AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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June 25, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1694-P
7500 Security Blvd, Mail Stop C4-26-05
Baltimore, MD 21244-1850

*Via Electronic Submission:* http://www.regulations.gov

**Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims**

Dear Administrator Verma:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) *Inpatient Prospective Payment System CY 2019 Proposed Rule* published in the May 7, 2018 *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. Our comments are as follows.

## Documentation of Admissions Orders

ASPS was pleased to learn of the Agency's intent to remove existing requirements that mandate written in-patient admission orders as a condition of payment. We understand that documentation and orders must exist for patients to be considered inpatients under the hospital Conditions of Participation, but believe that this step recognizes that when all the necessary information can exist based on the information available,

Medicare Administrative Contractors should not be denying payment for otherwise medically necessary services. We appreciate the work CMS is doing to reduce that existing policy creates, and look forward to identifying additional opportunities for reducing administrative burden and streamlining regulatory requirements.

**Addressing Administrative Burdens in Hospital Quality Reporting and Value-based Purchasing Programs**

The Agency is also proposing to make changes to several in-patient payment programs to eliminate overlap in measures and reporting. We concur that the Hospital Value Based Purchasing Program should focus solely on measurements not covered by the Hospital Readmission Reduction Program or the Hospital Acquired Conditions Reduction Program. Additionally, the proposed changes to the Hospital Inpatient Quality Reporting program are the appropriate first step in addressing measure overlap. We appreciate the work CMS has done to identify and reduce the administrative burden inherent in these programs.

**Rebranding of Meaningful Use**

For 2019, the Agency has proposed to rebrand the meaningful use program and introduces polices to make the program more flexible and less burdensome, including a shortening of the reporting period to 90-days.

While we appreciate the flexibility CMS had introduced into the required reporting period, we note with disappointment that the Agency continues to propose technology be certified to the 2015 edition of CEHRT as a requirement for participation in the Electronic Health Record meaningful use program. This requirement is problematic for several reasons including the lack of acknowledgement surrounding the struggle providers, vendors, and consultants continue to experience as they work to ensure products are triaged, fully tested and implemented, with staff trained and workflow adjustments validated to ensure safe, effective and efficient implementation and use of 2015 Edition Certified EHR Technology (CEHRT). We respectfully remind the Agency that specialty-focused CEHRT is virtually non-existent which is why the percentage of physicians in CEHRT (66 percent at last estimate) is much lower than hospitals. This is because, in order for the systems to work, they must be specified with specialty-specific needs.

Additionally, the lack of a coordinated communication plan about the proposed changes for the inpatient program compared to or contrasted against what we assume will be forthcoming changes to the Merit-based Incentive Payment System (MIPS) program requirements for the 2019 Medicare Physician Fee Schedule/Quality Payment Program make it difficult to provide significant feedback at this time.

As such, ASPS respectfully asks the Agency to consider hosting Town Hall meetings, listening sessions, or conference calls to provide education and training on the nuances of the two programs. We also request that the Agency not implement changes to the Hospital Promoting Interoperability program until further discussions, outside of any comment period, have occurred.

**Code Editor Changes**

The Agency is proposing several changes to the software edits used to detect coding errors, including updates to ensure diagnosis codes match gender edits. As an example, the Agency believes codes from the N35 (Urethral Stricture) code family should be flagged to routinely compare patient gender to the gender descriptor included in the specific ICD-10-CM code used to report urethral stricture.

Any major surgical procedure can produce post-operative complications. In patients undergoing gender confirmation surgery, urethral complications, including strictures and fistulas, are common after genital surgery. Should the use of a diagnosis code to indicate a stricture be reported on a claim prior to the

finalization of legal documents that are used to update gender identification on a driver's license and/or insurance policies, the assignment of gender-specific diagnosis codes will be problematic, and the probability of claim denials due to these suggested edits could be significant, requiring administrative workarounds.

ASPS acknowledges the use of software edits may help reduce inappropriate payments, and that there is existing Medicare policy in place to allow for reporting of condition code 45 (Ambiguous Gender Category) on inpatient or outpatient claims, as well as utilization of the -KX modifier on professional claims, which both allow gender-related edits to be bypassed. However, we respectfully ask the Agency to thoughtfully consider the unintended consequences of including gender edits for the ICD-10-CM codes in the N35 code family before implementing these proposed software edits.

**Price Transparency**

In this proposed rule, CMS indicates they will require hospitals to publish a machine-readable list of standard charges via public access sites on the internet by January 1, 2019. The Agency also seeks public comment on five key focus areas.

Based on a 2016 Medscape Medical News report that indicates those that do shop for price information does not, in itself, decrease healthcare spending based on data obtained as well as a paucity of literature that shows an increased demand in consumer shopping electronically for pre-treatment pricing, we can offer the following:

a) *The definition of standard charges.*

*As the Lewin Group noted in 2005[1], hospital charge setting practices are complex and varied and can be based on an individual hospital's market position, mission, ability to estimate costs and overall financial circumstances. These competing influences can produce charges which may not relate systematically to costs. Additionally,* dividend income, profits and losses from investments, asset write-downs and other non-operating revenue and expenses can impact the listed price per service.

*While most hospitals utilize charge master lists, which include every chargeable item in the hospital, unless a concerted effort has been made to use the same pricing structure, hospitals that utilize a second charge master for pharmacy charges may have significant disparities in the formulas used to identify and set costs and or mark-ups.*

*The issues identified in the study highlight the pitfalls then and still today when relying on posting of charges as a tool for empowering health care consumers. We concur that developing a standard format for posting and defining charges is a laudable goal, but believe that CMS efforts would be better focused on other issues if the ultimate goal of the Agency is to provide patients with information to help in the selection of health care providers.*

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1. Dobson, A. et al. (2005, December) A Study of Hospital Charge Setting Practices. http://67.59.137.244/documents/Dec05_Charge_setting.pdf

b) *The type of information that would be most meaningful for patients*

*We understand that CMS must implement a mechanism for hospitals to post their charges, but ASPS believes that CMS must provide a clear disclaimer that the data provided is not a guarantee of price. Instead actual cost may be higher or lower depending on many factors, including but not limited to treatment choice, actual services rendered, complications and the details of any insurance coverage. These lists should also include a caveat that there are no guarantees that insurance will provide coverage, and that ultimately the patient is responsible for costs not covered by an insurance payer. ASPS believes that information other than charges (e.g., estimated patient out of pocket costs) will be more helpful in moving patients to become informed consumers of health care.*

c) The need to discuss out-of-pocket costs prior to the furnishing of the service

*While we understand that there are operational complexities to providing patients with information about estimated out-of-pocket costs, we believe that this type of information would be much more valuable to patients than provided charges. In addition, as indicated in our response to the previous question, the patient should be informed prior to or during the admission process that they are ultimately responsible for any services not covered by insurance.*

*We also believe that in CMS' efforts to reduce administrative burdens on physicians and staff that the Agency be cautious in ensuring that it does not place undue burden on providers to communicate out-of-pocket costs. Providers will not have access to accurate information about health plan cost-sharing policies. This is a role that is much more appropriately filled by insurance providers (including the Medicare program itself).*

**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,

Jeffrey Janis, MD
President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS Board Vice President of Health Policy & Advocacy
Andrea Pusic, MD – ASPS Board Vice President of Research
Steve Bonawitz, MD – Chair, ASPS Healthcare Delivery Subcommittee

Aamir Siddiqui, MD – Chair, ASPS Quality and Performance Measurement Committee
Paul Weiss, MD – Chair, ASPS Coding and Payment Policy Subcommittee