September 8th, 2017

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1676–P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via online submission at www.regulations.gov

RE: CMS-1676-P – Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma:

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 2018 Revisions to Payment Policies under the Medicare Physician Fee Schedule (MPFS). ASCA represents the interests of more than 5,600 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 MPFS provisions that most directly impact ASC surgeons and the Medicare patients they serve.

Proposed Payment Rates and Setting Methodology under the MPFS for Items and Services Furnished by Nonexcepted Provider-Based Departments

The Bipartisan Budget Act of 2015 (Pub. L. 114–74) included Section 603 entitled, "Treatment of Off-Campus Outpatient Departments of a Providers." Effective January 1, 2017, payment for items and services furnished at an off-campus provider-based department (PBD) "shall be made under the applicable payment system under this part if the requirements for such payment are otherwise met," unless the facility was billing as a department of a hospital prior to the date of enactment (November 2, 2015). In the CY 2017 OPPS/ASC Final Rule (81 FR 79720) CMS finalized the MPFS as the ''applicable payment system'' for the majority of the items and services furnished by nonexcepted off-campus PBDs.

CMS is now proposing to recalibrate the MPFS Relativity Adjuster to equal 25 percent of the OPPS rate. ASCA opposes CMS's proposal for the following reasons.

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First, ASCA interpreted the "applicable payment system" in the statute as whichever system the facility was being reimbursed through prior to becoming an off-campus PBD. For instance, an off-campus PBD that used to be a physician's office would be paid under the MPFS, and PBDs that were previously ASCs would be reimbursed under the ASC fee schedule. ASCA continues to believe that this is the correct interpretation of the statute.

Second, CMS has not yet established a simple pathway for facilities that previously were ASCs, but became HOPDs, to easily convert back to ASC status. Many facilities that were formerly ASCs will find it financially infeasible to operate under payment rates that equal 25 percent of the OPPS rates. These entities may wish to convert back to ASCs, and should be able to do so. Moreover, CMS should want them to do so rather than close so that beneficiaries in those communities continue to have access to high-quality surgical services.

A hospital seeking to spin-out a facility that was once an ASC cannot provide services in that location until the facility relicenses and re-enrolls in Medicare as an ASC. There is no retroactive payment eligibility. With today's certification backlog, it is not uncommon for this process to take six to twelve months, during which time the facility would be subject to the payment rate defined in this rule. ASCA respectfully requests that CMS not finalize this proposed adjustment to the Relativity Adjuster until such time as a facility that was previously reimbursed as an ASC can simply and efficiently convert back to and enroll in Medicare as an ASC.

Finally, ASCA has serious concerns about CMS setting the MPFS Relativity Adjuster based on G0463. In describing the PFS Relativity Adjuster methodology, CMS itself admits that their data is imprecise, and that data that would be able to inform a more accurate rate setting process will not be available until the end of CY 2017 at the earliest. ASCA believes that CMS should be wary of setting precedents for such drastic technical payment cuts without sufficient data to support the exact rate identified.

Furthermore, ASCA has broad concerns about CMS relying on single, non-surgical codes for site neutral rate setting. CMS's analysis does not take into consideration the service mix variability among nonexcepted HOPDs. CMS relies on the fact that G0463 represents a significant number of claims billed using the PO Modifier, but CMS must recognize that many nonexcepted HOPDs, particularly those that were formerly ASCs, may never bill a G0463. These facilities are more likely to bill surgical services, and CMS has not modeled a relativity adjustment that would be more appropriate for facilities that are principally furnishing surgical services. While the process to arrive at the initial 50 percent PFS Relativity Adjuster may have been imprecise it was as least based on a portfolio of 22 major codes, codes that represented a diversity of clinical, surgical, and procedural areas. ASCA believes that this type of holistic analysis better represents payment needs than relying on a single evaluation and management code.

Until such time as better, precise data can inform the rate-setting process CMS should seek to take into account an array of codes that better reflect the range of services that facilities can and do supply.

CMS Acceptance of RUC Recommendations for Valuation of Specific Services

Since the 1992 institution of the Fee Schedule as Medicare's mechanism to reimburse physicians, the Relative Value Scale Update Committee (RUC) has provided CMS with invaluable guidance in the technical process of computing annual reimbursement updates. CMS clearly understands the important nature of collaboration with the RUC for the purposes of correctly valuing services rendered under Medicare, detailing an extensive history of shared PFS maintenance and review in this rule. CMS also notes that this history of collaboration allows the RUC to consider concerns that CMS has raised on a historical basis with new, revised, or potentially misvalued codes.

ASCA is pleased that for CY 2018 CMS is proposing values that reflect RUC recommendations "without as many refinements as CMS has proposed in recent years." ASCA believes that the RUC, with its specialty society representatives many of whom work in ASCs, continues to provide valuable and unique expertise when it comes to correctly valuing physician services.

ASCA urges CMS to finalize its proposal to approve RUC recommendations.

Updates to Evaluation and Management Documentation Guidelines

ASCA is pleased to see that CMS broadly agrees with healthcare stakeholders that the current Evaluation and Management (E/M) Documentation Guidelines, released in 1995 and 1997, are burdensome, outdated, and do not accurately document patient care. As discussed in the rule, documentation standards established 25 years ago cannot adequately capture modern medical practices and decisions that lead to differences in levels of care.

While E/M services are not provided in the ASC, many of the Medicare beneficiaries who have procedures performed in an ASC will see their physician for an E/M visit in the physician's office setting. ASCA does not recommend entirely eliminating documentation guidelines for history of present illness. While recognizing CMS' belief that the History component is the most outdated, it nonetheless is instrumental for surgical specialties determination of complexity of care. While ASCA understands that the documentation guidelines must be modified to take into account modern patient histories and the systems that house them, assuming patient history documentation as part of medical decision making may be inadequate.

ASCA agrees with stakeholders that the E/M code itself may be part of the problem. ASCA requests that surgical specialties are consulted if CMS initiates the process of reforming either the documentation guidelines or the underlying E/M code.

E/M services are provided in high volume by almost all providers. As a result, any changes to the documentation guidelines that impact which E/M level is reported will have an enormous impact on the Medicare system as well as the administrative workings within practices across the country. Therefore CMS needs to take a transparent and collaborative approach as they launch into this multi-year effort to revise the E/M guidelines. The development of any proposals should be made with stakeholder input, all proposals should be open for public comment and vetted

thoroughly and finally and proposed guidelines should be tested prior to their implementation being mandated.

ASCA recommends that CMS release a detailed proposal on the process they will use to review and revise the E/M documentation guidelines. The focus of any effort should be on reducing the burden of any unnecessary documentation.

Revisions to CY 2016 Physician Quality Reporting System Requirements

With the institution of the Medicare Quality Payment Program (QPP) as established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the CY 2016 reporting period is the last for the Physician Quality Reporting System (PQRS). The Merit-based Incentive Payment System (MIPS) collapsed PQRS, Meaningful Use, and the Value-Based Payment Modifier – under one payment adjustment system.

ASCA agrees with stakeholders that the transition can be burdensome for clinicians, and appreciates CMS modifying the requirements for successful reporting under the 2018 PQRS payment adjustment. ASCA believes this will reduce clinician confusion as they acclimate to new quality reporting requirements under MIPS. ***ASCA urges CMS to finalize this proposal.***

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ASCA appreciates that CMS acknowledges that all settings of care and practices of all sizes are necessary in order to provide higher quality and more efficient care, and the Agency's willingness to listen to our concerns as we strive to help 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
Chief Executive Officer