AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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March 1, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
200 Independence Avenue SW
Washington. DC 20201

*Via Electronic Submission:* episodegroups@cms.hhs.gov

**Re: Request for Information Regarding Episode Groups**

Dear Acting Administrator Slavitt:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) **Request for Information (RFI) on Episode Groupers**.

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 key areas of concern ASPS has identified in relation to the information shared in this RFI.

**Defining Episodes of Care**

MACRA gives CMS some latitude to create new care episodes in addition to using existing resource measures. ASPS is concerned that the Agency's plan to start the program by only repurposes existing measures, without defining and implementing new metrics, may create unintended hardships.

The forty-four conditions the Agency has proposed to include in the initial year of resource use scoring are problematic for several reasons. There are many conditions that may generate high spending, not because they are overused or overpriced, but because they are prevalent in a certain population. Additionally, there are conditions where variations in patients and the treatment they receive may make defining an episode difficult. For example, not all patients with breast cancer undergo reconstructive care in the same year as their mastectomy. Assigning them to a care episode based on the diagnosis of breast cancer may not capture all resources expended to treat the patient. As such, we encourage the Agency to consider specialty input to design conditions that may need unique resource-use episodes.

**Transitioning from the Value Modifier to New Resource Measures**

While the use of well-constructed episode groups might be a potential means of making more accurate comparisons of physician resource use; we respectfully remind the Agency that the actual impact of the

*current* Value Modifier program is still unknown. This is due, in part, to the fact that any impact of the program will be not recognized by solo practitioners and small group eligible providers until reimbursement is received in calendar year 2017.

Additionally, Quality and Resource Use Reports (QRUR) are not yet a routine feedback loop for this physician population, and any comparative performance information will not be meaningful, or received in time to make the necessary adjustments before the calendar year 2017 reporting has begun. Because the Agency has historically used a 2-year lag time for determining payment adjustments, we fear the mandated start date of calendar year 2019 may become especially punitive when calculating resource use reported for solo practitioners and small group eligible providers in 2017.

As such, we respectfully request the Agency use a phased-in approach, staggering the implementation of resource use calculation in the same manner used for the Value Based modifier program.

**Additional Administrative Burdens**

ASPS concurs that care coordination has the potential to not only improve quality, but also reduce duplicative resources. However, we remind the Agency that while many physicians routinely invest in after-hours care coordination, not all are currently eligible to report specific CPT codes designed to indicate care coordination. As such, the Agency may not currently be calculating resource estimates correctly, and without adjustments, may continue to inaccurately analyze resource use.

Additionally, phone calls and email used to ensure their patients receive all necessary services are not compensated under the Medicare program. As such, the totality of care coordination may not be adequately reflected in current or future resource use measures.

ASPS encourages the Agency to not only consider care coordination information already collected on claims, but to thoughtfully evaluate the options available to track resources without unduly burdening the physician community.

**Conclusion**

ASPS appreciates the opportunity to offer these comments, and we look 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,

David Song, MD – President, American Society of Plastic Surgeons

cc: Anne Taylor, MD – ASPS Board Vice President of Health Policy & Advocacy
Andrea Pusic, MD – ASPS Board Vice President of Research
Mark Villa, MD – Chair, ASPS Coding and Payment Policy Committee
Steven Bonawitz, MD – Chair, ASPS Health Policy Committee
William Wooden, MD – Chair, ASPS Quality and Performance Measurement Committee