September 9, 2025

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: [CMS-1809-P] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs

Dear Administrator Brooks-LaSure,

Anatomy IT (AIT) is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2025 Ambulatory Surgical Center Quality Reporting Program (ASCQR). AIT's Value-based Care division helps small to medium sized specialty practices implement and manage EHR technology and comply with quality reporting requirements. We support over 1,000 clinicians in quality compliance and reporting nationwide.

Provided below is a summary of the key points from our comments on the ASCQR portion of the proposed rule. These comments are more fully developed in the body of this letter along with other issues and comments not highlighted in our summary.

AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM EXECTIVE SUMMARY

We appreciate the thought and time that went into the development of this proposed rule. We focus our comments on the proposed changes and requests for comment related to the ASCQR.

2025 ASCQR Measures

- **We strongly support CMS' decision to maintain ASC-11: Cataracts: Improvement in Patient's Visual Function as voluntary.**
- **Anatomy IT strongly disagrees with the proposed addition of "Screening for Social Drivers of Health", due to its inability to address SDOH for the patient and its potential for unintended harm.**
- Similarly, Anatomy IT strongly disagrees with the proposed addition of the "Screen Positive Rate for SDOH" measure as this would also require screening the patient and comes with the same concerns for potential unintended harm.
- Anatomy IT supports the proposed "Facility Commitment to Health Equity" measure *with modification*. Given the concerns with SDOH screening without available resources, we recommend only implementing Domains 1 and 5 of this measure.

Detailed ASCQR Comments of Anatomy IT: Contents

SPECIFIC ISSUES ON THE ASC QUALITY REPORTING PROGRAM

I. 2025 Proposed Changes

A. ASC-11: Cataracts – Improvement in Patient's Visual Function

Maintaining ASC-11 as Voluntary

AIT applauds CMS' decision to maintain ASC-11 voluntary in all future years. As mentioned in previous comments, this measure has had problems before it was even implemented, with the Ambulatory Surgery Center Association (ASCA), the American Society of Cataract and Refractive Surgeons (ASCRS), and the American Academy of Ophthalmology (AAO) strongly advocating against its use from its inception. This measure has ill-defined logic as an evaluation of individual physicians and is a high burden for facilities to complete.

B. Proposed New Measure: Screening for Social Drivers of Health (SDOH)

AIT commends CMS for prioritizing health equity and the inclusion of social drivers of health (SDOH) into ASCQR, but **we strongly disagree that this measure in its current form will improve health equity or address SDOH and we recommend that, if it is adopted, it is adopted as voluntary in all future years.** We have three main concerns with the measure: harm to the provider-patient relationship, lack of equivalence with the AHC model leading to excessive burden to physicians, and inconsistency with data collection standards.

Harm to Provider-Patient Relationship

We believe that SDOH must be comprehensively addressed, and this requires the development and provision of centralized information regarding accessible referral services relevant to positive screens and patient needs. Without these resources, all doctors would be doing is asking the question, hearing a vulnerable patient admit their vulnerability, and then moving on because they do not have the tools to help. This has high potential to do irreparable harm to the provider-patient relationship and decrease patient comfort in disclosing information and asking for help. **These resources are best developed by city, county, state, and federal governments so that they can be standardized, centralized, and trusted.**

To expect clinicians, who are already overstrained, and ASCs, which are likely understaffed, to provide data collection services, navigation services, referral services, and reorganize their entire operational output with no additional resources is unreasonable and out of the scope of the medical services that physicians and ASCs provide. We agree with the evaluations of the NQF Health Equity and Rural Health Advisory committees that simply screening when no actual community resources are available and accessible to patients would damage the provider-patient relationship. As

research has shown in intimate partner violence[1] and alcohol use[2] scenarios, screenings can be detrimental to the integrity of the provider-patient relationship if resources provided after a positive screen are not seen as sufficient by the patient. **We urge CMS to prioritize patient safety and assess the appropriateness of screening in this environment.**

Lack of Equivalence with the AHC Model

The AHC model is referenced in the proposed rule as the prototypical example of the inclusion of SDOH in healthcare. In the first AHC model evaluation commissioned by CMS, the evaluation team determined that navigation and referral services necessitated a separate "workflow managed by new staff." [3] The evaluation also found that every participating facility had to customize and optimize their workflow and navigation services to meet the needs of the population they serve. There are potential unintended consequences discussed on page 18 of the evaluation that need to be more fully understood before this model can be scaled.

This is especially important given that the model sites were highly resourced health systems, hospitals, health departments, and networks. Applying this model to lower resourced settings, such as independent ASCs, is likely to exacerbate any unintended consequences caused by this model's implementation in its current form.

Given the concerns laid out by CMS' contractors in the AHC evaluation, we are especially concerned with CMS' proposal to make this mandatory under the ASCQR beginning in 2026. The discussion of having this measure be mandatory in 2026 makes it fundamentally different from the MIPS Quality measure of the same name, as that measure can be chosen, but is not required. **Making this measure mandatory amplifies our concerns for negative consequences.**

Inconsistency with Data Collection Standards

According to section 4302 of the Affordable Care Act, data collection on race, ethnicity, sex, primary language, and disability status must be standardized across Medicaid and Children's Health Insurance Program (CHIP) and must comply with HHS' guidance. HHS' guidance currently states that:

> Agencies would also be permitted to include additional response categories for data standards with as much additional detail and granularity as desired, provided that the additional detail could be aggregated back to the minimum standard and the sample design and sample size support estimates at that level of granularity.

---

[1] https://www.sciencedirect.com/science/article/abs/pii/S0196064407017866
[2] https://www.bmj.com/content/325/7369/870.short
[3] https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt

AIT requests clarification from HHS regarding which aspects of SDOH would be exempt from necessary aggregation due to intrinsic intersection with race, ethnicity, sex, primary language, and disability status. If the data collected by a tool developed for this new proposed measure is not applicable or in line with Medicaid and CHIP data standards, it does not align with the first priority of CMS' Health Equity Framework of the "collection… of standardized data… across CMS programs".

We note that the Mandatory Medicaid and CHIP Core Set Reporting Rule, published in August 2022, highlights stratification of core-sets by race, but also does not provide a standardized tool by which to compare data across analyses. We are concerned that this level of data fragmentation will delay the collection of truly standardized national-level data and could hinder attempts to analyze and address SDOH.

We agree that it is vital to collect data regarding social drivers of health as comprehensively as possible, while "[m]inimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating", as the Affordable Care Act states. The impacts of SDOH cannot be overstated, but ASCQR measures are not the only available avenue through which we can address the needs of the American population, nor are they the most effective.

C. Proposed New Measure: Screen Positive Rate for SDOH

AIT opposes this proposed measure for the same reasons outlined above. At minimum, if CMS adopts this measure, it should be voluntary in all future years or until a centralized repository of resources to address the SDOHs identified is available.

We believe that SDOH must be comprehensively addressed, and this requires the development and provision of centralized information regarding accessible referral services relevant to positive screens and patient needs. Without these resources, all doctors would be doing is asking the question, hearing a vulnerable patient admit their vulnerability, and then moving on because they do not have the tools to help. This has high potential to do irreparable harm to the provider-patient relationship and decrease patient comfort in disclosing information and asking for help. **These resources are best developed by city, county, state, and federal governments so that they can be standardized, centralized, and trusted.**

D. Proposed New Measure: Facility Commitment to Health Equity (FCHE)

AIT offers conditional support for this proposed measure with modification – only requiring Domains 1 and 5. Much like outlined above, there are serious concerns surrounding screening for SDOH without providing resources to address them. That said, we agree that it is important for facilities to develop and regularly review a plan for responding to health equity issues. That is why we support the portions of this proposed measure that do not require screening. We note that ASCs are less resourced than large

hospital systems and, due to their nature of providing one-time, same-day care, are often not able to maintain social workers or case managers. Therefore, **until CMS can make a list of resources to address SDOH (resources specific to the location of care), we urge CMS to either limit this measure to Domains 1 and 5, or make the measure voluntary.**

II. RFI: Development of Frameworks for Specialty Focused Reporting and Minimum Case Number for Required Reporting

Specialty-Select Framework

AIT is concerned that the current ASCQR measures available do not support the implementation of this framework. The current measure set does not provide enough specialty coverage to ensure that every ASC would be able to meet any specified number of non-claims-based specialty-specific measures. Therefore, it is unclear how this framework under consideration would provide higher quality data collection at this time.

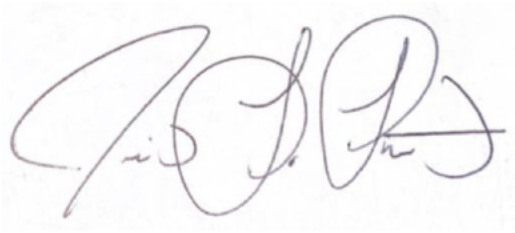
Specialty Threshold Framework

For the Specialty Threshold Framework, it is not clear from the description when the case count for each measure would be calculated. It is possible that ASCs would not know definitively which measures they would be required to report on until after the end of the reporting period. Additional clarification on when CMS plans to released this information is needed before we can comment on whether this would be either helpful or burdensome to ASCs.

Conclusion

Anatomy IT appreciates the opportunity to work with CMS to improve the Ambulatory Surgical Center Quality Reporting Program. If you have questions or need any additional information regarding any portion of these comments, please contact Dr. Jessica Peterson, Senior Director of Health Policy at jessica.peterson@anatomyit.com.

Sincerely,



Jessica L. Peterson, MD, MPH
Senior Director of Value-Based Care Policy at Anatomy IT