS would eradicate a reliable and comprehensive list of services for which site-of-service reviews do not apply, leaving much room for confusion and delays in care as physicians, hospitals, and coding staff are stripped of clear guidelines for proving the medical necessity of inpatient care.

***Medical Advantage and Commercial Insurer Coverage***

[1] Tsai TC, Brownlee SA, Dai D, et al. Disparities in Access to Outpatient Surgery Related to Removal of Procedures from Medicare's Inpatient-only List. *Ann Surg*. 2025;281(5):779-786.
[2] Amba V, Izadi S, Ramesh T, Yu H. Outpatient surgical institutions in the rural United States: Trends from 2010 to 2020. *Am J Surg*. 2025; 242.
[3] Centers for Medicare & Medicaid Services. Inpatient or outpatient hospital status affects your costs. Accessed September 3, 2025. https://www.medicare.gov/what-medicare-covers/what-part-a-covers/inpatient-or-outpatient-hospital-status



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Other insurers, including Medicare Advantage Organizations (MAOs), may also use the lack of the IPO list to inappropriately force care into the outpatient setting purely to generate cost-savings for their plans. CMS itself noted that stakeholders have indicated that removing a service from the IPO list creates expectations that the service must be furnished in the outpatient setting "regardless of the clinical judgment of the physician or needs of the patient."[4] This proposed policy risks creating an inequitable system in which Medicare Advantage beneficiaries are effectively forced into the outpatient setting for surgical procedures with potentially adverse implications for quality and cost of care. In contrast, beneficiaries enrolled in Traditional Medicare would continue to have coverage for the same procedure in either the inpatient or outpatient setting based on their clinical needs.[5] Peer-reviewed studies have demonstrated that MAOs deny up to 17 percent of initial claims, and one in three Medicare Advantage beneficiaries experience at least one claim denial annually.[3,6] Eliminating the IPO list would significantly heighten the likelihood that MAOs will deny coverage for medically necessary inpatient surgical procedures and only approve outpatient coverage, thereby restricting beneficiary access to the most clinically appropriate site of service.

**The ACS urges CMS to maintain its current annual IPO list review process to identify procedures that should be removed or added from this list, which offers stakeholders an opportunity to provide input and has historically been an effective mechanism to gather reliable and objective clinician data regarding the safety and efficacy of procedures furnished in the outpatient setting.** High quality surgical care involves much more than providing services at the lowest possible cost, and CMS should not eliminate the IPO list as a mechanism to allow any procedure to be performed as an outpatient service without evidence of patient safety. As noted above, complications can occur with any surgical procedure, particularly during the post-operative period. For many services on the IPO list, such complications will be best identified early and treated promptly in the inpatient hospital setting. We believe that CMS would greatly benefit from coordinating with the surgical community to identify which specific procedures on the existing IPO list may be safely provided in an outpatient setting, instead of simply selecting a subset of codes for removal without first seeking input from the relevant specialty societies.

## CROSS-PROGRAM PROPOSALS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR), RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM, AND THE AMBULATORY SURGERY CENTER QUALITY REPORTING (ASCQR) PROGRAM

### Proposed Removal of the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program Beginning with the CY 2025 Reporting Period/CY 2027 Payment or Program Determination

CMS proposes to remove the Hospital Commitment to Health Equity (HCHE) measure from the Hospital Outpatient Quality Reporting (OQR) Program and the Rural Emergency Hospital (REH) Quality Reporting (REHQR) Program measure sets and the Facility Commitment to Health Equity (FCHE) measure from the ASC Quality Reporting (ASCQR) Program measure set beginning with the CY 2025 reporting period/CY 2027 payment or program determination. CMS states that it believes the cost of reporting the measure outweighs its benefit. They also explain that based on feedback received

[4] 85 FR 48772
[5] Gondi S, Kadakia KT, Tsai TC. Coverage Denials in Medicare Advantage – Balancing Access and Efficiency. *JAMA Health Forum*. 2024;5(3):e240028.
[6] Vabson B, Hicks AL, Chernew ME. Medicare Advantage Denies 17 Percent of Initial Claims; Most Denials Are Reversed, But Provider Payouts Dip 7 Percent. Health Aff (Milwood). 2025;44(6):702-706.



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from hospitals, REHs, and ASCs—as well as a re-focus on clinical outcomes and direct patient care—that the burden of collecting these measures may outweigh the benefits.

**First, the ACS would like to highlight the importance of environmental and social factors when considering the health of the whole patient. It is essential that healthcare facilities commit to supporting high-risk patients and continue looking at all relevant factors—procedural risk, condition risk, and social determinants that contribute to the patient's success before, during, and after an operation. It will be very difficult for CMS to achieve quality and cost targets without considering the whole patient and the circumstances surrounding that patient. We encourage CMS to consider alternative methods to account for the social needs of patients. The ACS welcomes the opportunity to work with CMS to develop an alternative measure.**

Additionally, evidence demonstrates that structural measures—alongside outcome and process measures—are essential to building an effective quality program and should be viewed as complementary components. Therefore, the ACS questions the Agency's assumption that care would be improved by removing structural measures in order to focus efforts solely on outcomes. In fact, it has become evident that outcome measurement alone without the drivers of structure and process, has led to unintended consequences, and has been the subject of "measure gaming," where hospitals and health systems demonstrate improvements on measures that are disconnected from true improvements in patient care.[7,8,9] The Donabedian Model of Quality, the foundation upon which quality measurement has been built, gave Structure, Process, and Outcome as its fundamental building blocks.[10] No one component was ever intended to become the centerpiece of the model, as each part, structure, process and outcome are fundamentally interconnected in the orchestration of complex and competent care.

In the ACS' experience running quality programs, it is clear that high quality outcomes are nearly impossible to achieve without the supporting infrastructure of hospital structures and processes of care. This point is reinforced in the outpatient setting where procedures are lower risk, episodes are shorter, and there is less variation in patient outcomes. Therefore, current quality measure frameworks in this setting that are focused on adverse events will be of limited use and uninformative due to low adverse events incidence. Instead, when compared to typical cost and quality outcome measures, quality frameworks that focus care teams around the needs of the patient to achieve their goals, evaluate patient experience, and foster efficient, effective systems in outpatient settings can be better indicators for gaps in care. Rather than turning away from structure and process measures, the future of quality measurement must lean into these types of measures alongside outcome measures to avoid repeating mistakes of the past. To that end, the ACS strongly urges CMS to maintain structural measures in its programs.

## AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM (ASCQR)

### Proposed Adoption of the Information Transfer PRO–PM Beginning with Voluntary Reporting for the CY 2027 and CY 2028 Reporting Periods Followed by Mandatory Reporting Beginning with the CY 2029 Reporting Period/CY 2031 Payment Determination

CMS proposes to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance

[7] Konetzka RT, Polsky D, Werner RM. Shipping out instead of shaping up: rehospitalization from nursing homes as an unintended effect of public reporting J Health Econ. 2013;32(2):341-52. doi: 10.1016/j.jhealeco.2012.11.008.
[8] Werner RM, Asch DA, Polsky D. Racial profiling: the unintended consequences of coronary artery bypass graft report cards. Circulation. 2005;111(10):1257-63. doi: 10.1161/01.CIR.0000157729.59754.09.
[9] Roth S, Gonzales R, Harding-Anderer T, et al. Unintended consequences of a quality measure for acute bronchitis. Am J Manag Care. 2012;18(6):e217-24.
[10] Donabedian A. Evaluating the Quality of Medical Care. *Milbank Q*. 2005;83(4):691-729.



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Measure (Information Transfer PRO–PM) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination. The Information Transfer PRO–PM assesses patient understanding of provided discharge information for patients aged 18 years or older who had a procedure (surgical or non-surgical) at an ASC via a 9-item survey. The survey evaluates patient-reported understanding of information received across three domains: applicability to patient needs, medication, and daily activities. CMS believes that survey results provide PRO data that can demonstrate ASCs' discharge instruction communication efforts and enable ASCs to reduce future risk of patient harm related to patients not fully understanding their recovery information. CMS also proposes that the Information Transfer PRO–PM would be calculated based on PRO data collected by ASCs directly or through their authorized third-party vendors through the Information Transfer PRO–PM survey instrument distributed to patients or their caregivers by electronic mail or text. CMS notes that the Information Transfer PRO–PM survey is nonproprietary and free to use. CMS also proposes that the survey be distributed within two to seven days post-procedure or surgery.

**The ACS has been extremely supportive of the use of patient-reported outcome measures (PROMs) in quality programs and supports the adoption of the Information Transfer Patient-Reported Outcome- Performance Measure (PRO-PM) in the ASCQR. Patient-reported outcome measures (PROMs) and PRO-PMs can offer meaningful insight from the patient's perspective, which is foundational to determining the value of care based on what matters to the patient.** When thinking about surgical care, measuring rare or adverse events is important. Still, it only affects a limited number of patients. On the other hand, PROs can assess every surgical patient and offer the opportunity for a patient to express their experience, satisfaction, level of goal attainment, and so forth. Where few other measures help to inform referring physicians and patients, PROs fill a gap. They provide valuable insights into patients' perspectives on their health, quality of life, and functional status. Patient-reported measures are especially important in the outpatient setting where procedures and patients are typically less complex compared to the inpatient setting, and therefore there is less variation in care for rare events.

PROMs also give insight into the performance of the care team that cannot be captured in traditional outcome or process measurement mechanisms. Measures such as the Information Transfer PRO-PM can help ensure continuity of high quality care in situations where a patient may not have ready access to their care team after discharge. The Information Transfer PRO-PM measure is important to help ASCs identify the post-discharge information that is most useful to patients and where patients may need more information to optimize their recovery.

**While we support this measure, we strongly encourage CMS to also prioritize PROMs that assess whether the patient's goals for surgery were identified and achieved.** Understanding patient goals for an operation and then receiving direct feedback from the patient about whether their goals were attained, their experience, and/or their physical function following an operation is invaluable to the surgical team, the patient/patient caregivers, and referring doctors. These metrics give patients a voice while also giving physicians useful insight on areas for improvement and determining whether the patient's goals of care were met.

To fill this gap, the ACS recently submitted a measure, CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients, that was developed to assess the quality of patient shared decision-making (SDM) for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care. This measure was submitted due to the lack of metrics in CMS programs that focus on patient preferences or the appropriateness of surgical decisions. Where the Information Transfer PRO-PM collects important information about experience and safe recovery, we



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believe an SDM measure, such as the CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients measure, should be a top priority to assess and promote alignment between an individualized decision to operate and patient goals.

Finally, just as quality metrics should vary and align with each episode, the same should be considered for PROMs—even in the context of patient understanding of key information and goal attainment. A one-size fits all PROM environment may not be suitable—we have seen this in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measure, for example, which provides limited meaningful information to the care team and patients/patient caregivers regarding a specific episode of care. As CMS builds out its catalog of PROMs and PRO-PMs, it will be important to define the episodes and understand the specific needs of patients and care teams. The move to surgical episodes of care would be enhanced if the performance metrics in cost, quality, safety and outcomes map back to the patient's episode of care. This would reveal the aspects of the care journey for a focused effort to improve. PROMs and other quality metrics should be designed with the intent to inform patients about where to seek the care they need, to help primary care providers to refer care, and to educate facilities where they need improvement.

It is also important to acknowledge past challenges to engage patient responses to PRO surveys. As we look to build out an inventory of PROs in quality programs, identifying ways to promote patient participation in PRO surveys will be key to ways to ensure PROs can meaningfully enhance the patients entire care journey. **The ACS is eager to work with CMS and other impacted stakeholders to help develop PROs that assess important elements of surgical care and strategies to encourage patient engagement in PROs.**

## UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES

The ACS recognizes the importance of increasing the accuracy and utility of pricing data, including both the Hospital Price Transparency (HPT) requirements as well as Transparency in Coverage (TiC) and No Surprises Act (NSA) policies. We appreciate that CMS is taking an iterative approach toward the goal of ensuring that information available is actionable and reflective of what a patient can expect to pay for care. We agree with CMS that the lack of consistent standards in pricing information provided (both among hospitals' efforts to comply with HPT requirements and across transparency programs) has the potential to create unnecessary confusion for patients and researchers and limit the value of transparency efforts. Instead**, CMS should consider a ground-up re-thinking of cost measurement and transparency to create a unified system that better achieves the dual goals of increasing transparency and value-based care.**

CMS proposes to make several amendments to the HPT regulations to enhance standardization of the data reported, which will in turn improve clarity and the value of the information to patients and physicians making decisions on where to seek care. Specifically, the proposed rule would remove the requirement that hospitals disclose estimated allowed amounts and replace this with a requirement for hospitals to disclose the 10$^{th}$ percentile, median, and 90$^{th}$ percentile allowed amounts along with the total count of allowed amounts.

The Agency also proposes requiring hospitals to standardize how these data are reported by mandating use of electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data. Any negotiated charges that can be expressed as a dollar amount must be expressed as such. In cases where this is not possible, all information necessary to be able to derive a dollar amount such as fee schedules, percentages, formulas or algorithms must be included. Requiring hospitals to comply with this



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methodology which is already widely used to calculate the percentile and median allowed amounts is intended to reduce variability in the machine-readable file (MRF), which will speed research and the development of tools and dashboards to make more meaningful and comparable information available to patients and referring physicians. Requiring hospitals to comply with the EDI 835 methodology which is already widely used to calculate the percentile and median allowed amounts is intended to reduce variability in the machine-readable file (MRF), which will speed research and the development of tools and dashboards to make more meaningful and comparable information available to patients and referring physicians. To increase compliance, the Agency proposes that the MRF must include the name of the senior official designated to oversee the transmission of accurate and complete data.

In the proposed rule CMS acknowledges that the average dollar amounts provided in current regulations do not necessarily represent the actual dollar amount an individual would pay for an item or service. This is especially true for more complex care such as a major surgical procedure. For this reason, the ACS continues to question the benefit of requiring hospitals to report standard charges, especially given other transparency efforts such as TiC and the good-faith estimates (GFEs) required by the NSA. Even with the proposed changes showing a range of negotiated allowed amounts, such price information will not be specific to an individual patient. The TiC requirements, on the other hand, are more beneficial to a patient than the hospital transparency requirements because health plans are required to provide real time cost-sharing liability under the plan's deductible, coinsurance, and copay structure that is based on actual rates, allowed amounts, and individual-specific cost-sharing requirements. The NSA GFE requirements cover, in part, uninsured and self-pay patients. As such, the TiC and NSA requirements are broader than the hospital transparency requirements, making the details shared by hospitals less useful to consumers.

Having multiple competing requirements for transparency, likely resulting in different published amounts for the same item or service, has the potential of adding additional confusion rather than providing clarity. **Patients should have access to standardized, trusted, and validated price information, and making this information available to patients will be more straightforward with health plans as the primary generator of this information. In addition, we believe that hospitals and health systems should instead focus on delivery of care rather than providing price information.**

While some regulatory obligations are necessary, requiring institutions to perform regulatory activities, such as those related to transparency, that are not focused on care delivery should be limited. In the case of price transparency, heath plans are also better situated to provide patient-specific information in a consumer-friendly format given that the plan is responsible for determining the patient's cost-sharing liability. However, patients must be able to assess out-of-pocket cost estimates for a given episode in its entirety, not simply for the individual service items. For that reason, the **ACS maintains that pricing information should be presented as episodes rather than single services so that patients receive a more comprehensive picture of the care they will receive.** The episodes should also be sufficiently nuanced to encompass atypical patients. Patients have comorbidities, and more complex patients with multiple comorbidities tend to require more clinical services in support of treating the primary condition under consideration. In sophisticated pricing models, it is possible to define expected prices based on patient comorbidities.

CMS also suggests that the change from reporting the average amount to reporting percentile and median amounts would better enable healthcare consumers to compare cost information across hospitals and empower them to make more fully informed and value-conscious health care choices. **The ACS argues that, while having accurate and standardized data showing the range of allowed amounts may be an improvement over average amounts, it is still of limited value on its own. Without**



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**access to commensurate and actionable information on quality, no meaningful conclusions on the value of care provided can be drawn.** For complex care such as surgery, the episode of care, including all providers, items and services involved in the patient's care journey, is the most suitable unit both for cost and team-based, programmatic quality measurement. Defining an episode of care in terms of both cost and quality is possible using tools that are currently available. However, the proliferation of different measures and methodologies to measure the cost and price of care for each payment program, payer, or purpose threatens to not only add unnecessary burden but also to confuse patients and make transparency unmanageable.

The goal of increasing transparency in health is among the most important next steps in the transformation of federal and commercial payment programs to benefit patients. However, the piecemeal approach across payers and within federal programs (fee-for-service and alternative payment models) confound the ability of patients and clinical decisionmakers to make determinations on value in the moment of care. While patients may focus on the immediate cost experienced through a co-pay or deductible, they also experience the monthly recurring costs of coverage which have grown steadily over time. The multiple fiscal disconnects fail to look at cost as a whole for the entire episode of care, which prevents patients from having any sense of the cost the system incurs or their expected total contribution and further hinders their ability to have a clear vision of their entire care pathway from diagnosis to discharge and return to preventive and maintenance care.

For these reasons, the **ACS holds that transparency efforts will provide the highest benefit if they are inclusive of the full span of care. This is the true information needed by both patients and referring physicians to make informed decisions on where to seek care that meets their preferences on value. We urge CMS to consider a ground-up rethinking of cost measurement and price transparency and to develop a unified, episode-based metric that would better meet the needs of both clinicians and patients**.

The ACS appreciates the opportunity to comment on these important issues, and we look forward to continuing dialogue with the CMS on issues impacting outpatient surgical care. Please contact Vinita Mujumdar, Chief of Regulatory Affairs, at vmujumdar@facs.org, Jill Sage, Chief of Quality Affairs, at jsage@facs.org or Matt Coffron, Chief of Health Policy Development, at mcoffron@facs.org with questions.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director and CEO



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