September 9, 2024

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1809-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, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (CMS-1809-P)

Dear Administrator Brooks-LaSure:

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) 2025 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule published in the *Federal Register* on July 22, 2024.

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 2025. Our comments below are presented in the order in which they appear in the rule.

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SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES

Changes to the Inpatient Only (IPO) List

As part of its annual OPPS/ASC payment system update process, CMS works with interested parties, including professional societies, hospitals, surgeons, hospital associations, and beneficiary advocacy groups, to evaluate the IPO list and to determine whether services should be added to or removed from the list. For the CY 2025 OPPS/ASC proposed rule, the Agency received requests from interested parties recommending that certain services be removed from the IPO list. Following clinical review, CMS states that it did not find sufficient evidence that any of those services meet the criteria to be removed from the IPO list, and therefore does not propose to remove any services from the list for CY 2025. **The ACS is concerned about the lack of transparency in CMS' assessment of stakeholder requests regarding the removal of services from and/or addition of services to the IPO list. We urge the Agency to publish requests for removal/addition of services for the IPO list in the OPPS/ASC proposed rule (or in an associated addendum to the rule) for the purposes of public review.**

NONRECURRING POLICY CHANGES

Coverage Changes for Colorectal Cancer (CRC) Screening Services

For CY 2025, CMS proposes to make the following revisions, as also proposed in the CY 2025 Medicare Physician Fee Schedule proposed rule, to update and expand coverage for CRC screening:

- Remove coverage for the barium enema procedure;
- Add coverage for the computed tomography colonography (CTC) procedure; and
- Expand the existing definition of a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare covered blood-based biomarker CRC screening test.

In recognition of the extensive evidence indicating that barium enema is now an outdated and ineffective CRC screening modality relative to modern CRC screening technologies, the ACS supports this proposed change in coverage for barium enema procedures. We also support CMS' proposal to add coverage for CTC as a CRC screening test and to expand the applicable regulatory definition of a complete CRC screening to include CTC.

AMBULATORY SURGERY CENTER (ASC) POLICIES

Changes to the List of ASC Covered Surgical Procedures for CY 2025

CMS annually reviews requests to add procedures (that are not on the IPO list) to the ASC Covered Procedures Lists (ASC-CPL). For CY 2025, CMS proposes to add 20 medical and dental procedures to the ASC-CPL. **The ACS urges CMS to improve the transparency provided with respect to requests for addition to the ASC-CPL.** We wish to highlight that, under other policies (e.g., Inpatient New Technology Add-on Payment, the Medicare Physician Fee Schedule's Potentially Misvalued Code Initiative), CMS includes in the relevant proposed rule the requests that were made under those policies even when the Agency decides not to propose inclusion as the stakeholder requested. This enables the public to weigh in on CMS' decision to decline requests made by stakeholders. However, under the ASC-CPL policy, the Agency does not disclose procedures that were requested for inclusion beyond those that CMS proposes for addition. It is imperative to the integrity of federal rulemaking that CMS include all requests made of it under a given policy so that the public can provide input in support of or

in opposition to CMS' decision to decline the request. We urge CMS to remedy this in the CY 2025 OPPS/ASC final rule and, for CY 2026 rulemaking and beyond, publish the list of all ASC-CPL requests in the proposed rule even when the Agency declines such requested additions.

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

Proposal to Adopt the Hospital Commitment to Health Equity (HCHE) Measure for the Hospital Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting (REHQR) Programs and the Facility Commitment to Health Equity (FCHE) Measure for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program Beginning with the CY 2025 Reporting Period/CY 2027 Payment Determination or Program Determination

CMS proposes to adopt the Hospital Commitment to Health Equity (HCHE) measure in the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) measure in the ASCQR Program beginning with the CY 2025 reporting period/CY 2027 payment or program determination. The HCHE measure is currently used in the Hospital Inpatient Quality Reporting (IQR) and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Programs. The FCHE measure is currently used in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program and the End Stage Renal Disease Quality Incentive Program (ESRD QIP). The HCHE and FCHE measures are attestation-based structural measures that assess hospitals' and facilities' commitment to health equity across the following five domains: equity as a strategic priority, data calculation, data analysis, quality improvement, and leadership engagement.

The introduction of the HCHE measure has taken a step toward moving federal quality programs forward, especially when seeking to drive hospitals toward inclusivity and health equity. It has proven difficult to reliably measure health care disparities due to current inconsistencies in demographic data collection and availability, a shortage of resources in facilities to track patients over time, and more. **The HCHE measure serves as a starting point to ensure that hospitals have the proper structures and processes in place to move towards a culture of inclusivity. The ACS commends CMS for developing and implementing this measure across programs to assess how a hospital promotes an organizational culture of equity-focused leadership, its commitment to robust demographic data collection, quality improvement, and the active review of disparities in key quality outcomes.**

The ACS supports comprehensive quality programs built around the team-based nature of patient care delivery, providing patients with the information they need to meet their health goals, and driving surgical teams toward a culture of excellence. To accomplish these objectives, **a quality program must include components that evaluate the structures, processes, and the interdependencies that are in place to build toward patient's goals, be informed by measurable outcomes, and incorporate patient experiences**. Attestation that key structures and processes are in place can assure the right care is applied for the right indication. These components are part of ACS Quality Programs, referred to as verification or accreditation programs, where care is verified for a specific condition by the ACS.

This HCHE is similar to the Age Friendly Hospital Measure, recently finalized for the Hospital Inpatient Quality Reporting (IQR) program beginning with the CY 2025 reporting period/FY2027 payment determination. The Age Friendly Hospital Measure should similarly be adapted for outpatient, rural, and ambulatory hospital settings. The Age Friendly Hospital Measure includes domains that target high-yield points of intervention for older adults—Eliciting Patient Healthcare Goals, Responsible Medication Management, Frailty Screening and Intervention (i.e., Mobility,

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Mentation, and Malnutrition), Social Vulnerability (social isolation, economic insecurity, ageism, limited access to healthcare, caregiver stress, elder abuse), and Age Friendly Care Leadership. The measure encourages hospital systems to reconceptualize the way they approach care for older patients with multiple medical, psychological, and social needs at highest risk for adverse events. As a large proportion of the U.S. population ages, it is critical that the care of older adults is prioritized across settings.

Proposal to Adopt the Screening for Social Drivers of Health (SDOH) Measure for the Hospital OQR, REHQR, and ASCQR Programs Beginning with Voluntary Reporting for the CY 2025 Reporting Period Followed by Mandatory Reporting for the CY 2026 Reporting Period/CY 2028 Payment or Program Determination

CMS proposes to adopt the SDOH measure in the OQR, REHQR and the ASCQR beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment or program determination. The Screening for SDOH measure is a process measure, already used in the Hospital IQR Program, that assesses the total number of patients, age 18 years or older on the date of service, are screened for social risk factors (specifically, the five health related social needs (HRSNs) of food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) when they receive care from a hospital outpatient department (HOPD), rural emergency hospital (REH), or ambulatory surgery center (ASC). CMS proposes that facilities should use a self-selected screening tool to collect these data. In alignment with the Hospital IQR Program, CMS also proposes that HOPDs, REHs, and ASCs could confirm the current status of any previously reported HRSNs in another care setting and inquire about others not previously reported, in lieu of re-screening a patient within the reporting period. In addition, if this information has been captured in the EHR in another outpatient setting or the inpatient setting during the same reporting period, the HOPD, REH, and ASC could use that information for purposes of reporting the measure in lieu of screening the patient.

The ACS supports CMS' efforts to align measures across programs and increase screening for social drivers of health in outpatient, rural, and ambulatory surgical settings. We also thank CMS for allowing hospitals to utilize previous screens to avoid the burden of re-screening patients. We offer additional rationale and feedback to both the Screening for Social Drivers of Health Measure and Screen Positive Rate for Social Drivers of Health Measure in the next section.

Proposal to Adopt the Screen Positive Rate for Social Drivers of Health (SDOH) Measure for the Hospital OQR, REHQR, and ASCQR Programs Beginning with Voluntary Reporting for the CY 2025 Reporting Period Followed by Mandatory Reporting Beginning with the CY 2026 Reporting Period/CY 2028 Payment or Program Determination

CMS proposes to adopt the Screen Positive Rate for SDOH measure in the OQR, REHQR and ASCQR beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment or program determination. The Screen Positive Rate for SDOH is a process measure, already used in the Hospital IQR Program, that provides information on the percent of patients receiving care at an HOPD, REH, or ASC, who were 18 years or older on the date of service, who were screened for all five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety—and who screened positive for one or more of those HRSNs. Healthcare facilities would report this measure as five separate rates, one for each of the HRSNs. Unlike the SDOH measure, the Screen Positive Rate for SDOH measure would allow facilities to capture the magnitude of needs by requiring healthcare facilities to report the rates of patients who screened positive for each of the five core HRSNs.

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The ACS supports CMS' efforts to align measures across programs and increase screening for social drivers of health, however we see a missed opportunity to drive hospitals towards creating processes that offer action plans for patients who screen positive for certain social risk factors. CMS should not simply evaluate who conducts screenings, and if a patient screened positive for certain social drivers, but whether the hospital has action plans in place to address the risk factors. When patients screen positive for one of the domains, processes should be in place to share that information with an interdisciplinary care team to organize around the patient and coordinate to optimize care, communication, follow-up, and tracking of the patient following treatments. To make these measures more valuable, the ACS encourages CMS to work with measure developers to develop a measure that focuses on the actions that were taken following a positive screen. Eventually, the two proposed measures, and a third designed to evaluate the follow-up action, could be combined into a single metric with stratification of the results for screened positive versus those who did not.

As part of these proposals, CMS describes their methodology for selecting the five domains to be included in the screening tools. The effect of social drivers is experienced at the local level, and many factors—such as, geographic location, available resources, and populations characteristics—can play a role in the prevalence of social drivers and their impact on healthcare outcomes and delivery. Therefore, **the ACS supports flexibility in the selection of screening tools. Flexibility should be allowed until we can better understand SDOH and their impact before standardizing screening tools across care settings, geographic locations, and patient populations. Moving forward, CMS should evaluate the impact of SDOH on health outcomes so that they continue to evaluate and adjust the domains for social drivers.**

Finally, the title of the measure, "screen positive," is misleading. From a patient's perspective screening positive for social factors intuitively would be positive, whereas in this measure, it is determining a patient's needs and indicating complexities that may require additional resources. Considering how patients might seek care, the measure title is important if this is to be publicly reported in the future.

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

Proposal to Adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) Beginning with Voluntary Reporting for the CY 2026 Reporting Period Followed by Mandatory Reporting Beginning with the CY 2027 Reporting Period/CY 2029 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 Measure (PRO-PM)-Measure Methodology Report (Information Transfer PRO-PM) beginning with voluntary reporting for the CY 2026 reporting period followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination. The Information Transfer PRO–PM aims to assess the level of clear, personalized recovery information provided to patients aged 18-years or older who had surgery or a procedure at an HOPD. The measure reports the average score of a patient's ratings on a three-domain, 9-item survey to evaluate the clarity of the clinical information patients are given before, during, and after an outpatient surgery or procedure. The survey covers three domains for patients or their caregivers to rate the clarity of information received regarding their post-discharge recovery: applicability to patient needs, medication, and daily activities. CMS believes that the results from the survey provide hospitals with patient reported outcome (PRO) data designed to assess communication efforts and enable hospitals to reduce the risk of patient harm that may occur if the patient does not fully understand the recovery information. CMS proposes that the Information Transfer

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PRO–PM would be calculated based on PRO data collected by HOPDs directly or through their authorized third-party vendors through a web-based survey instrument distributed to patients or their caregivers. CMS also proposes that the survey would be administered two-to-seven days post-procedure or surgery and proposes a 65-day window for patient response.

The ACS has been extremely supportive of the use of patient reported outcome measures (PROMs) in quality programs, and thanks CMS for highlighting their importance through this RFI. 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 you think about surgical care, measuring rare or adverse events is important. Still, it only affects a limited number of patients. On the other hand, PROs 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 on the performance of the care team that cannot be captured in traditional outcome or process measurement mechanisms**. The ACS supports the adoption of the Information Transfer PRO-PM, but we encourage CMS to build on this measure to better align with patient goal identification and attainment across the episode of care**. In general, the ACS is supportive of the adoption of PRO-PMs in quality programs and believe they provide valuable insight into the patient's experience following a procedure. In some instances, patients may not have ready access to their care team after discharge and this information can serve as a proxy. If a patient does not have clear guidance or understanding of the next steps after discharge, it could be harmful to their recovery. This measure is important to help hospitals identify the post-discharge information that is most useful to patients and where patients may need more information to optimize their recovery.

Although we generally support PROMs and this measure, we encourage CMS to think beyond the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery measure. While we strongly agree that it is critical for patients to go home with a clear understanding of key information post-discharge, we see this as a missed opportunity for also understanding whether the patient's goals for surgery were achieved. The recovery plan should be laid out before a procedure occurs. It is important that patients understand that recovery begins before the operation and extends afterwards. This measure would be more effective if it also assessed goal attainment, which would require a discussion prior to surgery to identify the patient's health related goals and treatment preferences to inform shared decision making and goal concordant care. Patients should have their goals defined and a PRO should assess the degree to which the entire care journey–not just the operative details–are well understood and accepted. For example, when thinking about centering care around the patient, understanding their expectations or 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 patients' goals of care were met can really distinguish facilities and providers.

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), for example which provides limited

meaningful information to the care team and patients/patient caregivers**. 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 and design the measurement system around these needs to have a better understanding of the areas where PROMs will have the most impact.** The move to surgical episodes of care would be enhanced if the performance metrics in cost, quality, safety, and outcomes mapped back to the patient's episode. 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, for PCPs to help refer care, and facilities where they need improvement. **The ACS would be willing to work with CMS and other impacted stakeholders to help develop a more comprehensive measure.**

AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM

Request for Information (RFI) – Development of Frameworks for Specialty Focused Reporting and Minimum Case Number for Required Reporting

The ASCQR Program's current measure set captures clinical quality across all ASCs, including specialty clinical procedures performed only by a subset of ASCs. Thus, a portion of the ASCQR Program measure set only applies to an ASC if it performs those specialty procedures. Currently, ASCs are required to attest if they do not have cases for a given measure, thereby increasing reporting burden. CMS seeks to ensure the most meaningful measures apply to each facility. In this section, the Agency seeks comment on potential future frameworks which would achieve the following outcomes: (1) the addition of case minimums for specialty measure reporting; (2) the removal of the zero case attestation requirement for specialty measures to decrease reporting burden; and (3) the verification of individual measure case counts using claims data to determine which specialty measures would potentially be required for reporting for individual ASCs. They discuss two possible frameworks:

1. "Specialty-Select" Framework which would require ASCs to report all specialty-specific, claims-based measures (currently, four) because these measures are not administratively burdensome as well as select a specified number of the remaining non-claims-based specialty-specific measures (currently, four) to report if those measures are applicable to that ASC Operating Room.

2. "Specialty Threshold" Framework: CMS is considering requiring reporting for all non-claims-based specialty-specific measures for which case counts reach a specified case threshold minimum. This case threshold minimum would not apply to claims-based specialty-specific measures, as their reporting would be mandatory since these measures are not administratively burdensome.

While we appreciate CMS identifying the burden these measures put on the clinical team to which these measures do not apply and seeking feedback on two alternative frameworks, we would recommend CMS choose the framework that is most relevant to the care provided. However, we think that the questions posed in this RFI are a clear indication that the measures in the ambulatory setting are lacking in terms of relevancy to the clinical team, patients, and referring clinicians. We agree that CMS should continue to track administrative claims-based measures important to the Agency that do not require additional reporting burden. As part of the RFI, CMS asks if there are specialty-specific measures that commenters would recommend for development and adoption in the ASCQR Program measure set to create a more robust selection. **In response to this, ACS strongly supports the development of condition or procedure specific PROMs or PRO-PMs for patient goal attainment and patient experience**. We believe they are an appropriate and meaningful tool for this setting.

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Following up from our earlier comments on the Information Transfer PRO-PM, ACS asserts that PROs and PROMs are increasingly important in healthcare, especially for surgical patients. When you think about surgical care, measuring rare or adverse events is important. Still, it only affects a limited number of patients. On the other hand, PROs 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. For surgical patients, several categories of PROs/PROMs are particularly relevant. When implementing PROs/PROMs for surgical patients, it is important to:

- Choose validated measures when available.
- Balance comprehensive assessment with patient burden.
- Consider the timing of assessments (pre-op, immediate post-op, short-term follow-up, long-term follow-up).
- Ensure the measures are sensitive to clinically important changes.
- Use measures that are actionable and can inform clinical decision-making.
- Consider electronic collection methods to improve efficiency and data quality.

For surgical patients, relevant categories of PROs/PROMs are outlined in Table 1. The specific PROs/PROMs are cited in Table 2. Please note the list of PROs/PROMs tools are for illustrative purposes only.

Table 1: Use Cases for Patient-Reported Outcomes and Patient-Reported Outcome Measures

Category	Use Cases
Functional Outcomes	• Physical function (e.g., mobility, strength, range of motion) • Activities of Daily Living (ADLs) • Return to work or normal activities • Sports and exercise capacity (for relevant surgeries)
Pain and Discomfort	• Pain intensity scales (e.g., Numeric Rating Scale, Visual Analog Scale) • Pain interference with daily activities • Analgesic use
Quality of Life	• General health-related quality of life (e.g., SF-36, EQ-5D) • Disease-specific quality of life measures
Mental Health and Well-being	• Anxiety and depression scales (e.g., HADS, PHQ-9) • Emotional well-being • Social functioning
Symptom Burden	• Fatigue • Sleep disturbances • Gastrointestinal symptoms (for relevant surgeries)
Patient Satisfaction	• Satisfaction with surgical outcomes • Satisfaction with care process • Willingness to recommend the procedure/provider
Recovery and Rehabilitation	• Progress in rehabilitation • Adherence to post-operative instructions • Complications or adverse events from the patient's perspective

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Table 2: Examples of PROs and PROMs (for illustrative purposes)

Full Name	Abbreviation	Category	Description
Numeric Rating Scale[1]	NRS	Pain and Discomfort	A scale used to measure pain intensity on a scale from 0 to 10, where the 2 respective endpoints are "no pain" and "worst possible pain."
Visual Analog Scale[1]	VAS	Pain and Discomfort	A line to measure pain intensity with anchor statements on the left (no pain) and on the right (worst imaginable pain).
36-Item Short Form Survey[2]	SF-36	Quality of Life	A survey designed to capture adult patients' perceptions of their own health and well-being.
EuroQol[3]	EQ-5D	Quality of Life	A measure of self-reported health which is accompanied by weights reflecting the relative importance of different types of health problems.
Hospital Anxiety and Depression Scale[4]	HADS	Mental Health and Well-being	A self-report rating scale of 14 items, each scored from 0-3, to measure anxiety and depression in the general medical population.
Patient Health Questionnaire-9[4]	PHQ-9	Mental Health and Well-being	A self-report rating scale of 9 items, each scored from 0-3, to measure the severity of depression.

[1] Hawker GA, Mian S, Kendzerska T, French M. Measures of Adult Pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Chronic Osteoarthritis Pain (ICOAP). *Arthritis Care Res*. 2011;63(S11):S240-S252.
[2] Ware JE. SF-36 Health Survey Update. *Spine*. 2000;25(24):3130-3139.
[3] Devlin NJ, Brooks R. EQ-5D and the EuroQol Group: Past, Present and Future. *Appl Health Econ Health Policy*. 2017;15(2):127-137.
[4] Smarr KL, Keefer AL. Measures of Depression and Depressive Symptoms: Beck Depression Inventory-II (BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), and Patient Health Questionnaire-9 (PHQ-9). *Arthritis Care Res*. 2011; 63(S11):S454-S466.

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For a comprehensive approach to PROs in surgery, consider the following categories:

1. Generic Health Status:

   Use widely validated tools like SF-36 or EQ-5D to assess overall health status and quality of life. These allow for comparisons across different surgical procedures and patient populations.

2. Procedure-Specific Measures:

   Implement measures tailored to specific surgical procedures. For example:

   - Oxford Hip Score for hip replacements
   - BREAST-Q for breast surgery
   - International Prostate Symptom Score (IPSS) for prostate surgery

3. Functional Status:

   Assess physical function relevant to the specific surgery. This could include measures of mobility, strength, or specific functional indices like the Oswestry Disability Index for spine surgery.

4. Symptom Assessment:

   Focus on symptoms most relevant to the surgical procedure, such as pain, fatigue, or procedure-specific symptoms.

5. Psychosocial Outcomes:

   Include measures of mental health, social functioning, and overall well-being to capture the broader impact of surgery on patients' lives.

6. Recovery Trajectory:

   Implement measures that track patients' recovery over time, assessing milestones like return to work or normal activities.

7. Patient Experience:

   While not strictly a clinical outcome, patient experience measures can provide valuable insights into the care process and may influence overall outcomes.

8. Goal Attainment:

   Consider using patient-specific goal attainment scaling to assess whether individual patient goals for surgery were met.

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CHANGES TO THE REVIEW TIMEFRAMES FOR THE HOSPITAL OUTPATIENT DEPARTMENT PRIOR AUTHORIZATION PROCESS

The *CMS Interoperability and Prior Authorization* rule, finalized in January 2024, shortened the timeframe for certain payers to respond to standard prior authorization requests for covered items and services from 10 business days to 7 calendar days. While Medicare FFS is not an impacted payer under the *CMS Interoperability and Prior Authorization* final rule, CMS proposes to align its prior authorization review timeframe for standard review requests for HOPD services with the timeframe finalized in that rule. **We support CMS' proposal to change the standard review timeframe, which we believe will both streamline prior authorization processes across payers and reduce how long patients must wait to access the care they need.**

The ACS appreciates the opportunity to provide feedback on this proposed rule and looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Mujumdar, Chief of Regulatory Affairs, at vmujumdar@facs.org or Jill Sage, Chief of Quality Affairs, at jsage@facs.org.

Sincerely,

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

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