

September 11, 2017

**VIA E-MAIL FILING**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1676-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

**RE: CY 2018 Medicare Physician Fee Schedule Proposed Rule**

The American Association of Hip and Knee Surgeons (“AAHKS”) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) on its Medicare Physician Fee Schedule (“MPFS”) proposed rule for calendar year 2018 (hereinafter referred to as “CY 2018 MPFS proposed rule” or “proposed rule”).

AAHKS is the foremost national specialty organization of more than 3,000 physicians with expertise in total joint arthroplasty (“TJA”) procedures. Many of our members conduct research in this area and are experts on the evidence based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS offers these comments in anticipation of continued close collaboration with CMS to ensure Medicare physician payment reforms benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of the CY 2018 MPFS proposed rule:

**I. Proposed Payment Reduction for Services Furnished by Nonexcepted Off-Campus Provider Based Departments (“PBDs”)**

CMS is proposing to change the MPFS payment rates for services in nonexcepted PBDs from 50% of the Medicare Hospitals Outpatient Prospective Payment System (“HOPPS”) payment rate to 25% of the HOPPS rate. CMS characterized establishing the MPFS as the appropriate alternative payment system for nonexcepted off-campus PBDs as only one step towards implementing Section 603 of the Bipartisan Budget Act of 2015. CMS also considered it necessary to estimate and adjust for the relativity of these services compared to MPFS services.

CMS established an interim payment rate (the “PFS Relativity Adjuster”) for these services for 2017, estimating that scaling the HOPPS payment rates by a “best estimate” of 50% would “strike an appropriate balance” that avoided potentially underestimating the relative resources involved in furnishing services in nonexcepted off-campus PBDs as compared to the services furnished in other settings for which payment was made under the MPFS. The PFS Relativity Adjuster consists of established site-specific rates under the MPFS for the technical component of the broad range of nonexcepted items and services furnished by nonexcepted off-campus PBDs to be paid under the MPFS that was based on the OPPS payment amount for the same items and services, scaled downward by 50%.

CMS proposes the 2018 PFS Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25% of the HOPPS payment rate. CMS identified this level by making a code-level comparison for the service most commonly billed in the off-campus PBD setting under the HOPPS: a clinic visit reported using HCPCS code G0463. In order to determine the analogous payment for the technical aspects of this service under the MPFS in nonfacility settings, CMS compared the CY 2017 HOPPS national payment rate for HCPCS code G0463 (\$102.12) to the difference between the nonfacility and facility MPFS payment amounts under the MPFS using 2017 rates for the weighted average of outpatient visits (CPT codes 99201-99205 and CPT codes 99211-99215) billed by physicians and other professionals in an outpatient hospital place of service.

**AAHKS Comment:** CMS should not implement a 25% PFS Relativity Adjuster for 2018. Maintaining the 50% level as the interim policy until precise data is available to CMS to better identify and value nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals.

CMS explicitly implemented the 50% rate as a transitional policy because such data was insufficient at the time. If such data remains unavailable for use in 2018, CMS should maintain the current transitional policy. The proposed 25% rate is based solely on the comparison for the visit services that reflect greater than 50% of services billed in off-campus PBDs. CMS acknowledges that this comparison is imperfect and that the rates for other services vary greatly between the HOPPS and MPFS. Further, CMS acknowledges that there are other factors, including the specific mix of services furnished by non-excepted PBDs, policies related to packaging of codes under HOPPS, and payment adjustments like MPPRs and bundling under the MPFS that rely on empirical information about whether or not codes are billed on the same day, that contribute to the differences in aggregate payment amounts for a broader range of services.

For these reasons a 25% rate applied to all nonexcepted items and services furnished by all nonexcepted off-campus PBDs risks undervaluing certain items and services that, while not the highest volume of billed services, are still important to maintain operating PBDs. Planning for consistent provision of services in PBDs would be imperiled by frequent, wide variation in reimbursement. CMS should focus its efforts on developing the most accurate, data-based final payment rates rather than proposing frequent swings in the interim rate based on projections.

## **II. Proposed Modifications to the Satisfactory Reporting Criteria for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment**

CMS proposes to lower the required Physician Quality Reporting System (“PQRS”) reporting requirement from 9 measures across 3 NQS domains, to only 6 measures with no domain or cross-cutting measure requirement. For group practices, this would apply to the reporting through qualified registries, QCDRs, direct EHR products, and EHR data submissions vendor products.

Further, CMS proposes to revise § 414.90(j)(9)(viii) to provide that group practices are not required to may administer the CAHPS for PQRS survey. CMS intends this change to create consistency with the upcoming data submission criteria for the MIPS quality performance category, under which groups may voluntarily elect to participate in the CAHPS for MIPS survey.

**AAHKS Comment:** We support these proposed changes. We appreciate that CMS is using its discretion in the last year of the PQRS to synchronize its reporting requirements with those of MIPS. These changes will markedly lessen the burden in time and money on physicians and practices as they transition to MIPS for its first payment year in 2019.

## **III. Value-Based Payment Modifier and Physician Feedback Program**

### **a. Quality-Tiering for Groups and Solo Practitioners in Category 1**

For the last year of the program, CMS proposes to hold all groups and solo practitioners who are in Category 1 (those meeting the criteria to avoid payment adjustment) harmless from downward payment adjustments based on the Value Modifier (“VM”). This proposal would apply to groups and solo practitioners who would have otherwise received downward adjustments based on their quality composite score and/or cost composite score.

**AAHKS Comment:** We support this proposed change. We appreciate that CMS is using its discretion in the last year of the PQRS and VM to ease the transition to MIPS. CMS states that one of the reasons for this proposal is that it is possible that groups and solo practitioners may have selected fewer or different PQRS measures to report or may have chosen to report through a different PQRS reporting mechanism, which could have resulted in a higher quality composite score under the VM.

We believe there are additional reasons that justify this change. First, as this is the final year of the VM, we believe there is little to gain from penalizing physicians for performance under a quality system that Congress chose to replace. Physicians’ time in 2018 will be better spend focusing on delivering the best care possible to their patients and preparing for the burdens of the new MIPS system. Providers should not be distracted from care, or put time and energy into, quality performance for two separate systems.

Second, the VM adjustments have been flawed to begin with due to their lack of risk stratification. Under VM, physicians have been at risk of adverse quality scores on certain measures due to the high proportion of complicated, high-risk beneficiaries they may treat. We have performed extensive education of CMS on the need for appropriate risk adjustment or risk stratification for quality measures under the MIPS program and alternative payment models. AAHKS members have been penalized under the VM for treating the most vulnerable and complex patients. CMS should utilize the last year before MIPS payment adjustments to add appropriate risk adjustment to the program.

**b. Automatic Downward Adjustments for Groups and Solo Practitioners in Category 2**

In the last year of the program, CMS proposes to reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who have not avoided the payment adjustment) to negative 2% (down from 4%) for groups with 10 or more eligible providers (“EPs”) and at least one physician, and negative 1% for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

**AAHKS Comment:** We support this proposed change. CMS states that this proposal is intended to smooth the transition into MIPS. We appreciate that CMS is using its discretion in this way. The total maximum downward adjustment in 2017 under the PQRS and VM programs combined is negative 6%, while the maximum downward adjustment under MIPS in 2019 is negative 4%. As stated earlier, we believe there is little to gain from penalizing physicians at a higher level in the final year of a program that Congress chose to replace.

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AAHKS appreciates your consideration of our comments. If you have any questions, you can reach me at [mzarski@aahks.org](mailto:mzarski@aahks.org), or you may contact Joshua Kerr at [jkerr@aahks.org](mailto:jkerr@aahks.org).

Sincerely,



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