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VIA ELECTRONIC TRANSMISSION

August 31, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244–8010

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots [CMS-1850-P]

Dear Administrator Oz:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons nationwide, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2027 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems and Quality Reporting Programs proposed rule published in the *Federal Register* on July 7, 2026.

The proposed rule addresses several issues of significant importance to neurosurgical patients and providers. In particular, the AANS and CNS comment on CMS's proposed phase-out of the Inpatient Only (IPO) list, prior authorization requirements for cervical fusion with disc removal and implanted spinal neurostimulators, and proposed changes to hospital outpatient and ASC quality measurement. Collectively, these proposals present important opportunities to ensure that Medicare payment and quality policies appropriately reflect clinical complexity and judgment, patient outcomes, and resource requirements.

In summary, the AANS and CNS:

- Urge CMS to retain a clinically meaningful IPO list and conduct a rigorous, procedure-specific review before transitioning complex neurological procedures to outpatient payment;

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- Call on CMS to eliminate prior authorization requirements for cervical fusion with disc removal and implanted spinal neurostimulators, which have resulted in significant delays and administrative burdens without sufficient evidence of clinical benefit;
- Encourage CMS to appropriately target the proposed Advance Care Planning measure to clinically relevant patient populations, include appropriate exclusions, maintain facility-level accountability, and conduct adequate testing before implementation; and
- Support CMS efforts to stratify the ASC All-Cause Transfer/Admission measure by phase of care while ensuring that medically appropriate transfers and escalations of care are not inappropriately characterized as quality failures.

The AANS and CNS appreciate CMS's consideration of these comments and look forward to continued engagement on policies that promote patient safety, preserve physician-led clinical decision-making, and ensure that the OPPS and ASC payment and quality programs support access to medically necessary care.

SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES

Proposed CY 2027 Changes to the Inpatient Only (IPO) List

The AANS and CNS remain strongly concerned about CMS's decision to phase out and eliminate the IPO list. Advances in surgical technique, anesthesia, imaging, and perioperative care have made some inpatient procedures safe to perform on an outpatient basis for carefully selected patients—but that does not justify eliminating the IPO list as a matter of Medicare payment policy.

The IPO list identifies procedures that, due to their invasive nature, the beneficiary's condition, or the need for postoperative recovery or monitoring, require inpatient care and are not paid under the OPPS. Under 42 C.F.R. § 419.23, CMS must assess annually whether a service should be removed based on criteria such as whether most outpatient departments can furnish it, whether it is already performed in numerous hospitals on an outpatient basis, and whether it can be performed safely in an ASC.[1] Beginning in CY 2026, the Agency replaced that annual, service-specific review with a three-year phase-out intended to eliminate the IPO list entirely by CY 2029—CMS removed nearly 300 procedures in CY 2026, making them eligible for Medicare payment in the hospital outpatient setting in addition to the inpatient setting.[2] For CY 2027, CMS proposes removing an additional 637 services while deferring the neurological, cardiovascular, and transplant clinical families until CY 2028.[3]

The AANS and CNS recognize that some procedures historically included on the IPO list may be safely furnished in an outpatient setting for certain Medicare beneficiaries. CMS's longstanding annual review process provided an appropriate mechanism for identifying and removing such services based on clinical evidence and stakeholder input. However, the AANS and CNS do not support the shift from the evidence-based, procedure-specific IPO list approach to a predetermined phase-out of the list as a whole. The existence of clinical advances that permit selected procedures to be performed safely on an outpatient basis does not establish that all procedures remaining on the IPO list are appropriate for routine outpatient payment, nor does it eliminate the need to consider differences among procedures, patient populations, postoperative risks, and available resources.

The CY 2028 review of neurosurgical procedures—many of which involve the brain, spinal cord, intracranial vasculature, or other critical structures for which a postoperative complication may require

[1] 42 C.F.R. § 419.23(a)–(b)
[2] CMS-1834-FC
[3] CMS-1850-P

immediate evaluation and intervention—therefore represents an important opportunity for CMS to reconsider whether the remaining services satisfy the clinical and payment criteria necessary for outpatient care, rather than treating their removal as an inevitable final step in the phase-out. The Agency should use this additional time to work collaboratively with the neurosurgical community to determine whether individual procedures can safely and appropriately transition to the outpatient setting and whether the OPPS has an adequate payment structure to support them.

Implications for Patient Safety and Access

The elimination of the IPO list would make increasingly complex procedures that have historically required extensive inpatient treatment payable in outpatient settings, raising significant concerns about patient safety and quality of care. Even with advances in medical practice and technology, certain procedures remain too complex to be routinely furnished in an outpatient environment. Neurosurgical patients may face substantial postoperative risks or have comorbidities requiring the resources and capabilities of an inpatient hospital to prevent or manage complications, including the ability to provide timely imaging, neurological monitoring, reoperation, or other interventions when clinically necessary. Before removing procedures from the IPO list, CMS should evaluate risk-adjusted clinical outcomes demonstrating that the services can be safely and effectively furnished in the outpatient setting—such an assessment should consider pre- and postoperative morbidity and mortality, patient comorbidities, expected recovery, complication rates, and the ability to provide timely intervention when complications arise.

The elimination of the IPO list could also have unintended consequences for Medicare beneficiaries in rural and underserved communities, particularly where outpatient surgical infrastructure is limited. MedPAC reports that approximately 94% of ASCs were located in urban areas in 2024, meaning only approximately 6% were located in rural areas; MedPAC also notes that rural Medicare beneficiaries are less likely than their urban counterparts to receive surgical care in ASCs.[4] A shift toward outpatient payment must therefore not inadvertently create incentives that limit access to inpatient surgical care for beneficiaries who live in communities where outpatient alternatives are unavailable or inappropriate. CMS should assess the impact of IPO elimination on access to care, including geographic disparities and the ability of rural hospitals to continue providing comprehensive surgical services.

Pressure to Shift Site-of-Service

The elimination of IPO list also has implications beyond Medicare's technical ability to pay for a procedure in the hospital outpatient setting. The AANS and CNS are concerned that, over time, a service's removal from the list may be interpreted by Medicare Advantage organizations (MAOs) and other payers as evidence that outpatient care should be the expected or preferred setting, rather than one option that may be appropriate for an individual beneficiary.

This concern is particularly relevant to site-of-service determinations. CMS itself has acknowledged that removal from the IPO list could create an expectation that a given service should be furnished in the outpatient setting regardless of the physician's clinical judgment or the needs of the patient.[5] Nevertheless, the Agency continues the three-year phase-out, stating in this proposed rule that evolving medical practice allows more procedures to be performed on an outpatient basis and that the policy provides physicians greater flexibility to determine the appropriate site of service. The AANS and CNS

[4] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 11, "Ambulatory Surgical Center Services: Status Report" (Mar. 2026).
[5] CMS-1850-P

agree that, when appropriate, patients may receive certain procedures safely as outpatients; however, payment policy should not inadvertently convert clinical flexibility into a payer expectation.

The elimination of the IPO list should not become a mechanism for payers to pressure physicians to furnish complex neurosurgical procedures in the outpatient setting simply because that setting is less costly, nor should patients face delays in medically necessary care because of erroneous shifts in site-of-service requirements. Medicare beneficiaries should have access to the clinically appropriate setting based on their individual circumstances, regardless of whether the procedure remains on the IPO list.

For these reasons, the AANS and CNS believe that CMS should retain a mechanism that clearly distinguishes procedures for which inpatient payment is presumptively appropriate from those that may reasonably be considered for outpatient payment. Medicare regulations expressly contemplate annual assessment of individual services against specific removal criteria, and the Agency should maintain and strengthen this evidence-based review rather than eliminate the IPO list according to a predetermined phase-out schedule.[6]

Beneficiary Cost Sharing

The AANS and CNS are further concerned about the potential implications for beneficiary cost sharing. Under section 1833(t)(8)(C)(i) of the Social Security Act, beneficiary copayments for a procedure furnished under the OPPS are subject to a limit tied to the inpatient hospital deductible. However, this limitation does not necessarily mean that an outpatient surgical encounter will result in lower aggregate beneficiary cost sharing than an inpatient admission. Beneficiaries may incur cost sharing for multiple outpatient services furnished as part of a single surgical episode.

Moving increasingly complex surgical care from the inpatient to the outpatient setting may therefore have financial consequences for Medicare beneficiaries that are not apparent from payment for the primary procedure alone. CMS itself has justified the IPO phase-out in part on the premise that beneficiaries may have greater choice and potentially lower out-of-pocket costs, and as such, should ensure that this assumption holds by prohibiting any policies that shift additional financial responsibility to beneficiaries who seek care in the outpatient setting.[7]

Administrative Burden and Program Integrity

Elimination of the IPO list will also create significant administrative and compliance burdens for physicians and hospitals. Once a procedure is removed from the IPO list, physicians and hospitals may face greater scrutiny regarding whether inpatient care was reasonable and necessary, including potential utilization review, prior authorization, documentation, and audit requirements.

CMS should clearly establish program integrity, documentation, reporting, and utilization management requirements before removing procedures from the IPO list. Physicians and hospitals should have clear guidance regarding how to document the clinical circumstances supporting inpatient care and how Medicare Administrative Contractors (MACs) and MAOs will evaluate such determinations. A longstanding benefit of the IPO list has been its ability to provide clear expectations regarding the circumstances under which inpatient payment is appropriate. Eliminating that framework without replacing it with equally clear guidance risks confusion, inconsistent coverage determinations, administrative burden, and delays in care.

[6] 42 C.F.R. § 419.23(a)–(b)
[7] CMS-1850-P

The potential for administrative burden is particularly concerning given the documented problems with MA utilization management. OIG found that some MAOs denied prior authorization requests that met Medicare coverage rules because of the use of additional clinical criteria or alleged documentation deficiencies, even when OIG physician reviewers determined that the existing medical records supported medical necessity.[8] CMS should not create additional ambiguity around the appropriate site of service without simultaneously establishing clear protections against inappropriate utilization management.

Payment Adequacy and APC Structure

CMS should separately determine whether an appropriate OPPS payment structure exists for each procedure proposed for removal. Where an existing Ambulatory Payment Classification (APC) does not adequately reflect the clinical profile or resource requirements of a complex neurosurgical procedure, CMS should not force the procedure into an ill-fitting APC simply to complete the three-year phase-out.

CMS's APC methodology is intended to group services that are clinically similar and comparable with respect to resource use. Accordingly, the existence of an APC should not substitute for a procedure-specific assessment of whether the payment methodology appropriately captures the resources required for complex neurosurgical care.[9] CMS has itself recognized in this proposed rule that the remaining complex clinical families warrant additional consideration as the Agency moves toward the final phase of IPO elimination. A craniotomy, intracranial vascular procedure, or complex spinal cord operation does not become clinically less complex because CMS has reached the third year of a predetermined phase-out schedule, nor does the existence of an OPPS APC for such procedures necessarily mean that the APC appropriately reflects the resources necessary to safely furnish the procedure, including the potential intensity of postoperative care and the hospital capabilities required to manage complications. The availability of an APC should not be viewed as sufficient evidence that a procedure is appropriate for outpatient payment.

CY 2028 Review of Neurological Procedures

The AANS and CNS appreciate that CMS did not include the neurological clinical family in the CY 2027 phase of IPO elimination, noting that such remaining services are among the more complex procedures and recognizes that additional review may be necessary before appropriate outpatient assignments can be determined.[10]

The AANS and CNS strongly agree that these procedures should not be rushed into the outpatient payment system. The additional year before the proposed CY 2028 phase-out should be used for substantive clinical and resource review—not treated merely as a delay before predetermined removal. The neurological procedures remaining on the IPO list encompass an extensive range of highly complex services, including:

- Burr-hole procedures
- Craniectomy and craniotomy
- Cranial decompression
- Intracranial tumor surgery

[8] U.S. Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, OEI-09-18-00260 (Apr. 2022).
[9] CMS-1850-P
[10] CMS-1850-P

- Skull-base surgery
- Cerebrovascular and intracranial vascular procedures
- Aneurysm surgery
- Intracranial angioplasty, stenting, and thrombectomy
- Cranioplasty
- Cerebrospinal fluid shunt procedures
- Implanted neuroelectrode procedures
- Complex spine and spinal cord procedures

The breadth and complexity of these services demonstrate why the CY 2028 review cannot be treated as an automatic final step toward eliminating the IPO list. Whether a neurosurgical procedure should be performed on an inpatient or outpatient basis must remain a clinical decision made by the neurosurgeon based on the needs of the individual patient. Removal from the IPO list should not substitute for that clinical judgment. **Accordingly, the AANS and CNS urge CMS to engage with the neurosurgical community before publication of the CY 2028 OPPS proposed rule to conduct a rigorous, evidence-based review of the neurological procedures remaining on the IPO list. This review should incorporate clinical outcomes data, patient safety considerations, access implications, quality measurement, beneficiary cost sharing, administrative requirements, and the adequacy of the applicable APC structure.**

CONTROLLING UNNECESSARY INCREASES IN THE VOLUME OF COVERED OPD SERVICES

<u>Prior Authorization for Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators</u>

The AANS and CNS continue to strongly oppose the use of prior authorization in the Medicare fee-for-service program for neurosurgical procedures. Since July 1, 2021, neurosurgical procedures, including cervical fusion with disc removal (CPT codes 22551 and 22552) and implanted spinal neurostimulators (CPT code 63650), have been subject to prior authorization. At that time and for multiple years thereafter, the AANS and CNS expressed significant concerns with the use of prior authorization for these procedures, detailing the harm the policy will have on patients and its lack of justification or meaningful evidentiary support. With these concerns still unresolved by CMS, year after year, neurosurgeons and their patients continue to face significant delays in medically necessary treatment, which in turn result in patient harm. Further, the Agency's continued use of prior authorization in this context is antithetical to its focus on addressing opioid use and substance use disorder in Medicare patients. **For the reasons stated below, we respectfully reiterate our request that CMS rescind its use of prior authorization for these neurosurgical procedures.**

Lack of Evidentiary Support for Prior Authorization

CMS's stated justification for requiring prior authorization for cervical fusion with disc removal and implanted spinal neurostimulators is that prior authorization is necessary due to an "unnecessary increase in the volume of these services."[11] However, CMS provides no causal link between an increase in the volume of these services and inappropriate utilization. Rather, CMS accepts, at face value, that an increase in volume of services inherently represents overutilization. This assumption is flatly incorrect, as demonstrated by the clinical evidence. Increases in procedure volume can be attributed to an

[11] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician- Owned Hospitals, 85 Fed. Reg. 48722, 49028 (Aug. 12, 2020).

increase in the number of Medicare beneficiaries that have conditions for which cervical fusion with disc removal and implanted spinal neurostimulators are clinically indicated. For cervical fusion with disc removal, a 2026 study of the procedure attributed increases in volume to an aging population and the increasing prevalence of significant conditions affecting the cervical spine.[12] For implanted spinal neurostimulators, increases in procedure volume have been attributed to the increasing prevalence of chronic pain conditions and efforts to use non-opioid modalities for pain management.[13]

Despite more than five years of experience with the requirement, CMS has not demonstrated that prior authorization for cervical fusion or implanted spinal neurostimulators improves clinical outcomes, reduces inappropriate utilization, or produces savings sufficient to justify the associated administrative burden and potential delays in care. When the result of CMS's policy decision is harm to patient access, this lack of justification or evidentiary support is unacceptable. Demanding prior authorization before these procedures can be performed in an outpatient setting, rather than allowing surgeons the option to choose the appropriate site of service for each patient, interferes in clinical decision-making and places both patients and the Medicare program at a disadvantage. Peer-reviewed research has demonstrated that prior authorization can adversely affect clinical outcomes, including through delays, treatment gaps, disease exacerbation, and avoidable hospitalizations.[14] We reiterate previously shared membership survey data, which shows significant delays in obtaining prior authorization from MACs. Approximately 66% of survey respondents have experienced delays over 10 days. Of these, 55% experienced delays from 11-20 days, 25% experienced delays from 21-30 days, and 10% experienced delays of more than 30 days. Neurosurgical practices have experienced the following issues related to prior authorization for these procedures:

- Initial denial requiring additional documentation (63%);
- Initial denial requiring peer-to-peer or other higher-level review (42%);
- Final denial requiring the patient to appeal (21%);
- Final denial resulting in the patient abandoning this treatment option (21%);
- Final denial resulting in procedure to be performed at another site of service (8%);
- No denials, and the prior authorization process is not overly burdensome (4%); and
- No denials, but the prior authorization process adds unnecessary practice burdens (46%).

These prior authorization barriers have a real and immediate negative impact on patient care. For neurostimulators, evidence shows that neurostimulation procedures are more effective if employed earlier in the pain syndrome. Delaying utilization of these devices through unnecessary and burdensome prior authorization processes will likely result in patients not obtaining the optimal relief from the therapy as the treatment will be delayed as the pain syndrome progresses and becomes more refractory.[15] As a result, patients will continue to have more pain-related disability and incur higher healthcare costs over time.[16] Similarly, for cervical fusion procedures, as symptom duration increases, the magnitude of improvement following surgery decreases.[17] Treatment with conservative management due to prior

[12] Paul G. Mastrokostas et al, *Trends in Anterior Cervical Discectomy and Fusion: Medicare Projections Through 2060*, 16 Global Spine J. 2337 (2026).
[13] Wesley Day et al., *Spinal Cord Stimulator Utilization Trends and Predictors of Unsuccessful Trial-to-Implant Conversion*, 22 N. Am. Spine Soc. J. 100616 (2025).
[14] Jacob Murphy et al., Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes: A Systematic Review, 139 Am. J. Med. 24 (2026).
[15] Krishna Kumar et al., *Impact of Wait Times on Spinal Cord Stimulation Therapy Outcomes*, 14 Pain Practice 709 (2014).
[16] Shivanand P. Lad et al., *Longer Delay from Chronic Pain to Spinal Cord Stimulation Results in Higher Healthcare Resource Utilization*, 19 Neuromodulation 469 (2017).
[17] Joseph E. Nassar et al., *The Impact of Symptom Duration on Postoperative Outcomes in Patients Undergoing Anterior Cervical Discectomy and Fusion: A Systematic Review and Meta-Analysis*, 25 Spine J. 1178 (2025).

authorization delays is costly, with some patients incurring more than $15,000 on average in outpatient charges in the two years preceding the cervical fusion procedure.[18]

Inconsistency with Federal Priorities

CMS's use of prior authorization for pain management procedures is difficult to reconcile with the federal government's longstanding efforts to address the opioid crisis by expanding access to evidence-based, non-opioid approaches to pain management. Congress has repeatedly recognized that addressing opioid misuse and substance use disorder requires more than limiting opioid prescribing; it also requires ensuring that patients and clinicians have meaningful access to effective alternatives. The SUPPORT for Patients and Communities Act of 2018 (SUPPORT Act) directed the U.S. Department of Health and Human Services (HHS) to review Medicare OPPS payments for opioids and evidence-based non-opioid alternatives for pain management, including drugs, devices, nerve blocks, surgical injections, and neuromodulation, with the goal of ensuring that Medicare payment policies do not create incentives to use opioids instead of non-opioid alternatives.[19] To carry out this directive, in CY 2020 OPPS rulemaking, CMS reviewed payment and utilization patterns for non-opioid alternatives, including nerve blocks and neuromodulation products.[20] More recently, the Consolidated Appropriations Act of 2023 authorized additional payments for non-opioid treatment of pain relief through 2028.[21] CMS implemented this directive in its CY 2025 OPPS rulemaking.[22]

The Trump Administration prioritized efforts to reduce opioid use and substance use disorder and expand treatment alternatives. Executive Order 14379, "Addressing Addiction through the Great American Recovery Initiative," issued January 29, 2026, established a White House initiative to coordinate the federal response to addiction and directed the Administration to increase awareness of addiction as a chronic, treatable disease, and to integrate prevention, early intervention, treatment, and recovery support across federal systems.[23] The Food and Drug Administration (FDA) prioritized the development of non-opioid treatments, including by approving the first novel non-opioid analgesic for acute pain in more than twenty years.[24,25]

Taken together, these policies demonstrate a consistent federal objective to facilitate, not impede, the use of non-opioid treatment alternatives. Prior authorization for neurosurgical procedures including cervical fusion with disc and implanted spinal neurostimulators undermine that objective. A requirement that patients obtain payer approval before receiving an evidence-based, non-opioid intervention introduces an additional administrative barrier precisely at the point where federal policy has sought to make alternatives to opioids more accessible. When authorization is delayed or denied, the practical consequence may be that a patient remains on opioids for pain treatment or goes without an effective treatment option while waiting for the authorization process to be completed. **To ensure that alternatives to opioids are more available and accessible to patients for pain management, we request**

[18] Sohrab Virk, Frank M. Phillips, & Safdar Khan, *Patterns of Healthcare Resource Utilization Prior to Anterior Cervical Decompression and Fusion in Patients with Radiculopathy*, 11 Int. J. Spine Surgery 1 (2017).
[19] SUPPORT Act of 2018, Pub. L. No. 115-271, § 6082, 132 Stat. 3894, 3992-94 (2018).
[20] *See* Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-Owned Hospitals, 85 Fed. Reg. 48722, 48796 (Aug. 12, 2020).
[21] Consolidated Appropriations Act of 2023, Pub. L. No. 117-328 § 4135, 136 Stat. 4459, 5921-24 (2022).
[22] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots, 90 Fed. Reg. 53448, 53472 (Nov. 25, 2025).
[23] Exec. Order No. 14379, 91 Fed. Reg. 5081 (Jan. 29, 2026).
[24] FDA, Ctr. For Drug Evaluation and Rsch., Development of Non-Opioid Analgesics for Chronic Pain: Guidance for Industry (2025).
[25] Olivier Sibomana, Melody Okereke, & Clyde Moono Hakayuwa, Suzetrigine Approval Breaks a 25-Year Silence: A New Era in Non-Opioid Acute Pain Management, 18 J. Pain Rsch. 2805 (2025).

that CMS remove prior authorization requirements for cervical fusion with disc removal and implanted spinal neurostimulators.

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

Request for Information on the Advance Care Planning Electronic Clinical Quality Measure

The AANS and CNS appreciate CMS's consideration of stakeholder feedback on a measure related to advance care planning. Advance care planning is an important component of high-quality care for patients who may benefit from discussions about prognosis, treatment preferences, and goals of care. If appropriately tailored, an advance care planning measure can ensure that discussions regarding goals of care, treatment preferences, and surrogate-decision making occur where warranted. **However, we strongly caution CMS against applying this measure indiscriminately across all patient populations.** If CMS proceeds with incorporating an advance care planning measure into the HOPPS Quality Reporting Program, we urge the Agency to limit the use of the measure to patients where such discussions are clinically relevant. To that end, we offer the following guiding principles:

- **The advance care planning measure must be targeted to appropriate patient populations and clinical circumstances.** The clinical relevance of advance care planning varies substantially according to the patient's age, comorbidities, prognosis, procedural risk, treatment setting, and reason for the encounter.[26] For neurosurgical patients, this distinction is particularly important. Advance care planning may be highly relevant for a frail older patient with substantial comorbidity undergoing a major intervention, a patient with advanced neurologic disease, or an individual facing treatment with meaningful risks to function or independence.[27] The same requirement may have little clinical relevance to a younger or otherwise healthy patient undergoing a limited elective outpatient procedure. Therefore, if CMS moves forward with an advance care planning measure, the measure should not be applicable to all patients, but instead only those who would benefit from advance care planning discussions.

- **The advance care planning measure must include appropriate exclusions.** In addition to including appropriate patients, the measure must allow for exclusions where the clinical circumstances do not justify advance care planning activities. CMS should consider exclusions where an advance care plan has recently been completed, is being managed by another clinician or care setting, or is not clinically appropriate for the encounter.

- **The advance care planning measure must meaningfully drive quality improvement.** If hospitals are evaluated on whether advance care planning was documented for every eligible patient, hospitals may reasonably respond by incorporating standardized language or checkboxes into the record simply to satisfy the measure, transforming what should be a substantive, patient-centered conversation into perfunctory compliance. This "checkbox" approach can create the appearance of high-quality care without establishing that the physician had a meaningful discussion with the patient or that the discussion was clinically appropriate. Narrowly tailoring the measure to appropriate encounters safeguards against the measure functioning as a check-the-box exercise.

[26] Susan E. Hickman et al., *The Care Planning Umbrella: The Evolution of Advance Care Planning*, 71 J. Am. Geriatrics Soc'y 2350 (2023).
[27] Joanna M. Roy et al., *Frailty as a Predictor of Postoperative Outcomes in Neurosurgery: A Systematic Review*, 68 J. Neurosurgical Sciences 208 (2023).

- **Accountability must remain at the hospital/facility level.** An advance care planning measure must maintain hospital-level accountability and should not be designed in a way that shifts responsibility for a facility-level process onto individual physicians. CMS's determination of whether the advance care planning measure is satisfied should focus on factors within the hospital's control, such as the hospital's electronic health record (EHR) configuration, screening protocols, coding, and data transmission capabilities. This focus will ensure that the measure captures advance care planning activities without shifting documentation burden to individual physicians. Procedural specialists such as neurosurgeons should not be scored or penalized for the hospital's documentation systems or advance care planning workflows outside of their control.

- **The advance care planning measure should not be extended to ASCs.** If CMS proceeds with implementation of an advance care planning measure in OPPS, we urge the Agency to refrain from carrying the measure over to the ASC context until it thoroughly evaluates if the measure is warranted in the ASC context. If CMS ultimately determines that an advance care planning measure is appropriate for the hospital outpatient setting, that determination should not automatically establish that the measure is appropriate for ASCs. Hospital outpatient departments and ASCs are not clinically identical environments. A freestanding ASC generally has a narrower scope of services and may not have access to the records or staff to execute advance care planning discussions. Further, since the patient populations between outpatient departments and ASCs also differ, advance care planning discussions may not be appropriate for ASC patients.[28] Any future proposal to extend the measure to ASCs must be separately evaluated and validated by CMS.

- **The advance care planning measure should be adequately tested.** The advance care planning measure must be tested in real-world clinical workflows before using it for accountability or payment purposes. CMS should conduct robust testing in real-world clinical workflows and across a representative range of hospital outpatient settings. Such testing should establish that the measure accurately captures meaningful advance care planning rather than merely the presence of a particular documentation element, and should evaluate the measure's validity, reliability, feasibility, and administrative burden.

Proposed ECQM Data Validation Framework

The AANS and CNS applaud CMS's efforts to integrate eCQMs into OPPS, including via the data validation requirements outlined in this proposed rule. The AANS and CNS have long advocated for the use of more seamless and automatic methods of reporting and analyzing quality data. Digital measures, when used appropriately, can make quality reporting more efficient and less burdensome for neurosurgeons. Appropriately designed digital measures can improve data quality, enable more clinically meaningful and patient-centered measures, facilitate interoperability and advanced analytics, and reduce the administrative burden of quality reporting.

As CMS moves toward increasingly automated and Fast Healthcare Interoperability (FHIR)-based measurement, CMS must ensure that it maintains a clear distinction between data validation accuracy and clinical performance. Hospitals, not individual clinicians, should remain accountable for the failures in data capture, extraction, mapping, or submission. Where validation identifies inaccurate data, the participating hospital should remain accountable for investigating and remediating the problem via its

[28] Chad D. Meyerhoefer et al., *Patient Mix in Outpatient Surgery Settings and Implications for Medicare Payment Policy*, 69 Med. Care Rsch. Review 62 (2011).

EHR configurations, data workflows, and vendor arrangements through which quality data are generated and submitted. Where CMS identifies recurring problems attributable to a health IT vendor or common technical implementation issue, CMS should coordinate with the Office of the National Coordinator for Health Information Technology (ONC) and other relevant federal health IT authorities to address the systemic problem.

ASC QUALITY REPORTING PROGRAM

Request for Information on the Stratification of ASC All-Cause Transfer/Admission Measure

The AANS and CNS support CMS's consideration of stratifying the ASC All-Cause Hospital Transfer/Admission measure by phase of care. At the outset, the AANS and CNS applaud CMS for soliciting stakeholder feedback on ways that quality measurement can be more clinically meaningful and relevant to practitioners, patients, and the Medicare program. The AANS and CNS have long encouraged CMS to ensure that quality measures are true indicators of quality, evidenced by our longstanding opposition to volume-based measures that do not have a direct relationship to the assessment of high-quality or high-value care.

The stratification of the all-cause transfer-admission measure offers an opportunity to ensure that the quality measures used in the ASC Quality Reporting Program drive quality improvement. Pre-procedure, intra-procedure, and post-procedure transfers or admissions represent clinically different events and may have very different implications for quality. Reporting them as a single undifferentiated outcome can obscure rather than clarify the circumstances surrounding an escalation of care.

A pre-procedure transfer may reflect appropriate recognition that a patient's condition or risk profile is unsuitable for the ASC setting. For example, patient comorbidities and recent complications such as body mass index (BMI), dialysis, corticosteroid use, or recent sepsis can influence whether it is proper to perform a spine surgery in an ASC.[29] Separately, an intra-procedure transfer may reflect an unexpected complication requiring hospital-level resources. Even in appropriately selected ASC patients, complications can occur that require transfer to an inpatient hospital, such as respiratory failure, motor-signal changes, epidural hematoma, and other complications.[30] These complications can require hospital-based resources to manage. A postoperative transfer may arise from a different set of clinical circumstances. An inpatient transfer, for example, may be necessary because the ASC lacks imaging or monitoring resources needed to evaluate a problem that emerges post-procedure.[31] These events are diverse and should not automatically be interpreted as equivalent quality failures.

Beyond phase of care stratification, we urge CMS to also consider mechanisms to distinguish potentially preventable transfers from medically appropriate escalation of care, regardless of the point at which the transfer is initiated. A clinician or ASC should not be penalized for recognizing a change in clinical status and transferring a patient to a higher level of care when doing so represents appropriate patient safety practice. In ambulatory spine surgery, for example, appropriate patient selection is an important component of safety, but even appropriately selected patients may experience unexpected complications that require transfer to a hospital capable of providing services unavailable in the ASC.[32] In such circumstances, timely recognition of a change in clinical status and escalation to a higher level of care may represent appropriate patient-safety practice rather than a quality failure.

[29] Michael C. Gerling et al., *Ambulatory Spine Surgery*, 5 J. Spine Surgery S147 (2019).
[30] Tristan Blasé Fried et al., *Reasons for Transfer and Subsequent Outcomes Among Patients Undergoing Elective Spine Surgery at an Orthopedic Specialty Hospital*, 14 J. Craniovertebral Junction & Spine 159 (2023).
[31] Evan D. Sheha & Peter B. Derman, *Complication Avoidance and Management in Ambulatory Spine Surgery*, 5 J. Spine Surgery S181 (2019).
[32] *Id.*

Most importantly, the AANS and CNS urge CMS to ensure that any modification to the all-cause transfer-admission measure does not create a direct or indirect incentive to delay or avoid a medically necessary hospital transfer. It is critical to patient safety that patients continue to be timely transferred to higher levels of care when appropriate. Physicians, including neurosurgeons, should retain the full ability to decide whether a transfer is appropriate in their clinical judgment, and their decision calculus should not be influenced by the potential for negative payment adjustments. As such, the decision to transfer a patient who needs hospital-level care should not automatically be classified as a quality failure, recognizing that those cases may still warrant review.

CONCLUSION

The AANS and CNS appreciate the opportunity to comment on the CY 2027 OPPS and ASC Payment System and Quality Reporting Programs proposed rule and look forward to continued engagement with CMS on these important issues. If additional information would be helpful or questions arise regarding these comments, please contact Lauren M. Foe, MPH, Director of Regulatory Policy for the AANS/CNS Washington Office, at lfoe@neurosurgery.org. Thank you for considering these recommendations and for your continued efforts to improve care for Medicare beneficiaries.

Sincerely,

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