AAHKS
AMERICAN ASSOCIATION OF
HIP AND KNEE SURGEONS

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August 28, 2014

Ms. Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Payment Policies under the Proposed Physician Fee Schedule for CY 2015 [CMS-1612-P]

Dear Ms. Tavenner

The American Association of Hip and Knee Surgeons (AAHKS) is a national association of orthopaedic surgeons formed to advance and improve hip and knee patient care through leadership in education, advocacy and research AAHKS is committed to promoting high-quality care for all of our patients, including Medicare beneficiaries. We therefore appreciate this opportunity to provide comments on the proposed calendar year (CY) 2015 Medicare Physician Fee Schedule (MPFS) proposed rule (Proposed Rule), concentrating on provisions impacting the provision of orthopaedic services to Medicare beneficiaries.

In brief, our comments are as follows:

- Potential Reduction in Conversion Factor. AAHKS is concerned about the potential impact of a more than 20 percent across-the-board payment cut that could be triggered on April 1, 2015. While we agree that a legislative solution ultimately is necessary to solve the recurring sustainable growth rate (SGR) problem and ensure predictable and reasonable payments under the MPFS, we urge CMS to work with the medical community to identify administrative steps that may be taken to mitigate the impact of the cuts in the absence of timely Congressional action.

- Potentially Misvalued Services/Finalize Interim RVUs for Total Hip and Total Knee Procedures. We appreciated that CMS adopted less of a reduction in work relative value units (RVUs) than the AMA Specialty Society Relative Value Update Committee (RUC) recommended for 2014. We believe the CMS interim value comes closer to reflecting the resources associated with total hip and total knee arthroplasty. Given the need to achieve a level of stability in payment for these critical services, and to avoid disruptive year-to-year swings, we strongly recommend that CMS make no further reductions as you finalize these interim values in the final 2015 MPFS rule. Going forward, AAHKS appreciates the opportunity to work with CMS and other stakeholders to develop more objective tools for valuing physician services in general.

- Transparency in MPFS Ratesetting. We commend CMS for responding to concerns of AAHKS and others about its use of interim values to change established rates without a meaningful and timely public comment opportunity. We agree that CMS should maximize public review and comment opportunities when contemplating significant payment changes that impact procedures

currently being performed by physicians. At the same time, we agree that CMS should preserve a mechanism to accelerate valuation of codes for new services to promote beneficiary access to medical advances.

- Global Period. We do not support the proposal to transform all 10- and 90-day global codes to 0-day global codes for orthopaedic codes. The CMS concerned about the accuracy of post-surgical visit assumptions for particular procedures would be more appropriately addressed by CMS working with impacted specialty societies or undertaking reviews of those procedures under the existing review framework, rather than essentially ending the concept of the global surgical period.

- Quality Reporting Measures. CMS is proposing to add two measures to the Physician Quality Reporting System (PQRS) Total Knee Replacement Measure Group for 2015 and beyond: (1) Documentation of Current Medications in the Medical Record, and (2) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. AAHKS accepts the proposed measures, and recommends potential revisions for future years. We also appreciate that CMS is providing early notice that it is considering creating a Total Knee Replacement (TKR) composite group for reporting on Physician Compare, and we look forward to carefully reviewing the measure specifications and how the data will be reported to the public. We hope to work with CMS to educate orthopaedic surgeons on implementation of the new composite measure.

- Physician Value-Based Payment Modifier. CMS proposes a major expansion of the Physician Value-Based Payment (VBP) Modifier program for 2017. We believe that CMS is proposing too accelerated a schedule for implementing the final stage of this program. We urge CMS to proceed carefully in adopting any future expansion, and work with the provider community to improve education about the VBP parameters.

- Open Payments/Physician Payment Sunshine Act Changes. We are concerned that CMS's proposed changes to the regulations implementing the Physician Payment Sunshine Act would actually result in more confusion for consumers, and could discourage participation in important medical education opportunities. We urge CMS not to finalize these proposals.

I. Potential Reduction in Conversion Factor

The Proposed Rule provides for a 0.0 percent update the MPFS conversion factor for the first three months of 2015, in conformance with the Protecting Access to Medicare Act of 2014 (PAMA). The Proposed Rule does not set forth the conversion factor that will apply effective April 1, 2015, when the temporary PAMA update expires. CMS has estimated, however, that the statutory Sustainable Growth Rate (SGR) formula would trigger a 20.9 percent cut for 2015 if no other legislative steps are taken.

We are deeply concerned about the impact that such a dramatic cut in MPFS payments would have on Medicare beneficiaries and health care providers alike. In the face of severe underpayments that undermine efforts to provide the highest quality of care, many providers simply will not be able to continue to serve Medicare beneficiaries, and patient access to care could be compromised.

We agree that a legislative solution ultimately is necessary to solve the recurring SGR problem and ensure predictable and reasonable payments under the MPFS. Under the current SGR formula, physician payment updates are tied to arbitrary factors outside of the control of any single provider, with no direct relationship

between quality of care and reimbursement. For too long, the SGR formula's steep cuts in annual payments – while typically overridden by Congress -- have caused unnecessary uncertainty and anxiety for both patients and physicians.

In the absence of a timely legislative solution, however, we urge CMS to work with the medical community to identify administrative steps that may be taken to mitigate the impact of the cuts, whether through a multi-year phase-in, use of waiver authority, or other emergency steps within CMS's authority. CMS also should maximize flexibility for physicians with regard to participation agreements in light of the considerable uncertainty surrounding 2015 rates over the course of the year.

II. Potentially Misvalued Services/Finalize Interim RVUs for Total Hip and Total Knee Procedures

In the Proposed Rule, CMS does not discuss its ongoing review of the work RVUs for CPT code 27130 (total hip arthroplasty) or CPT code 27447 (total knee arthroplasty), which are currently valued based on interim RVUs established in the final CY 2014 MPFS rule. As you know, we had serious concerns about the processes used to establish these rates and the accuracy of certain data used by the RUC in developing its recommendations.

We therefore appreciated that CMS adopted less of a reduction in work RVU values than the RUC recommended, for 2014. We believe the CMS interim value comes closer to reflecting the resources associated with total hip and total knee arthroplasty. Given the need to achieve a level of stability in payment for these critical services, and to avoid disruptive year-to-year swings, we strongly recommend that CMS make no further reductions as you finalize these interim values in the final 2015 MPFS rule.

Going forward, AAHKS appreciates the opportunity to work with CMS and other stakeholders to develop more objective tools for valuing physician services, including the most appropriate reconciliation for the conflicting data and alternatives to the use of surveys for determining time values. While we recommend that CMS ensure a period of stability with regard to the values for hip and knee arthroplasty for several years given the tremendous resources just expended by physicians and CMS alike on valuation of these codes, we are hopeful that more accurate valuation methodologies will benefit CMS as it reviews the relative values of any procedures reimbursed under the MPFS in the future.

III. Transparency in MPFS Ratesetting

AAHKS previously expressed its strong concerns about the use of an interim final rule to cut Medicare reimbursement for established medical procedures – especially total joint replacement procedures. This practice -- which has become more common as a result of the expansion of CMS's potentially misvalued code reviews – deprives stakeholders of a meaningful opportunity to analyze the data or present additional information to the Agency before the rate cuts are enacted. When CMS announces cuts in a November interim final rule, physicians have only weeks to review any new recommended values and formulate a response before the values – and corresponding reduced rates – go into effect on January 1. While CMS offers a limited comment period, CMS typically does not consider making any adjustments to the interim RVUs in response to those comments a subsequent year. AAHKS therefore has recommended that CMS to provide stakeholders with an open and transparent process to consider any future proposed payment revisions for these procedures.

We are pleased that CMS has responded to AAHKS's concerns about its use of interim values to change established rates without a meaningful and timely public comment opportunity, although we note that CMS's process unfortunately comes too late to enhance transparency with regard to the dramatic rates reductions for total knee and total hip arthroplasty procedures imposed through the 2014 interim final rule. Under the Proposed Rule, beginning with the CY 2016 rulemaking process, CMS would include in the proposed rule the proposed values for all services for which it has RUC recommendations by January 15, 2015. If CMS does not receive the RUC recommendations to change established RVUs by January 15th of a year, CMS would delay revaluing the code for at least one year. For new codes that describe wholly new services, if CMS does not have RUC recommendations in time for the proposed rule, CMS would establish interim values in a final rule with comment period, as under current policy.

Given our commitment to transparency in the valuation process, we agree that CMS should maximize public review and comment opportunities when dramatic payment changes are being contemplated that impact procedures currently being performed by physicians. At the same time, we agree that CMS should preserve a mechanism to accelerate valuation of codes for new services to promote beneficiary access to medical advances. We encourage the AMA and CMS to continue to work together to establish more coordinated review schedules and promote a smoother, more transparent review process for all CPT codes.

IV. <u>Changes to the Global Period</u>

In the Proposed Rule, CMS proposes transforming all 10- and 90-day global codes to 0-day global codes. Under this proposal, CMS would include in the value for these procedures all services provided on the day of surgery, and pay separately for visits and services actually furnished after the day of the procedure. This policy would be effective beginning in CY 2017. CMS states that it is proposing this because of its concerns about the accuracy of global surgery period payments. The Agency believes the typical number and level of post-operative visits during global periods can vary greatly across Medicare practitioners and beneficiaries.

We maintain that a blanket 0-day policy is unwarranted for orthopaedic total joint procedures. The global period is an important concept for orthopaedic surgical procedures, encouraging appropriate follow-up care, providing a settled bundled payment structure for surgeons, and ensuring copayment certainty for patients. In fact, the concept of a bundle of follow-up services that are typically associated with surgery is one of the reasons major orthopaedic procedures such as total joint procedures have been featured in the earliest bundled payment initiatives.

Post-operative hospital and office visit resources are currently part of the RUC valuation; revising the global period would necessitate disruptive re-review of numerous surgical procedures that have recently undergone review. Moreover, CMS would need to establish values/reimbursement for a wide range of miscellaneous post-operative care that would be unbundled and separately-reported under this proposal (e.g., dressing changes, removal of sutures/staples/casts, catheter and tracheostomy tube care, among many others). Likewise, the administrative burden associated with the additional claims this proposal would generate could be staggering for surgical practices and CMS itself.

The CMS concern about the accuracy of post-surgical visit assumptions for particular procedures, would be more appropriately addressed by working with impacted specialty societies or undertake reviews of those procedures under the existing review framework, rather than essentially end the concept of the global surgical period. If CMS does nevertheless adopt this proposal, we urge the Agency to delay implementation to allow for the

systemic, accurate review and valuation of global codes and the miscellaneous post-operative services. Likewise, CMS should concurrently broaden coverage of and payment for alternative means of physician follow-up with surgical patients, such as allowing physicians to bill for all post-surgical telephone consultations, post-op check ins, and clinical care-related email communication with patients.

V. Quality Reporting Programs

CMS is proposing to update its PQRS measures groups to increase the minimum number of measures to six measures, which would necessitate the addition of two measures to the Total Knee Replacement Measure Group for 2015 and beyond: (1) Documentation of Current Medications in the Medical Record, and (2) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. AAHKS accepts the six measures in the total knee replacement measure group, including the two new proposed measures. AAHKS agrees that tobacco use is an important public health issue. Our experience with patients indicates that the number of Medicare beneficiaries who use tobacco is decreasing. Therefore, in future years, AAHKS believes it would be more appropriate to replace the tobacco use measure with a measure similar to the Functional Status Assessment for Knee Replacement quality measure to be used in CMS's EHR Incentive Program for Eligible Professionals.

CMS also is considering expanding public reporting on Physician Compare by making a broader set of quality measures available for publication on the website. CMS is considering creating composites, including a Total Knee Replacement (TKR) group, and publishing composite scores on Physician Compare, if technically feasible, beginning in 2016. We appreciate CMS providing early notice that these changes are being contemplated and we await additional details. In particular, we look forward to carefully reviewing the TKR group specifications and how the data will be reported to the public to ensure that information is clinically relevant and clearly presented to beneficiaries. We also would like to work with CMS to ensure that orthopaedic surgeons subject to the measure are fully educated on the workings of the program, including the evaluation period and measure specifications.

VI. Physician Value-Based Payment (VBP) Modifier

CMS proposes a major expansion of the VBP modifier program for 2017, including expanding the program to physicians in groups with two or more eligible professionals (EPs) and to physicians who are solo practitioners. CMS also would increase the potential payment adjustment under the VBP program for 2017, with physicians being subject to a potential 4.0% upward or downward adjustment.

We believe that CMS is proposing too accelerated a schedule for implementing the final stage of this program. Given that physician payments have been held to artificially low levels over recent years (far below the cumulative rate of inflation), the penalty associated with this new program is disproportionately high. We urge CMS to "go slow" in adopting any future expansion, and work with the provider community to improve education about the VBP parameters.

VII. Open Payments/Physician Payment Sunshine Act Changes

CMS is proposing changes to the regulations implementing the Physician Payment Sunshine Act, which require pharmaceutical and medical device manufacturers and group purchasing organizations (GPOs) to submit data to CMS on their financial relationships with physicians and teaching hospitals. This data will be made publicly available on the CMS Open Payments website. Among other things, CMS is proposing to require reporting of the marketed name – rather than the general therapeutic area or product category -- of the drug, device, biological, or medical supply related to the payment being reported. CMS also is proposing to delete a reporting exclusion for certain payments made to speakers at accredited continuing medical education (CME) events.

AAHKS supports efforts to increase transparency. We are concerned, however, that these proposals would actually result in more confusion for consumers, and could discourage participation in important CME opportunities. With regard to reporting marketed name of devices, we agree with CMS's observations in the February 8, 2013 final Sunshine Act rule that flexibility is needed in reporting "devices where the product name is less recognizable to consumers." Moreover, CMS noted that reporting a therapeutic area or product category was appropriate since a single device may actually be comprised of multiple devices. Because of the practical difficulties associated with identifying an appropriate "marketed name" of a device, the confusion CMS has acknowledged it could cause for consumers, and the additional review and verification efforts it would impose on physicians, we urge CMS to abandon this proposal.

We also object to CMS's proposal to delete a reporting exclusion for certain payments made to speakers at accredited CME events. This proposal could undermine support for important educational activities that promote high-quality care. If CMS is concerned that its specific regulatory language tacitly endorses particular organizations sponsoring CMS events, we urge CMS to work with industry to find a less disruptive path that generalizes the accreditation standards for such events.

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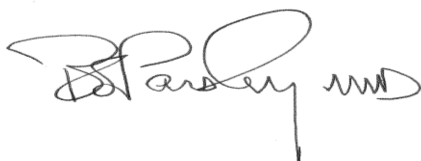
AAHKS appreciates your consideration of our comments. We would be pleased to discuss any of these issues with you in greater depth. You can reach me at brian.parsley@hosphysicians.com, or you may contact Michael Zarski, JD at mzarski@aahks.org.

Sincerely,



Brian S. Parsley, MD
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