September 6, 2016

Centers for Medicare & Medicaid Services
US Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington DC 20201

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

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; etc.; CY 2017 Proposed Rule CMS-1656-P

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) Proposed Rule on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment; CY 2017 Proposed Rule published in the July 14, 2016 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.

**Proposed Additional Comprehensive APCs for CY17**

In this proposed rule, CMS is planning to continue to apply the C-APC payment policy methodology for CY2017 and subsequent years, adding an additional 25 C-APCs for CY 2017.

While we recognize the Agency reviews items and services within an APC group to determine comparability of the use of resources via the “2 times rule,” it is the opinion of ASPS that combining surgical procedures that are clinically dissimilar and packaging payment for all adjunctive services and procedures into the most
expensive procedure is inappropriate and may have unintended ramifications on the patients’ care, including access from the surgical perspective.

Treatment decisions should rely on a surgeon’s expertise and training, rather than cost. The continued use of comprehensive APCs will detract from quality of care, focusing instead only on cost. Any short term cost savings will increase costs in the longer term and negatively impact not only surgeons and hospitals, but most importantly patients. APCs should include services that are alike not only in terms of resource use but also in terms of clinical similarity, and we believe that CMS should reevaluate its packaging policy to ensure that clinically dissimilar are not lumped into the same APC.

**Proposed High Cost/Low Cost Threshold for Packaged Skin Substitutes**

ASPS notes the Agency has once again revised their reimbursement formula for several skin substitutes used in the field of plastic surgery, and respectfully requests a more predictable, long-term approach to calculating reimbursement for these products. We are deeply concerned that the continuous changes to the reimbursement formula for skin substitutes has already and will continue to force surgeons to make treatment decisions based on cost, rather than their experience, expertise, and careful analysis of potential risks, benefits, alternatives, and consequences to the patient.

To ensure quality care, ASPS encourages the Agency to develop a process that provides more stability in the reimbursement calculations for skin substitute products.

**Requirements for the Hospital Outpatient Quality Reporting (OQR) Program**

CMS is not proposing any change to the CY2018 and CY2019 Hospital OQR program measure sets. The Agency is however, proposing a total of seven new measures related to outpatient care - two of which are claims-based measures and five of which are Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures for the CY2020 payment determination and subsequent years.

ASPS is concerned that OAS CAHPS will be an undue burden to facilities. Adding increased burdens will increase costs with unclear benefits.

**Proposed Removal of HCAHPS Pain Management Dimension**

The nation has become increasingly aware of an epidemic of prescription opioid abuse over the past year, and CMS has responded to this concern by proposing a change to evaluation of the HCAHPS survey-based patient experience measure in the hospital value-based purchasing program.

ASPS, along with other stakeholders, have long been concerned that the Pain Management dimension questions on the HCAHPS survey were inappropriate for this pay-for-performance program due to their focus on pain control rather than communication and the potential perverse incentives to prescribe more in order to score higher on performance. We applaud CMS for agreeing to remove these questions from the HCAHPS survey.

We understand that CMS intends to replace the current Pain Management dimension questions with alternative pain management questions and respectfully request that as the Agency works to develop these questions, it keep in mind the sensitive balance it must strike with measuring pain and ongoing concerns with the epidemic of prescription opioid abuse.
Proposed Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

The Agency is proposing to implement numerous changes to the objectives and measures that hospitals must report under the Medicare and Medicaid Hospital EHR Incentive Program, including the elimination of Clinical Decision Support and Computerized Provider Order Entry objectives and measures and the reduction of thresholds for a subset of objectives and measures in Modified Stage 2 for 2017 and in Stage 3 for 2017 and 2018 so that they better align with changes proposed for eligible professionals (EPs) under the MACRA rule. CMS also proposes a change to the EHR reporting periods in 2016 for returning participants from the full CY2016 to any continuous 90-day period within CY2016, which would apply to all EPs and eligible hospitals.

ASPS agrees with these decisions and would like to thank CMS for recognizing and adjusting these guidelines to better accommodate the physician population, specifically plastic surgeons. We do ask however, for the Agency to provide education about the 90-day reporting period for CY2016 prior to the release of the final rule, to ensure providers can adjust their reporting accordingly.

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,

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President, American Society of Plastic Surgeons

cc: Anne Taylor, MD – ASPS Board Vice President of Health Policy & Advocacy
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