THE AMERICAN SOCIETY OF
Breast Surgeons

September 6, 2022

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

Submitted electronically via regulations.gov

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-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) 2023 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 2023 MPFS Conversion Factor & Reimbursements

The Centers for Medicare and Medicaid Services (CMS) has proposed a CY 2023 Medicare Physician Fee Schedule (MPFS) conversion factor of $33.0775, almost 4.5% less than the CY 2022 MPFS conversion factor. CMS is implementing this cut for two reasons: first, CMS reduces the conversion factor by 1.55% because of budget neutrality requirements triggered by CMS proposals made in CY 2023 rulemaking; second, CMS reduces the conversion factor due to the expiration of the one year 3.0% boost to the conversion factor provided by Congress as part of the *Protecting Medicare and American Farmers from Sequester Cuts Act*. This 3.0% boost was needed 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. When that provision expired, Congress provided yet another fix of +3.0, the expiration of which is now combining with a *new* budget neutrality adjustment to exact cuts on physicians providing care to Medicare beneficiaries. These numbers do not take into account the 2% sequestration that applies to Medicare payments since July 1, 2022 due to the *Budget Control Act of 2011* and an additional 4% sequestration looming over physician payments at the end of the year due to Statutory Pay-As-You-Go (PAYGO) provisions.

ASBrS understands that many of these provisions require Congressional action. Therefore, ***ASBrS asks that CMS work with Congress to enact legislation that would avoid these cuts to payments for services provided to Medicare beneficiaries***. While the Agency and Congress have instituted methodologies for nearly every other Medicare payment system that include annual update mechanisms that generate positive payment updates and take into account medical inflation, the Agency and Congress have allowed the payment system that reimburses the direct provision of care to Medicare beneficiaries by their physicians to become a fixed pie where they expect providers to tangle with each other over reimbursements and, worse yet, to be used as a funding mechanism by reducing Medicare physician payments to pay for spending in other parts of the federal budget. This must stop. It is critical that CMS and Congress work together to ensure stability in the Medicare program for beneficiaries and the health care system overall.

In addition to taking steps that will address the immediate cuts planned for CY 2023, ***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.

Physicians are under the constant threat of reimbursement cuts while the cost of care and complexity of patients increases. We are also concerned that allowing this to continue will continue to exacerbate health care disparities and inequities. Population-based breast cancer mortality rates are higher among African American women and population-based incidence rates of triple-negative breast cancer are two-fold higher among African American women.[1] As shared by Susan G. Komen, "According to the most recent data available, breast cancer mortality is about 40 percent higher for African-American women in the U.S. than Caucasian

[1] The American Society of Breast Surgeons (ASBrS), Position Statement on Screening Mammography, https://www.breastsurgeons.org/docs/statements/Position-Statement-on-Screening-Mammography.pdf

women."[2] Ensuring that the U.S. health care system is providing services to patients and creating better access to screening, diagnosis, and treatment for patients is all dependent on a properly financed system. We hope that CMS will consider this as it devises future policies and work with Congress where it believes it needs additional authorities.

CY 2024 MPFS Conversion Factor

In the context of the ongoing pressures placed on MPFS reimbursements, ***ASBrS urges the Agency to rescind plans to implement reimbursement in CY 2024 for G2211*** *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).* We would remind the Agency that G2211, which was proposed by the previous administration and which Congress prohibited CMS from implementing as proposed, would have generated a significant cut to the MPFS conversion factor. The Congressional prohibition on implementation of G2211 avoided an approximately 3% reduction to the CY 2021 MPFS conversion factor. This code, for which CMS has provided changing rationales as to the purpose of it and the need for it, would create a giant disruption across the entire Medicare Physician Fee Schedule if CMS implements it. ***ASBrS urges CMS to withdraw G2211 as a reportable code and to make no further proposals regarding payment for G2211 in future rulemaking.***

Rebasing and Revising the Medicare Economic Index (MEI)

CMS is seeking input on rebasing and revising the MEI. ASBrS believes that the Medicare Physician Fee Schedule must devise better ways to account for inflation in health care spending. However, we believe that CMS must proceed cautiously with any proposals that might create a significant disruption to a payment system that is premised on relativity and in the context of a budget neutral environment. ***ASBrS agrees with the American Medical Association that CMS pause consideration of other sources of cost data for use in the MEI until the AMA completes its effort to collect practice cost data from physician practices*.**

Evaluation & Management (E/M) Visits

- Split (or Shared) Services
  As part of CY 2022 rulemaking, CMS finalized a CY 2023 policy for when a service has been furnished by both a physician and a non-physician practitioner (NPP). CMS had stated that that practitioner who delivers the "substantive portion" of the service is the one that should submit the claims for the service. As part of that finalized CY 2023 policy, CMS stated that the "substantive portion" would be defined as "more than half of total time." CMS proposes to delay this definition of "substantive portion" based only on time until CY 2024 while it considers additional input. ***ASBrS supports CMS'***

[2] https://www.komen.org/about-komen/our-impact/aa-health-equity/ending-breast-cancer-health-disparities/ (accessed August 10, 2022).

decision to maintain its current policy for split (or shared) E/M services. We believe the ability to select the billing practitioner based on either time or a key element of the E/M (e.g., medical decision making) is the right one. ***ASBrS urges CMS to permanently finalize its current policy that allows for selection of the billing practitioner based on performance of a key element of the E/M or more than half of total time.*** It is imperative that billing guidelines reflect care in the real world and acknowledge that CMS has implemented a policy whereby E/M visit levels are selected by either medical decision making or time. It is inappropriate to assign the billing privileges to a provider that has not performed the medical decision making on a service when that E/M level was chosen based on the MDM documentation guidelines. We believe CMS' current policy is sound, reflective of the new structure of E/M codes, and avoids the unnecessary administrative burden of calculating time even when not using the time-based approach to level selection.

- Global Payment Policy

  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 AMA 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. Yet again, here in CY 2023 rulemaking, CMS failed to adopt the AMA RUC recommendations to ensure commensurate valuation changes to global services for the inpatient and discharge visits that are bundled into 10- and 90-day packages.

  ***ASBrS again urges CMS to reverse course and implement the AMA RUC recommendation to extend the value changes in office/outpatient, hospital, and discharge visits to global codes*.**

  First, we believe that CMS' statements of 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 E/M 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 E/Ms are updated accordingly by extending the updates to 10- and 90-day globals***.

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 when it altered office and outpatient E/Ms, 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."[3] We believe the revaluation of inpatient/observation E/Ms provides an opportunity for CMS to correct this mistake.

We are dismayed that CMS continues to use the globals data collection direction provided by Congress as part of MACRA as a rationale for inaction. First, the Congressional mandate for CMS to collect data on global services was issued in 2015. *The data collection and analysis has extended almost eight 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 eight-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 not extend the increases for even those services calls into question the

[3] 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).

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. For instance, leading up to CY 2021 rulemaking, ASBrS and its members participated in the AMA RUC revaluation efforts for CPT 19307 (*Modified radical mastectomy*). After this review, CMS finalized a revised work RVU of 17.99, a reduction from its previous value. In doing so, however, CMS is affirming the number of post-op visits associated with this CPT code: 0.5 day hospital discharge day management service, three level 3 established patient office visits and a single level 4 established patient office visit. The AMA RUC estimates that CMS' policy of failing to provide the increases to these visits to modified radical mastectomies has resulted in an over 8% decrease to the work RVUs for this procedure that is critical in the treatment of breast cancer patients. As a society, ASBrS and our members have demonstrated ourselves as good partners to the Medicare program, ongoing efforts to improve and update the accuracy of code values, and to CMS. However, CMS continues to cite examples of the few as a means to punish the many, including our members who have demonstrated their willingness to provide quality care and improve payment methodologies. Most disheartening of all, CMS' refusal to appropriately reimburse the extensive post-operative work required after a modified radical mastectomy – despite the agency having confirmed that this work is necessary – amounts to a message to breast cancer patients that their post-operative care, however much needed, is simply not worth paying for.

Quality Payment Program (QPP)

- 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.*** 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.
- MIPS: MIPS Value Pathways (MVPs)- Advancing Cancer Care MVP
  As CMS continues with its plan to provide additional options for MIPs participation, we would like to highlight the Advancing Cancer Care MVP. This MVP does not include any measures specific to breast cancer other than Q450: Appropriate Treatment for Patients with Stage I (T1c) – III HER2 Positive Breast Cancer. We believe that this MVP should expand on the evaluation of care delivered to breast cancer patients by included the aforementioned ASBrS' measure, Measure #264, *Sentinel Lymph Node Biopsy for Invasive Breast Cancer.* ***ASBrS urges CMS to add Measure #264 (Sentinel Lymph Node Biopsy for Invasive Breast Cancer) to the Advancing Cancer Care MVP***.

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@breastsurgeons.org.

Sincerely,

Nathalie Johnson, MD
President