

October 5, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1736-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at www.regulations.gov

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-owned Hospitals

Dear Administrator Verma:

We appreciate this opportunity to submit comments on behalf of four leading ophthalmology organizations with regard to CMS-1736-P, *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*. Collectively, the members of our societies are responsible for performing the vast majority of all ophthalmic surgical procedures performed in the US, and most within the ophthalmic ASC setting.

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 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 2021 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 2021 would be \$1,041, while reimbursement for the same procedure in the HOPD would be \$1,997. The beneficiary's financial obligation in the form of copayments is \$208 in the ASC and at least \$400 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 \$956. 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.

I. SUMMARY OF RECOMMENDATIONS

- **CMS should maintain use of the hospital market basket as the annual update mechanism for ASC payments.**
- **CMS should apply the OPSS 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 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, separately under Part B.**
- **CMS should lower the device-intensive threshold from 30 to 25 percent, refrain from adjusting the device portion of the payment by the local wage index, and encourage Congress to implement an ASC copayment cap with respect to devices implanted during surgery in an ASC**
- **CMS should eliminate its prohibition against ASCs billing for services that are reported using a CPT unlisted surgical code.**
- **CMS should adopt in the final rule a quality measure for ASCs to report on Toxic Anterior Segment Syndrome (TASS) in cataract patients.**
- **CMS should reestablish ASC quality measures ASC-1, ASC- 2, ASC-3, and ASC-4 in the ASC Quality Reporting Program. CMS should maximize efforts to align quality measures across all sites of service.**

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 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 2021. 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 about 5,800 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 a year 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 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 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, 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 0.8494, 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 OPSS and ASC utilization and mixes in services to establish a single weight scaler.** By incorporating the ASC volume into OPSS weight scaler calculations, CMS would improve the alignment of the payment systems and more accurately scale for outpatient volume across both sites of service.

Packaging of Items and Services Under OPPS and the ASC Payment Systems— Cataract Surgery

Three years ago, CMS solicited public comment regarding a number of packaging and bundling policies under its OPPS and the ASC payment systems, among them whether they might adversely impact patient access and or provide inadequate payment. We are extremely concerned that CMS has not responded to the significant comments we submitted, or the letters sent by bipartisan members of Congress on this issue, and is only proposing to continue to pay for one specific non-opioid pain management drug separately in the ASC. 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. *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 drug (Exparel) CMS removed from the facility fee for that reason. Without addressing this issue, CMS' policy will have the unintended consequence of stifling innovation because manufacturers do not have the assurance there will be a payment pathway when these new and innovative drugs come off transitional pass-through payment status.*

Our organizations oppose CMS' policy that restricts separate payment for drugs administered at the time of the cataract procedure but are intended to treat post-operative pain and/or inflammation because it prevents patient access to these medications in the ASC setting. These medications 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 conditions, and comorbidities. Medications, administered by the surgeon at the time of surgery, 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.

Yet, once these drugs come off pass-through status and are bundled into the APC payment, ASCs typically cannot afford them. ASCs, who typically operate on tight margins, are paid at a significantly lower rate than HOPDs, but must purchase the drugs at the same price. Drugs that have recently come off pass-through have experienced a precipitous decline in use once their cost is bundled into the APC payment because the payment is far from being high enough for ASCs to afford the drug. CMS recognized this challenge and began paying separately for one non-opioid pain management in the ASC because the cost of available non-opioid options may prevent ASCs from using the drug. We believe, though, that the exclusion, which cites only Exparel, is too narrow. While we appreciate and support the efforts CMS is taking to combat the nation's opioid epidemic, we believe, as indicated

above, that ASCs may also be unable to provide patients access to all FDA-approved medications with post-operative indications because they are too costly to provide as part of the current bundled facility fee.

While we commend CMS for adopting a limited separate payment policy in CY 2019 (which CMS is proposing to extend without change for CY 2021) — to unpackage and pay separately for the use of non-opioid pain management drugs that function as a supply when used in a surgical procedure in the ASC setting — we are disappointed that CMS has applied this policy to only one drug thus far. CMS has made clear in prior rulemaking that it would unpackage and pay separately for *any* non-opioid pain management surgical drugs that become available on the U.S. market. We know of at least one such drug used during cataract surgery — OMIDRIA — that also qualifies under this policy. OMIDRIA is a non-opioid pain management drug used during cataract surgery and, now following expiration of its pass-through status on October 1, 2020, should also be unpackaged and paid separately under CMS' existing CY 2020 policy and under CMS' proposed CY 2021 policy when used in ASC settings. Moreover, as stated above, we believe that CMS' policy for non-opioid pain management surgical drugs should extend to all FDA-approved drugs that are administered at the time of cataract surgery — either during or at the end of the procedure — that have an indication for the treatment of post-operative pain and/or inflammation and/or other sequela of the surgery.

We are also concerned that CMS' policy is having the unintended consequence of stifling innovation as branded products on the market or in the pipeline for FDA approval will be virtually impossible for Medicare beneficiaries to access once they come off pass-through. 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 discontinue their innovation in this area.

We are fortunate as clinicians and ASCs to have multiple options to treat our patients' post-operative challenges — which are excellent self-administered drugs and new, 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, our organizations 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/or inflammation, and in the future, infection, separately under Medicare Part B.

Device-Intensive Codes

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. While we do not as yet have 2019 volume data, it is clear that prior endeavors to lower the ASC device threshold have resulted in meaningful migration of services from the HOPD to the ASC. **Therefore, we strongly believe that the device intensive threshold should be further lowered to 25 percent.**

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.**

Finally, 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.

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.**

ASC Quality Reporting Program

ASCERS, 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.

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 within two days of undergoing anterior segment surgery in the ASC. The measure was reviewed by the Measures Applications Partnership (MAP) three 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. 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.**

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 2021 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; Jill Blim, ASRS, jill.blim@asrs.org 312.578.8760; 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
American Society of Retina Specialists
Outpatient Ophthalmic Surgery Society,
Society for Excellence in Eyecare**