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Docket No. CMS-2026-2344

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: CMS-1850-P, CY 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

Dear Administrator Oz:

I am writing on behalf of the Obesity Action Coalition (OAC), a nonprofit organization representing more than 90,000 individuals affected by obesity and committed to improving access to care, eliminating weight bias and stigma, and ensuring that the voices of people living with obesity are reflected in policy and public dialogue. OAC appreciates the opportunity to comment on the CY 2027 OPPTS/ASC Proposed Rule.

OAC supports CMS's proposal to remove metabolic and bariatric surgery codes from the inpatient-only list. We believe patients and their healthcare providers should have greater flexibility to determine the most appropriate setting for care.

At the same time, we want to make sure that greater flexibility does not unintentionally become less access.

For OAC, the key issue is straightforward: removing a procedure from the inpatient-only list should give patients another option. It should not take an option away. A patient who can safely and appropriately undergo surgery in an outpatient setting should have that opportunity. A patient whose health, comorbidities, surgical complexity or other individual circumstances make inpatient care more appropriate should continue to have access to that setting without unnecessary barriers.

Patient needs, not payment policy, should determine the site of care

The decision about whether metabolic and bariatric surgery should be performed in an inpatient or outpatient setting should be based on the individual patient. That decision is best made by the patient and their treating healthcare team, taking into account the patient's overall health, comorbidities, surgical risk and the complexity of the procedure.



CMS has appropriately stated that removing a procedure from the inpatient-only list does not require it to be performed on an outpatient basis and that inpatient admission remains appropriate when a patient's needs warrant it. We strongly support that principle. Our concern is making sure it holds true in practice.

OAC has seen across obesity care how coverage and reimbursement policies can influence treatment decisions in ways that were never intended. We do not want removal from the inpatient-only list to become a de facto outpatient requirement, particularly if Medicare Advantage or commercial plans use the CMS designation to deny inpatient care that a patient's physician believes is medically appropriate. That concern is especially important for older adults, people living with multiple obesity-related conditions, and patients undergoing complex or revisional procedures. These are precisely the patients for whom individualized clinical judgment matters most.

We also recognize that reimbursement can affect whether care remains practically available. If payment for complex procedures does not adequately reflect the resources required to provide them safely, that too can influence where and whether patients can receive appropriate care. We therefore support addressing the apparent undervaluation associated with the proposed APC 5303 assignment and defer to the surgical societies regarding the appropriate technical payment methodology.

CMS should make clear that outpatient does not mean outpatient-only

CMS can help prevent unintended consequences by being explicit in the final rule.

We urge CMS to state clearly that removal of these metabolic and bariatric surgery codes from the inpatient-only list does not establish outpatient care as the preferred, expected or default site of service. Inpatient admission should remain appropriate and payable when the treating physician determines that it is warranted for the individual patient.

We also urge CMS to preserve the existing exemption from site-of-service claim denials and Recovery Audit Contractor patient-status reviews for these procedures while practice patterns evolve.

Just as importantly, CMS should consider how its policies will be interpreted by Medicare Advantage plans and other payers. Patients should not face an inpatient denial simply because a procedure is no longer on the inpatient-only list. Removing a regulatory requirement for inpatient care should not be interpreted as creating a regulatory expectation for outpatient care.

CMS's own experience supports an individualized approach

CMS has previously recognized that patient acuity and comorbidities matter when determining the appropriate site of care. When CMS removed total hip arthroplasty from the inpatient-only list in the CY 2020 OPPS/ASC final rule (84 FR 61354 through 61355), the agency noted that patients requiring revision or living with complicating conditions such as obesity, diabetes and heart disease may not be strong candidates for outpatient procedures.



That same principle is particularly relevant to metabolic and bariatric surgery. Many Medicare beneficiaries considering these procedures are living with multiple chronic conditions, and the procedures being removed include complex and revisional operations. We ask CMS to apply the same patient-centered reasoning here and affirm that inpatient care remains an appropriate option for higher-risk beneficiaries.

The evidence supports maintaining meaningful access to inpatient care

The available evidence also reinforces the importance of individualized patient selection.

Peer-reviewed evidence supporting outpatient metabolic and bariatric surgery is strongest for sleeve gastrectomy among younger, lower-comorbidity, carefully selected patients treated under appropriate protocols. Evidence is more limited for gastric bypass and particularly limited for complex and revisional procedures and for older patients with multiple comorbidities.

Importantly, research suggests that outcomes depend heavily on selecting the right patients for same-day discharge. This should reinforce, rather than replace, the role of clinical judgment.

The appendix to this letter summarizes the relevant evidence. OAC is not presenting this evidence to argue against removing these procedures from the inpatient-only list. We support the additional flexibility CMS is proposing. Rather, the evidence demonstrates why the inpatient option must remain genuinely available when it is the safest and most appropriate choice for an individual patient.

OAC recommendations

As CMS finalizes this policy, OAC respectfully asks the agency to:

1. **Affirm that removal from the inpatient-only list does not make outpatient care the default or expected site of service.** Inpatient admission should remain appropriate and payable based on the treating physician's clinical judgment and the individual patient's needs.
2. **Preserve appropriate protections during the transition.** Maintain the exemption from site-of-service claim denials and Recovery Audit Contractor patient-status reviews for these procedures while practice patterns evolve.
3. **Protect patients from unintended payer restrictions.** Take steps to discourage Medicare Advantage and other payer policies from using removal from the inpatient-only list as a basis for overriding physician judgment or denying clinically appropriate inpatient admissions.

Obesity is a chronic disease, and metabolic and bariatric surgery is an important, evidence-based treatment option for many people living with obesity and related conditions such as type 2 diabetes, hypertension, sleep apnea and fatty liver disease.

OAC supports giving patients and their healthcare providers more options, including greater access to outpatient surgery when it is appropriate. But greater flexibility should mean more choices for patients, not fewer.



Ultimately, the site of care should be determined by what is safest and most appropriate for the individual patient, not by a reimbursement designation or a payer policy. We encourage CMS to ensure that this principle is clearly reflected in the final rule and in its implementation.

OAC appreciates the opportunity to provide the patient perspective and stands ready to serve as a resource to CMS as this policy is finalized.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Nadglowski", is positioned above the printed name.

Joseph Nadglowski
President and Chief Executive Officer
Obesity Action Coalition

Appendix

Selected Evidence on Site of Service and Outcomes in Metabolic and Bariatric Surgery

This appendix summarizes peer-reviewed evidence relevant to the site-of-service and access issues raised above. Numbered references correspond to the reference list that follows.

1. Outpatient safety is best established for carefully selected, lower-risk sleeve gastrectomy.

A 2025 synthesis of the 2016 to 2024 literature concluded that same-day discharge sleeve gastrectomy shows complication and readmission rates comparable to inpatient care when guided by strict protocols and patient selection [1]. The only randomized trial to date evaluated day-case versus conventional-hospitalization sleeve gastrectomy [2]. This evidence is specific to sleeve gastrectomy in selected candidates and does not extend to the complex codes at issue in APC 5303.

2. Adoption is outpacing selection, and same-day discharge is not risk-neutral.

In the largest registry analysis, same-day discharge sleeve patients were systematically lower-risk (younger, lower body mass index, ASA class I to II) yet experienced significantly more 30-day adverse outcomes than patients kept overnight; same-day discharge rose from a stable 2.9 percent (2015 to 2019) to 9.6 percent in 2021 [3]. A 2020 to 2023 MBSAQIP analysis found that half of same-day discharge sleeve patients were high-risk, and that high-risk patients discharged the same day had significantly higher odds of serious adverse events than those discharged the next day [4]. These findings indicate that outcomes track patient selection, not site-of-service policy.

3. Evidence for gastric bypass is thinner, and for complex and revisional procedures it is limited.

The 2025 synthesis reports similar trends for same-day Roux-en-Y gastric bypass and only limited feasibility data for more complex procedures such as single-anastomosis duodeno-ileal bypass with sleeve [1]. A 2025 systematic review and meta-analysis of same-day discharge anastomotic (bypass-type) surgery concluded that safety concerns, particularly regarding mortality and complications, remain unresolved [5]. A dedicated MBSAQIP analysis of early discharge after revisional Roux-en-Y gastric bypass confirms that revisional cases carry distinct, elevated risk [6].

4. Among Medicare-age patients, the safety of same-day discharge is unclear and confined to a small, highly selected group.

The only large analysis focused on adults 65 and older found that just 2.12 percent underwent same-day discharge, and that those who did had proportionally fewer comorbidities than patients discharged later. The authors concluded that the safety of same-day discharge in this age group is unclear and that careful patient selection is critical [7]. This is the population most relevant to Medicare, and the evidence does not support routine outpatient migration for it.

References

1. The Safety and Efficacy of Ambulatory Bariatric Surgery. Current Surgery Reports. 2025. doi:10.1007/s40137-025-00475-7.
2. Alqahtani AR, Elahmedi M, Amro N, et al. Laparoscopic sleeve gastrectomy as day-case surgery versus conventional hospitalization: results of the DAYSLEEVE randomized clinical trial. Surg Obes Relat Dis. 2022;18(9):1141-1149. PMID: 35803849.
3. Mahan ME, Petrick G, Dove J, Obradovic VN, Parker DM, Petrick AT. Ambulatory discharge of patients undergoing sleeve gastrectomy results in significantly more adverse outcomes. Surg Obes Relat Dis. 2024;20(11):1026-1036. PMID: 39261161.
4. The value of patient selection in same-day discharge implementation: insights from the MBSAQIP database. Surg Obes Relat Dis. 2025.
5. Ortega PM, Sabatella L, Ahmed AR. Safety outcomes in same-day discharge anastomotic metabolic/bariatric surgery versus regular overnight discharge protocol: a systematic review and meta-analysis. Obes Surg. 2025;35(7):2567-2577. PMID: 40392475.
6. AbuHasan Q, Hunt M, Massoud L, Burney CP, Holmstrom AL, Yuce TK, Stefanidis D. Safety and factors associated with early discharge in revisional laparoscopic Roux-en-Y gastric bypass: analysis of the MBSAQIP database. Surg Endosc. 2024;38(10):6097-6104.
7. Hamid SA, Graetz E, Esdaille CJ, Schneider EB, Gibbs KE. Same day discharge after metabolic and bariatric surgery in adults 65 years and older: an analysis of the 2015 to 2022 MBSAQIP. Obes Surg. 2025;35(1):25-32. PMID: 39636520.