The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Room C4–26–05,
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Via online submission at https://www.regulations.gov/commenton/CMS-2024-0089-0001

Re: Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services

Dear Administrator Brooks-LaSure:

The undersigned organizations appreciate the opportunity to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS)' notice of its intent to develop and implement a prior authorization demonstration for certain ambulatory surgical center (ASC) services (CMS–10884). Our organizations include physicians who provide care in surgery centers. We oppose this proposed demonstration.

The notice indicates that CMS seeks to implement a demonstration project, believing that it "will assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring in ambulatory surgical centers providing services to Medicare beneficiaries."

There is already a mechanism in place for addressing fraud: the Medicare Fee for Service Recovery Audit Program. Through this program, Recovery Audit Contractors (RACs) "identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries." Instead, this demonstration appears to be a solution in search of a problem—imposing additional burden on providers and additional cost on the Medicare program and taxpayers without evidence of widespread fraud in ASCs.

There are forty procedures listed in CMS-10884 Supporting Statement Part B. CMS indicates that data "from 2019 to 2021 shows these services have experienced significant increases in utilization in the ASC setting" and that "CMS selected the targeted services for inclusion in this demonstration, based upon problematic events, data, trends, and potential billing behavior impacts of the OPD Prior Authorization Program which requires prior authorization as a condition of payment for these services."

Yet, of the forty codes listed, there is only **one** code, J0585, that saw an increase from 2019 to 2021. The increase during that timeframe was 1.5 percent. Twenty-one of the procedures (52.5 percent) CMS proposes for this demonstration had 100 or fewer claims nationwide. Six of the codes (15847, 36474, 36476, 36479, 36481, and 36483) have a payment indicator N1, meaning they are **not**

separately payable in the ASC setting. Since they do not receive reimbursement, it does not make sense to include them in a prior authorization demonstration.

If CMS wishes to establish a policy that requires additional burden on ASCs and the providers who practice in these facilities, it should clearly delineate the criteria and exclude procedures that fall below a certain volume threshold or overall spend within the Medicare program. Then, when evaluating increased utilization, CMS should specify a percentage increase that will trigger the prior authorization. Based on the list that has been provided, there is a concerning lack of effort in identifying procedures that merit such concern. When imposing new burdens on well-regulated healthcare providers, CMS should have to show that there is a clear gain to be had by the taxpayers and the Medicare program. As presented, this demonstration misses the mark.

In addition, we have questions regarding the demonstration design and which payment system is ultimately impacted. The demonstration mentions "ASC providers that submit claims with place of service 24 (Ambulatory Surgical Center), perform certain ASC services in the 10-demonstration states, and submit claims to Medicare fee-for-service." Since the term "ASC provider" is not one we typically use to describe the facility itself, the Ambulatory Surgery Center Association (ASCA) contacted the CMS staff referenced in the demonstration notice, asking whether the facility or the provider (physician) was responsible for obtaining prior authorization. They were informed that the "physician needs to submit the prior authorization request or materials requested by the MAC for preclaim review and that drives the process."[1]

However, in Supporting Statement Part B, under Small Businesses, it indicates that the "collection will impact small businesses or other entities to the extent that those ambulatory surgical centers that qualify as small businesses bill Medicare for the services that require prior authorization." We request clarification as to whether the ASC's facility fee, the provider's professional fee, or both are potentially impacted by failure to obtain prior authorization.

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Medicare reimbursement is not keeping pace with costs, and we object to this additional burden on ASCs and our providers practicing in these facilities without a clear indication the demonstration is needed. We appreciate the Agency's past willingness to listen to our concerns. We stand ready to work with you and your staff on proposals to encourage migration to the lower-cost ASC setting, resulting in savings for the Medicare program and its beneficiaries.

Sincerely,

[1] Email from Justin Carlisle (Justin.Carlisle@cms.hhs.gov) to Alex Taira, ASCA staff, on Wednesday, February 24, 2024.