



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION™

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September 1, 2014
Marilyn B. Tavenner, Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington DC 20201

Via Electronic Submission: <http://www.regulations.gov>

Re: Calendar Year 2015 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1612-P)

Dear Administrator Tavenner:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule on *the revisions to payment policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for calendar year 2015* published in the July 11, 2014 *Federal Register*.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

Outlined below are several key areas of concern in relation to the proposed rule.

Resource Based Practice Expense (PE) Relative Value Units (RVUs)

ASPS is pleased to see that CMS has reconsidered the proposal to use OPPS and ASC rates in developing PE RVUs. It has and continues to be the position of the ASPS that RBRVS values are more reliable than OPPS rates. We would encourage the Agency to continue its analysis of ASC approved services provided in the OPPS setting to validate current assumptions on the accuracy of expenses across the two locations, but utilizing that data for purposes of developing PE RVUs would be inappropriate given the different cost and accounting structures utilized in hospital versus other settings.

With regards to the proposed development of a HCPCS modifier to collect frequency of services provided by off-campus provider based departments, we respectfully remind CMS of the many studies that have shown a single set of submission rules for all payers significantly reduces the administrative complexity in physician practices. The likelihood of inappropriate or inadequate application of a modifier is significant when the modifier is not reported to all payers. While we recognize and support the need to validate the accuracy of practice expense data, we would encourage CMS to work with the

National Uniform Claim Committee to standardize the reporting process for identification of healthcare services provided at hospital off-campus locations for not just government payers, but private payers as well.

Potentially misvalued codes

ASPS applauds the work of the American Medical Association (AMA) and the Agency to identify codes with an incorrect number of hospital days included in the work time files and supports the proposal to update the total times associated with the global surgical package for these codes.

As a long-time participant in the AMA RUC and PE Subcommittee processes, ASPS has had opportunity to participate in reviews of codes that CMS has previously identified as “potentially misvalued.” We have found the current process can produce redundant requests, with the same code included in several “screens” run over a short period of time. Because the criteria for most “screens” are very specific, codes that are being incorrectly reported can be excluded from review.

Looking forward, we would encourage CMS to work with specialty societies to improve transparency in the process currently used to develop target areas/screens for future reviews. In addition, we believe societies could provide a wealth of ideas on ways to identify incorrectly utilized HCPCS codes.

Improving the Valuation and Coding of the Global Surgical Package

Our society has significant concerns regarding the proposal to transition from global surgical packages to separate billing for individual postoperative visits. While we appreciate the concern that payments for services be appropriate, we are also concerned that such a plan would cause difficulty with patient compliance with follow up care, increased costs to beneficiaries, and adverse impact to patient safety. The current postoperative global packages were reached by survey, and we feel that they accurately reflect the typical postoperative care of the patient.

If each postoperative visit were separately billed, the patient would incur a copayment responsibility for each visit. That would become a significant financial hardship on the patient and would disproportionately affect the sickest, old, and most complicated patients. We are troubled by the concern that many patients will not be compliant with recommended postoperative visits due to cost consideration. We are also concerned that the increased financial burden, particularly in the event of complications, will encourage increase in medical liability claims from patients to recoup their financial losses, and are especially concerned about the ability of a provider to waive out-of-pocket expenses without violating Medicare or private pay rules of participation. Finally, the current system encourages efficient and necessary care, and rewards providers who have few complications. The proposed system could encourage abuse by financially rewarding additional visits.

Our members frequent perform reconstructive surgery at the same operative session as another surgeon. An example would be a breast cancer patient undergoing mastectomy with immediate reconstruction. ASPS is concerned that some patients will be financially incentivized to pursue follow up care with only one provider, with the expectation that the de facto provider will now fill prescriptions, order follow up testing and provide other services typically provided by the provider (e.g., the surgeon) who could no longer be seeing the patient. In most cases of this type, each provider has distinct capabilities and concerns, and they are not interchangeable. Patient safety would be compromised by providers functioning outside of their area of expertise. Additionally, we are extremely concerned about liability

issues that will undoubtedly result when the de facto provider assumes full care, as described in the scenario above.

Recognizing the current proposal includes a beginning implementation date of 2017, the elapsed time between release of this rule and the deadline for comments leaves societies will little time to fully evaluate the proposal. As presented, the proposal leads ASPS to believe a significant amount of administrative burden could be placed on small practices if the policy change impacts only government payers. If private payers also adopt this proposal, we are concerned about the volume of claims that will need to be generated, as well as the necessary claims follow-up. As such, we respectfully request time for additional analysis of this proposal by societies, the AMA RUC and CPT Editorial Panel and the Agency, as well as detailed communications from the Agency to ensure patients receive the appropriate post-operative care, protect beneficiaries from increased financial liability due to increased cost sharing, ensure providers are accurately paid for all postoperative visits and provide sufficient guidance to providers so they are ready to help successfully implement any future change to the process for the billing of post-operative care.

Malpractice Relative Value Units (RVUs)

In today's market, it is rare for any physician or surgeon to not carry malpractice insurance. Many states require practicing physicians to carry professional liability insurance (PLI) and mandate minimum levels of coverage. Other states may require proof of financial responsibility. It is our understanding, that regardless of state regulations, hospitals require proof of coverage. As such, it is unclear why the Agency was unable to obtain "good data" on the PLI rates for some providers. We would suggest the Agency work with the AMA to obtain the necessary data to ensure the process for reviewing and updating PLI rates is accurate for all providers.

Medicare Telehealth Services

For ASPS members, telemedicine has the potential to improve access to important plastic surgery services. Given the benefit that could be realized by beneficiaries, particularly those who have complex medical issues and lack access to in-person treatment options, we look forward to working with CMS to identify additional services that could be included in the list of covered telehealth services.

Valuing New, Revised and Potentially Misvalued Codes

ASPS appreciates the Agency's proposal to provide timely updates about new and revised codes via the proposed rule. Greater public input and dialogue with CMS has the potential to improve the current rate-setting process. Unfortunately, the Agency's proposal appears overly complex, and appears to shrink the timeline for recommendations to be submitted via the current AMA CPT and RUC process. In addition, the proposed rule does not provide adequate information on how feedback would be shared when societies disagree with CMS determinations of relative values in future proposed rules, especially given the proposal to eliminate Refinement Panels. As such, we request CMS provide additional information about the process, including details about feedback loops, before this proposal moves forward.

In addition, ASPS believes the Refinement Panel process should be reformed, rather than removed from current or future rule-making processes used to set code values. The Panel provides a 'safety valve' for societies, allowing for independent peer-review of CMS actions and ensures the Agency is following standards set in place during the CPT and RUC process.

Reports of Payments or Other Transfers of Value to Covered Recipients

ASPS appreciates the attempts the Agency has suggested to simplify the rules regarding Open Payments, but is concerned that the elimination of the certified and accredited CME exemption opens the door to a myriad of unintended and negative consequences.

All providers of accredited and certified CME adhere to the strict firewalls established by Accreditation Council for Continuing Medical Education's (ACCME) *Standards for Commercial Support: Standards to Ensure Independence in CME Activities (SCS)*. These standards protect the integrity of CME, safeguarding against commercial influence by distinguishing between independent, certified CME and promotional educational programming offered directly by industry. The importance of maintaining this distinction cannot be overstated. All CME credit systems in the United States – the American Academy of Family Physicians, the American Medical Association, and the American Osteopathic Association – have adopted the ACCME SCS and as such, CMS appropriately names these accrediting bodies in the Open Payments final rule (§403.904(g)(1)(i)).

ASPS understands the desire by CMS not to appear to be endorsing certain accrediting bodies, but should CMS maintain the exemption and wish to consider other accreditors and equivalent standards, a mechanism already exists for review. An inter-professional coalition of accreditors of continuing education in the health professions called *Joint Accreditation*, exists and has been convening since 2009. The coalition is comprised of ACCME, the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center and is a function of self-regulation and the desire to preserve the integrity and independence of CME.

ASPS strongly supports maintaining the CME exemption in its entirety and recommends that CMS reconsider its proposal to eliminate the reporting exemption for accredited and certified CME (§403.901(g)).

The proposal to eliminate §403.904(g) because it is redundant with the exclusion in §403.904(i)(1), which exempts indirect payments or other transfers of value where the manufacturer does not know or is unaware of the identity of the covered recipient of the value transfer during the reporting year or by the end of the second quarter of the following reporting year is also troublesome. ASPS disagrees that these sections are interchangeable due to the nature of CME programs. CME events are planned months and even years in advance and promoted far enough in advance of the program date that the attainment of commercial support grants by the CME provider is often incomplete. Additionally, as the CME provider fills out the roster of faculty for an event, the faculty names are promoted and publicized to the intended audience. It is not realistic, nor would it be in the interest of transparency, if CME faculty names were hidden until the program commences, nor would physicians attend such events. As a result of the way CME programs are developed and promoted, companies providing commercial support to CME providers are likely to learn the identity of the program faculty, usually before the event, but certainly at or shortly after and within the timeframe of the §403.904(i)(1) exemption. Therefore, using this arbitrary time determination for reporting exemption is unworkable for CME and does not provide the protection for CME faculty that CMS has recognized should exist due to the fact that a grant from a company to a CME provider does not establish a relationship between the faculty and that company.

For the reasons stated above, §403.904(g) and §403.904(i)(1) are not interchangeable and CMS should reconsider the proposal to eliminate the specific CME exemption as it serves a unique purpose to protect CME faculty and preserve the integrity of CME programs.

Physician Compare Website

ASPS has provided numerous comments in the past about our concerns with the Physician Compare website and are especially disappointed to see CMS has announced plans to continue their phased-in approach to public reporting of performance information. Many specialty providers struggle to identify measures that are applicable to their practice. Until a more robust group of measures is available for all provider types, we question the value of sharing unequal data points with the general public.

In addition, we are concerned with the proposal to begin reporting EMR Meaningful Use Incentive Program attestation on the website, as we believe electronic medical record usage has yet to be adopted by many small practices. Perhaps most importantly, we are not convinced this type of data will be meaningful for patients without extensive guidance on how to interpret and utilize the information. As such, we strongly encourage the Agency to reconsider the sharing of quality or meaningful use indicators via the Physician Compare website without first developing a tutorial that allows the public to better understand the data. We also encourage CMS to recognize improvements by individual providers and groups, over time.

Composites

ASPS is concerned about the proposal to create composite measures using 2015 data and to publish composite scores in 2016, by grouping measures based on the PQRS GPRO measure groups. The quality measures included in the PQRS program were developed as standalone measures, to be reported individually. Measure developers consider feasibility of both bundling measures as well as creating composite measures, early in the measure development process. This is largely due to potential feasibility issues, particularly with regards to the development of measure specifications. That said, should CMS decide to proceed with forming composite measures, we recommend seeking input from the original measure developers as well as providing clarification regarding how the potential composite measure scores will be calculated, as measures components may need to be revised, in order to be feasible for being reported as composites.

Benchmarks

While ASPS understands the importance of the development of benchmarks for quality reporting, we strongly oppose the development of the quality scoring points system. This would essentially give consumers the idea that providers should be selected based on grades from participation in the PQRS program. Performance measure reporting and performance rates are confusing to some physicians and are very likely also confusing to consumers and patients. To assign a quality score to physicians may be misleading, without more public education, as noted above. It is also unclear whether exception rates will also be reported, along with performance rates, and whether these rates will impact the quality scores. Therefore, we request clarification, in this regard.

Consumer concept testing

ASPS recognizes the importance of ensuring that measures are easily interpreted by consumers and patients. However, not including a measure on the Physician Compare site may prove to be beneficial to some providers and detrimental to others. The providers that receive great scores on a measure would

run the risk of having a measure reported that is easily interpreted by the patients but has a lower performance rate, than a different measure that is more difficult to interpret but has a higher performance rate. Should this proposal go forward, we encourage CMS to share the results of the consumer testing with measure developers and allow measure developers to provide supplemental information or work with CMS to develop tools to further patient understanding of each measure.

Specialty Society Measures

ASPS does not support the inclusion of specialty society measures on Physician Compare, at this time, unless specifically requested by the society. Publicly sharing more performance measure data without providing additional education for the public, would lead to more confusion and create more of a burden for physicians that are using the non-PQRS measures for internal quality improvement, but are not currently participating in the PQRS program.

Qualified Clinical Data Registry Measure Data

CMS proposes to require that QCDRs make measure data available to the public beginning with data collected during CY 2015, either by making these data available on Physician Compare, or by linking from Physician Compare to the QCDR's Web site. ASPS does not support this proposal because this timeline is too aggressive to ensure that data will be valid and reliable. Requiring public reporting before providers have had the opportunity to evaluate the measures and their performance rates and make necessary adjustments may discourage eligible professionals from participating in QCDRs. Additionally, the information may not be understood by consumers. Sharing this data prematurely could result in the misclassification of care which could misinform the public. Therefore, we encourage CMS to delay the public reporting of QCDR data until accurate benchmarking data can be developed, providers have the opportunity to analyze their performance and make improvements, and the data can be presented in a format that is easily understood by consumers.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting

As CMS is well aware, the current list of measures included in PQRS is not applicable to all specialties. Currently there are only 18 individual measures and 1 measure group that are potentially applicable to a typical plastic surgery practice. ASPS and other specialty societies are working to develop measures applicable for their membership, but it is still too early in the process to have a robust portfolio of measures for plastic surgeons to report. It should be noted that 10 percent of the list of measures CMS has proposed to remove from the 2015 program are measures that are applicable to plastic surgery.

TABLE 24: Measures Proposed for Removal from the Existing PQRS Measure Set Beginning in 2015

Recently, there has been a national surge in the focus on overuse and appropriate use of treatment and resources. The Chronic Wound Care measures, proposed for removal from the PQRS program, are both overuse measures. Measure # 245 Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers is extremely important, as it focuses on reducing the use of wound surface culture technique, as there is evidence that surface swab cultures are inaccurate and unreliable for obtaining specimens for culture and accurately determining the pathogenic cause of infections determines the method of treatment. Measure #246 Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers is also important, as wet-to dry dressings should not be utilized in the care of patients with chronic wounds, potentially impeding healing. These dressings are also associated with an increased risk of infection, prolonged inflammation, and increased patient discomfort.

The Chronic Wound measures are also the only relevant appropriate use measures included in the PQRS program relevant to plastic surgery.

There is an abundant amount of evidence surrounding inappropriate use of antibiotics and management of surgical site infections (SSIs). This has led to the creation of performance measures as well as national quality initiatives, encouraging appropriate use. The majority of the Perioperative Care measures have been developed and implemented as a part of this national effort to reduce the incidence of surgical wound infections as well as potential antibiotic resistance and ensure that the correct antibiotic is given to surgical patients. An additional Perioperative Care measure was developed with a focus on VTE prophylaxis, as VTE is a common complication in surgical patients. The perioperative care measures have been broadly implemented by plastic surgeons and are extremely important in improving surgical outcomes.

Although performance rates on all of these measures are high, we urge CMS to continue to include the Chronic Wound Care and Perioperative Care measures in the program. If these measures are removed from the PQRS program, there is an opportunity for the performance gaps to increase, therefore reintroducing care that is unnecessary and potentially harmful to chronic wound and surgical patients. If retaining the measures is not feasible, we respectfully request that CMS create a category of “special circumstance” measures for providers with limited reporting options or to implement a one year grace period, for specialty societies to identify or develop new measures for use in the PQRS program.

TABLE 25: Existing Individual Quality Measures and Those Included in Measures Groups for the PQRS for Which Measure Reporting Updates will be Effective Beginning in 2015

CMS has proposed a change to the reporting mechanism for several measures. ASPS is still concerned with the Agency’s rapid transition away from claims-based reporting, as for many small plastic surgery practices there are limited resources available to purchase and maintain the systems necessary to report through registries and electronic health record (EHR) systems. With such a significant percentage of plastic surgery practices being small and reporting via claims, we encourage CMS to take a slower approach to moving away from claims-based reporting for individual measures, by waiting until more physicians are able to utilize alternate reporting options. As previously noted, the number of measures in the PQRS program that are applicable to plastic surgery is quite limited. Therefore, ASPS urges CMS to reconsider their proposal to change the reporting mechanism for Measure#46: Medication Reconciliation to registry only. It would be helpful to allow eligible professionals to report the measure via claims and registry, for another year, before phasing out claims reporting for this measure.

PQRS Measures Groups

CMS proposes to modify the definition of a measures group for 2014, requiring a measures group to consist of six measures, rather than four. EPs must report on all measures contained in the measures group. Increasing the number of measures does not take into account the overall intent of a measures group, which is to present a complete picture of patient care. We believe that measures that have been proposed for addition to the measures group to bring the total number of measures in the group to six are not necessarily clinically relevant to the care being provided by all specialties that may report the specific measures group. We urge CMS to only add measures to a measures group when the additional measures are substantively appropriate to the clinical topic rather than choosing an arbitrary number.

As previously stated, although performance rates on the perioperative care measures group are high, we urge CMS to continue to include this measures group in the program. If this measures group is removed, there is an opportunity for the performance gap to increase, therefore reintroducing care that is unnecessary and potentially harmful to surgical patients. This is also the only measures group that is currently applicable to plastic surgeons and removing it from the program could potentially prohibit plastic surgeons from participating in the PQRS program.

Proposed Changes to the Criterion for the Qualified Registry

In addition to the requirements finalized in the CY 2014 Rule, CMS is proposing that in CY 2015, any EP or group practice that sees at least one Medicare patient in a face to face encounter would be required to report on at least two cross cutting PQRS measures that are specified on Table 21 of the proposed rule. CMS would require qualified registries to collect data on all of the cross cutting measures specified in Table 21 of the proposed rule for which the registry's participating EPs are able to report.

ASPS believes that the requirements for satisfactory participation for reporting individual measures through claims and registry based reporting will be nearly impossible for surgeons to meet. Should the cross cutting measure criterion be finalized, the requirement for registries to include all 18 cross cutting measures will be very burdensome especially for small and specialty-specific registries. We believe that the qualified registry should be given the option to choose which measures from the cross cutting list are relevant to their registry participants, at a minimum of two measures with a goal to support all 18 cross cutting measures over a reasonable time period.

Proposed Changes to the Requirements for the Qualified Clinical Data Registry

For 2014, CMS finalized the addition of a new qualified clinical data registry (QCDR) option whereby EPs report the measures used by their QCDR instead of those on the PQRS measures list. In 2014, EPs would meet the criteria for satisfactory participation by reporting through the registry on at least nine measures covering at least three of the NQS domains, and reporting each measure for at least 50 percent of the EP's applicable patients. Additionally, for 2014 at least one of the measures must be an outcome measure. While we are pleased that CMS has moved forward with the QCDR reporting option, ASPS opposes to the proposal to increase the number of outcome measures required for reporting through a QCDR to three (or in lieu of three outcome measures, EPs can report at least 2 outcome measures and 1 resource use, patient experience of care, or efficiency/appropriate use measure). The requirement to report on nine measures across three quality domains is already burdensome for smaller specialties, and many smaller specialties are currently working to develop specialty-specific measures while simultaneously establishing a QCDR based on the initial requirements, finalized in 2014. Additionally, the number of outcome measures available to specialty societies is quite limited and it is premature to require the reporting of 3 outcome measures. We would like to emphasize that any modifications to requirements for reporting via a QCDR should be on hold until more specialties are able to participate in the program and meet the initial requirements.

Data Requirements

CMS has included a proposal to require EPs to report on measures 50 percent of the time for all applicable patients. A 50 percent requirement would force physicians to report on their entire patient population, which is more than is required for traditional PQRS reporting. This requirement represents a significant reporting burden for physicians with busy practices and/or for those whose registries are collecting longitudinal quality data. Additionally, the size of a sample needed for valid and reliable

results may vary based on the type clinical procedure as well as what is captured in the measure. Therefore, ASPS strongly urges CMS to provide more flexibility by incorporating the use of a sampling methodology, which will allow physicians participating in QCDRs to provide CMS with data on a statistically valid sample of patients, rather than on 50 percent of all applicable patients.

S-CAHPS

We appreciate CMS encouraging surgical specialties to include S-CAHPS measures in QCDRs but we continue to urge CMS to include the S-CAHPS as an individual measure in the PQRS program, consistent with the inclusion of the CG-CAHPS, as not all surgical specialties have established a QCDR and will be able to report the S-CAHPS through a QCDR in 2015.

If S-CAHPS is included in PQRS for individual reporting, it will be voluntary, which would allow physicians to select the patient experience of care survey that is most appropriate for their patient population. In the proposed rule, CMS acknowledges the importance of inclusion of the S-CAHPS in PQRS, noting that the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG-CAHPS) survey would not accurately reflect the care provided by single- or multispecialty surgical or anesthesia groups, as well as how the S-CAHPS expands on the CG-CAHPS by focusing on aspects of surgical quality, which are important from the patient's perspective and for which the patient is the best source of information.

However, CMS explains that due to the cost and time it would take to find vendors to collect S-CAHPS data, it is not technically feasible to include the S-CAHPS measure for the 2017 PQRS payment adjustment. This delay is in the best interest of the surgical patient. The NQF's Measure Applications Partnership has recommended the inclusion of S-CAHPS in PQRS for two consecutive years. It is atypical that two years later CMS explains that it is not technically feasible to include the S-CAHPS, particularly when CMS has already identified vendors to administer and collect CG-CAHPS data.^{1,2} The S-CAHPS has broad support across surgical specialties—the S-CAHPS Technical Advisory Panel (TAP) included 21 members from various specialty societies, and nine surgical specialties participated in the main field test conducted during the development of the survey, which included colon and rectal, ophthalmology, general surgery, orthopaedic, plastic surgery, otolaryngology, thoracic, urology, and vascular. Therefore, because the S-CAHPS follows the same collection mechanism as the CG-CAHPS, we strongly encourage CMS to prioritize the time and resources needed to include the S-CAHPS as a PQRS measure.

Use of External Entity

While ASPS appreciates the proposal to allow an entity that uses an external organization for purposes of data collection, calculation, or transmission to meet the definition of a QCDR, requiring that the written agreement be on file, as of January 1 of the year prior to the year for which the entity seeks to become a QCDR will prohibit specialty societies seeking to participate in the QCDR in 2015 from moving forward with participation. If CMS would like to move forward with this requirement, it would

¹ National Quality Forum. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. Available at: http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx.

² National Quality Forum. MAP 2014 Recommendations on Measures for More Than 20 Federal Programs. Available at: http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

be more feasible to delay this requirement until participation in a QCDR as of 2016. Otherwise, specialty societies will not have had any advanced notice of this requirement and will not have had the opportunity to meet this requirement for 2015.

Value-Based Payment Modifier (VM) and Physician Feedback Program

ASPS is disappointed to see the Agency is moving forward with implementation of the value based payment modifier program.

Payment Adjustment Amount

ASPS strongly opposes the potential increase in the downward adjustment under the VM, from -2 percent in CY 2016 to -4 percent in CY 2017 for groups and solo practitioners that do not meet satisfactory quality reporting requirements for PQRS. While we understand that Congressional action would be necessary to address the statutory mandates of the VM program, we believe CMS can and should control the pace of any penalties that are assessed. CY 2017 will be the first year that many physicians (solo practitioners and those in groups of less than 10 EPs) and all NPPs will be subject to the VM, and a large number of ASPS members work in small or solo practices. In addition, given that surgeons, in particular, will have a much harder time meeting the PQRS requirements, we urge CMS to maintain the current adjustment at -2 percent, or to gradually increase the downward adjustment by 0.5 percent, as done in previous years, for the EPs that do not meet PQRS requirements and for those that are low quality/high cost under the VM quality tiering framework. The proposed adjustment from -2 percent to -4 percent would be quite dramatic. Penalties assessed to already thin operating margins would only serve to force many of our members to make difficult decisions about the case-mix of their patients.

Potential Expansion of the Informal Inquiry Process to Allow Corrections for the VM

CMS proposes to expand a currently existing limited informal inquiry process for EPs subject to the VM to review and identify any possible errors prior to application of the VM. CMS also proposes to establish an initial corrections process that would allow for some limited corrections. For CY 2015, CMS proposes to classify a group or EP as “average” quality if CMS determines that the agency made an error in the calculation of the quality composite. CMS proposes to recompute the group or EP’s cost composite if the agency determines it made an error in the calculation. While we support CMS expanding the informal inquiry process, ASPS also believes that CMS should recalculate the quality and cost composites, rather than simply classifying groups or EPs as “average,” if an error is identified.

All-Cause Readmissions

Lastly, although we agree with the proposal to exclude the measure from the VM quality domain, ASPS believes that the proposal to increase the minimum number of cases for the All-Cause Readmissions measure from 20 to 200 is entirely too drastic. We believe that the increase should be more gradual and less drastic. This will allow CMS to determine the feasibility of increasing the minimum, in the future.

Summary

In summary, ASPS is pleased to see CMS has responded to the many requests of societies to increase transparency in the fee-setting process. However, we continue to be concerned by the potential for increase in the administrative and financial burden a typical small practice will incur under the Medicare

program and encourage CMS to begin dialogues with ASPS to identify alternative approaches that will allow solo and small practice physicians to continue to treat Medicare-eligible patients without significant financial repercussions to their practice.

ASPS appreciates the opportunity to offer these comments, and looks forward to working with CMS to ensure reimbursement is fair and adequate. Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Manager, at cfrench@plasticsurgery.org or at (847) 981-5401.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Murphy, Jr.", with a long horizontal line extending to the right.

Robert X. Murphy, Jr., MD – President, American Society of Plastic Surgeons

cc: Debra Johnson, MD – ASPS Board Vice President of Health Policy & Advocacy
Charles Butler, MD – ASPS Board Vice President of Research
Jeffrey E. Janis, MD – ASPS Board Vice President of Education
Martha Matthews, MD – Chair, ASPS Coding and Payment Policy Committee
Loree Kalliainen, MD – Chair, ASPS Health Policy Committee
Karol Gutowski, MD – Chair, ASPS Quality and Performance Measure