THE AMERICAN SOCIETY OF Breast Surgeons

August 29, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Baltimore, Maryland 21244-8016

RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (CMS-1715-P)

Dear Administrator Verma:

The American Society of Breast Surgeons (ASBrS) appreciates the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) input on the calendar year (CY) 2020 Medicare Physician Fee Schedule and Quality Payment Program 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.

The comments below are intended to assist CMS in its policymaking with the goal of ensuring patient access to quality care provided by breast surgeons and appear in the order in which CMS addresses them in the proposed rule.

Potentially Misvalued Services

As part of the public nomination process for the list of potentially misvalued codes, CMS received stakeholder input that the following codes should be added to the list:

- CPT 10005 (*Fine needle aspiration biopsy; including ultrasound guidance*)
- CPT 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*)

CMS states that the public nomination cited an inappropriate decrease in the amount of physician time attributed to the codes resulting in undervaluation of these procedures. ***ASBrS agrees that CMS should finalize the addition of CPT 10005 and 10021 to the list of potentially misvalued codes*.** We agree that the current values attributed to these codes fail to take into account the increased intensity of these procedures as well as other methodological flaws that led to an inappropriate level of decrease in wRVUs for these codes.

Payment for Evaluation and Management (E/M) Visits

In follow-up to the CY 2021 polices that CMS finalized as part of last year's rulemaking cycle, CMS puts forward a series of new proposals for CY 2021. In particular:

- CMS proposes to rescind its previously finalized CY 2021 policy to create a collapsed payment rate for office and outpatient E/M visits for levels 2-4 (one for new patients and one for established patients; ***ASBrS supports the CMS proposal to rescind this policy***.

- CMS proposes to maintain its finalized CY 2021 policy to allow for selection of office/outpatient visit level based on either just medical decision-making (MDM) or just on based on time; ***ASBrS supports the CMS proposal to allow for selection of level of visit based on either MDM or time.***

- CMS proposes to rescind the addition of G-codes for "additional resources" inherent to primary care visits and visits for "nonprocedural specialized medical care." ***ASBrS supports the CMS proposal to rescind the previously finalized G-codes given the lack of clarity on how to bill for those codes and because of concern that the codes did not account for the complex care provided in E/M visits for cancer patients that are having to contemplate treatment plans***.

- CMS proposes the creation of a new, single G-code for use to reflect increased complexity in an office and outpatient E/M visits with the following descriptor:

  > GPC1X (*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, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*)

  While we appreciate CMS' effort to ensure that payments accurately reflect the resources required to treat complex patients, particularly given the treatment decisions that breast cancer patients must navigate with their surgeons, we are concerned that this newly conceived G-code is in need of more thorough vetting. In addition, stakeholders would benefit from better clarity from CMS on the intended use of the code and whether it truly intends for the code to be used in conjunction with

most all claims for office/outpatient visits as the impact tables seem to indicate. Therefore, ***ASBrS requests that CMS delay implementation of GPC1X for increased complexity (or any similar code) and allow for the CPT Editorial Panel to review and define the code parameters.***

- As part of the package of AMA RUC recommendations that are the basis of CMS' current set of proposals for office/outpatient E/Ms, the RUC recommended that CMS make commensurate increases to CPT codes with global periods because they have values that are connected the office and outpatient E/M visits packaged into the global codes. Contrary to the RUC recommendation, CMS failed to extend the proposed increases in wRVUs for office and outpatient E/Ms to codes with global periods. ***ASBrS recommends that CMS 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 out 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, mechanisms which are supposed to be based on data and stakeholder input. Here, CMS has decided that it will abandon the relativity of the entire Medicare Physician Fee Schedule because of a belief that the agency keeps repeating but fails to be able to produce 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.***

Global Surgical Packages

In the proposed rule, CMS reiterates its previously finalized plan for collecting data on the post-op visits during the global period via CPT 99024. CMS reviewed statistics on the data it received (including some reporting data *by specialty*). The data has shown low levels of reporting of 99024s, particularly in conjunction with 10-day globals causing CMS to ask whether this is because the post-op visits are not being reported or because they are not being furnished. There is widespread concern that practices in the 10 states continue to be unaware of this requirement. We have no knowledge of any recent educational material from CMS that attempts to increase awareness of this requirement. In fact, in this precise proposed rule where it discusses the "data" obtained from the effort, CMS even fails to mention that this is an ongoing requirement that is still on the books, and by referring to the analyzed reporting

period of July 1, 2017 to June 30, 2018, even seems to inadvertently suggest that it was a past requirement. CMS also cites the 3 RAND reports related to post-op visits included in the global period. ***ASBrS continues to be concerned about the accuracy of the data provided via reporting of CPT 99024 and believes that without proper validation it would be inappropriate to rely on the data for purposes of revaluing the codes that were associated with the 99024 data collection effort. In addition, the RAND reports stretch to reach conclusions based on flawed data, and the RAND reports provide no sound basis for an across-the-board revaluation of global periods given that the "data" presented is from the flawed 99024 data collection and a limited separate survey of only cataract surgery, hip arthroplasty, and complex wound repair.*** ASBrS is firmly committed to the accurate valuation of the RBRVS, and we will continue to work with CMS and the AMA RUC to ensure that codes are properly valued. ***We agree with other stakeholders that if CMS believes a code is misvalued, CMS should include it on the list of potentially misvalued codes for review and analysis by the AMA RUC so that an accurate code-specific assessment can be conducted.*** But the "data" referred to by CMS via collection of a flawed claims-based data mechanism and a limited survey only examining 3 procedures is no basis for an across-the-board revaluation of a large volume of MPFS codes.

Merit-Based Incentive Payment System

Cost Category

The ASBrS appreciates CMS's ongoing work with clinical stakeholders to develop more focused episode-based cost measures. ASBrS members served on the Wave 2 Oncologic Disease Management Clinical Subcommittee (CS), and one of our members led the smaller workgroup that produced the draft cost measure titled, "Lumpectomy, Partial Mastectomy, Simple Mastectomy." Despite our involvement, we continue to have concerns with aspects of the measure development process, including a rushed and inadequate field-testing period which prevented CMS from gathering meaningful input. We are also concerned that only 3 of the 18 episode-based cost measures proposed for 2020 have been endorsed by the NQF. Of the 8 measures developed during Wave 1, only 3 were reviewed and eventually endorsed by the NQF Cost and Resource Use Committee. The other 5 did not pass muster with the Scientific Methods panel and were unable to move on for formal evaluation by the Cost Committee, yet are currently being used in MIPS. Similarly, none of the Wave 2 measures, including the Lumpectomy, Partial Mastectomy, Simple Mastectomy measure, have yet been considered by the NQF. It is concerning that CMS is moving ahead with using these measures for accountability when the Measures Application Partnership (MAP) provided conditional support for use of these measures pending NQF endorsement.

In light of these ongoing issues, ***we do not support CMS's proposal to increase the weight of the Cost Category for the 2020 performance year from 15% to 20%, while simultaneously decreasing the weight of the Quality category***. CMS should maintain the current weight of the Cost category for 2020. CMS also should remain flexible with this category for the next few years as it continues to further refine and test existing cost measures and conducts additional education and outreach so that clinicians can better understand how to use the data produced by these measures. ***We also strongly urge CMS to***

continue to make improvements to the field-testing period, such as extending the timeline to access the reports and provide feedback. Finally, ***we recommend that CMS conduct better and more frequent education and outreach to ensure clinicians understand how to interpret the measure specifications and feedback report data***.

Topped Out Quality Measures

The ASBrS is very concerned with CMS's proposal to remove multiple measures from the MIPS in 2020 due to topped out status. Removing measures due to topped out status is problematic for multiple reasons:

- The accuracy of topped out measure determinations is challenged by shifting MIPS requirements from year to year.
- Topped out measures may reflect performance of only a portion of clinicians who self-select the measure because of expected high performance rather than true performance across all eligible clinicians.
- Removal of certain topped out measures could lead to unintended consequences if declining performance becomes difficult to track over time.

We urge CMS to conduct more thorough analyses of factors potentially influencing topped out performance. For example, CMS should consider factors such as whether performance varies by group versus individual reporting, by practice setting, by geography, by volume of cases, or by physician experience with quality reporting.

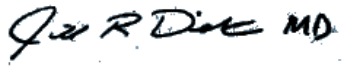
Topped out measure determinations must also account for the importance of the measure, as well as consider the number of other measures available to a particular specialty.

CMS states that it will take other factors into consideration when considering the removal of a topped out measure, such as whether the removal would impact the number of measures available to a specialist or if the measure addresses an area of importance to the agency. However, there is little discussion in this rule about whether and how these other factors were considered for each measure proposed for removal. ***We request that CMS adopt a more transparent thorough process for considering measures for removal proposals in the future***.

CMS also seeks feedback on potentially increasing the data completeness threshold for extremely topped out measures that it retains in the program. While we are interested in a solution that would allow CMS to maintain topped out measures in MIPS, this particular policy does not sufficiently address the need to improve the accuracy of current topped out determinations. Adopting another distinct reporting threshold will add to the complexity of the program, rather than helping to simplify it. To maintain program stability and choice, ***we urge CMS to maintain topped out measures over time so that it can conduct more thorough analyses of what is contributing to topped out performance and how best to maintain them in the program***.

Again, ASBrS appreciates the opportunity to provide input on the provisions contained in this year's 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, Manager, Advocacy, Communications, & Quality Initiatives at sgrutman@breastsurgeons.org.

Sincerely,



Jill Dietz, MD
President