

September 6, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1656-P – Medicare Program; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2017 Payment Rates and ASC Quality Reporting Program

Submitted Electronically

Dear Mr. Slavitt:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing over 10,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association representing over 1,100 ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical services in cost-effective outpatient surgical environments, particularly ASCs. OOSS is also 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 education 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.

Our members provide the vast majority of ophthalmic surgical procedures performed in ASCs in the United States. On behalf of ASCRS, OOSS, and SEE, we are taking this opportunity to comment on this important regulation governing CY 2017

Medicare ASC payment rates and the Quality Reporting Program for ambulatory surgical centers. Particularly with respect to the latter, we are 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. We have serious concerns regarding elements of the payment provisions of the proposal, which are discussed below.

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. 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. Yet, elements of the proposed regulation, particularly the payment provisions, continue to thwart, rather than enhance the ability of our facilities to continue to serve the nation's Medicare beneficiaries.

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.

- An analysis conducted by the University of California-Berkeley in 2013 determined that ASCs saved the Medicare program and its beneficiaries \$billion from 2008 to 2011 over what the Medicare program and patients otherwise would have expended had their care been provided in other settings. *In 2011, cataract surgery alone accounted for \$829 million in savings to the program.* Extrapolated to 2022, the projected savings for Medicare and its beneficiaries range from \$1.5 billion to \$2.95 billion per year.
- In 2014, the Office of the Inspector General, HHS issued a report in which it determined that surgery performed in ASCs from 2007 to 2011 saved the Medicare program almost \$7 billion and beneficiaries an additional \$2 billion, citing even greater potential savings in the future.
- A study published 2014 in the journal *Health Affairs* concluded that not only did ASCs perform outpatient surgery as effectively and more efficiently than HOPDs, but that they “provide high quality care, even for the most vulnerable patients.” The authors admonished that “recent {Medicare} reimbursement changes have lowered payments to ASCs, which reduces the incentives to start or expand these facilities.”

Under the proposed rule, facility payment for cataract removal (CPT 66984) would be \$964.88, while reimbursement for the same procedure in the HOPD would be \$1,805.67. The beneficiary's financial obligation in the form of copayments is \$193 in the ASC and at least \$361 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 \$840. With nearly three million cataract surgery cases performed per year, the impact of savings to the program and the beneficiary by performing cataract surgery in the ASC, as confirmed now by a multitude of studies and reports, is well into the hundreds of millions of dollars annually. Yet, overall growth in Medicare spending on services provided in the lower-cost ASC has been at historic lows – approximately 3 percent per year. Our organizations caution CMS that there is a point at which rates can be reduced too much and have negative ramifications for the program and to the Medicare patients for whom it strives to provide quality surgical care.

• SUMMARY OF RECOMMENDATIONS

A. Payment Recommendations

- CMS should adopt the Hospital Market Basket instead of the Consumer Price Index – Urban as the annual inflation index for ASCs, as the CPI-U is an unreliable indicator of ASC costs, with inputs unrelated to medical inflation or the costs of delivery of surgical services.**
- 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 mirror in ASC payments any changes to the APCs adopted in the OPPS in a manner that preserves the alignment between the payment systems and ensures fair and accurate payment for services within the ASC. The agency should engage stakeholders in discussions regarding how to implement those changes given the proposed differences in how services are reported and paid.**
- CMS should implement further policy changes in setting payments for device-intensive procedures to encourage migration of services into the less-expensive ASC setting.**
- CMS should eliminate its prohibition against ASCs billing for services that are reported using a CPT unlisted surgical code.**

B. Quality Reporting Recommendations

- CMS should adopt in the final rule its proposal for ASCs to report on unplanned anterior vitrectomy in cataract patients.**

- **The agency should adopt a measure regarding toxic anterior segment syndrome and should continue to collaborate with the ophthalmology and ASC communities to develop and implement appropriate ophthalmic measures for the ASC community.**
- **CMS should maintain the current August 15 deadline for submission of data on web-based measures.**
- **CMS should significantly refine the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS/CAHPS) to reduce the number of surveys that must be collected and expand the modalities for collecting information from patients, thereby ameliorating unnecessary financial and administrative burdens.**

II. ASC PAYMENT ISSUES

A. Problems with the Current ASC Payment System

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. Over the past seven years, we have expressed grave concerns that the continued use of the Consumer Price Index – Urban (CPI-U) rather than the Hospital Market Basket (HMB) as the ASC update factor as well as maintenance of the rescaler to achieve budget neutrality will continue to significantly widen the gap between the ASC and HOPD payment rates in ways that were unrelated to actual cost differences in the provision of care in the two settings.

Failure to increase payments to ASCs to reflect inflationary pressures cannot help but exacerbate disturbing trends in ASC payment, beneficiary access, program expenditures, and competition between the HOPD and ASC. Just nine years ago, aggregate ASC payments as a percent of HOPD rates were 84 percent; when the new system was established in 2008, the percentage had dropped to 65 percent; under the proposed 2011 rates, the percentage would be further reduced to approximately 49 percent (actually, 47 percent, when excluding codes that represent comprehensive APCs in the OPSS system). This change in rates is the result of the application of different inflation updates and an irrational and punitive budget neutrality policy and it is entirely unrelated to the cost of providing services to Medicare patients within the respective outpatient surgical environments.

When the new ASC payment system was launched in 2008, CMS articulated a host of optimistic projections emanating from the new rules, ranging from diversification of the ASC industry to rapid volume growth as facilities enjoyed higher rates and eligibility to perform a broader list of procedures. At the time, the industry responded with concerns that the growth estimates were too aggressive and that the conversion factor the agency established was too low to promote significant migration of services into the lower-cost ASC environment. Our concerns are being realized. Strikingly, ASC growth has been essentially flat since the implementation of the new payment system in 2008. Moreover, migration of Medicare services to the ASC setting has significantly diminished. Notwithstanding the appropriateness of cataract in the ASC, surgery centers realized only a three percent increase in market share over HOPDs from 2010 to 2013.

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 and insidious 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, including standard screening colonoscopy.

The agency's continued utilization of the CPI-U as an update factor and rescaling to achieve budget neutrality in the 2015 proposal, as well as the reclassification of procedures into new APCs and packaging policies discussed below, have 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, 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 appreciate the agency's willingness to work with the ASC industry, the ophthalmology community, and others. 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, summarized below:

B. Annual Payment Update

ASCRS, OOSS and SEE object to the application of any payment update mechanism that widens the gap between ASC and HOPD payment rates unless it is based upon actual differences in the costs of providing such care. During the past quarter-century, ASCs have been provided annual updates on only a sporadic basis and facilities received no adjustments for inflation for the period 2004-2009. As discussed in detail below, subsequent updates have been meager and, with the exception of 2016 (when HOPDs were subject to the 2 percent MFP adjustment that was applied to our

facilities several years ago), the hospital update is typically at least one percent higher than the ASC (in the proposed 2017 rule, 1.9 percent higher). This occurs notwithstanding the fact that surgery centers are treating the same patients for the same conditions and expending comparable resources to provide that care.

Unless the ASC is afforded an annual update comparable to the HMB, it is unlikely that ASCs will receive reimbursement rates that reflect the increases in the costs of providing services to beneficiaries. Importantly, as CMS acknowledged as far back as the 2008 ASC payment rate rulemaking, it possesses “considerable discretion in determining an appropriate update mechanism” and that the CPI-U is mandated for update purposes only as “the default update mechanism in the absence of any other update.” The differential between the factors applied to HOPDs and ASCs cannot be justified by real differences in the increase in costs of the goods and services of ASCs and HOPDs and should not be perpetuated by CMS when it possesses the authority to make an administrative correction. **In the final rule, CMS should adopt the Hospital Market Basket as the annual update factor for the ASC.**

- **The CPI-U does not reflect ASC cost growth; the HMB is a better proxy for ASC cost increases.** The CPI-U measures the average change in prices over time of all goods and services purchased by households, primarily those related to food, transportation, and housing. The HMB reflects the increase in the cost of the mix of goods and services (based on hospital inpatient operating costs) for the period at issue over the cost of such mix of goods and services for the prior 12-month cost reporting period. A comparison of the weights placed on goods in the CPI-U with those in the HMB demonstrates the fundamental differences in spending by consumers and hospitals. The CPI-U is dominated by inflation in the housing sector (accounting for about 40 percent of its weight); only 7.5 percent of the index’s inputs track anything having to do with health care. With respect to the HMB, about 60 percent is attributable to wages and benefits and virtually no weight is allocated to housing. As such, the very construction of the CPI-U limits its ability to predict ASC cost growth. The HMB, to the extent that it is applied to hospital outpatient departments, should be utilized to update ASC rates since the inflationary pressures on HOPDs and ASCs, e.g., hiring personnel and purchasing equipment and supplies, are virtually identical. Pharmaceutical products and medical devices, including implants, have far outpaced all other categories of expenses, with many commonly used drugs experiencing price increases of 200 to 400 percent; these costs must be covered by facilities whose base rates and updates have remained flat.
- **ASCs and HOPDs consume commensurate resources.** CMS has never offered convincing evidence for the proposition that ASCs consume fewer or different types of resources than HOPDs. Indeed, the surgical services performed by ASCs are identical to those furnished by hospitals and the costs incurred by the freestanding facility for staffing, equipment, supplies, overhead, and administration are commensurate with those incurred by hospitals which treat the same patients. Therefore, the higher update proposed to be awarded to the

HOPD arguably rewards its inefficiencies while penalizing the cost-conscious behaviors of the ASC.

- **Application of different inflation factors unjustly expands the gap in payments to HOPDs and ASCs.** Each year over the past decade, the HMB has exceeded the CPI-U by an average of about one percent. In combination with the application of the rescaler and the recent efforts to restructure APCs, the continued utilization of different annual update measures totally compromises the goal of aligning the HOPD and ASC payment systems. Applying the CPI-U to ASC payment rates for inflation drives a difference in the conversion factor between the HOPD and the ASC that is wholly unrelated to the actual cost of performing surgical procedures. Indeed, for the first time, in 2017, the ratio of ASC to hospital payments will drop below 50 percent, compared to 65 percent at the advent of the ASC payment system in 2008. In a regulatory system under which CMS should be attempting to parallel-track payments to HOPDs and ASCs (albeit subject to a conversion factor), it makes no sense to literally build into the equation an update factor that promises to further distort payment rates for comparable services. Application of the HMB to both the HOPD and ASC settings would ameliorate some of the divergence in payment rates.
- **CMS should immediately adopt the Hospital Market Basket instead of the CPI-U as the inflator for ASC payment rates or consider other equitable alternatives.** In the past, CMS has selected the best available proxy when no direct means of measuring the cost weights and price proxies is available. While the HMB might be an imperfect measure of ASC costs, as discussed above, it is more accurate than the CPI-U in that it reflects producer price inputs, measures health care delivery-related costs, and is utilized by the HOPD setting that provides a similar mix of services. Indeed, the ASC is among the last CMS-regulated payment systems to be linked to a CPI-update (the others being ambulance and clinical lab fee schedules and DME). The agency should, at the very least, adopt the HMB as the inflation update factor for ASCs until such time that a more accurate one is developed. In the alternative, if CMS insists on using the Consumer Price Index as an update factor, it should consider adopting one of the CPI-U subsets such as Medical Care, Medical Care Services, or Outpatient Hospital Services, the inputs of which are more consistent than the CPI-U with the services provided in the ASC setting.

C. Rescaling Adjustment Applied to ASC Relative Weights

ASCRS, 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 setting. 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 OPSS 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 it is proposed to be 0.9030 in 2017 – a three percent change in the scaler in one year. 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.*

We strongly recommend that the agency discontinue the use of the rescaler. If CMS is unwilling to do so, we believe that the agency should create a minimum ratio of ASC payment to OPSS payment for any service whose payment rate is based on OPSS rates. We would suggest that the floor should be implemented in such manner that no ASC service is paid less than 55 percent of the comparable OPSS rate. This represents the payment ratio between the sites before the comprehensive APCs were developed and exacerbated the more substantial disparity between the payment systems. We recommend that for OPSS codes that fall within C-APCs, the floor should be implemented relative to the alternative payment rate (i.e., without C-APC status) for these codes that CMS already calculates in the process of establishing ASC rates.

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.

D. Ambulatory Payment Classifications Restructuring

As stated above, it is imperative that CMS mirror in ASC payments any changes to the APCs adopted for OPSS in a manner that preserves the alignment between the payment systems and ensures fair and accurate payment for services within the ASC. We understand that APC restructuring is intended to promote clarity and simplicity in the OPSS system. However, restructuring has had the unintended effect of reducing payments to ASCs and further distorting the relative reimbursement of HOPDs and

ASCs. In developing its C-APC policy, the agency conducted a comprehensive review of OPPS claims data, but it appears that no consideration was afforded the impact on surgery centers. It is notable that over half of ASC approved procedures were encompassed within the C-APCs constructed in 2016 and, hence, facility payments were based on the revised OPPS relative weights. *We strongly recommend that, going forward, CMS study the impact of restructuring on ASCs as well as HOPDs and make appropriate adjustments to ensure that ASCs are appropriately reimbursed.*

In 2016, there were only nine codes in the ASC top 100 by volume that were encompassed within C-APCs. For 2017, that number will increase to 55. We argued in our comments two years ago that, through weighting and rescaling, these C-APCs would cause reductions in net payments to ASCs and significant volatility in rates from year to year. Our concerns have been realized. With respect to 65770, Keratoprosthesis, ophthalmic ASCs have experienced one such deleterious rate fluctuation. While the C-APC to which this service was assigned, 5493, was identical in the proposed and final 2016 rules, CMS added a second code to the APC in the final regulation. The payment rate for this APC group is based primarily on the overall volume within the APC and because 65770 is a low volume service, it did not weigh as heavily in the calculations. Moreover, importantly, the implant used in keratoprosthesis is, due to the C-APC structure that exists for hospitals but not ASCs, covered separately in the HOPD but not in the ASC. While the proposed rule contemplated a payment rate of \$7,455, in the final rule, the code had a payment indicator of G2 with a final rate of \$2,261, resulting in a 70 percent reduction in payment at 25 percent of the HOPD rate. It was not feasible to continue to perform the procedure in the ASC in 2016.

While the agency has addressed the 65770 problem in the proposed 2017 rule, we are very concerned that other codes may be similarly impacted in the future. Abrupt and substantial changes in rates embody the potential to seriously compromise the ability of ASCs, particularly single specialty facilities like ophthalmic centers that furnish a limited set of services, to treat patients within the facility. *We believe that it is imperative that the agency monitor the impact of APC changes on ASCs and, in restructuring APCs, solicit the views of stakeholders from the ASC community and make appropriate adjustments to ASC facility fees.*

D. Payments for Device-Intensive Procedures

Like hospitals, ASCs have occasion to use expensive devices and operative supplies during certain surgical procedures. Although surgery centers are adept at achieving greater operational efficiencies than HOPDs, they are typically not able to extract greater discounts on devices and supplies than hospitals.

We were relatively pleased last year that CMS reevaluated its device-intensive policy by defining ASC device-intensive as those procedures that were assigned to any APC with a device offset percentage greater than 40 percent based on the standard OPPS APC rate-setting methodology. Unfortunately, many procedures with high fixed

costs are not designated as device-intensive on the ASC list because while the cost of the device for many codes is greater than 40 percent of the total ASC cost for the service, it does not meet the 40 percent threshold in the HOPD setting and, therefore, the ASC is not reimbursed for the service. *We strongly recommend that the agency set the threshold at 40 percent of the unadjusted ASC payment rate*, thereby mirroring the current policy for establishing device-dependent services and pass-thru payments under the OPPS; this policy change is all the more important because ASCs are not included in the new C-APCs.

The proposed rule states that a “HCPCS code-level device would, in most instances, be a better representation of a procedure’s device cost than an APC-wide average device offset based on the average device offset of all of the procedures assigned to the APC.” CMS is proposing to assign device-intensive status to procedures that require the implantation of a device and have an individual HCPCS code-level device offset of greater than 40 percent, regardless of the APC assignment. Our organizations fully support the proposal, believing that it should more accurately reflect the true costs of performing these procedures and promote the migration of more services to the ASC.

If the agency insists on linking ASC device-dependent status to a threshold applied to HOPDs, CMS should consider further reducing the threshold to 30 percent since the ASC’s non-device payment is already under 50 percent of that paid to hospitals.

E. 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 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 procedure 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.

III. QUALITY REPORTING PROGRAM FOR AMBULATORY SURGICAL CENTERS

ASCRS, 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.

A. Measure for Unplanned Anterior Vitrectomy in Cataract Patients Treated in the ASC

The proposed rule would require ASCs to measure the number of cataract surgery patients who had an unplanned anterior vitrectomy. The procedure is performed while the patient is in the facility for cataract procedure. While the complication is generally not the fault of the facility – it is typically dependent upon the complexity of the patient's condition or the surgeon's expertise – collection and reporting of data will enable facilities to better identify surgeons who have higher rates of complication than the norm. Measuring this outcome embodies the potential to reduce the rate of unplanned vitrectomies. Moreover, there is little burden associated with reporting on the measure because the patient is still in the ASC when the complication occurs and the patient's ASC record will include the relevant information that will be reported.

We believe that measuring this event in the ASC setting presents an opportunity to improve the quality of cataract surgery for Medicare patients by the ASC. Moreover, these measures would serve as an important complement to the outcomes measures already being reported through the Physician Quality Reporting System (PQRS).

We recommend that the measure be incorporated within the final rule. The measure is fully developed and has been specifically tested in the ASC setting. It was reviewed last year by the MAP and received conditional support pending endorsement by the National Quality Forum. Reliability testing was completed in 2014 with very strong results and the measure is already in use in the ASCQC's quarterly public reporting program.

B. Toxic Anterior Segment Syndrome Measure (TASS) in Cataract Surgery Patients Treated in the ASC

CMS has invited public comment regarding the adoption of a measure, developed by the ASC Quality Collaboration, that would assess the number of patients diagnosed with TASS within two days of undergoing anterior segment surgery in the ASC. The measure was reviewed by the Measures Applications Partnership (MAP) last year and received conditional support pending endorsement by the National Quality Forum (NQF).

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. Incidence of TASS is measurable, attributable to the ASC, and can be actionable by the facility. There are published guidelines regarding cleaning and sterilizing 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 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 appropriately followed.

ASCRS, OOSS, and SEE strongly support inclusion of the TASS measure in the ASCQR program.

C. May 15 Deadline for Web-Based Measures

Presently, data for quality measures reported via QualityNet must be submitted during the period January 1 to August 15 in the year prior to the relevant payment determination year. The agency is proposing to abbreviate the submission to between January 1 and May 15 in the year prior to the payment determination year. The proposal would apply to several existing measures as well as potential new ones, such as Unplanned Anterior Vitrectomy.

The ostensible goal for aligning all Web-based data submission deadlines to May 15 is to provide for earlier public reporting of measure data and to reduce the administrative burden of facilities tracking multiple submission deadlines. While we appreciate the effort to streamline program requirements and concur with selecting one data submission timeline, we are very concerned regarding providing ASCs less time to submit data. The mandates of the ASCQR program are already complex and demanding and we believe that shortening the data submission time period will augment, rather than reduce, the administrative burden of facilities. An August deadline for web-based data submission has been in effect since the advent of the program and the proposed change embodies the potential to confuse facilities and cause them to unwittingly miss the May deadline, thereby forfeiting their full payment update.

ASCRS, OOSS and SEE believe that the agency should maintain the August 15 deadline in the year prior to the relevant payment determination year. If consistency in reporting deadlines is a CMS priority, it should apply the August 15 deadline to its other reporting programs.

D. Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measure for CY 2020 Payment Determination Year

We appreciate the agency's efforts to assess patient outcomes and satisfaction with providers. Our organizations have submitted comments with respect to prior iterations of this measure, most recently, CMS-4171-NC, in March of 2013. At that time, we emphasized several concerns: the need to minimize the administrative and financial burdens of participation; efficient and effective survey administration; the imperative of limiting survey questions/topics provided by the facility; and, the challenges of patient self-reporting on outcomes. We are disappointed that the survey under discussion at this time, in great measure, does not address these concerns. ASCRS, OOSS, and SEE fully support the recommendations proffered by the ASC Quality Collaboration with respect to this rulemaking and are incorporating them herein by reference. Our main concerns include the following:

The survey instrument is too long. Simply stated, in our experience, patients will not participate in surveys that require an inordinate amount of time to complete. Most of our member facilities request that their patients participate in patient experience surveys. Our members report that these instruments are short and concise, typically including from 5 to 10 questions/topics; even with the simplicity of these forms, the response rates are only in the 15-30 percent range. Participation in the OAS CAHPS measure would be a substantially more intense undertaking by the patient. Despite the reduction of the number of items from the original 49 to the current 37, the instrument remains much too long. The Hospital CAHPS survey includes only 32 items and, given the potential complexity of patient stays, it is incomprehensible that a longer survey would be appropriate for the ASC. The ASCQC's comments address specific survey items that should be omitted or revised.

Information technology should be used to minimize the burden on facilities and patients. In addition to the proposed survey modes, facilities should be permitted to send surveys by email as well as text message (SMS) and use a web-based survey administration modality. The agency states, incorrectly we believe, that "any additional forms of information technology, such as web surveys, would be less feasible with OAS CAHPS patients, as patient information is not readily available through HOPDs and ASCs." To the contrary, email addresses are as routinely collected by facilities as the patients' addresses and phone numbers. CMS also suggests that Medicare beneficiaries are not likely to respond to surveys administered online; the reality is that government studies have concluded that internet use among the elderly is well above 50 percent and is

growing. Besides the convenience that online distribution of surveys and web-based survey administration offers patients, ASCs have found that significant savings can be accrued compared with traditional survey approaches. If CMS intends to make this survey mandatory for both ASCs and hospitals commencing in 2018, it is imperative that email and web-based survey modes be permitted and, indeed, encouraged.

Required Number of Completed Surveys. CMS is proposing a minimum of 300 completed surveys annually as the target for each participating outpatient facility. We believe that this number is unduly burdensome and unrealistic. The sample size needed to ensure 300 respondents using CMS' assumed response rate of 32 percent for mail only or telephone only surveys is 938 patients each year. Moreover, our experience suggests that the length of the survey instrument will also impede patient participation, rendering the agency's compliance projections further overstated. CMS has permitted lower minimums with respect to other providers: a minimum of 200 completed surveys for the In-Center Hemodialysis CAHPS initiative and thresholds of 100 completed surveys for its HCAPHS Star Ratings initiative under the Hospital Inpatient Quality Reporting program and the Hospital Value-Based Purchasing program. It is important that CMS recognize that most ASCs are small businesses, with two or fewer operating rooms, and that the costs of securing 300 completed surveys will be prohibitive for many facilities.

Thank you for providing our organizations with the opportunity to present our views on the proposed regulation regarding 2017 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: Nancey McCann, Director of Government Relations, ASCRS, nmccann@ASCRS.org, 703.591.2220; Michael Romansky, JD, Washington Counsel, OOSS, mromansky@OOSS.org, 301.332.6474; and, Allison Shuren, JD, Washington Counsel, SEE, allison.shuren@aporter.com, 202.942.6525.

Thank you for your consideration of our views.

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

