



September 13, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

RE: 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 [CMS-1751-P]

Dear Administrator Brooks-LaSure:

On behalf of the American Society of Breast Surgeons (ASBrS), we would like to thank you for the opportunity to comment on the calendar year (CY) 2022 Medicare Physician Fee Schedule proposed rule. ASBrS, the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases, is committed to continually improving the practice of breast surgery by serving as an advocate for those who seek excellence in the care of breast patients. Founded in 1995, the Society now has more than 3,000 members throughout the United States and in 35 countries around the world.

CY 2022 MPFS Conversion Factor

Because of significant changes in the values of the office and outpatient evaluation and management (E/M) code set implemented in CY 2021, CMS had originally proposed a CY 2021 conversion factor that would have decreased by -10.6% from CY 2020. In response, Congress passed several provisions in the *Consolidated Appropriations Act, 2021*, including a single year +3.75% increase to the CY 2021 conversion factor. With that provision set to expire at the end of this year, CMS is again proposing to cut the MPFS conversion factor, further subjecting physicians to cuts.

First, **ASBrS asks that CMS work with Congress to pass a similar provision that would extend the +3.75% payment adjustment.** In an uncertain environment, it is critical that CMS and Congress work together to ensure stability in the Medicare program for beneficiaries and the health care system overall. Second, **ASBrS requests that CMS begin to consider steps that can be taken to create longer term stability in the Medicare Physician Fee Schedule.** Now several years after the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the numerous alternative payment models (APMs) that were a primary goal of the legislation have not materialized, particularly for surgeons and specialists. Without available APMs in which to participate, physicians are left to participate in the Merit-Based Incentive Payment System (MIPS), which has few relevant measures for our specialty and has not met its goal of serving as an adequate payment update system to provide incentives to receive payment updates that might look similar to the inflationary adjustments that we see in other CMS payment systems, such as the Inpatient Prospective Payment System (IPPS), Hospital Outpatient Prospective Payment System (OPPS), and the Ambulatory Surgery Center (ASC) Payment System. Physicians are under the constant threat of reimbursement cuts while the cost of care and complexity of patients increases. We hope that CMS will consider this as it devises future policies and work with Congress where it believes it needs additional authorities.

Revaluing Services Analogous to Office and Outpatient E/Ms: Global Services

As part of CY 2021 rulemaking, CMS finalized proposals to increase the values of several services that it cites as being closely tied to the values of the office and outpatient E/M visit codes. However, CMS failed to adopt the RUC recommendations to make commensurate increases to global services for the office visits that are bundled into those 10- and 90-day packages. In numerous separate instances, CMS extended increases based on the office and outpatient E/M codes to end-stage renal disease monthly capitation payment services, transitional care management services, maternity care services, assessment and care planning for patients with cognitive impairment, initial preventive physical examination and initial and subsequent annual wellness visits, emergency department visits, behavioral healthcare services, and therapy evaluations. CMS even went so far as to state that it is increasing the valuation of therapy evaluations based on the office and outpatient E/M increases even though the therapy evaluation codes **“do not specifically include, were not valued to include, and were not necessarily valued relative to, office/outpatient E/M visits.”** Yet CMS neglected its own precedent from 1997, 2007, and 2011 by failing to make the RUC-recommended increases to global services, even though those CPT codes have a direct relationship to office and outpatient E/M services.

For the following reasons, **ASBrS again urges CMS to reverse course and implement the RUC recommendation to extend the value changes in office and outpatient E/M visits to global codes.** First, we believe that CMS' statements that its decision was based on concern over the number of post-op visits included in 10- and 90-day global codes is an inappropriate rationale to make an across-the-board arbitrary payment policy. In using this rationale, CMS inappropriately conflates two different issues: (1) the relativity of the resource-based relative value system; and (2) the services that are considered “typical” in a 10- and 90-day global code. CMS has mechanisms for revaluing potentially misvalued

codes that are based on data and stakeholder input. Here, CMS has decided that it will forgo these mechanisms and instead abandon the relativity of the entire Medicare Physician Fee Schedule because of a belief that the Agency keeps repeating but fails to support with data that can accurately result in revaluation of the codes. Second, this is a drastic departure from past CMS policy when there has been a significant revaluation of the E/M code set. Recognizing the equivalent work in stand-alone office visits and visits included in 10- and 90-day globals, CMS has always ensured that increases in value for visits in the global period were made commensurately with increases to office and outpatient visits including in 1997 as part of the first Five-Year Review, in 2007 under the third Five-Year Review, and in 2011 when the elimination of consultation codes created budget neutrality adjustments to office visits. ASBrS urges CMS to follow its past policy to ensure that values of codes that are derivative of the wRVUs of the office and outpatient E/M are updated accordingly by adopting the RUC recommendation to extend the updates to 10- and 90-day globals. This is not only consistent with past CMS policy but would ensure that CMS creates consistency in its approach to increasing services related to office and outpatient E/Ms as it did for the services listed above. As we have already commented along with members of the surgical community, while we believe the Agency should have made the adjustments to the globals in CY 2021 rulemaking rather than in CY 2022, we would highlight that it would not be without precedent to address the valuation of the global codes in the subsequent year. After changes were made as part of the 1st Five Year Review of the PFS, CMS (then-Health Care Financing Administration (HCFA)) initially declined to apply the E/M increases to the globals. However, the following year, in the CY 1998 PFS final rule, the Agency directly stated, "Upon further examination of this issue, we are increasing the work RVUs for global surgical services to be consistent with the 1997 increases in the work RVUs for evaluation and management services."¹

We are dismayed that CMS continues to use the globals data collection direction provided by Congress as part of MACRA. First, the Congressional mandate for CMS to collect data on global services was issued in 2015. ***The data collection and analysis has extended almost seven years: a period of time that is unreasonable, particularly when the Agency has begun to use the ongoing analysis to justify payment cuts.***

Second, this data collection exercise should not be used as an excuse for the Agency not to update the value of services bundled into the global codes, since it is not the value of the services that CMS is gathering data on, but rather the number of services provided. Furthermore, it is disingenuous for the Agency to assert that the almost seven-year data collection means that increases to globals should be halted across the board, given that the agency recently agreed with and implemented AMA RUC recommendations for certain surveyed and revalued global services with packaged E/M visits. If there was concern about the accuracy of the number of visits, CMS should propose codes for the list of Potentially Misvalued Services. But for those codes that have undergone a recent survey and revaluation, there is no reasonable argument that CMS should not extend the office and outpatient E/M increases proportionally based on the office visits packaged into those global services. CMS' decision to

¹ Medicare: Physician Fee Schedule for Calendar Year 1998; Payment Policies and Relative Value Unit Adjustments and Clinical Psychologist Fee Schedule, 42 C.F.R. § 400 (1998).

not extend the increases for even those services calls into question the overall rationale that CMS provides for extending these increases for some services that are related to office and outpatient E/MS and not to global services that have packaged office visits in their values.

MIPS: Quality Performance Category- General Surgery Specialty Measure Set

Under the traditional MIPS pathway, CMS continues to propose the inclusion of specialty measure sets. As part of the General Surgery Specialty Measure Set, CMS proposes to continue the inclusion of ASBrS' Measure #264, *Sentinel Lymph Node Biopsy for Invasive Breast Cancer*. **ASBrS commends CMS' decision to continue to include this measure in the program.** As previously mentioned, meaningful, applicable measures included in the MIPS program are often lacking for certain specialties. We thank CMS for ultimately maintaining measure #264. We believe this demonstrates CMS' appreciation for the need to ensure that specialties have a sufficient number of relevant measures in the program.

ASBrS appreciates the opportunity to provide input on the provisions contained in the proposed rule. We look forward to working with you to ensure that Medicare policies support patient-centered care and continue to provide the appropriate incentives to drive quality improvement. If you have any questions, please contact Sharon Grutman, Director, Advocacy, Communications, & Quality Initiatives at sgrutman@breasturgeons.org.

Sincerely,



Julie Margenthaler, MD
President