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Andrew M. Slavitt,
Acting Administrator,
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1631-FC,
P.O. Box 8013,
Baltimore, MD 21244-8013

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 [CMS-1631-FC]

On behalf of our nearly 15,000 members in the United States, the American Urological Association (AUA) welcomes the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for calendar year (CY) 2016 final rule. The AUA is a leading advocate for the specialty of urology, providing invaluable support to the urologic community as it pursues its mission of fostering the highest standards of urologic care through education, research and the formulation of health policy. As CMS prepares final payment rates and policy changes for the coming year, we offer the following comments for consideration.

CY 2016 Interim Final Codes

Laparoscopic Radical Prostatectomy (CPT Code 55866)
In the final rule, CMS reduced the work RVU for CPT code 55866 (Laparoscopic, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) from 32.06 to 21.36 for CY 2016, representing a decrease of more than 33 percent. The AUA wholeheartedly disagrees with CMS that an interim final work RVU of 21.36 is an appropriate valuation based on the time and the resources typically used to furnish the procedure. CMS should accept the RUC recommendation to reduce the value to 26.80.

We are very concerned that CMS used less than the 25th percentile of the
RUC survey to determine that 55866 was comparable to 55840 (Prostatectomy, retropubic radical, with or without nerve sparing). Although 55866 states "...includes robotic assistance when performed" the descriptor unfortunately describes two very different procedures in one code. The vast majority of radical prostatectomies are performed with the robot, not open and not laparoscopic. Although the outcomes are the same, removing the entire prostate for malignancy, the procedures are completely different. CPT code 55866 requires more skill and competency even though the survey respondents indicated that the time to perform both surgeries is the same for the typical patient.

The intensity scoring by the survey respondents determined that 55866 was more complex than 55840. AUA members chose CPT code 55840 from the key reference list because this was the closest procedure to "removing a prostate", however the physician work of the two procedures is totally different. The RUC instructions advise respondents to choose the code that is closest in work to the surveyed code and then determine the work RVU based on the key reference code. There was no laparoscopic/robotic code on the reference list, so by default 55840 was chosen because the outcome was the same. CMS should not discount the survey intensity and complexity comparison gauged by the respondents by choosing to crosswalk to a lower value without providing clinical evidence to support that the physician work is exactly the same.

In addition to 55840, the RUC provided the additional four reference codes to support the survey recommended value: 1) 50543 Laparoscopy, surgical; partial nephrectomy (work RVU = 27.41 and 240 minutes intra-service time), 2) 23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component (work RVU = 25.00), 3) 32670 Thoracoscopy, surgical; with removal of two lobes (bilobectomy) (work RVU = 28.52), and 4) 43281 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplsty, when performed; without implantation of mesh (work RVU = 26.60).

According to the Patient Access to Medicare Act of 2014 (PAMA), regarding potentially misvalued codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total RVUs for the previous year, the applicable adjustments in work, practice expense, and malpractice RVUs shall be phased-in over a two-year period. The Achieving a Better Life Experience Act of 2014 (ABLE) accelerated the beginning date for adjustments of relative value targets for potentially misvalued services from 2017 to 2016. CMS will phase-in CPT code 55866 over two years with a 19 percent reduction to comply with the requirements of the ABLE Act for 2016 and further reductions in 2017. However, the AUA disagrees with the initial reduction of the physician work value and requests that CMS reconsider and accept the RUC recommendation of 26.80 for the physician work value.
CPT code 55866 recently was surveyed in 2015, and passed the CMS plan for scheduling of reviewed codes. Recognizing there was no explanation or rationale included in the proposed rule for the significant reduction in work RVU, and noting that the final rule comments do not provide clear explanation, we respectfully request to meet with CMS by conference call or in-person to clarify the work RVU reduction. In the meantime, the AUA requests that this code be referred to the Refinement Panel for review.

**Physician Compare Website**

**Public Reporting of Performance and Other Data**
The AUA remains opposed to the 30-day preview period for Physician Compare. In the final rule, CMS acknowledges the numerous demographic information inaccuracies derived from the Provider Enrollment, Chain, and Ownership System (PECOS). Yet, CMS continues to ignore public stakeholder requests to expand the review period to address these and other data concerns.

If the primary goal of Physician Compare is to help consumers make informed health care decisions, CMS should place more emphasis on the validity of the data, and less emphasis on promoting data transparency. Individual eligible professionals (EPs) and group practices need—at a minimum—45-days to view and verify their performance data collected across multiple quality programs prior to posting on the website. Thirty days is simply too short of a timeframe to analyze the data, cross-reference it with other public quality feedback reports, and dispute any errors if needed. As CMS continues to expand public reporting of physician performance data on Physician Compare, we urge the agency to reconsider expanding the preview period from 30 days to 45 days to allow ample time for providers to ensure their information is accurate and up-to-date.

In the final rule, CMS states they “will continue to reach out to stakeholders in the professional community, such as specialty societies, to ensure that the measures under consideration for public reporting remain clinically relevant and accurate.” The AUA appreciates CMS’ willingness to collaborate with specialty societies and would welcome an opportunity to meet either by conference call or in-person to further discuss which measures are relevant to the practice of urology. While the addition of several new urogynecology measures in 2016 will apply to some urologists, there remains a deficiency of meaningful and relevant measures applicable for all urologists.

As previously stated in our comments on the proposed rule, we are concerned that the release of raw data to the general public through a downloadable database will have unintended consequences. Again, if CMS considers certain data unsuitable for posting on a physician’s profile page, then release of that data to consumers, researchers and the
general public, in any format, might be misinterpreted and misused. Professional societies stand to benefit most from raw data and may determine how best to use it to help their members improve performance.

The AUA supports CMS’ decision to not include a visual indicator (green checkmark) on Physician Compare for individual EPs and group practices who received an upward Value Modifier (VM) adjustment. We agree that it may be confusing to consumers to add a new checkmark indicator for only a short period of time followed by potentially another indicator related to the Merit-based Incentive Payment System (MIPS) in later years.

**Benchmarking**

CMS finalized its proposal to display an item or measure-level benchmark on Physician Compare, based on the Achievable Benchmark of Care (ABC™) methodology, which will compare physician’s PQRS measures to a benchmark, represented as a five-star rating. CMS claims the ABC methodology is a well-tested, data driven model. However, we continue to question how this methodology accurately will translate complex data into a star rating. EPs need time to internally use the data before it is publicly reported in order to understand aspects of the data, risk stratify, and use it to improve quality of care—the ultimate goal of all the federal quality reporting programs. We also continue to have concerns with the phase-in approach of this methodology because it is too soon to publicly report a benchmark.

**Addition of VM Information**

The AUA is disappointed to see CMS add cost and quality tier information, as well as payment adjustment information to the Physician Compare downloadable database for the 2018 VM based on 2016 quality and cost data. The final rule notes “that most average consumers do not want or believe they know what to do with” the level of detailed VM data that CMS plans to release. CMS further acknowledges “that these or any other data provided in the downloadable database could be misused.” Yet, CMS is convinced that the benefits of disclosing complex VM information at this time outweigh the risks. **The AUA disagrees, and we seriously urge CMS to reconsider its approach to using VM information due to concerns that the information may be misused or lead consumers to drawn inaccurate conclusions regarding a physician’s value.**

Furthermore, CMS notes that a key focus of the VM program is gradual implementation to gain experience with physician measurement tools and methodologies. We recommend that CMS grant additional time for solo practitioners to transition to the VM program for these very same reasons.
Open Payments Data
The AUA fully supports CMS' decision to continue to test Open Payments data with consumers before considering for inclusion in Physician Compare. We agree this approach will establish the context and framing needed to best ensure Open Payments data are accurately understood and presented in a way that supports consumer decision making.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

New PQRS Measures Available for Reporting for 2016 and Beyond and Changes to Existing PQRS Measures
The AUA appreciates the addition of six new Urogynecologic measures to the PQRS measure set, as well as the new Multiple Chronic Conditions measure group. These measure options will add relevant alternatives for some urologists, but not all. CMS must not lose sight of the fact that there are still very few urologic specific measures available for PQRS reporting. While CMS has made significant improvements to the PQRS measure set, the continuous focus on primary care providers and ongoing lack of specialty-specific measures remains a constant frustration for urologists and specialists alike.

The MIPS will be applicable January 1, 2019 based on performance during CY 2017. The quality category score will account for 30 percent of a physician's performance and will have a tremendous impact on reimbursement. Physicians participating in alternative payment models must also report quality measures comparable to those used in the MIPS. Currently, the only way for specialists to report both process and outcome measures relevant to their area of practice is through a qualified clinical data registry (QCDR). The AUA is deeply concerned, and many specialty groups would agree, due to the lack of specialty-specific measures, using only the measures available in PQRS may threaten the ability of specialists to successfully participate in the new MIPS payment model. As CMS prepares to transition to MIPS, the AUA calls on the agency to add more specialty-specific measures to PQRS, and asks that existing QCDR measures be included in the set of reportable MIPS measures starting in 2019. The AUA stands ready to work with CMS to create additional urologic measures, including a urologic measure group in 2017.

The CAHPS for PQRS Survey
We applaud CMS on the decision not to require group practices of 25-99 EPs registered for the Group Practice Reporting Option (GPRO) via the GPRO Web Interface to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures. While it is important to understand patient experience to improve service delivery, not all group practices are able to satisfy PQRS reporting requirements through use of the CAHPS survey because it is an inappropriate option for group practices that do not provide
primary care services. The CAHPS survey should continue to remain optional for those groups that choose to conduct it.

Conclusion
The AUA appreciates the opportunity to comment on the final payment rates and policy changes for the CY 2016 Physician Fee Schedule. If you have any questions regarding our comments, please contact Lisa Miller-Jones at (410) 689-3772 or by email at lmiller@auanet.org.

Sincerely,

David F. Penson, MD, MPH  
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