THE AMERICAN SOCIETY OF Breast Surgeons

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Baltimore, Maryland 21244

Submitted electronically via www.regulations.gov

RE: **Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1784-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) 2024 Medicare Physician Fee Schedule proposed rule. ASBrS is the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases. ASBrS 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 3,100 members throughout the United States and in 35 countries around the world. Active membership is open to surgeons with a special interest in breast disease.

CY 2024 MPFS Conversion Factor & Reimbursements

The Centers for Medicare and Medicaid Services (CMS) has proposed a CY 2024 Medicare Physician Fee Schedule (MPFS) conversion factor of $32.7476, nearly 3.4% less than the CY 2023 MPFS conversion factor. CMS is implementing this cut for two reasons: first, CMS reduces the conversion factor by 2.17% because of budget neutrality requirements triggered by CMS proposals made in CY 2023 rulemaking (largely due to the G2211 add on code that ASBrS previously requested that CMS permanently rescind); second, CMS reduces the conversion factor due to the reduction of the boost to the conversion factor provided by Congress (from 2.5% in 2023 to 1.25% in 2024). These Congressional boosts while inadequate were necessitated by the significant changes in the values of the office and outpatient evaluation and management (E/M) code set implemented in CY 2021 when CMS had originally proposed a CY 2021 conversion factor that would have decreased by -10.6% from CY 2020. While CMS finalized a 10.2% reduction to the conversion factor that year, it nonetheless would have created a unstable cut in

Medicare reimbursements for a tremendous number of providers including surgeons who care for patients with breast cancer. 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 another fix of +3.0%, the expiration of which combined with a *new* budget neutrality adjustment to exact cuts on physicians providing care to Medicare beneficiaries.
- When that provision expired, Congress, via the *Consolidation Appropriations Act, 2023* (*CAA, 2023*) provided a 2023 boost of 2.5%.
- Through the *CAA, 2023*, Congress also then enacted a 1.25% boost in 2025.

In sum, CMS in conjunction with Congress have slowly been phasing in the 10.2% reduction that CMS finalized for CY 2021.

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 next year due to Statutory Pay-As-You-Go (PAYGO) provisions.

ASBrS understands that avoiding the consequences of 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 leaving physicians in an adversarial competition for resources 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 2024, ***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 many specialties including ours and has not met its goals of serving as an adequate payment update system while provide incentives to improve measurable quality.

Physicians are under the constant threat of reimbursement cuts while the cost of providing care and complexity of patients increases. We are also concerned that allowing this to continue will 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 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.

E/M Services

G2211 Add-on Code

In the context of the ongoing pressures placed on MPFS reimbursements, ***ASBrS urges the Agency to rescind its proposal 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 hesitate to even make reference to CMS' use of the word "complexity" in reference to the G2211 because CMS has insufficiently provided guidance or parameters to define the use of the code, what "complexity" is not accounted for by higher lever E/M codes or prolonged services codes, how practitioners could properly provide medical record demonstration that supports billing of the code beyond the documentation that would be used for an E/M visit level selection, makes no distinction in practice expense for facility and non-facility billing of the code, and CMS references to "primary care" and "other longitudinal care of complex patients" when those terms do not appear in the code descriptor.

In sum, if CMS finalizes payment for G2211, it will violate the core tenets of the Medicare Physician Fee Schedule being "resource-based," it will inject an un-auditable service into the billing system distorting the relativity of the E/M visit code sets, and as the unfettered use of the un-auditable code is expected to explode after the first year of the budget neutrality adjustment, it will heap millions, if not hundreds of millions of dollars, in co-payments on beneficiaries.

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

[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

[2] https://www.komen.org/about-komen/our-impact/breast-cancer/stand-for-h-e-r/ (accessed August 16, 2023).

to the MPFS conversion factor. The Congressional prohibition on implementation of G2211 avoided an approximately 3.2% reduction to the CY 2021 MPFS conversion factor. While CMS estimates that the budget neutrality adjustment is now only 2.0%, CMS explanation for this change does not provide for clarity on when and by whom this code should be utilized. In addition, despite surgeons providing care that is indubitably complex and the performance of a procedure on the same visit as an E/M code is likely to be in the patient's best interest, despite the disruption to the surgeon's schedule, CMS now indicates that use of this code would be prohibited for office and outpatient E/Ms billed with a ~25 modifier calling into question what the purpose of this code might be. 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, payable code and to make no further proposals regarding payment for G2211 in future rulemaking.***

Split (or Shared) Services

As part of previous rulemaking, CMS finalized a CY 2024 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 2024 policy, CMS stated that the "substantive portion" would be defined as "more than half of total time." As it has done before, CMS proposes to delay this definition of "substantive portion" based only on time "through at least December 31, 2024." ***ASBrS supports CMS' 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.

VALUATION OF SPECIFIC CODES: INTRAOPERATIVE ULTRASOUND

The AMA RUC recently reviewed CPT 76998 (*Ultrasonic guidance, intraoperative*). The previous iteration of this code was used by multiple specialties. A new code structure has been approved that creates a series of additional intraoperative ultrasound codes for use by certain specialties. Because the other new CPT codes exist, the expected dominate specialty that will now report CPT 76998 is breast surgery. Given the new coding design, the AMA RUC surveyed CPT 76998 and as a result the RUC recommended a value of 1.20 work RVUs for CPT 76998. However, CMS is proposing a work RVU of 0.91. ***ASBrS urges CMS to finalize the RUC-recommended value of 1.20 work RVUs for CPT 76998.*** As CMS itself articulates, "*CPT*

code 76998 includes multiple, separate ultrasound maneuvers during a surgical procedure that require a more intense, immediate interpretation in order to direct resection of the breast tissue and ensure a thorough and complete surgical excision of the abnormal breast tissue."

We join the AMA RUC in expressing concern about the time references made by CMS in putting forward its 0.91 work RVU proposal. CMS states that the survey times went down. We would remind CMS that this service was not Harvard surveyed and has never been previously reviewed by CMS or the RUC. CPT 76998 currently includes times (i.e., "CMS/Other time") when the resource-based relative value scale (RBRVS) was initially implemented 30 years ago, times that CMS included with some unknown, non-transparent methodology. For CMS to use these times as a reference point is inconsistent with best practices given that there is more recent survey data. The more recent survey results support the 1.20 work RVU RUC recommendation and basing a lower work RVU on a time trend line that starts with a random CMS calculation from 30 years ago does not represent a strong rationale.

QUALITY PAYMENT PROGRAM (QPP)

Merit-Based Incentive Payment System (MIPS) Performance Threshold

CMS proposes to increase the MIPS performance threshold from 75 points to 82 points for the CY 2024 performance period/CY 2026 payment year. CMS also proposes to revise the methodology used to calculate this threshold. Under statute, CMS is required to compute the MIPS performance threshold each year using the mean or median of final scores for all MIPS eligible clinicians with respect to a "prior period" specified by CMS. As previously finalized, CMS selected a single performance period as the prior period for the CY 2022 through CY 2023 performance periods/2024 through 2025 MIPS payment years. In this rule, CMS proposes to adopt a reinterpretation of "prior period", beginning with the CY 2024 performance period/2026 MIPS payment year, so that it is the mean of three years spanning the CY 2017 through CY 2019 MIPS performance periods.

The ASBrS appreciates CMS' desire to use a three-year average rather than a single performance period to calculate the MIPS performance threshold. We agree with CMS that doing so can help to level any aberrant variations in performance that might be related to a specific year. **However, ASBrS strongly opposes CMS' proposal to increase the performance threshold starting with the CY 2024 performance year and requests that CMS hold off on applying this new methodology at this time and recommends maintaining the current performance threshold**. Physician practices are still facing staffing and other resource challenges related to the pandemic. Many physicians have also relied on the COVID-19 MIPS hardship exception since as early as 2019. Assuming that CMS will not make this hardship exception available indefinitely, these physicians will be returning to a program that now has very different and much more challenging reporting requirements and scoring rules, measures, and performance thresholds. CMS estimates that if it finalizes an 82-point threshold for the 2024 performance year, 54% of clinicians could receive a penalty in 2026, with the average penalty being 2.4%. Physicians are already facing significant Medicare payment cuts, resulting in year-after-year payment updates that are well below inflation and that fail to keep up with the cost of practicing medicine. To subject more than half of eligible clinicians to a MIPS penalty based on data from as far back as 8 years ago is simply unjust, particularly at this time, and will have no significant impact on the quality of patient care. In fact, further straining these practices might have the opposite effect and lead to poorer quality care.

MIPS Quality Measures

CMS proposes to remove measure #112: Breast Cancer Screening from traditional MIPS for the 2024 performance year. However, this measure concept will be added to a new Preventive Care and Wellness composite measure, which combines seven preventive care measures. CMS is also proposing to retain measure #112 for use under a new MIPS Value Pathways (MVP) titled "Focusing on Women's Health MVP." To the extent that measure #112 is being maintained in MIPS, CMS is also proposing substantive changes to the specifications. **While ASBrS appreciates CMS proposing to maintain #112 as a standalone measure in specific MVPs, ASBrS opposes CMS' proposal to remove measure #112 as a standalone measure in traditional MIPS.** Our members already have very few relevant breast cancer quality measures available to them under MIPS. If measure #112 is removed and instead added to the composite measure, which includes other primary care-focused measures that are not relevant to or reportable by breast surgeons, it would no longer be available to our members choosing to participate in traditional MIPS. Overall, we believe there is still value in measuring the individual components of the proposed composite measure separately.

MIPS Cost Measures

Although CMS does not make any specific proposals related to the episode-based cost measures developed during Wave 2 and now undergoing a comprehensive re-evaluation, ASBrS would like to reiterate concerns that it recently submitted to Acumen. Multiple ASBrS members served on the Wave 2 workgroup that developed the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* episode-based cost measure, which was adopted for use under MIPS starting in 2020. Due to the COVID-19 pandemic, CMS decided to re-weight the MIPS cost performance category for both the 2020 and 2021 performance periods since it could not reliably calculate scores for cost measures. The scoring of the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* measure resumed in 2022, but CMS has not yet released aggregate MIPS participation data on which to evaluate the application of this measure.

ASBrS appreciates that CMS, working with Acumen, has adopted a process for periodically reevaluating cost measures in use under MIPS. This process is important in terms of ensuring that a measure reflects the most current clinical evidence, as well as any coding updates that might have been adopted since the measure was first developed. It is also critical in terms of assessing the real-world impact of the measure and ensuring that it is capturing and measuring data as intended. However, we are concerned that there is very limited data on which to accurately assess the impact and appropriateness of the measures now under review. Even where data exists (e.g., the 2021 patient-level data supplemental performance feedback reports distributed to clinicians and group practices), it is not necessarily representative of normal times or standard performance trends. **We strongly recommend that Acumen revisit its evaluation of all Wave 2 measures once more data are available and the impact of the pandemic is no longer a concern. We also strongly urge CMS to work with Acumen to provide the public with comprehensive analytics regarding the real-world application of these cost measures so that stakeholders can better determine whether they are achieving their intended goals.**

Appropriate Use Criteria for Advanced Diagnostic Imaging Program

The ASBrS very much supports CMS' proposal to pause efforts to implement the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services program and to rescind the current AUC program regulations. This program has been plagued with operational issues since it was first authorized in 2014, resulting in ongoing implementation delays. Furthermore, numerous quality measures and other initiatives that similarly target appropriate use of imaging have been adopted since that time,

making the program duplicative and unnecessary, especially in light of all of its problems. We appreciate CMS' decision to not move forward with this program at this time and would be happy to assist the agency with evaluating alternative ways to continue to meet the goals of the program.

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ASBrS appreciates the opportunity to provide comments on the CY 2024 MPFS proposed rule. If you have questions or if ASBrS can ever be of assistance, particularly on any patient education efforts, please do not hesitate to reach out to Sharon Grutman, Director of Advocacy, Communications, and Quality Initiatives, at sgrutman@breastsurgeons.org.

Sincerely,

Susan K. Boolbol, MD, FACS
President
The American Society of Breast Surgeons