August 30, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1654-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Administrator Slavitt,

On behalf of the 13,500 U.S.-based members of the American Academy of Dermatology Association (AADA), I am writing to provide comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017, published in the Federal Register on July 15, 2016. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We appreciate the opportunity to provide comments on the proposed rule.

Potentially Misvalued Services Under the Physician Fee Schedule: CY 2017 Identification and Review of Potentially Misvalued Services

CMS has noted that several high volume procedure codes are typically reported with modifier 25 that unbundles payment for Evaluation and Management (E/M) visits from the procedure. CMS believes the services may be misvalued.

The screen criteria that CMS proposes are:

- 0-day global codes billed with an E/M 50 percent of the time or more, on the same day of service, with the same physician and same beneficiary.
- The codes that have not been reviewed in the last 5 years, and with greater than 20,000 allowed services annually.
CMS is proposing to prioritize 83 services for review as potentially misvalued based on these criteria.

We were disappointed that CMS did not review the RVS Update Committee (RUC) rationale for RVU (relative value unit) recommendations that had been submitted to CMS, since most included statements that made it clear there was no overlap in value between E/M services and the procedures. We recommend that CMS remove all 15 dermatology codes that were included on the list of potentially misvalued services because the RUC has already accounted for the E/M values. Here is a list of those codes and an explanation for each on why it should not be on the list:

**Dermatology Codes Recommended for Removal from Potentially Misvalued Codes:**

**Services Frequently Reported with E/M Using a 25 Modifier**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Long Descriptor</th>
<th>E/M</th>
<th>Most Recent RUC Survey</th>
<th>Comment to NPRM for 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>11100</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion</td>
<td>79%</td>
<td>Aug05</td>
<td>The RUC rationale stated that this is typically reported with an E/M. The RUC accounted for this in its valuation.</td>
</tr>
<tr>
<td>11300</td>
<td>Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less</td>
<td>74%</td>
<td>Apr12</td>
<td>Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. &quot;Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&amp;M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.&quot;</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
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<td></td>
</tr>
<tr>
<td>11301</td>
<td>Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm</td>
<td>73%</td>
<td>Apr12</td>
<td></td>
</tr>
<tr>
<td>11302</td>
<td>Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm</td>
<td>67%</td>
<td>Apr12</td>
<td></td>
</tr>
<tr>
<td>11305</td>
<td>Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less</td>
<td>48%</td>
<td>Apr12</td>
<td></td>
</tr>
<tr>
<td>11306</td>
<td>Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm</td>
<td>58%</td>
<td>Apr12</td>
<td></td>
</tr>
</tbody>
</table>

Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11307</td>
<td>Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm</td>
<td>57%</td>
<td>Apr12</td>
<td>Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. &quot;Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&amp;M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.&quot;</td>
</tr>
<tr>
<td>11310</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less</td>
<td>66%</td>
<td>Apr12</td>
<td>Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. &quot;Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&amp;M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.&quot;</td>
</tr>
<tr>
<td>11311</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm</td>
<td>68%</td>
<td>Apr12</td>
<td>Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. &quot;Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&amp;M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.&quot;</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Apr</td>
<td>Remarks</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>11312</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids,</td>
<td>64%</td>
<td>Apr12  Does not meet screen criteria. This code was surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm</td>
<td></td>
<td>&quot;Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&amp;M, to maintain relativity across the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting.&quot;</td>
<td></td>
</tr>
<tr>
<td>11900</td>
<td>Injection, intralesional; up to and including 7 lesions</td>
<td>71%</td>
<td>Apr10  There is no duplication in description of pre or post-service time between the procedure and E/M services.</td>
<td></td>
</tr>
<tr>
<td>11901</td>
<td>Injection, intralesional; more than 7 lesions</td>
<td>58%</td>
<td>Apr10  There is no duplication in description of pre or post-service time between the procedure and E/M services.</td>
<td></td>
</tr>
<tr>
<td>40490</td>
<td>Biopsy of lip</td>
<td>73%</td>
<td>Sept11 Does not meet screen criteria; surveyed within the last 5 years</td>
<td></td>
</tr>
<tr>
<td>67810</td>
<td>Incisional biopsy of eyelid skin including lid margin</td>
<td>64%</td>
<td>Sept11 Does not meet screen criteria; surveyed within the last 5 years and RUC rationale specifically states that this service is typically reported with an E/M and accounted for in its valuation.</td>
<td></td>
</tr>
<tr>
<td>69100</td>
<td>Biopsy external ear</td>
<td>82%</td>
<td>Apr09  SOR stated typically reported with an E/M and the RUC accounted for this in its valuation.</td>
<td></td>
</tr>
</tbody>
</table>

These codes should be removed from the list of potentially misvalued codes: 11100, 11300, 11301, 11302, 11305, 11306, 11307, 11310, 11311, 11312, 11900, 11901, 40490, 67810, and 69100.

Potentially Misvalued Services Under the Physician Fee Schedule:
Collecting Data on Resources Used in Furnishing Global Services

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to collect information to better value codes that have 10- and 90-day global periods. Here is the pertinent section from the Act:

“…the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be
The statute requires CMS to develop a process to gather information from a representative sample of physicians. However, when CMS cited MACRA in the proposed rule, the reference to the representative sample was omitted. Instead, CMS referenced Section 220, which gives the HHS Secretary the authority to collect information on resources used to furnish services from surveys or other sources of information.

CMS proposes a three-part data collection strategy to meet this requirement: claims based reporting of post-operative care using new G codes, a survey of a representative sample of providers, and direct observation of the pre- and post-operative services in a few Accountable Care Organizations.

- **Claims-based data collection from all Medicare providers.** CMS proposes to require all providers to report post-operative care in 10 minute increments using new G codes. There will be no payment for these codes, and no penalty for not reporting them.

CMS is soliciting comments as to whether the G-codes can also be used to collect pre-operative services and if the activities identified capture all necessary activities for a typical visit. They also would like to get input on how to handle post-operative care that may not be appropriately linked to related procedures.

**PROPOSED GLOBAL SERVICE CODES**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>GXXX1</th>
<th>Inpatient visit, typical, per 10 minutes, included in surgical package.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX2</td>
<td>Inpatient visit, complex, per 10 minutes, included in surgical package.</td>
<td></td>
</tr>
<tr>
<td>GXXX3</td>
<td>Inpatient visit, critical illness, per 10 minutes, included in surgical package.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office or Other Outpatient</th>
<th>GXXX4</th>
<th>Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX5</td>
<td>Office or other outpatient visit, typical, per 10 minutes, included in surgical package.</td>
<td></td>
</tr>
<tr>
<td>GXXX6</td>
<td>Office or other outpatient visit, complex, per 10 minutes, included in surgical package.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Via Phone or Internet</th>
<th>GXXX7</th>
<th>Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX8</td>
<td>Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package.</td>
<td></td>
</tr>
</tbody>
</table>

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¹ Pub. L. No. 114-10, 129 Stat. 177
A survey of representative sample of providers. CMS would survey about 5,000 practitioners by asking them to respond to 20 discrete pre-operative and post-operative visit questions. The survey would be based on a random sample from providers that billed Medicare for more than the threshold of surgical procedures in the most recent available prior year of claims data. To the extent that this data results in proposals to revalue any surgical services, that revaluation will be done through notice and proposed rulemaking at a future time.

Direct observation of the pre- and post-operative services. CMS is planning to collect primary data by surveying a small number of ACOs to get a more in-depth look at the volume, level of services, activities and inputs involved in furnishing global services.

The AADA strongly opposes the requirement of reporting the proposed G-codes for these reasons:

1. This proposal goes far beyond Congress’ intent as stated in MACRA, which was that CMS use a sample to determine whether codes should be revalued.
2. The G code will be extremely and unnecessarily burdensome to all physicians who deliver the more than 4,000 services subject to this proposal. Attention and resources will be diverted away from patient care.
3. It would complicate the claims reporting process for those physicians who use clearinghouses to process their claims. Many of the clearinghouses do not have the capability to process a $0.00 claim line item.
4. Reporting of these G codes would be intermittent and unreliable, at best, since there is no reporting incentive. Therefore, the data would be of little use for determining either time or resources used.
5. This new set of regulations comes as physicians already will be attempting to comply with Merit-Based Incentive Payment System (MIPS) or Advanced Alternate Payment Model (APM) requirements, the most significant payment system changes in the last 25 years.
6. Even with good documentation of post-operative visits in medical records, information such as the length of those visits and the level of complexity cannot be determined. Including this type of information is simply not part of good record keeping.
7. The meaning of typical and complex patients varies according to the type of surgery, as does the complexity of care and the resources used. These G codes will not sufficiently differentiate post-operative visits to help with valuation of services.

Instead of implementing the proposed G codes, we offer these recommendations:

- Congress authorized use of a representative sample of physicians to gather information about services related to the surgery and furnished during the global period. CMS should comply with Congressional intent.
- RAND relied on a technical expert panel to help develop the proposed G codes. We recommend using the expert panel that is already established – the CPT Editorial Panel for development of new codes, and the RUC for valuation of physician work and other resource use.
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- A representative sample of good medical records should be reviewed to determine what information could be extracted from those records that would be useful for determining getting post-operative resource use, rather than establishing new standards for medical record keeping and reporting requirements.
- Reporting of any new codes first should be tested using a small pilot study, to determine the ability of practices to report and the usefulness of the data. Then the larger representative sample can be required to report the new codes, to help CMS gather the information needed to evaluate visits and other resources used.

MACRA requires that CMS develop and implement (begin) a process to gather information needed to value surgical services by January 1, 2017. There is no expectation that the first information gathered will be sufficient to develop new values. Rather, the initial efforts should be used to determine which codes merit additional scrutiny. New codes that define pre- or post-operative services may be needed, but CMS should not circumvent established and functional processes for developing codes and valuing physician services.

Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services

CMS proposes to use new G codes to:
- Improve payment for care management services provided in the care of beneficiaries with behavioral health conditions (including services for substance use disorder treatment), including three codes used to describe services furnished as part of the psychiatric collaborate care model (CoCM) and one to address behavioral health integration more broadly.
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment.
- Adjust payment for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities. This add-on code could only be billed in conjunction with certain office/outpatient E/M codes and the transitional care management codes.

The AADA objects to the CMS proposal to eliminate the physician payment increase that Congress provided for 2017 in the MACRA legislation and repurpose that money to fund a newly proposed add-on payment for services provided to patients with mobility impairments. While we support efforts to improve access to care for patients with these and other impairments, there is no justification for funding the service with an across-the-board cut in payment rates.

For some procedures, persons with mobility impairments may be typical patients, so the additional cost of treating those patients is included in the valuation of the code. The additional payment proposed by CMS would, in effect, be paying twice for the additional resources used in their
treatment. For other services, patients with mobility impairments are not typical. There is an understanding during the code valuation process, at both the RUC and at CMS, that treatment for some patients will be more difficult and costly than for others. At the same time, treatment for some patients will be easier and therefore will require less effort and resources. We do not support increasing payment for the more difficult patients or reduction for the less difficult group in these circumstances.

The proposal is also likely to increase out-of-pocket costs for patients with disabilities.

We recommend that, if CMS wants to test whether additional payment for care of patients with mobility impairments will improve access and quality, then CMS should test this theory in a pilot program.

Phase-In of Significant RVU Reductions

CMS is required to limit one year changes in value for services that are not new or revised codes to less than 20 percent, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more. Every service is evaluated anew each year, and any applicable phase-in is limited to a decrease of 19 percent. For example, if CMS were to adopt a 50 percent reduction in total RVUs for an individual service, the reduction in any particular year would be limited to a decrease of 19 percent in total RVUs. Because CMS does not set rates 2 years in advance, the phase-in transition continues to apply until the year-to-year reduction for a given code does not meet the 20 percent threshold.

The AADA supports the phase-in requirement. We encourage CMS to maintain the reduction limit and continue to phase in the reduction over multiple years.

Valuation of Specific Codes

Establishing valuations for newly created and revised CPT codes is a routine part of maintaining the physician fee schedule (PFS). Since inception of the PFS, it has also been a priority to revalue services regularly to make sure that the payment rates reflect the changing trends in the practice of medicine and current prices for inputs used in the practice expense (PE) calculations. For codes being valued, CMS reviews the current work RVU (if any), RUC-recommended work RVU, intensity, time to furnish the preservice, intra-service, and post-service activities, as well as other components of the service that contribute to the value.

Reflectance Confocal Microscopy (CPT codes 96931, 96932, 96933, 96934, 96935, and 96936)

For Calender Year (CY) 2015, the CPT Editorial panel established six new Category I codes to describe reflectance confocal microscopy (RCM) for imaging of skin. For CPT codes 96931 and 96933, the specialty society and the RUC agreed that the physician work required for both codes was identical, and therefore, should be valued the same. The RUC recommended a work RVU of 0.80 for CPT codes 96931 and 96933 based on the 25th percentile of the survey. Based on the
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similarity of the services being performed in CPT codes 96931 and 96933 and the identical intra-service times of 96931, 96933 and 88305, the key reference code from the survey, CMS believes a direct crosswalk from CPT code 88305 to 96931 and 96933 would more accurately reflect the work involved in furnishing the procedure. Therefore, for CY 2017 CMS is proposing a value of 0.75 RVUs for CPT codes 96931 and 96933. In addition, CMS is removing 3 minutes of preservice time in CPT codes 96931 and 96933 since it is not included in CPT code 88305 and as a result, they do not believe it is appropriate in CPT codes 96931 and 96933 either.

For CPT codes 96934 and 96936 the specialty society and the RUC agreed that the physician work required for both codes was identical, and therefore, should be valued the same. In its recommendation, the RUC stated that it believed the survey respondents somewhat overestimated the work for CPT code 96934 with the 25th percentile yielding a work RVU of 0.79. Consequently, the RUC reviewed the survey results from CPT code 96936 and agreed that the 25th percentile work RVU of 0.76 accurately accounted for the work involved for the service. Therefore, the RUC recommended a work RVU of 0.76 for CPT codes 96934 and 96936.

CMS accepted the incremental difference between the RUC-recommended values for the base and add-on codes accurately captures the difference in work between the code pairs. However, CMS mistakenly assigned a lower value to the base codes, and therefore proposed a work RVU of 0.71 for CPT codes 96934 and 96936. CMS also reduced the preservice clinical labor for reviewing patient clinical information and questionnaire by the technologist, order from physician confirmed and exam protocled by physician CPT codes 96934 and 96936 as this work is performed in the two CPT base codes 96931 and 96933. The service period clinical labor for “Prepare and position patient/ monitor patient/ set up IV” was reduced from 2 to 1 minute for CPT codes 96934 and 96936 since we believe that less positioning time is needed with subsequent lesions. The service period clinical labor for “Other Clinical Activity - Review imaging with interpreting physician” was refined to zero minutes for CPT codes 96933 and 96936 as these are interpretation and report only codes and not image acquisition.

It is correct that 88305 was identified as the key reference code, but there are very significant differences in the technologies used and the work involved. A reference service is not defined as an exactly equivalent service. CMS has perverted the meaning of reference service, which is merely something comparable, and hopefully somewhat similar in both work and value. CMS does not explain the similarities of the services, probably because such an explanation is not possible. During reflectance confocal microscopy the physician first reviews information about the patient, such as clinical history, photos, and referral information. Physician preservice work for 88305 does not involve reviewing information about the patient. In RCM, the technician acquires images. The physician then reviews multiple mosaics of images at multiple depths. The physician views stacks of images, which are used for determining tumor margins. 88305 consists of reviewing slides. For RCM, more is done in the same amount of time, and it is more intense. That is why the RUC assigned it a higher relative value. CMS also incorrectly removed technician time for “Other Clinical Activity - Review imaging with interpreting physician” for CPT codes 96933 and 96936, saying that these are not image acquisition codes. That is correct, but the technician still must review the imaging with the interpreting physician. There are significant differences between
the reference service and the RCM. *CMS should accept the RUC recommendations for the Reflectance Confocal Microscopy codes. If CMS does not agree with the RUC recommendations, we would like to request that these codes be referred to and reviewed by a Refinement Panel.*

**Refinement Panel**

For more than 25 years, CMS has convened the Multi-Specialty Refinement Panel to carefully review public comments, hear testimony from practicing physicians and independently recommend refinements to relative values when review is requested by a medical specialty society. Until 2011, the Refinement Panel conclusions were uniformly implemented by the Agency, with 100% acceptance from 1997 to 2010.

In 2011, CMS modified the process to only consider appeals which include “new clinical information.” Additionally, CMS began to independently review each of the Refinement Panel recommendations, rather than accepting the recommendations. Since the implementation of these changes, CMS has rejected the majority of requests for Refinement Panel review and only accepted 36 percent of recommendations from the Panel. CMS no longer relies upon outside stakeholders to provide accountability in the code valuation process. Absent any independent mechanism for appeal, CMS officials are free to make valuation decisions without having to provide a compelling rationale when rejecting relative value recommendations from the RUC and other stakeholders.

In the CY 2016 NPRM, CMS proposed to permanently eliminate its Refinement Panel process. In the CY 2016 Final Rule, instead of finalizing the exact language of that proposal, CMS announced they would “…retain the ability to convene Refinement Panels for codes with interim final values” and that “…CY 2016 is the final year for which we anticipate establishing interim final values for existing services.” We object to the CMS intention to eliminate the Refinement Panel appeal option. We strongly urge CMS to allow Refinement Panel review for all procedures and services that are under CMS review during the current rulemaking process.

As part of their original proposal to eliminate the Refinement Panel, current CMS officials objected to the widely-held understanding that the Refinement Panel served as a formal appeals process prior to 2011. The AADA disagrees with this conclusion. The original Refinement Panel was clearly a textbook example of a standard appeals process. The original Refinement Panel process, coupled with the input from the RUC, provides the best mechanism to utilize the expertise from physicians and other health care professionals to determine the resources utilized in the provision of a service to a Medicare beneficiary. We are hopeful that CMS will return to a Refinement Panel process that is fair to physicians, other health care professionals, and the patients that they serve.

**Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio (MLR) Data**
CMS proposes releasing two data sets in order to provide increased transparency about how insurers spend federal expenditures through Medicare and how rates are determined.

The first data set CMS proposes releasing is the Part C and Part D Medical Loss Ratio (MLR) which reflects the percentage of revenue spent on enrollee medical expenses. Through the release of MLR data the public is able to discern how much revenue is spent by plans on “non-claim” administrative expenses. This data will be released no earlier than 18 months after the end of the applicable contract year.

The second data set CMS proposes to release is the Medicare Advantage (MA) bid pricing data, which is the information insurers must submit during the annual bid submission process. This data consists of multiple inputs that reflect prior years claim utilization (e.g., cost and utilization by service type, enrollment, revenue, gain/loss margin, etc.) as well as their projections for the upcoming benefit year. This data informs their bid for the upcoming benefit year, and is considered proprietary. Due to the sensitive nature of this data, CMS is proposing a five-year delay in its release, but is considering limited release before the five-year period for approved research purposes.

The AADA is supportive of CMS releasing information for research purposes in an attempt to improve healthcare delivery and the cost of healthcare.

**Accountable Care Organization (ACO) Participants Who Report Physician Quality Reporting System (PQRS) Quality Measures Separately**

Current Shared Savings Program regulations do not allow eligible professionals (EPs) billing through the Taxpayer Identification Number (TIN) of an Accountable Care Organization (ACO) participant to participate in PQRS outside of the Shared Savings Program. These EPs and the ACO participants through which they bill may not independently report for purposes of the PQRS apart from the ACO.

CMS proposes, for purposes of the reporting period for the 2018 PQRS payment adjustment, (that is, January 1, 2016, through December 31, 2016), EPs who bill under the TIN of an ACO participant have the option of reporting separately as individual EPs or as group practices. Since affected EPs are not able to register for the PQRS Group Practice Reporting Option (GPRO) by the applicable deadline for the 2018 PQRS payment adjustment, CMS proposes that such EPs would not need to register for the PQRS GPRO for the 2018 PQRS payment adjustment, but rather mark the data as group data in their submission. Thus, CMS is proposing to eliminate a registration process for groups submitting data using third party entities. When groups submit data utilizing third party entities, such as a qualified registry, QCDR, direct EHR product, or EHR data submission vendor, CMS is able to obtain group information from the third party entity and discern whether the data submitted represents group submission or individual submission. If the ACO fails to satisfactorily report on behalf of such EPs or group practices, CMS is proposing to consider this separately reported data for purposes of determining whether the EPs or group practices are subject to the 2018 PQRS payment adjustment.
CMS also proposes to provide this option to EPs that participate in an ACO to report separately for purposes of the 2017 PQRS payment adjustment, allowing them to report 2015 data during the period of 2016 data submission.

The AADA agrees that the EP should be held harmless from a negative payment adjustment if the ACO fails to report. We also appreciate the elimination of the registration process for groups using third party entities. We agree that EPs should have the option to report separately.

Recommendations:
- **For 2016 reporting**, we recommend that, in cases where measures are submitted by both the EP and the ACO, the best performance be counted, and the EP would be eligible for payment adjustment.
- **In cases where the EP opts to report through an ACO, but the ACO fails to report**, the EP receives a neutral payment (no negative or positive adjustment). The EP would be held harmless from negative adjustments and not eligible for a payment adjustment.
- **Reporting previous year data is burdensome – particularly for registry measures** - and effectively penalizes the EP for the ACO error. Instead, we suggest CMS impose a negative adjustment on the ACOs when they fail to report.
- **For 2015 reporting**, we recommend that the EPs be held harmless by receiving no payment adjustment. Retroactive reporting would be burdensome to the EPs and would require QCDRS and EHRS to simultaneously meet the reporting requirements/measures of multiple years.

**Physician Self-Referral Updates: Unit-based Compensation in Arrangements for the Rental of Office Space or Equipment**

The Physician Self-Referral [Stark] Law prohibits physician referrals for certain designated health services paid by Medicare to an entity in which the referring physician—or their immediate family member—has a financial relationship, unless an exception can be met. Using its regulatory authority granted under this law, CMS is re-proposing certain compliance requirements to ensure that compensation/payment formula for business arrangements involving the renting or leasing office space or equipment cannot be based on “per-unit/per-click” of service rental charges.

The AADA appreciates the clarification CMS is proposing with technical modifications to physician lessor-lessee arrangements, limiting how per-unit rental charges are determined between the parties. The changes preserve the ability of physicians to lease office space and/or equipment from other physicians, though it imposes reasonable restrictions on the rental payments formula. The Academy understands that a careful balance must be established between permitting physicians to lease office space or equipment to ensure access to patient care and avoiding potential risks of abuse of the Medicare program.
The AADA agrees with the proposed modification.

Regulatory Impact Analysis

We were disappointed that CMS did not include any analysis of the financial impact of its proposal to require physicians to use G codes to report care during the post-operative period for 10 and 90 day global codes. The modifications in workflow, additional work, and lower productivity will be significant. CMS should complete analysis of the probable impact before implementing any changes to requirements for reporting care.

Conclusion

The AADA appreciates the opportunity to provide comments on the Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 proposed rule. We look forward to additional opportunities to discuss these issues and to provide feedback that may help guide policy development. Please contact James Scroggs, at (202) 842-3555 or jscroggs@aad.org if you would like clarification or additional information on any of the comments in this letter.

Sincerely,

Abel Torres, MD, JD
President, American Academy of Dermatology Association

CC: Henry Lim, MD, AAD President-Elect
    Elaine Weiss, JD, Executive Director