September 4, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1600-P,
P.O. Box 8016,
Baltimore, MD 21244-8016

Subject: CMS-1600-P Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determination and Appeals

Dear Ms. Tavenner:

The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to comment on the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determination and Appeals rule published in the July 8, 2013 Federal Register.

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)/AMBULATORY SURGERY CENTER (ASC) PAYMENT POLICIES
The proposed OPPS rule would update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDS) and ambulatory surgical centers (ASCs) beginning January 1, 2014. Under the proposed OPPS rule, HOPDS will receive an increase of OPPS rates of 1.8 percent, and ASCs will receive an increase of 0.9 percent.
Payments for ASCs continue to be updated annually based on the Consumer Price Index of 1.4% minus a multifactor productivity adjustment of 0.5% for urban centers, while the HOPD update is based on the “hospital market basket.” The Consumer Price Index for All Urban Consumers (CPI-U) is not a good indicator of costs of goods affecting ASCs. Using the CPI-U methodology creates a volatile update factor that does not accurately predict ASCs costs. Accordingly, AAOS continues to urge CMS to use the hospital market basket, aligned with the HOPD productivity adjustment, to update the ASC payment system.

The AAOS is concerned that the relationship between ASC and HOPD rates continues to further diverge with these proposed rule policies. The gap between the two payment systems is creating financial incentives to use the HOPD rather that the ASC setting, even if the ASC setting is more appropriate for the patient.

Outpatient procedures performed at the hospital can be less efficient and more costly than those performed at free standing ASCs. CMS policy, which gives more dollars to hospitals, sustains that inefficiency and does not result in adding value to the system. The combined impact of differential policies results in a flawed system that may perpetuate inefficiency and increase Medicare costs. AAOS believes that using the same factor to update both systems would be a tool for CMS to use to facilitate continued utilization of these efficient, lower-cost ASCs.

HOSPITAL OUTPATIENT EVALUATION AND MANAGEMENT SERVICES

CMS proposes to restructure how outpatient hospitals code evaluation and management services performed in the outpatient setting or the emergency department within an outpatient setting. Current coding policy follows the standard Current Procedural Terminology (CPT) structure. However, for CY 2014, CMS is proposing to require hospitals to code all evaluation and management services with a single Health Care Professional Coding System (HCPCS) code with an assigned Ambulatory Payment Classification (APC) for three categories: clinic visits (currently coded as CPT/HCPCS codes 99201-99205 and 99211-99215), “type A” emergency department visits (currently coded as CPT/HCPCS codes 99281-99285) and “type B” emergency department visits (currently coded as CPT/HCPCS codes G0380-G0385). The AAOS believes this proposal, while well-intentioned, is unlikely to result in positive changes, either in terms of cost savings, or improved patient care. It is unclear why CMS feels it is necessary to implement these changes as there has not
been any indication by the agency or by analysts that evaluation and management coding in outpatient hospitals was problematic.

There are several potential negative consequences to the proposal. Firstly, there is the risk that Medicare and Medicaid patients may receive less comprehensive care, with less face-to-face time as hospitals have no way of accounting for the additional resources employed in longer and more intense patient encounters. Furthermore, outpatient facilities with higher percentages of traumatic and acute care case-mixes would be disadvantaged, thus punishing the outpatient facilities providing the most critical and time-sensitive care.

The AAOS is also concerned that, if implemented, the proposal would reduce granularity for tracking and research purposes since there would be no way to differentiate between levels of evaluation and management services in the outpatient setting under the proposal. Given that CMS is committed to the transition to ICD-10 in October 2014 for the purpose of increasing granularity over ICD-9, the proposal to collapse evaluation and management services into single categories runs contrary to the stated goals of the agency to improve transparency and granularity in coding. More specifically, this proposal may disrupt any future assessment of the cost and quality of evaluation and management services provided in differential settings.

Given the lack of basis for pursuing changes, the AAOS recommends that CMS abandon the proposal and maintain their current coding and payment structure for evaluation and management services furnished in hospital outpatient settings. We believe the current approach, while imperfect, does allow for identification and differentiation for lower complexity and higher complexity services.

**COMPREHENSIVE APCS FOR “DEVICE DEPENDENT” APCS**

CMS proposes a major restructuring of “device dependent” APCs (device dependent APCs are HCPCS’ codes that always include the insertion of a specified device) to create 29 device department comprehensive APCs that would bundle pre and post-operative components of care such as drugs, biological and radiopharmaceuticals that are used in a diagnostic test or as supplies or devices within the surgical procedure, diagnostic laboratory tests, “add-on” codes, ancillary services such as therapy, and device removal procedures. This is considerably different from the current payment methodology for these device-dependent services which provides a pass-through APC for each device. The intent of the
proposal is to provide a comprehensive payment that incentivizes efficient use of inputs for surgical procedures.

While the AAOS is supportive of efforts by CMS and other payers to create incentives for efficient resource utilization, and while the AAOS appreciates that CMS exempted 10 device-dependent services, we also caution the agency to consider a more incremental approach. For instance, we believe CMS could begin with 4 or 5 device dependent APCs and determine whether their proposed “bundles” are accurate and productive and then apply these lessons to additional device dependent APCs. We believe the volume of services affected by this proposal is large and the impact too unpredictable to justify this large change.

INCREASED PACKAGING FOR IMAGING SERVICES

In the proposed rule, CMS asks for input from stakeholders on the potential packaging of imaging services into associated surgical packages. The rule makes clear the agency is not considering any policy in this area for FY 2014, however, they may wish to propose changes for FY 2015. The AAOS believes that packaging of imaging services with associated surgical services may have a negative impact on patient care furnished in the outpatient setting. We believe, that while it could generate some limited savings and efficiencies, it also would create several negative consequences, chief among them, the potential that Medicare and Medicaid patients will not receive the correct or necessary imaging services as outpatient facilities will be incentivized to use less expensive and potentially less beneficial imaging services. If implemented, it would also remove any incentives for outpatient hospitals to invest in the maintenance and upgrading of their imaging services. We believe these and other potential changes would negatively impact patient care.

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Thank you for considering our comments on these important matters. If you have any questions on our comments, please do not hesitate to contact Graham Newson, AAOS Director by email at newson@aaos.org.
Sincerely,

Joshua J. Jacobs, MD
President, American Association of Orthopaedic Surgeons

cc: Karen Hackett, FACHE, CAE, AAOS Chief Executive Officer