

January 29, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9915-P
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted electronically via <http://www.regulations.gov>

**Subject: (CMS-9915-P)
Transparency in Coverage**

Dear Administrator Verma:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS), Internal Revenue Service's, and Employee Benefits Security Administration's ("the agencies") Transparency in Coverage (CMS-9915-P) Proposed Rule published in the Federal Register on November 27, 2019.

The AAOS appreciates the efforts of the agencies to foster a system of clear prices for health services. Both providers and patients benefit when health care decision-making is built on a mutual understanding of all aspects of treatment, including cost. A lack of clarity surrounding the costs of care can lead to undue stress for patients. According to a study by the American Psychological Association, regardless of income, over 50% of Americans report stress caused by medical bills.¹ Developing a system where the prices for services are not a secret until the explanation of benefits statement arrives in the mail is critical to addressing this source of stress and improving the well-being of Americans.

Toward that end, AAOS supports efforts to provide patients with easily understandable cost and quality information to encourage the use of high-value care options. Allowing healthcare consumers to search for medical providers based on both measures of price and quality will

¹ "Stress in America: Uncertainty About Healthcare" American Psychological Association, 2019
<https://www.apa.org/news/press/releases/stress/2017/uncertainty-health-care.pdf>

increase patient empowerment when making serious decisions about medical treatment. AAOS has supported similar efforts, including the “Procedure Price Lookup Tool” which allows patients to compare average national prices for procedures in both ambulatory surgery center and hospital outpatient department settings.

However, mandating the publication of commercially negotiated rates risks devaluing independent physician’s professional fees to the lowest common denominator. Such a decrease could have a chilling effect on access to care. When a physician’s professional fees from commercial insurance are decreased, there is less income produced to cover the overhead costs of sustaining a practice. Certainly, the reimbursement rates from Medicaid and Medicare do not fulfill that. Historically, it has been this balance between the public and private markets that has allowed physicians to provide care for those most vulnerable populations while remaining afloat. This proposal risks undercutting the partnership with the agencies that physicians, particularly orthopaedic surgeons, have spent the past years cultivating during the shift to value-based care. Orthopaedic surgeons have acted in good faith to increase participation in value-based models for Medicare and commercially insured patients receiving musculoskeletal care. It would be in the best interest of patients for the agencies to continue nurturing this relationship.

Moreover, it is the premise of the concept of price transparency that participants in the health care market behave in a manner similar to the traditional free market.² That is, when the price for a given service or product is known, there tends to be greater competition to provide it at the lowest price and highest quality in order to generate the most profit. However, this assumption may not be true for health care markets and it would be a risk to assume that shifting the health care sector to this model would lead to insurers offering care at this “best value” price. While AAOS has advocated in favor of bipartisan legislation that would remove antitrust exemptions for health insurance, it is unclear how the implementation of this proposed rule would impact the application of existing laws. The potential exists for prices to increase overall, as some of the already consolidated health systems realize they have been reimbursed less than others for the same services and subsequently demand equal reimbursement.

To upend the existing system without considering the consequences of a future construct would be a burden to providers and patients alike. We urge the agencies to move towards a solution that is deliberate in its approach for navigating between present regulation and a future state of health care payment—one that is both markedly helpful to patients and limited in the administrative responsibility it places on providers.

Third-party developers

While AAOS is supportive of improved interoperability and reduced burden from electronic health record systems (EHR), we have serious concerns regarding the risk of requiring health insurers to make cost-sharing information available to third-party applications. It is alarming that the agencies acknowledge in the proposed rule that “this could present a risk to sensitive

² Mwachofi, Ari, and Assaf F Al-Assaf. “Health care market deviations from the ideal market.” *Sultan Qaboos University medical journal* vol. 11,3 (2011): 328-37. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3210041/>

information about enrollees' health status if the third party subsequently misuses the data or has a security breach" but "nevertheless...view that consumers should have access to this information to empower them to make informed health care decisions." The value of sharing patient data must not outweigh a patient's right to have their personal health information remain confidential.

At the very least, the third-party application developers should be required to meet stringent standards for security. Given the proposal to use application programming interface (API) to integrate cost information into the EHR for "point-of-care" medical decision-making, it is certainly possible that a breach of security from the API could lead to an unintended distribution of protected health information that is housed within the EHR.

RFI: Provider Quality Measurement and Reporting in the Private Health Insurance Market

In order to provide a complete representation of an item or service's value to patients, AAOS believes that quality information should be disclosed along with price information. To provide cost information in the absence of contemporaneous quality data would be a disservice to patients looking to act as informed consumers. Consistent with our previous comments on reducing regulatory burden for providers, we encourage the agencies to make the format and type of quality reporting information consistent across plans and issuers.

Using measures that are already required, such as those reported through the Merit-based Incentive Payment System (MIPS), would offset the immense burden associated with the proposed reporting requirements of this rule. For patients, using a consistent set of quality measures would help to accurately compare and assess the value of different providers and sites of service. Like the proposal for the ability to filter services by geographic region, we propose that the sets of quality measures be organized by specialty. For example, when a patient is searching for an orthopaedic surgeon, they will see their in-network cost-sharing along with the same 3-5 quality measure ratings used to compare all orthopaedic surgeons.

Examples of these could include Quality ID-109: Osteoarthritis (OA): Function and Pain Assessment; Quality ID-358: Patient-Centered Surgical Risk Assessment and Communication; Quality ID-355: Unplanned Reoperation within the 30 Day Postoperative Period; and Quality ID-356: Unplanned Hospital Readmission within 30 Days of Principal Procedure.

The AAOS has recently developed comprehensive definitions of quality and value in orthopaedics. Whereas quality is defined as the successful delivery of appropriate, evidence-based musculoskeletal healthcare in an effort to achieve sustained patient-centered improvements in health outcomes and quality of life exemplified by a physician-led musculoskeletal team focused on the individual patient's preferences in the delivery of care that is safe, accessible,

equitable, and timely; and that fosters evidence-based innovation essential for the advancement of professional and scientific knowledge. Value is defined as the relationship of a patient-centered health outcome to the total cost required to reach that outcome, given that care is: evidence-based, appropriate, timely, sustainable, and occurs throughout a full cycle of musculoskeletal care for a patient's condition; and that cost of musculoskeletal care is an investment and includes consideration of greater lifestyle and economic impacts.

We encourage the agencies to consider these definitions vis-à-vis the goals of assessing quality and value in a price transparent health care environment.

Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' suggestions. We commend the agencies on their continued efforts to improve care quality and access. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, FAAOS, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,



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