

September 17, 2021

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1753-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Via online submission at [www.regulations.gov](http://www.regulations.gov)

**Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals**

Dear Administrator Brooks-LaSure:

We appreciate this opportunity to submit comments on behalf of four leading ophthalmology organizations with regard to CMS-1753-P, *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals*. Collectively, the members of our societies are responsible for performing the vast majority of all ophthalmic surgical procedures performed in the US, most of which, in the ophthalmic ASC setting.

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing 6,500 ophthalmologists in the United States and abroad who share a particular interest in and commitment to advancing the art and science of ophthalmic surgery.

The American Society of Retina Specialists (ASRS) is the largest retinal organization in the world, representing over 3,000 members. Retina specialists are board certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and enhance the ability of its members to provide the highest quality of patient care.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical society that represents over 4,000 ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical services in cost-effective ASC environments. The programs and services of OOSS are designed to ensure top-quality and sustainable patient

care and safety in surgical environments that support ever-changing technology and regulation.

OOSS is a member of the ASC Quality Collaboration (ASCQC), a cooperative effort of organizations and companies interested in ensuring that ambulatory surgical center (ASC) quality data is appropriately developed and reported. (ASCQC developed the claims-based quality measures incorporated within the recent rulemakings governing ASC quality reporting.)

The Society for Excellence in Eyecare (SEE) is a professional organization of ophthalmologists dedicated to educating its members about the most effective and advanced developments in ophthalmology, developing and implementing standards of practice for the effective and ethical provision of ophthalmologic services to patients, and serving as an advocate for patients in the promotion of high quality, cost-effective eye care services.

On behalf of ASCRS, ASRS, OOSS, and SEE, we are taking this opportunity to comment on this important regulation governing CY 2022 Medicare ambulatory surgical center (ASC) payment rates and the Quality Reporting Program for ASCs. Particularly with respect to the latter, we are very pleased that a number of the recommendations of the ASC and ophthalmology communities have been adopted in the recent past and appreciate the close collaboration among industry, medicine, and the agency that has characterized the development of the QR program. Most importantly, we strongly support the agency's decision in 2019 to change the ASC update factor from the Consumer Price Index – Urban (CPI-U) to the Hospital Market Basket (HMB). We will discuss below other payment policy changes that should ameliorate some of the distortions in relative payments to ASCs and HOPDs.

We would draw your attention to a recent study by the KNG Group, *Medicare Cost Savings Tied to Ambulatory Surgery Centers*, which concluded that annual Medicare cost savings attributable to ASCs increased from \$3.1 billion in 2011 to \$4.1 billion in 2018. (We note that ophthalmology accounted for more than one-third of these savings.) Importantly, if volume migration continues at the same rate as 2011-2018, surgery centers are projected to save Medicare \$74.2 billion from 2019-2028. Policies that encourage migration embody the potential to generate even greater savings than those projected. Our comments reflect our organizations' commitment to providing the highest quality and most accessible care at lower cost to the Medicare program and its beneficiaries.

The nation's ophthalmic ASCs are committed to providing Medicare beneficiaries with access to the highest quality surgical care while lowering their cost-sharing obligations and assisting the Medicare program in the containment of health expenditures. Since 1982, ASCs have expanded their role in meeting the surgical needs of the Medicare population and have done so saving billions of dollars annually. Simply stated, at a time when public policymakers are searching for meaningful health care reform -- improving quality and access, while reducing costs -- ASCs embody the potential to be a significant part of the solution. Despite CMS' decision in 2019 to change the ASC update factor from the CPI-U to the HMB, elements of the proposed regulation, particularly the use of the rescaler to achieve budget neutrality, will continue to thwart, rather than enhance the ability of our facilities to continue to serve the nation's Medicare beneficiaries.

Under the proposed rule, facility payment for cataract removal (CPT 66984) in 2022 would be \$1,077, while reimbursement for the same procedure in the HOPD would be \$2,131. The beneficiary's financial obligation in the form of copayments is \$215 in the ASC and at least \$425 in the HOPD; patient cost-sharing is always lower in the ASC. Therefore, for each cataract operation performed in an ASC instead of an HOPD, the program and beneficiary save over \$1,054. With nearly three million cataract surgery cases performed per year, the impact of savings to the program and the beneficiary by performance of cataract surgery in the ASC, as confirmed now by a multitude of studies and reports, is well into the billions of dollars annually. While ASCs perform about 70 percent of cataract surgeries, there is still significant opportunity for volume migration as virtually every cataract operation can be safely and effectively performed in ASCs.

## **SUMMARY OF RECOMMENDATIONS**

- ❖ **CMS should maintain use of the hospital market basket as the annual update mechanism for ASC payments.**
- ❖ **CMS should apply the OPPS relative weights to ASC services and discontinue the rescaling of ASC relative weights. Rescaling has had the effect of arbitrarily and inappropriately reducing ASC payment rates and causing a substantial divergence in payment rates between HOPDs and ASCs that is unrelated to the costs of delivering services in those settings.**
- ❖ **CMS should develop a policy that covers all drugs that are administered at the time of cataract surgery, but are not integral or necessary to the cataract procedure, and have an FDA-approved indication to treat or prevent post-operative concerns, such as pain and inflammation (or, alternatively, indications reflected in specialty society guidelines or medical compendia) separately under Part B.**
- ❖ **In determining payment rates for MIGS + Cataract procedures, CMS should assign new CPT codes 669X1 and 669X2 to APC 5493 or a new technology APC, and by assigning new CPT code 0X12T to APC 5492. The agency should also correct its miscalculation with respect to the applicable device threshold.**
- ❖ **With respect to payment for Dextenza, CPT 68XXX should be assigned to APC 5503. CMS should finalize its proposal to make threshold determinations based on the percentage the device accounts for in the ASC rather than the HOPD. The agency should also, with respect to insertable devices, use alternative measures to calculate the device-offset percentage when necessary to ensure fair payment to ASCs.**
- ❖ **CMS should withdraw proposed Measure ASC-11 from the ASC Quality Reporting Program, resume reporting on Measure ASC-1-4, and establish a measure reporting on TASS.**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that CMS implement by January 1, 2008, a new ASC payment system. Our organizations and the entire ambulatory surgery community reached consensus on the appropriate contours of an equitable and rational program. In the final ASC payment regulation that became effective in 2008, CMS adhered to the spirit, if not the letter, of many of these principles, most importantly, that the new payment system should be modeled on the methodology and payment rates applicable to surgical services furnished in HOPDs.

For well over a decade, we have expressed grave concerns that the continued use of the

Consumer Price Index – Urban (CPI-U) rather than the HMB as the ASC update factor as well as maintenance of the rescaler to achieve budget neutrality will continue to exacerbate the gap between the ASC and HOPD payment rates in ways that were unrelated to comparable cost differences in the provision of care in the two settings, with respect to which technology and staffing costs are identical. **We appreciate that CMS has responded to some of our concerns, particularly taking the important step of replacing the CPI-U with the HMB as the annual update factor for ASCs (at least through 2023), a key step in encouraging additional procedures to be performed in the more cost-effective ASC. To ensure that this proposal has its intended effect, however, we recommend CMS also eliminate the secondary rescaler.**

In 2003, aggregate ASC payments as a percent of HOPD rates were 85 percent. When the new system was established in 2008, the percentage had dropped to 65 percent; under the proposed 2021 rates, Medicare will reimburse HOPDs, on average, 100 percent more than ASCs performing the same procedures. We note further that whereas ASCs accounted for 6.63 percent of total expenditures in 2016, the ASC percentage of that spend is declining, representing only 5.9 percent in 2022. This situation is the result of the application of the rescaler and is entirely unrelated to the cost of providing services to Medicare patients within the respective outpatient surgical environments. At a time when ASCs offer the very real potential of augmenting access to high quality services at substantially lower cost, policymakers and the public should be concerned about the growing risk of surgery migrating back to the higher-cost HOPD. Since the advent of the new payment system, hospital market share is growing for many high-volume procedures.

In formulating ASC policy and establishing payment rates, it is imperative that the agency recognizes that most ASCs are small businesses that must run efficiently to remain in operation. There are over 6,000 Medicare-certified ASCs – about 1,200 of which specialize in ophthalmology – and over half have only one or two operating rooms. Our facilities purchase the same equipment, devices, implants, and supplies as HOPDs and must compete with hospitals for the same nurses and other personnel, while complying with the same federal and state patient health and safety requirements and the ever-growing demands of the Medicare ASC quality reporting program. Our centers operate efficiently; however, receiving reimbursement that is about half that of competing hospitals compromises the ability of our facilities to continue to provide the care and technology that Medicare beneficiaries deserve.

As discussed in greater detail below, the agency's continued utilization of rescaling to achieve budget neutrality in the 2021 proposal, as well as the recent reclassification of procedures into new APCs and packaging policies, has exacerbated distortions in payment rates to ASCs and hospitals. In a very real sense, these policies compromise the integrity of the ASC payment system, reduce realizable program savings, increase beneficiary out-of-pocket costs, and inhibit transparency regarding price and quality among Medicare providers, thereby jeopardizing beneficiary access to affordable, high quality surgical care.

Since CMS decided almost a decade ago to overhaul the ASC payment system, our organizations have been engaged in discussions of ideas and review of data with the agency regarding the issues presented in this and recent rulemakings. We have appreciated the

agency's willingness to work with the ASC industry, the ophthalmology community, and others and believe that there are many positive components to the proposed rule. With this spirit of cooperation and commitment to formulating a rational and equitable ASC payment system, we join the ASC industry and other surgical specialty organizations in offering our specific comments:

## **ANNUAL PAYMENT UPDATE AND REQUEST FOR COST DATA**

**As we emphasized in our comments two years ago, our organizations strongly support the agency's decision to change the ASC update factor from the CPI-U to the Hospital Market Basket (HMB).** The CPI-U does not reflect ASC cost growth; the HMB is a better proxy for ASC cost increases. ASCs and HOPDs treat the same patients for the same conditions and consume commensurate resources and incur similar costs. Application of different inflation factors unjustly expanded the gap in payments to HOPDs and ASCs. We believe that applying the same update factor to both types of facilities can potentially promote appropriate migration of services from the HOPD to ASC, generating significant cost savings to the Medicare Program. ASC growth has been compromised by lack of parity in payment to HOPDs and ASCs. Aligning conversion factors – in addition to eliminating the rescaler, as discussed below – will equitably level the playing field between hospital and freestanding surgical facilities.

CMS has, in the proposal, again expressed a desire to “assess the feasibility of collaborating with stakeholders to collect ASC cost data in a minimally burdensome manner.” For the reasons stated above, we believe that the HMB is an appropriate update factor for ASCs. **If, however, CMS elects to collect data to establish a new market basket, the agency should expand its analysis to create an index that will be applied to both the HOPD and ASC to ensure that payments using the same relative weights are aligned over time.** In developing a data collection modality, CMS should keep in mind that ASCs already incur excessive administrative burdens in complying with current regulations; requiring formal cost reports would diminish the agency's commitment to promulgate rules and policies that allow facilities to maintain efficiency in the delivery of services to our patients. We look forward to collaborating with CMS on this endeavor.

## **RESCALING ADJUSTMENT APPLIED TO ASC RELATIVE VALUE WEIGHTS**

ASCRS, ASRS, OOSS, and SEE strongly believe that CMS should eliminate the rescaling of the ASC relative weights, as this practice has increasingly exacerbated the gap between ASC and HOPD payments and inappropriately reduced payments to ASCs without evidence of growing differences in capital and operating costs in the two settings. As we have noted in our comments to past ASC payment rulemakings, our organizations support the utilization of the same APCs and relative weights in creating a rational and coherent payment system encompassing the services offered by both HOPDs and ASCs:

“. . . the rescaling of ASC relative weights . . . will result in further divergences in weights and payments, exacerbating exactly the types of distortions that the new system was presumably intended to correct. The only legitimate basis for change in relative payments to HOPDs and ASCs should be changes in the relative costs of providing specific outpatient services. There is little basis for believing that these variations will

occur, and to the extent that they do, they should be accounted for directly through adjustments to the conversion factor.”

It is important to note that APC relative weights are already adjusted once for budget neutrality. Contrary to CMS’ assertion in 2007 that rescaling would protect ASCs from decreases in payments for procedures due to changes in OPPS relative weights, recent experience reflects otherwise. *The rescaling adjustment has had the opposite effect, decreasing the relative weights on ASC surgical procedures each year. Since 2010, our relative weights have decreased by an average of 7 percent each year.* In 2016, the rescaler was 0.9332 and, in 2017, 0.9030; in 2018, the rescaler fell to .8995 for a 10.1 percent reduction to ASC weights. Under the proposed rule, the relative weight would be 0.8591 which, if implemented, would result in a 15.06 percent reduction in ASC weights. There is no evidence to suggest that there are growing differences in capital and operating costs in the two settings to support such an accelerating differential. This historical trend suggests that the application of the rescaler in the ASC environment will continue to erode the relationship between ASC and HOPD payments. The agency is needlessly increasing Medicare program costs by making it financially impracticable to furnish these services that are clinically appropriate for the ASC, and hence encouraging physicians to provide these procedures in the more expensive HOPD setting. **We strongly recommend that the agency discontinue the use of the rescaler.**

We note that CMS is not required to maintain rescaling. Congress imposed a budget neutrality requirement on the new ASC payment system *only* during the inaugural implementation year of 2008; CMS is under no legal obligation to continue to apply rescaling and should not do so when it creates significant disparities in relative payments to ASCs and hospitals that are not related to the costs incurred in providing such services. Therefore, we implore the agency to encourage savings and greater access to ASCs for Medicare beneficiaries by eliminating the ASC weight scaler.

Our organizations realize that the elimination of the ASC weight rescaler would increase Medicare program costs, at least initially until cost savings are achieved by volume shifting to the ASC setting. In the alternative, **we propose that CMS refrain from the applying the secondary rescaler to the ASC payment system and, instead, combine the OPPS and ASC utilization and mixes in services to establish a single weight scaler.** By incorporating the ASC volume into OPPS weight scaler calculations, CMS would improve the alignment of the payment systems and more accurately scale for outpatient volume across both sites of service.

## **COVERAGE OF NON-OPIOID DRUGS**

We are pleased that CMS has proposed to codify a modest expansion of its Non-Opioid Pain Management policy and solicit comments on several related implementation issues. To date, CMS is paying separately in the ASC for only a very limited number of specific non-opioid pain management drugs. Specifically, ASCRS, ASRS, OOSS, and SEE are concerned with the bundling of FDA- approved drugs that are administered at the time of ophthalmic surgery—either before, during or at the end of the procedure— and have an indication for the treatment of post-operative pain and/or inflammation and/or other sequela of the surgery. Our organizations believe that CMS should consider as part of future rulemakings to expand its proposed criteria for Non-Opioid Pain Management Drugs, in addition to the FDA label

indication, to also recognize a drug as having pain management attributes when demonstrated based on the recommendation of recognized specialty societies, or guidelines contained in medical compendia.

*ASCRS, OOSS, ASRS and SEE maintain that since these medications have a post-operative indication, they should not be considered surgical supplies bundled into the facility payment, but instead be covered and paid for under Medicare Part B, just as topical steroids and non-steroidals are paid under Part D. ASCs face the same challenges in affording to provide these drugs as they do to provide the specific non-opioid pain management drugs (Omidria is the only ophthalmic drug encompassed by existing policy for payment of non-opioid drugs) CMS removed from the facility fee for that reason. The problem is compounded by the reality that ASCs are receiving, as discussed in detail above, only half of the reimbursement provided to HOPDs.*

Medications administered during surgery are intended to replace some, or all, of the eye drops patients must administer post-procedure and that are covered and reimbursed separately under Medicare Part D. Many ophthalmic surgery patients are aged, and many have memory limitations, significant physical limitations that make drop instillation difficult or impossible, and comorbidities. These medications are a valuable treatment alternative to post-op drops and have the potential to improve patient outcomes by reducing or eliminating the need for patient-administered post-operative medication. Because they have an FDA-approved post-operative indication, these drugs are unique and have benefits well beyond traditional surgical supplies.

Dexamethasone is one example of a drug commonly used in ophthalmology because of longstanding evidence that it reduces inflammation, and therefore, pain following cataract surgery. Some drugs that have the active ingredient dexamethasone, such as Dextenza, are already indicated for both inflammation and pain. Others, such as Dexycu, are indicated for post-operative inflammation alone. The agency should not treat label differences as determinative as to whether a drug like Dexycu can be designated as a non-opioid pain management drug. *Inflammation following ocular surgery is a risk factor for pain.* Ocular inflammation induces activation of neurons within the sensory trigeminal complex; altered activity in intracellular signaling caused by ocular inflammation also plays a role in the sensitization of ocular-related brainstem circuits, leading to the development of ocular pain. By reducing inflammation, ophthalmic dexamethasone reduces a key risk factor associated with post-operative pain.

Several companies are pursuing costly research and development of products that can deliver the medications necessary during the extended post-procedure period, including intracameral antibiotics that would be administered at the time of the ophthalmic surgery. Current policy will impede the development of these important pharmaceutical products. Without the assurance that ASCs will be able to afford to provide these treatments to patients, manufacturers will inevitably discontinue their innovation in this area.

We appreciate that CMS is soliciting comments regarding whether the agency should rely on factors other than FDA-approved indications labeling in its process for determining whether a drug qualifies as a non-opioid pain management drug. Our organizations believe that, in future rulemakings, CMS should consider as an alternative to the criterion based on FDA label to allow the recommendations of specialty societies or other national organizations such as medical compendia developers. Specialty societies and other clinical experts already play a key

role in identifying clinically recognized uses for drugs that extend beyond FDA-approved labeling. It is important to consider an alternative criterion as the guidelines contained in medical compendia are continually evolving as clinicians identify new uses for existing drugs and these uses are empirically tested by scientists and clinicians.

We are fortunate to have multiple options to meet the post-operative challenges our patients face, including excellent self-administered medications as well as innovative and effective surgeon-administered drugs. Our members and facilities believe that patients should be afforded the option of using self-administered eye drop medications post-procedure (Part D products) or to have FDA-approved drug products administered by the surgeon at the time of the ophthalmic surgery (Part B products). **Therefore, we urge CMS to develop a policy that covers and pays for drugs that are administered at the time of ophthalmic surgery, and have an FDA-approved indication to treat/prevent post-operative issues, such as pain and other sequela of ophthalmic surgery, including inflammation, and in the future, infection, separately under Medicare Part B.**

With respect to other implementation issues to which CMS is soliciting comments:

- We strongly support finalizing the agency's proposal to provide continued payment for drugs and biologicals with expiring pass-through status. We recommend that CMS exercise its equitable adjustment authority equitably and extend pass-through status for any drug on pass-through as of the January 27<sup>th</sup> extension of the public health emergency that suffered significant decreases in utilization due to the COVID-19 pandemic, including OMIDRIA (whose pass-through expired on September 30, 2020).
- We likewise support the extension of separate payment for qualifying products in the hospital outpatient setting. Recent data demonstrate that the lack of separate payment in the HOPD setting following the expiration of its pass-through status resulted in a significant drop in utilization for products (including OMIDRIA) in the HOPD setting. This was in contrast to the stable utilization in the ASC setting where OMIDRIA continued to be paid separately as a non-opioid pain management drug.
- We recommend that CMS continue to use the standard ASP + 6% payment methodology to mitigate payment differentials across settings.

To provide further context to our comments, the nation's opioid epidemic dictates that one of our goals as health professionals is the elimination of the need for opioid medications in the perioperative, intraoperative and post-operative periods of cataract surgery. Medications like Dexycu and Dextenza, as well as advances in anesthesia, are important steps towards attaining this objective.

## **FACILITY PAYMENT FOR MIGS + CATARACT SERVICES**

Under current authorities, when a micro-invasive glaucoma surgery (MIGS) and a cataract procedure are performed, the surgeon utilizes CPT code 0191T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion) and/or CPT code 66984. When the service is furnished in an ASC,



Medicare pays the ASC facility fee for 0191T and 50 percent of the ASC rate for the cataract procedure. For CY 2022, the combined MIGS cataract procedure will be paid with a new Category 1 code (669X1/669X2). We are deeply concerned that payment under these codes will dramatically undercompensate facilities for these services.

To address the issue, **CMS should ensure continued access to MIGS procedures by assigning new CPT codes 669X1 and 669X2 to APC 5493 or a new technology APC, and by assigning new CPT code 0X12T to APC 5492. Moreover, CMS should apply its policy of using the device offset percentage for an existing code that is clinically related or similar to a new code for the offset percentage used in determining the ASC rate for such new code.**

We are disturbed regarding the manner in which CMS would implement new procedure codes for MIGS procedures since what CMS proposes would result in significant payment reductions for these procedures, making it more difficult to furnish the procedures particularly in the ASC setting. The new Category I CPT codes for the combination of a cataract procedure (complex or routine) and a MIGS procedure, 669X1 (MIGS + complex cataract) and 669X2 (MIGS + routine cataract) are both proposed to be assigned to APC 5492, while the new MIGS only CPT code, 0X12T, is proposed to be assigned to APC 5491. These APC assignments are irrational, and we urge CMS to make different APC assignments in the final rule.

For CPT codes 669X1 and 669X2, the proposal would assign these combination procedures to the same APC that a MIGS-only procedure is now assigned. As a result, *there would be no recognition to facilities of the added resources for the cataract procedure.* To address this deficiency, CMS could assign the new codes to APC 5493, which is the next level in the Intraocular Procedures APC family. This is precisely the approach that CMS implemented when new combination CPT codes for a cataract and an endoscopic cyclophotocoagulation procedure (CPT codes 66987 and 66988) were created a few years ago. CMS assigned the new codes to the next level APC in that family, assigning the codes to APC 5492, up from APC 5491. Another way for CMS to address the deficiency in the proposed rates for CPT codes 669X1 and 669X2 would be to assign the procedures to an appropriate new technology APC. CMS should finalize either of these options to ensure that facilities continue to be paid appropriately in light of the resources expended in performing these procedures.

For CPT code 0X12T, CMS proposes to assign this code, according to Addendum B, to APC 5491. We cannot comprehend the basis for this proposal since this code is for a stand alone MIGS procedure just like CPT code 0191T. In fact, the language of the CPT codes 0X12T and 0191T is virtually identical. Yet, without explanation, CMS proposes to take a procedure that is now assigned to APC 5492 and assign it to APC 5491. While the code number for the procedure may be changing in CY 2022, the resources used in furnishing the procedure do not. As such, we recommend that CMS assign new CPT code 0X12T to APC 5492 for 2022. At a minimum, CMS should continue to reimburse for MIGS and cataract in CY 2022 at the CY 2021 rates.

As we have commented above, we support the agency's efforts to use the device-intensive policy to ensure appropriate payment rates to ASCs for these procedures. That includes decisions to designate procedures as device-intensive and the determination of the device offset percentage used to compute ASC payment rates. On the latter point, we appreciate the statement from CMS in the CY 2021 final rule that indicated that when an existing code is clinically related and similar to a new code, CMS would apply the device offset percentage from the existing clinically related or

similar code's claims data when computing the ASC rate for the new code. We agree that this better compensates ASCs for the resources for new codes.

In the proposed rule, though, CMS does not seem to be implementing this policy as written. With regard to the new MIGS procedure codes discussed above (new CPT codes 669X1, 669X2, and 0X12T), CMS proposes to use a 31 percent device offset percentage for ASC rate calculations despite the fact that all of these procedures are clinically related and similar to CPT code 0191T, which has a device offset percentage above 55.45 percent. As a result, it appears that CMS is not correctly implementing the policy discussed in the 2021 final rule. **These issues were presented to the Advisory Panel on Hospital Outpatient Payment, which recommended that CMS use the device offset percentage from the pertinent existing CPT codes. We agree and also request that CMS use the device offset percentages from related existing CPT codes in computing the ASC payment rates for new codes 645X1, 669X1, 669X2, and 0X12T.** Also, as recommended by the Advisory Panel, we support moving 669X1 and 669X2 up one level to APC 5493, as well as moving 0X12T up one level to ACP 5492

The vast majority of these cases are performed in the ASC setting, which, as we have discussed in detail above, is already reimbursed at a rate about half the HOPD rate. We strongly believe that payment for the combined MIGS cataract procedures at the proposed rate, *i.e.*, approximately \$800 lower than CY 2021 reimbursement, could impede the glaucoma patient's access to these vital services in the ASC. In the alternative, the patient may forego the procedure altogether and continue with a potentially ineffective eye drop regimen and risk loss of sight. **ASCRS, ASRS, OOSS, and SEE strongly recommend that the agency correct the obvious miscalculation with respect to the device intensive percentage assigned to 669X1 and 669X2 and consider migrating these procedures to a higher paying APC while data is collected and exploring the creation of an incremental, perhaps temporary, APC to maintain current payment rates and patient access to these services in the ASC.**

## **PAYMENT FOR DEXTENZA**

DEXTENZA (Dextenza) is approved for the treatment of ocular inflammation and pain following ophthalmic surgery and is reported using J1096 (Dexamethasone, lacrimal ophthalmic insert, 0.1 mg). Dextenza is a physician-administered corticosteroid intracanalicular insert that is inserted following an ocular procedure and is currently reported using Category III Current Procedural Terminology (CPT®) code 0356T (Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each), which will be converted to a new Category I CPT code—68XXX (Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each)—effective January 1, 2022.

We appreciate the agency's proposal to continue separate payment for J1096 through the end of 2022 due to the effects of the Covid-19 public health emergency and recommend that CMS finalize the proposal. That said, it is equally important that payment for Dextenza continue in the future. We note that one means for securing separate reimbursement would be to designate the drug as a non-opioid pain management drug. In addition, CMS should amend the proposed rule to adopt policies that will ensure continued payment even in the absence of such action.

CMS's proposal to assign CPT code 68XXX to APC 5692 with a proposed payment rate of

\$63.62 in the hospital outpatient setting and no separate reimbursement in the ASC setting due to the APC's OPPS status indicator of Q1 is arbitrary and irrational and should not be finalized since the level of payment is inadequate for hospitals and results in no payment to an ASC for the procedure. Importantly, the treatment of this procedure is also entirely inconsistent with how CMS proposes to pay for other similar ocular medication delivery procedures involving similar drugs to Dextenza, such as Dexycu.

Failure to provide payment for the procedure, when other similar procedures would be paid separately, e.g., CPT 0X78T, creates a disincentive for this product to be utilized in the ASC. This insertion procedure is a distinctly separate procedure that requires additional time following completion of the primary ophthalmic surgical service. Despite the similarity of the procedures noted above, CMS proposes to assign codes 66030 and 0X78T to APC 5491 with a proposed payment rate of \$2,131, while paying for CPT 68XXX at \$63. Neither CPT code 0X78T nor 68XXX have 2019 claims data for CMS to use to determine payment. Given that the 2019 claims data available for CPT code 66030 shows a geometric mean cost of \$1,742.68 (2019 claims data) and are used by CMS to assign CPT code 0X78T to APC 5491, CMS should similarly use that data to determine the appropriate APC procedure. The similar use of the geometric mean data for CPT code 66030 supports the assignment of CPT code 68XXX to APC 5503, which actually has a slightly lower proposed payment rate (\$2,053.25) than APC 5491 (to which CPT code 0X78T is proposed to be assigned). Further, the geometric mean cost for APC 5503 is \$1,949.14, which is in line with the geometric mean cost for CPT code 66030. **As such, based on the available 2019 claims data for a similar ocular medication insertion procedure, CPT code 68XXX should be assigned to APC 5503.**

This request for assignment of CPT code 68XXX to APC 5503 is supported by the available 2020 hospital claims data for the procedure, which represents the first usable hospital claims data for the procedure. While we recognize that CMS is proposing to use CY 2019 claims data instead of CY 2020 claims data due to the COVID-19 PHE, we believe that the CY 2020 data available pertinent to CPT code 68XXX is relevant to consider in setting the OPPS and ASC rates since there are single frequency claims for the procedure in the 2020 claims data, but not in the 2019 claims data. Since CMS is elsewhere proposing to use 2020 claims data in the absence of any usable 2019 claims data, for device offset purposes, **CMS likewise should take into account the 2020 claims data pertinent to CPT code 68XXX, in the absence of 2019 claims data, in determining OPPS and ASC rates for the procedure, especially since the 2020 claims data are fully supportive of assigning CPT code 68XXX to APC 5503.**

## **DEVICE INTENSIVE PROCEDURES**

Our organizations are appreciative of the agency's efforts to address the device threshold and its impact on ASC volume. The agency's recognition of the important role that devices play in our ability to perform surgical procedures – by reducing the devices threshold over the past several years from 50 percent to 40 percent and then to 30 percent-- has enabled our members to offer more high-quality services to our patients at great savings to the Medicare program and its beneficiaries. Unfortunately, the effectiveness of these changes has been compromised by the fact that the threshold determination was based on the costs of these devices *in the HOPD*. *We are, therefore, extremely grateful that the agency has determined that the threshold determinations should be based on the percentage the device accounts for in the surgery center.*

Recent changes to the device-intensive threshold have greatly increased the number of device-intensive codes on the ASC-CPL, but it has also shone a spotlight on how the lack of complete alignment in the HOPD and ASC payment systems serves as a barrier to access for Medicare beneficiaries. While there is a statutory cap on the patient responsibility when a procedure is done in a hospital, including an HOPD, that policy is not in place for the ASC setting. Even though the Medicare beneficiary's patient responsibility is capped, the hospital is made whole by the Medicare program. Beneficiaries who would otherwise have access to the high-quality, convenient ASC setting are disadvantaged by this lack of alignment in policy. **We recommend that CMS join the ASC community in encouraging Congress to implement an ASC copayment cap with respect to devices implanted during surgery in an ASC.**

Because of the copayment cap and its impact on many device-intensive codes, there are many areas, particularly in rural communities, where the wage index is so low that it makes it financially unsustainable for rural facilities to provide certain device-intensive procedures to Medicare beneficiaries. **To address this, CMS should refrain from adjusting the device portion of the payment by the local wage index.** This is consistent with the Agency's policy for separately payable drugs and biologics, and it is highly unlikely that a facility in a rural community is getting a better deal on devices than ASCs in large cities.

We are also concerned with the agency's device-intensive offset calculation for *insertable devices*. Devices that are insertable, i.e., not retained in the body post-procedure, as opposed to *implantable*, are not being reported accurately by HOPDs and are, therefore, not included in the cost calculation for device-intensive designation. The under-reporting of insertable device costs results in the denial of such status for procedures using insertable devices. Effective January 1, 2019, CMS modified the device-intensive criteria to allow procedures that involve single-use devices, regardless of whether they remain in the body following the procedure, to qualify as device-intensive procedures; this status was previously reserved for procedures with implanted devices. There is no clear revenue code for HOPDs to use to report costs for insertable devices. Revenue Code 278, which applies to "Other Implants," has historically been used for devices that remain in the body with no reference to insertable devices. Yet, CMS' methodology for calculating the device offset percentage relies upon accurate reporting of device costs to Revenue Code 278.

Using the example of glaucoma procedures requiring an insertable device (CPT 66174), it is evident that CMS' claims data do not accurately account for the cost of the eligible insertable device when calculating the percentage of device costs because these device costs are not reported by HOPDs under the CMS methodology. Analysis of 2019 Medicare claims reveals that, instead of reporting device costs under an eligible device HCPCS code and/or Revenue Code 278, most hospitals did not capture the device costs for CPT 66174 in a way that factored into CMS' device offset calculation, hence, leaving the device's true costs unreported. In fact, only approximately 20 percent of claims submitted with CPT 66174 reported any device cost using the appropriate revenue code to be used in the device intensive calculation. When faced with clearly inconsistent or inaccurate cost data reporting, the agency has historically adjusted the calculation methodology to avoid an inequitable payment policy. We strongly recommend that the agency use an alternative data set, such as a subset of accurate hospital claims data or manufacturers' invoices, to calculate the device-offset percentage, thereby safeguarding patient access to procedures that would otherwise be cost-prohibitive in the ASC setting.

## UNLISTED CODES

An important anomaly in CMS' effort to align the ASC and HOPD payment systems is the treatment of procedures for which there is not an appropriate CPT code. In some ASCs, surgeons utilize innovative techniques or new technologies to perform a procedure; this can mean that the service is not described by a specific CPT code. These services are reimbursed in the HOPD but are not eligible for payment in the ASC. In the proposed 2008 ASC payment rule, CMS stated that, without knowledge of the procedure's code, it cannot determine whether the procedure performed would have been excluded from the ASC payment under the rule's safety criteria.

Although an unlisted code doesn't allow the reporting of specific procedures, the code does include the narrowly defined anatomic region of the service that could provide the basis for a determination about the safety of the procedure in the ASC. There is no clear safety rationale for this policy and commercial insurers typically afford ASCs the flexibility to use unlisted CPT codes to make claims for payment. We note that the agency does permit HOPDs and even physician offices to use unlisted codes; allowing this practice for ASCs will enable CMS to derive savings for both the program and beneficiaries. If physicians are permitted to choose to perform a procedure with an unlisted code in HOPDs, facilities that are managed, staffed, and equipped like Medicare-certified ASCs, surgeons should be allowed to utilize unlisted codes in the ASC. **We urge CMS to revise the Federal Code of Regulations to eliminate this restriction on billing with unlisted codes.**

## QUALITY REPORTING PROVISIONS

ASCRS, ASRS, OOSS and SEE very much appreciate the efforts undertaken by CMS to implement the ASC Quality Reporting Program over the past several years and the agency's acceptance of many of the suggestions proffered by our organizations. Accommodating the perspectives and concerns of the ASC and surgical communities is undoubtedly a major factor in the exceptional 98-plus percent reporting rate by facilities with respect to measures implemented to date. We believe that the following are prerequisites to the adoption of a quality measure for the ASC. A measure should:

- Relate specifically to the episode of care in the ASC;
- Evaluate the practices and quality of the care facility;
- Involve reporting by the facility of data available in the ASC chart;
- Produce outcomes data that is actionable by the ASC, embodying the potential to improve the quality of care provided in the facility; and,
- Have been tested in the ASC environment.

### **ASC-11 Should Be Withdrawn as a Measure**

Since the publication of the 2014 ASC payment rule, we have strenuously objected to the application to ASCs of Measure ASC-11 (NQF 1536): *Cataracts – Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery*. We applauded the agency's decision to withdraw the measure for purposes of mandatory reporting by facilities and are disturbed that

this measure, misguided in its application to the ASC, has been proposed for inclusion in the 2022 payment rule.

ASC-11 should be withdrawn altogether. NQF 1536, from which it is derived, is a patient-reported outcome measure taken singularly from a measure group designed for registry-only reporting by physicians and was never intended to serve as a measure of facility-level quality and has never been tested for facility reporting. The bedrock foundation of quality reporting in the ASC is that facility-level measures should relate to *an episode of care that occurs within the confines of the ASC, encompass data that is available within the ASC chart, be collectable by ASC staff, generate conclusions that are actionable by the facility, and have been tested in the ASC environment.* ASC-11 meets none of these criteria. For the reasons stated herein, we are not surprised that only a few dozen facilities opted to report on ASC-11 on a voluntary basis, and, therefore, sparsely reported results could not possibly result in a sufficiently meaningful sampling in terms of measuring ASC quality, either on a facility-by-facility or industry-wide basis.

- **The data required for reporting by facilities should be available within the records of the ambulatory surgical center; facilities should not be required to access and report data that is only available to other providers, such as the physician’s office.**

Even if NQF 1536 was to be tested and resubmitted for endorsement by NQF at the facility level, there are insurmountable barriers to collecting data for these measures within the ASC. *All the currently implemented ASC quality measures utilize data that is housed within and collected by the ASC itself.* This new measure requires reporting on data that is located in the surgeon’s office and is wholly inaccessible by the ASC.

Data collection for ASC measures is complicated by the fact that ASCs are administratively and financially separate from physician offices. Under the Medicare program, an ASC operates exclusively for the purpose of furnishing ambulatory surgical services to patients requiring such a setting. Although the governing regulations permit the surgical facility to exist adjacent to a physician’s office under certain circumstances, Medicare ASC Conditions for Coverage state very clearly that the two entities must be physically, administratively, and financially separate from one another. *Importantly, medical record keeping must always be maintained separately and exclusively from other operations.* While CMS has referred to NQF 1536 as a “chart-based” measure, none of the data necessary to appropriately comply with the measures is located in the ASC patient records. In other words, even though a physician in the clinic may perform surgery in the ASC next door, the medical records of one entity are *never* readily accessible by the other. As a practical matter, the ASC is staffed by registered nurses, operating room technicians, and clerical staff who are neither qualified to evaluate surgical outcomes nor located in the physician’s office where pre-operative and post-operative care might be efficiently and accurately evaluated.

- **It is not appropriate to migrate a measure across settings of care that was not considered in the design, testing, and implementation of the measure and with respect to which the measure is not actionable by the facility.**

ASC-11 is inappropriate for reporting (mandatory or voluntary) by the ASC because facilities are not equipped to evaluate potential cataract outcomes. The facility is not involved in the baseline events preceding the surgery against which outcomes are measured in the post-

surgical events that encompass the healing process. It is inconceivable that the ASC, which is neither licensed nor qualified to evaluate the cataract patient and make these assessments, would be involved in the professional decision-making contemplated by the measure. *Any improvement in visual function would be attributable to the individual surgeon, not to the facility where the surgery occurred.* Physician-level measures such as those incorporated within the Quality Payment Program (OPP) are formulated to assess quality within the physician's office.

Importantly, and contrary to CMS' suggestion in the preamble to the proposed rule, *NQF 1536 has not been tested nor endorsed as a facility-level measure for the ASC setting.* Indeed, the Measures Application Partnership (MAP), in reviewing the measure, admonished that it should be tested and NQF-endorsed for the facility level of analysis; this has not occurred.

The goal of the ASC QRP should be to reflect those aspects of patient care that are within the control of the facility (e.g., patient safety, staffing, equipment) and for which it is reasonable to hold the ASC accountable. The surgeon's decision to recommend cataract surgery is based upon factors other than the potential for functional benefit – visual acuity and visual impairment are also considered. *It is inconceivable that the ASC, which is neither licensed nor qualified to evaluate the cataract patient and make these assessments would be involved in the professional decision-making contemplated by the measure.* As discussed above, a measure should be applied to the ASC only where actions that might be undertaken to improve such quality are within the purview of the facility. *We do not believe that it is possible for ASCs to influence outcomes with respect to this measure; therefore, it is not appropriate to include the measure in the ASC Quality Reporting Program.*

- **Implementation of this measure in the facility would be extremely burdensome and resource-intensive for the reporting ASC.**

The burden on ASCs to disseminate, collect, and report on this measure would be significant – even in a survey with a modest number of patient respondents-- given that the facility's exposure to the patient is essentially limited to the care provided at the ASC on the day of surgery. The measure requires that patients complete a visual function questionnaire both before and after their scheduled surgery. The results of the pre- and post-surgery questionnaires are then compared to assess patient-perceived improvement. The patient's visual acuity is measured before and after surgery in the physician's office, not the ASC. Single-specialty facilities like ophthalmic ASCs tend to be smaller, have fewer operating rooms and employees, and, typically, will have available diminished resources to meet the administrative burdens posed by regulatory initiatives like quality reporting.

These burdens are not trivial. The measure contemplates the administration of two visual function patient questionnaires, one completed by the patient prior to surgery and the other completed during the 90-day period following surgery. These survey instruments would be delivered to the patient during his pre-op and post-op visits *with the physician.* Facilities would be required to contract with an outside entity to administer pre- and post-surgical surveys and tabulate the results, a burdensome and expensive exercise considering the number of cataract surgeries performed in surgery centers, or somehow mandate that surgeons on the medical staff of the ASC conduct visual function surveys as a condition of maintaining ASC staff privileges. The process contemplated with respect to reporting on the measure, whether performed on a mandatory or voluntary basis, places the ASC in the arbitrary and unworkable role as "middleman" between the

physician and the government and forces the ASC and/or the physician to report data that is *already being collected under the Physician Quality Reporting System (PQRS)*. The numerous modifications to the manual specifications for ASC-11 -- which have continued to be confusing, ambiguous, and unrealistic – reflect the monumental challenge that even the agency has encountered in clarifying just what would be expected of facilities.

- **Adoption of ASC-11 would not produce data that is actionable by the ASC, and, as such, does not embody the potential to improve the quality of care provided by the ASC.**

Finally, the surgeon’s decision to recommend cataract surgery is based upon factors other than the potential for functional benefit – visual acuity and visual impairment are also considered. *It is inconceivable that the ASC, which is neither licensed nor qualified to evaluate the cataract patient and make these assessments, would be involved in the professional decision-making contemplated by the measure.* As discussed above, a measure should be applied only where actions that might be undertaken to improve such quality are within the purview of the facility. *We do not believe that it is possible for ASCs to influence outcomes with respect to this measure; therefore, it is not appropriate to include the measure in the ASC Quality Reporting Program.*

### **CMS Should Adopt a Quality Measure for TASS**

In 2018, CMS invited public comment regarding the adoption of a measure, developed by the ASC Quality Collaboration to assess the number of patients diagnosed with TASS (Toxic Anterior Segment Syndrome) within two days of undergoing anterior segment surgery in the ASC. The measure was reviewed by the Measures Applications Partnership (MAP) four years ago and received conditional support pending endorsement by the National Quality Forum (NQF). CMS did not finalize adoption of this measure in the 2018 rulemaking.

TASS, an acute and serious inflammation of the anterior chamber, or segment, of the eye following cataract surgery, is directly related to extraocular substances that inadvertently enter the eye during surgery. The incidence of TASS is measurable, attributable to the ASC, and is actionable by the facility. There are published guidelines regarding cleaning and sterilization of intraocular surgical instruments to help improve quality and prevent TASS. This measure would promote collaboration between the surgeon and the facility, as the surgeon, under current practice, would report back to the facility any incidence of TASS. Further, measuring the incidence may aid in better tracking and understanding of the prevalence of TASS, as the Food and Drug Administration contends that TASS is significantly underreported and surveillance is underway. Specific prevention guidelines have been developed and this measure would help ensure that they are being followed appropriately. ASCRS, ASRS, OOSS, and SEE strongly support inclusion of the TASS measure in the ASCQR program.

### **The Agency Should Resume Reporting on ASC-1 through ASC-4**

Our organizations further recommend that CMS reestablish measures ASC-1 (Patient Burn), ASC-2 (Patient Fall), ASC-3 Wrong Site, Wrong Side, Wrong Procedure, Wrong Implant), and ASC-4 (All-Cause Hospital Admission) in the ASCQR Program. CMS removed these measures because they represent rare events. However, we believe that they encompass information that is important for



patients and ASCs. These measures are currently reported using quality data codes on ASC Medicare claims. All stakeholders would benefit if this data were submitted via Quality Net and reporting expanded to all patients treated by the ASC, not just Medicare beneficiaries. Continued adoption of these measures would enhance provider accountability and the transparency of public reporting.

\*\*\*\*\*

Thank you for providing our organizations with the opportunity to present our views on the proposed regulation regarding 2022 Medicare ASC payment rates and the ASC Quality Reporting Program. Should you have any questions or require further information, please feel free to contact us at: Jillian Winans, Senior Manager of Government Relations, ASCRS, [jwinans@ASCRS.org](mailto:jwinans@ASCRS.org), 703.591.2220; Jill Blim, Executive Vice President, ASRS, [jill.blim@asrs.org](mailto:jill.blim@asrs.org) 312.578.8760; Michael Romansky, JD, Washington Counsel, OOSS, [mromansky@OOSS.org](mailto:mromansky@OOSS.org), 301.332.6474; and, Allison Shuren, JD, Washington Counsel, SEE, [allison.shuren@aporter.com](mailto:allison.shuren@aporter.com), 202.942.6525.

Thank you for your consideration of our views.

**American Society of Cataract and Refractive Surgery**  
**American Society of Retina Specialists**  
**Outpatient Ophthalmic Surgery Society**  
**Society for Excellence in Eyecare**