September 13, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at https://www.regulations.gov/document/CMS-2021-0119-0053

Re: CMS-1751-P – Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

I am pleased to submit the following comments on behalf of the Ambulatory Surgery Center Association (ASCA) in response to the Centers for Medicare and Medicaid Services' (CMS) Proposed CY 2022 Revisions to Payment Policies under the Medicare Physician Fee Schedule (MPFS) and updates to the Quality Payment Program (QPP).

ASCA represents the interests of the more than 6,000 Medicare-certified ambulatory surgical centers (ASCs) nationwide. ASCs are located in every state and offer a high-quality, convenient and low-cost choice for Medicare beneficiaries who do not require hospitalization after surgical or diagnostic procedures. We appreciate the opportunity to comment on a few of the proposed provisions that affect ASC clinicians and the Medicare patients they serve.

Physician Fee Schedule (PFS)

Conversion Factor

Almost all health care professionals and organizations are aligned in expressing severe concern over the expiration of the Consolidated Appropriation Act (CAA) 3.75 percent increase to the CY 2021 conversion factor. Although Congress would need to step in to extend the conversion factor, CMS should be concerned as Medicare beneficiaries stand to risk losing access to essential health services if the provider cuts take effect as anticipated. In particular, provider cuts may have an outsized effect on beneficiaries in rural areas or from historically underserved populations, directly opposing this administration's commitment to prioritizing care for those populations. ASCA urges CMS to work with Congress on extending the 3.75 percent increase to

the conversion factor, as well as considering long-term fixes for budget neutrality components of Medicare payment systems that are increasingly adversely affecting providers.

Clinical Labor Pricing Update

ASCA has heard concerns from its specialty society partners about CMS' proposed updates to clinical labor pricing. While the process of updating prices makes logical sense, ASCA would like to echo concerns about reimbursement rates for certain office-based specialties if the pricing updates are adopted as proposed.

As with many payment policies within Medicare, the issue seems to arise not from the clinical labor pricing update itself but rather from budget neutrality. United Specialists for Patient Access (USPA) estimates that the actual impact on reimbursement for a number of providers, including vascular surgeons, could be as significant as negative 11 percent[1]. Reimbursement cuts of this magnitude could have implications on the availability of certain office-based specialty procedures to Medicare beneficiaries. There is also the downstream risk of making independent physician practices financially infeasible and accelerating the trend of consolidation towards corporate entities and large health systems. Finally, reducing availability of care for these services could promote faster progression of advanced disease at a time when our nation's healthcare system is most strained. It's essential that non-hospital sites of service remain viable to relieve stress on hospitals dedicated to serving COVID-19 patients.

For these reasons, we request that CMS not finalize the clinical labor updates at this time. Additional time to consider the update may help CMS alleviate some of the concerns raised above and give providers time to adjust separate from other major updates in the PFS such as the scheduled 3.75 percent cut in the conversion factor.

Global Surgical Packages

ASCs do not receive a technical payment for evaluation and management (E/M) services furnished under Medicare, and as such, these visits are seldom, if ever, performed in ASCs. However, E/M visits are an essential part of the preoperative process and have a direct relationship to optimal patient and procedure referral in the ASC. ASCA joins the many organizations disappointed with CMS' continued decision not to apply Relative Value Scale Update Committee (RUC) recommended updates to office/outpatient E/M codes furnished as part of a global surgical package.

As other stakeholders have noted, this decision could have serious, detrimental consequences on payments for E/M visits furnished as part of a surgical package relative to other standalone E/M visits. Failure to update payments for certain E/M codes creates unfair payment differences between surgical specialties and other physician types for providing the same services, in direct violation of the Medicare statute that prohibits CMS from paying physicians differently for the same work. This decision also ignores the recommendation of the RUC, which represents all medical specialties and voted overwhelmingly (27to 1) in April 2019 that full relative value unit

[1] United Specialists for Patient Access (USPA) CY 2022 Physician Fee Schedule Comment Letter

(RVU) increases should be incorporated into global code packages[2]. In fact, the medical stakeholder community at large has been united in recommending that CMS incorporate the revised E/M values into visits bundled as part of global surgical packages.

For these reasons, ASCA implores CMS to finalize a policy that applies RUC-recommended changes to E/M visits furnished as part of global surgical packages. ASCA supports the American Medical Association's physician and health professional workgroup dedicated to analyzing E/M coding and payment issues and hopes that CMS will continue to consult surgical specialties when considering changes to reimbursement policy.

Changes to Beneficiary Coinsurance for Colorectal Cancer Screening Tests

ASCA appreciates the proposal which implements Section 122 of the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116-260), Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests. CAA adopts a modified version of the *Removing Barriers to Colorectal Cancer Screening Act*, legislation that ASCA has supported for years, ensuring that if a scheduled screening colonoscopy becomes therapeutic, the Medicare beneficiary will not face a copayment. Under the legislation, the Medicare beneficiary cost sharing for colorectal cancer screening will be phased out between January 2022 and January 2030. As the Medicare payment percentage increases, the beneficiary coinsurance percentage decreases until it is gone in 2030. Ultimately, this will greatly reduce patient financial burden, increase access to life-saving screening, and strengthen the fight against colorectal cancer.

ASCA requests that CMS consider another policy change that would increase access to life-saving colonoscopies for Medicare beneficiaries. In 2014, CMS approved coverage for Cologuard, a multitarget stool DNA test for asymptomatic, average risk beneficiaries aged 50 to 85 years.[3] While ASCA supports coverage for tools that will help with early detection of colorectal cancer, we believe that if a follow-up colonoscopy is required after use of the Cologuard screening test, Medicare should not penalize the Medicare beneficiary and should waive the copayment for that screening colonoscopy as well.

Merit-Based Incentive Payment System (MIPS)

Transition from MIPS to MVPs

In previous comments, ASCA expressed appreciation for CMS' desire to create new approaches to move physicians to value-based payments. ASC-based clinicians are generally not ideal candidates for traditional alternative payment models (APMs) despite delivering high-quality, cost-efficient care. ASCA agrees that moving toward models that are flexibly structured around clinical specialties and bring together focused, value-based measurements should remain the goal of the Quality Payment Program (QPP). Given the significant disruption caused by the COVID-19 pandemic, ASCA supported CMS' decision to delay implementation of the MIPS Value

[2] https://www.ama-assn.org/system/files/2019-07/ruc-voting-office-visits-final.pdf
[3] https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=277 (accessed September 2, 2021).

Pathways (MVP) framework. ASCA is generally supportive of the movement from traditional MIPS to the MVP framework. ASCA will defer comments on specific MVPs to the clinicians and specialty organizations that will have the expertise to propose relevant measures and activities. However, ASCA does have general comments on the MVP Guiding Principles, the timeline of MVP implementation and clarifications on category reweighting for ASC-based clinicians.

In comments submitted to the CY 2021 MPFS Proposed Rule, ASCA expressed concern about the fifth MVP Guiding Principle, "MVPs should support the transition to digital quality measures." These concerns persist but are outlined more specifically later in these comments in response to the Advancing to Digital Quality Measurement Request for Information (RFI).

ASCA is pleased to see CMS propose a long, phased transition to move clinicians from traditional MIPS to mandatory MVP reporting. Given that traditional MIPS just reached maturity this year, it is appropriate to give clinicians maximum time to adjust to a new value-based payment structure. Even if the MVP framework is more advantageous to clinicians than traditional MIPS reporting, it is still a new structure that will have significant implications on reimbursement. CMS should not hesitate to reassess the timeline after seeing data from the first year of MVP voluntary reporting in CY 2023.

ASCA strongly supports inclusion of ASC-based clinicians into the proposed "special status" codified definition. Clinicians who provide substantially all of their services in ASCs should not be penalized for lack of access to health information technology, a view clearly shared by Congress given their inclusion of Section 16003 in the 21st Century Cures Act. CMS did not make it clear in the proposed rule whether ASC-based clinicians, as defined under the "special status" definition, will still have their Promoting Interoperability scores reweighted in the new MVP scoring methodology as is currently the case in traditional MIPS. CMS should make these reweights clearer in the final rule and future rules, as they do for small practices that face similar challenges accessing electronic health record technology.

Request for Information (RFI) on Advancing to Digital Quality Measurement

While we applaud the goal of moving to all digital quality measures (dQM) by 2025, we have serious concerns about the ability of ASC-based Medicare providers that will be able to submit to such measures. It should be noted that while the Office of the National Coordinator of Health Information Technology (ONC) estimates that at least 86 percent of office-based physicians and 96 percent of acute care hospitals are currently using an EHR, we estimate that ***at most*** 50 percent of ASCs are using an EHR[4]. Additionally, many of those ASCs with EHRs are likely using inpatient products that are ill-fitted to the operational needs of an ASC. ASCs did not receive any federal funding for EHR adoption in the HITECH Act of 2009 and should not be penalized for slower adoption of health information technology (health IT).

[4] This estimate is based on a data from Definitive Healthcare, a 2021 survey of ASCA members and estimates from ASC-focused EHR vendors.

Both Congress and CMS have recognized the lack of EHR availability in ASCs. There is no federal requirement for ASCs to implement an EHR, and ASC-based clinicians (those clinicians who furnish 75 percent or more of their covered services in an ASC) are exempt from the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS). While ASCs are subject to the policies finalized in the ONC's 21st Century Cures Act Final Rule, it should be noted that that rule contains several exceptions for sites of service with limited access to electronically stored health information. For example, ASCs are not responsible under Information Blocking for any health information not stored in electronic format.

Given the current lack of health IT in ASCs it is likely that a transition to FHIR-based quality reporting would provide a considerable burden for many clinicians working primarily in ASCs. It would also provide an inaccurate picture of care quality provided in ASCs as compared to offices and hospitals who have had years to integrate health IT components into their clinical and administrative processes. ASCA has strong concerns about moving to dQMs by 2025. CMS should consider ASC stakeholder feedback before implementing policies that may penalize ASCs. ASCA has an ongoing working relationship with staff at ONC that can serve as a foundation for such stakeholder discussions.

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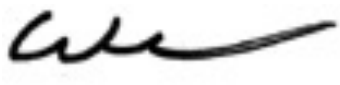
ASCA appreciates CMS' acknowledgement that all settings of care and practices of all sizes are essential to providing high quality, efficient care. We value the Agency's willingness to listen to our concerns as we strive to give our members the ability to continue providing provide high-quality patient care. We look forward to continuing to work with you and your staff. If you have any questions, please contact Kara Newbury at knewbury@ascassociation.org or 703.636.0705.

Sincerely,



William Prentice
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