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JOSEPH JACOT, PA-C, MBA
Chief Executive Officer

September 1, 2021

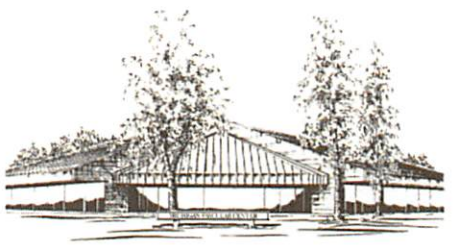
Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016
Submitted electronically: http://www.regulations.gov

Re: File Code CMS-1751-P; Medicare Program; CY 2022 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 23, 2021)

Dear Administrator Brooks-LaSure:

My name is Mark A. Mattos, MD, DFSVS, FACS. I am a Board-Certified Vascular Surgeon who works in Flint, Grand Blanc, and Saginaw Michigan providing surgical care of patients with end-stage-renal disease (ESRD) who require hemodialysis three times a week to survive.

I am writing regarding the Centers for Medicare and Medicaid Services (CMS) 2022 Physician Fee Schedule (PFS) proposed rule, released on July 13, 2021, which in its present form will result in reimbursement cuts as high as 20% to critical services I perform in my non-facility office-based hemodialysis access center. If these cuts are implemented on January 1, 2022, I will find it difficult to keep my non-facility hemodialysis practice open for the evaluation and treatment of patients with ESRD who currently receive hemodialysis. The proposed cuts will result in a near 100% shifting of the care of my hemodialysis patients from my non-facility office to facility hospital-based care. The direct consequence of this location shift in the care of hemodialysis patients from non-facility office-based care to facility hospital-based care will result in an overall 3 to 4 times greater increase in Medicare hemodialysis-related expenditures. Furthermore, the 20% decrease in reimbursement will have a major deleterious effect on my office-based employees as implementation of the cuts will more than certainly result in many of



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my office staff being dismissed from our office-based practice. The loss of valued staff members, many who have become my trusted colleagues at work and friends outside of work, will further limit my ability to provide cost-effective, time-efficient, point-of-service value-based care and outcomes for the patient with ESRD who requires maintenance of their hemodialysis access. The result of the proposed Medicare cuts will be the forced migration of patients with ESRD to seek their necessary care at facility hospital-based care where they will no longer receive priority treatment. This exodus of patients to hospital-based care will occur rapidly and without proper preparation by the hospitals, challenging the mental and physical wellness of these older, more vulnerable patients who have limited mobility and require frequent regular care.

Performing hemodialysis access preserving procedures in non-facility office-based settings for patients with ESRD has been identified nationally to be an effective healthcare strategy. Several of the most common reasons are described below.

- *Non-facility office-based care is more cost effective to Medicare:* Medicare reimbursement rates are 3 to 4 times higher in the facility hospital-based setting than in the non-facility office-based setting for the same hemodialysis access services provided.
- *Non-facility office-based care is less expensive to Medicare beneficiaries*: The patient with ESRD will have a procedural copay that is 2 to 3 times less expensive in the non-facility office-based setting for hemodialysis access services.
- *Non-facility office-based care is more convenient for all patients with ESRD:* Non-facility office-based care provides easier access to care, and renders care closer to home and supportive family and friends so crucial to the care of patients with ESRD on hemodialysis. Furthermore, the non-facility office is easy to navigate for the patient, families and friends of all socioeconomic status, race, or gender.
- *Non-facility office-based care is timely:* Scheduling is easier to adjust, resulting in more immediate access to care. Clinically dangerous delays in care so frequent in facility hospital-based care for patients with ESRD are avoided. Prompt site-of-service value-based care in non-facility office is the norm rather than the exception.
- *Non-facility office-based care offers continuity of care:* The patient-practice and patient-doctor relationship is maintained and emphasized in non-facility office-based care.
- *Non-facility office-based care prioritizes the patient with ESRD on hemodialysis:* Treatment of patients on hemodialysis is the primary healthcare mission of the non-facility office-based hemodialysis practice.
- *Non-facility office-based care is safe and time efficient:* Office-based care is clinically efficient and avoids unnecessary interactions with medical and nonmedical personnel; thus, minimizing exposure to COVID and other aerosol or contact-based diseases because of decreased actual time spent in the non-facility setting.

In summary, due to the many advantages listed above I have been able to provide near 100% care for my patients with ESRD on hemodialysis in my non-facility office-based hemodialysis center. The upcoming 20% cuts in Medicare reimbursement will ultimately result in the closing of my non-facility office-based practice. I will lose the ability to treat patients on hemodialysis in this setting. The net effect of these cuts will drastically alter the practice paradigm for patients with ESRD on hemodialysis in the United States, and at a cost three to four times higher than the current Medicare expenditure for these fragile at-risk patients.

PLEASE DO NOT IMPLEMENT the proposed Medicare cuts.

Sincerely,

Mark Mattos, MD DFSVS FACS
Board Certified Vascular Surgeon
Program Director, Vascular Surgery Fellowship
Michigan Vascular Center
Flint, Michigan