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 Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Ms. Tavenner:

The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Payment Policies Under the Physician Fee Schedule and Clinical Laboratory Fee Schedule & Other Revisions for 2014, published in the July 8, 2013 Federal Register.

CAPPING NON-FACILITY PHYSICIAN FEE SCHEDULE PAYMENT RATES AT OUTPATIENT/AMBULATORY SURGICAL CENTER PROSPECTIVE PAYMENT RATES FOR CERTAIN SERVICES

In the proposed rule, CMS put forth a policy to cap payments to services performed in the non-facility setting when those payments are greater than what is paid when the same service is performed in either the hospital outpatient department (HOPD) or ambulatory surgical center (ASC) facility setting. The agency stated they believe the proposal “provides a reliable means for Medicare to set upper payment limits for office-based procedures based on relatively more reliable cost information available for the same procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting.”

The proposed policy is premised on the idea that there are significantly greater indirect resource costs when a service is performed in a facility compared to the
non-facility setting and that the cost data used to set fees in the Hospital Outpatient Prospective Payment System (OPPS) and ASC is more reliable compared to cost data collected under the resource-based relative value scale (RBRVS). In some cases, the indirect costs for an outpatient hospital or ASC to provide a service will be greater than when the same service is provided in the non-facility (office) setting. However, we also believe there are many situations and valid reasons why the costs in the non-facility setting are greater such as less preferable pricing compared to hospitals, higher labor costs, higher per square foot rents, and other cost inputs. In the CMS proposal, all identified codes are treating similarly and broadly and without reviewing on a service-by-service basis. This runs the risk of paying incorrect and inaccurate rates in one or both settings. Furthermore, the proposal broadly assumes the OPPS cost rates are better than the physician fee schedule rate without any objective basis for this assumption.

The AAOS also disagrees with the CMS assumption that OPPS payment rates are more reliable than fee schedule rates. While hospital charge information is updated on a rolling basis, it does not mean that the cost data are more accurate on a service-by-service basis as discussed above. Rather than estimating the costs of each resource within a service on a per line item basis, this ratio is an average at the hospital department level. We believe that resource cost data collected under the physician fee schedule are as reliable, if not more so because direct resource costs are calculated on a line item basis.

The result of these flawed assumptions is that the CMS proposal results in several anomalies for the codes potentially affected by the policy. For instance, for a majority of the codes listed by CMS, the direct practice expenses, as currently exist in the physician fee schedule alone exceed the proposed payment cap rate. This means that for the vast majority of codes, the proposed payments would not even cover the direct costs, let alone indirect costs for the services. As an example CPT codes 22523-22525, for percutaneous kyphoplasty, the proposed revised non-facility cap is less than the direct costs, meaning that orthopaedic patients who currently receive the service in the non-facility setting will be forced to receive them instead at a HOPD or an ASC.

The AAOS is also concerned about potential unintended consequences that could very easily cause the policy to actually cost CMS more in terms of total Medicare expenditures for these services and increase patients’ risks of complications. The services under review would very likely migrate from the physician office to a hospital outpatient or ASC, forcing Medicare patients to face longer waits with greater paperwork and administrative burden. Further, transferring care to these
settings exposes these patients to additional risks of hospital acquired infections not present in the office setting. Pushing treatment to the hospital outpatient or ASC also adds additional out-of-pocket costs for Medicare patients through required co-payments in these settings, which are not required for in-office setting. This could negatively impact the ability of fixed-income patients to afford medically necessary care. Furthermore, moving services to the outpatient or ASC potentially increases total costs to Medicare, as the additional APC/ASC payment rate must be paid on top of the physician rate. We are also concerned that changing the incentives for the site in which these services are performed toward favoring hospital or ASC facilities could limit access for patients in rural and low-income areas if they do not live within easy traveling distance of an outpatient or ASC facility.

Under the proposal, the agency would exempt any services for which 5% or less of the total number of services are performed in the OPPS/ASC setting. However, the agency offers no rationale for this particular threshold and the AAOS believes it is far too low a threshold if the idea is to accurately capture the typical cost of providing a service. We would recommend that CMS use a threshold closer to 50% of the total number of services being performed in the OPPS/ASC setting as this would at least mean that the applied rate represents the setting where a majority or plurality of the services are performed. We also believe that should the agency go forward with implementing this proposal that the agency should use the 2014 OPPS/ASC payment rates and not the 2013 OPPS/ASC payment rates as the proposal indicates. It makes little sense to cap 2014 physician fee schedule non-facility rates at a rate lower than the 2014 OPPS/ASC facility payment rates and this would only further incentivize providers to use the OPPS/ASC facilities in order to capture the higher payments.

The AAOS supports the agency’s efforts to determine the most appropriate and accurate payment rates for services provided under the Medicare Physician Fee Schedule. However, we believe the CMS proposal to cap non-facility Practice Expense Relative Value Units (RVUs) at either the OPPS or ASC rate is sufficiently problematic that the agency should instead opt to set aside the proposed policy and continue to determine the most accurate and correct practice expense costs for individual services through the RBRVS. The implementation of the proposed policy is likely not only to increase cost to CMS for the same services, but will inconvenience Medicare patients, particularly those in rural areas, and force increased exposure of these elderly patients to hospital-acquired diseases and infections.
COMPLEX CHRONIC CARE MANAGEMENT SERVICES

The AAOS commends CMS for continuing to explore ways to pay physicians for non face-to-face work done in the service of improved care coordination amongst providers. It is essential to continue to reform our payment and delivery systems to have physicians properly incentivized to provide correct and comprehensive care coordination.

In the 2014 Medicare Physician Fee Schedule proposed rule, CMS indicated they will begin to provide payment for complex chronic care management (CCCM) services beginning January 1, 2015. Under the CMS proposal, payment will be made for services provided to patients with two or more complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. We applaud this step, and the CMS proposal is relatively consistent with the model envisioned by the joint workgroup of the AMA CPT Editorial Panel and the AMA Relative Value Update Committee (RUC), the Complex Chronic Care Workgroup (C3W). However, the CMS proposal deviates in several important ways from the CPT guidelines and we recommend that CMS revise their proposed policies to be more consistent with the CPT guidelines.

Under the proposal, CMS will utilize the parameters described in the CPT guidelines to identify the patients eligible for the CCCM services. For example, CMS will specifically require that payment be made only to patients with two or more chronic conditions. However, the Proposed Rule does not fully discuss the guidelines as described for CPT 2014. The agency should work closely with the CPT Editorial Panel to align their patient requirements to the CPT guidelines.

CMS plans to develop and seek public input on practice capabilities required to provide CCCM services. Several of the practice requirements are included in the CPT guidelines and we recommend that CMS incorporate the practice capabilities described in CPT guidelines, which have been developed in a consensus based manner and have the support of multiple medical specialty groups.

The agency’s proposal also deviates from the CPT guidelines by requiring that practices “must employ one or more advanced practical registered nurse or physician assistant.” We do not believe the requirements should be specific to advanced registered nurses or physician assistants but rather recognize that several types of care providers are fully capable and well qualified to provide complex care
management. We are also concerned with the Electronic Health Record (EHR) requirements outlined by the agency. We believe that physicians who can demonstrate timely access to a patient’s medical records regardless of whether it is electronically or paper should be eligible to report CCCM.

CMS indicates the agency could consider deeming any practice recognized as a qualified medical home by a national organization, such as the National Committee for Quality Assurance (NCQA) or the Joint Commission, to have demonstrated meeting standards to provide CCCM. We support this type of expedient identification of practices and physicians for purposes of CCCM payments. However, we also believe that any physician practice should be able to qualify for payment of CCCM as long as the individual practice meets the practice requirements established to report these individual codes and that no practice should be required to become accredited as a medical home in order to receive payment for complex chronic care management.

The AMA CPT Editorial Panel developed CCCM codes that are reported per calendar month and are quantified by first hour of clinical staff time, with an add-on code for each additional 30 minutes. CPT code 99487 is reported when no face-to-face visit was performed in a month and 99488 is reported when a face-to-face is performed. The CMS proposed code structure varies in two ways: 1) CMS proposes to pay for all visits independently of the CCCM code. CPT included a code with a face-to-face visit to ensure that pre and post work of the evaluation and management (E/M) code reported in the same month as care coordination was not duplicated into the payment for care coordination. If CMS is not concerned with this potential duplication and prefers that the E/M be reported separately, then CPT code 99488 becomes unnecessary and could potentially be deleted.

In addition, CMS proposes a 90-day global period for the services, rather than per calendar month as envisioned by CPT codes 99487 and 99488. A 90-day global period is problematic because it would be very difficult to accurately evaluate the work and practice costs over that time period versus over a month’s time. We recommend CMS instead utilize the CPT code structure of a monthly basis.

We also do not believe it is necessary to have separate codes for both subsequent and initial services. We believe the work and practice expense costs would be the same regardless of whether it is a subsequent or initial service and therefore there is no compelling reason to differentiate between initial or subsequent.

We recognize the importance of patient consent and notice. Under the CPT guidelines, a plan of care must be documented and shared with the patient and/or
caregiver. CMS proposes a more elaborate consent and notification process. We do not believe these additional elements proposed by CMS to be necessary and recommend that CMS rely on the more straightforward CPT guidelines.

We believe the inclusion of codes for complex chronic care management represent a significant step in the direction of properly paying and incentivizing physicians for care coordination work. These types of payments will, hopefully, result in increased patient satisfaction and lower overall costs to CMS as savings are realized through lower facility admissions, fewer patient face-to-face visits, and a more rational payment system. We encourage the agency to track the impact of these changes throughout the Medicare payment systems in order to document the efficacy of such efforts. We believe physicians and patients alike will respond positively and that the Medicare system will reap significant benefits as a result. However, between now and 2015 the agency should consider streamlining their proposal to better align with the CPT codes and guidelines.

**MEDICARE COVERAGE OF ITEMS AND SERVICES IN FDA INVESTIGATIONAL DEVICE EXEMPTION CLINICAL STUDIES-REVISION OF MEDICARE COVERAGE**

The Academy appreciates CMS’ intent to centralize the decision-making process involving Investigational Device Exemption (IDE) coverage to provide a consistent experience for stakeholders. It is important to eliminate duplication of effort and enhance the transparency of this process. However, there may be unintended consequences associated these streamlining activities. AAOS is concerned that many of the proposed standards for Category A IDE coverage are either redundant of Federal Drug Administration(FDA) IDE requirements, are overly burdensome and thereby present a barrier to the participation of Medicare beneficiaries in IDE studies, or are in direct conflict with established policies governing the management of data related to device regulation.

A comparison of the thirteen proposed standards with FDA’s IDE study requirements yields several redundancies. CMS should collaborate with the FDA to strengthen those study elements they feel are in need of reinforcement, rather than duplicate requirements for a subpopulation, namely Medicare beneficiaries.

One of the key principles underpinning the FDA’s concept of least burdensome regulation is that “Information unrelated to the regulatory decision should not be part of the decision-making process.” AAOS believes that maintaining a straightforward regulation is critical to continued innovation and enables
manufacturers to nimbly meet the needs of orthopaedic patients and their surgeons. CMS is now requesting that many pieces of information, not related to the substantiation of safety and effectiveness, be covered as a condition of payment for Category A IDE devices. This is inconsistent with the FDA concept of least burdensome regulation. The FDA website lists four principles of the least burdensome concept:

- The basis for all regulatory decisions will be found in sound science and the spirit and the letter of the law;
- Information unrelated to the regulatory decision should not be part of the decision-making process;
- Alternative approaches to regulatory issues should be considered to optimize the time, effort, and resources involved in resolving the issue consistent with the law and regulations; and
- All reasonable measures should be used to reduce review times and render regulatory decisions within statutory timeframes.

The first, third, eighth, and ninth standards proposed by CMS are in conflict with one or more of these principles. The standards would require the collection of information unrelated to the regulatory decision and present additional requirements that would increase the time, effort and resources necessary to meet the conditions of approval for marketing and payment. We are concerned that these additional burdens will slow the creation of new devices and increase the cost of the products. AAOS encourages CMS to consider the benefit of implementing these standards which are inconsistent with the FDA principles and we encourage the agency to align their proposals with the FDA’s already established guidelines. Standard eleven obligates the sponsor of data collection to include the “method and timing of public release of results on all pre-specified outcomes” and to release the results to the “public within 24 months of the end of data collection.” At present, the FDA does not release this information to the public and does disclose the existence of an IDE unless one of three conditions is met. Further, “If the existence of an IDE file has not been publicly disclosed or acknowledged, no data or information in the file are available for public disclosure except for information on banned devices and a report of an adverse effect to an individual on whom an investigational device has been used. [(§812.38)]” We believe this reporting requirement, if enacted, could have a chilling effect on the collaboration necessary to include critical subpopulations, such as Medicare beneficiaries, in IDE studies.

Finally, the requirement that coverage of Category B IDE devices and associated costs meet the additional criteria of the study being both pivotal and of a superiority study design will certainly diminish the ability of Medicare beneficiaries to
participate in IDE studies. The current standard for the determination of safety and effectiveness is the non-inferiority study design. A change in design may be beneficial for CMS in making coverage determinations, but the added resources required for superiority studies may prevent the sponsors from including Medicare beneficiaries in their study population. AAOS believes it is important for devices to be tested in the population they are intended to treat and in the manner in which they are most likely to be used. Barriers to the inclusion of intended populations should be reduced, not increased, by new standards. CMS should thoughtfully consider the impact of this requirement in this context.

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) PROGRAM

The AAOS appreciates CMS’ continual efforts to improve the Physician Quality Reporting System (PQRS) program. These improvements and increased flexibilities will hopefully encourage more widespread participation amongst physicians in the years to come. We encourage CMS to continue to work closely with the physician community to refine the program in ways that result in meaningful improvements in the quality of care provided to our patients and to promote more widespread participation.

PQRS Participation, Incentives, and Penalties

The AAOS is encouraged to see CMS propose to reduce the threshold percentage of applicable patients with reported PQRS measures data from 80% to 50%. This will increase the likelihood that physicians will be able to meet the reporting threshold and decreases the burden placed on physicians and patients to collect data on what can be an overwhelmingly large number of patients. Moreover, we believe it may encourage measure development beyond rudimentary process measures and may encourage physicians to use such measures, as more risk could be taken by physicians who no longer need to report complete data on 80% of their patients.

In addition to the reduced percentage threshold, the AAOS is also pleased to see the option for physicians to report CG-CAHPS data toward meeting satisfactory PQRS reporting requirements. We believe that the CG-CAHPS survey instrument has been utilized and validated to a high degree of rigor, and permitting the use of such surveys for PQRS reporting affords another degree of flexibility for physicians in meeting PQRS reporting requirements.

For CY 2014, CMS proposes to increase the number of reported measured needed to earn the PQRS reporting incentive from three to nine. Though we recognize that
this aligns with the Electronic Health Record (EHR) Meaningful Use program, this proposed change triples the number of measures needed to earn a rather modest incentive payment and creates a hurdle that many physicians may struggle to overcome. In light of the fact that incentive payments for PQRS are only scheduled to continue for one more reporting year, we believe that the minimum number of measures for the incentive should remain at three.

The AAOS is disappointed to see the minimum size of physician groups wishing to report to PQRS via the GPRO interface increase from 25 physicians to 100 physicians. We consider this to be a very large jump that will eliminate this reporting option for a substantial number of small physician group practices. We would recommend that the minimum group size remain unchanged in order to afford physicians the greatest number of reporting options and to maximize successful participation in the PQRS program.

CMS has indicated elimination of the 6-month reporting period for reporting individual measures via a registry as a way of aligning the PQRS reporting period with the EHR reporting mechanism and simplifying the reporting requirements for PQRS. However, we would recommend maintaining the 6-month reporting period. The AAOS believes quality reporting requirements should offer multiple reporting options and flexibility for participation.

**PQRS Measures and Measure Groups**

CMS has proposed to approximately double the number of outcome measures available for reporting by physicians while also proposing to reduce the number of available process measures. The AAOS commends CMS’s effort in incorporating more outcome measures in the PQRS program, particularly in conjunction with the reduction from 80% to 50% of applicable patients necessary to meet the reporting requirements. Together, these proposed changes allow greater flexibility to physicians in how they go about meeting PQRS standards while expanding the types and usefulness of quality data being collected.

The AAOS is also very pleased to see the inclusion of new measures related to total knee replacement and osteoporosis. These measures were developed by a collaborative of orthopaedic groups, led by the American Association of Hip and Knee Surgeons (AAHKS) and including the AAOS. It is our belief that orthopaedic surgery has lacked sufficient measure options specific to the specialty, and we strongly support the inclusion of these for the 2014 and beyond PQRS program.
Under the proposed rule, CMS proposes to delete the Osteoporosis Measures Group, introduced and finalized, during the CY 2013 MPFS rulemaking. This measures group was planned to consist of four measures that are included in the PQRS as individual measures and seven new measures developed by the American Board of Internal Medicine (ABIM). CMS cites as its rationale for deleting the seven ABIM measures that the Measures Group is proposed for deletion due to “measures that have duplicative medical concepts.”

Although we agree that the ABIM measures were largely duplicative of existing measures within the PQRS and other quality measurement programs, we do not support the Agency’s plans to remove the Osteoporosis Measures Group altogether. Instead, we recommend that CMS implement a revised Osteoporosis Measures Group, using the following six existing National Quality Forum (NQF)-endorsed PQRS measures:

1. **Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture of Hip, Spine, or Distal Radius for Men and Women Aged 50 Years and Older** (NQF# / PQRS# 0045/24).
2. **Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older** (NQF# / PQRS# 0046/39).
3. **Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older** (NQF# / PQRS# 0048/40).
4. **Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older** (NQF# / PQRS# 0049/41)
5. **Falls: Risk Assessment** (NQF# / PQRS# 0101/154)
6. **Falls: Plan of Care** (NQF# / PQRS# 0101/155)

We believe it is feasible for providers to report on an Osteoporosis Measures Group comprised of these six measures. This combination of measures within the Osteoporosis Measures Group should help encourage strong reporting through the PQRS. Finally, inclusion of the remaining two NQF-endorsed osteoporosis measures would allow this Measures Group to meet the new, proposed CMS requirement that a measures group maintain at least six measures to be formally considered as a group.

It is essential that clinicians and healthcare practitioners have the opportunity to enhance their tracking and reporting of Medicare osteoporosis patient activity. A formalized osteoporosis-focused measures group would serve that purpose while complementing the current PQRS individual osteoporosis measures by ensuring
that clinicians report on all measures within the group when they are evaluating, treating, and following up with osteoporosis patients.

Although we are encouraged to see the proposed changes in outcome measures and the inclusion of more orthopaedic-specific measures, the AAOS is disappointed to see a reduction in the number of process measures available to physicians for PQRS reporting. This reduction in the number of avenues that physicians have to meet PQRS reporting requirements may represent a burden for those physicians whose patients are not well-suited to outcome measures and may struggle to meet the 50% reporting threshold for such measures. In short, we would like to see an ample amount of both process and outcome measures for physicians to choose from when meeting PQRS reporting requirements.

**Potential Future Changes**

CMS indicated they are seeking comments on whether to completely eliminate the claims-based reporting option in the PQRS program. The AAOS recognizes that CMS is engaging in efforts to steer physicians towards other reporting options, such as registry-based reporting. The AAOS also acknowledges that claims-based reporting is used by a minority of PQRS program participants. However, we steadfastly believe in physicians having as many avenues and options as possible to allow them to meet PQRS reporting requirements. Until a greater portion of physicians are meeting PQRS reporting requirements using an alternative reporting modality, such as registry reporting, we believe that the claims-based reporting should remain an option.

CMS also indicated that they are seeking comments on potentially merging feedback reports to physicians from the Value Based Modifier program and the PQRS program. The AAOS believes that merged feedback reports would be beneficial for physicians, particularly if it means that the delay period to receiving a feedback report could be reduced in a merged report.

**PQRS Qualified Clinical Data Registries**

The AAOS is supportive of CMS’s proposal to create a Qualified Clinical Data Registry (QCDR) track for PQRS reporting. We believe that physicians should have as many different quality reporting modalities available to them as possible, and this represents a step forward in more clearly defining registries and encouraging registry-based participation.

While we are broadly supportive of CMS’s efforts to develop the QCDR reporting track, we are concerned about both the implementation and feedback timelines
proposed for QCDRs. First, the AAOS believes that the QCDR self-nomination process should be ongoing rather than ending on January 31st, 2014. At the very least, clinical data registries seeking qualification should be able to self-nominate at any point with quarterly or biannual review by CMS to be deemed as a QCDR. We anticipate that many organizations will be, or already are, developing registries they wish to have deemed as a QCDR. However, even these registries may still be in their infancies and not yet ready to self-nominate by the proposed January 31st, 2014 deadline.

Second, we are concerned about the requirement that QCDRs provide feedback to physicians on a quarterly basis. Though we agree timely feedback is important, we believe that providing quarterly feedback may not be realistic for many QCDRs, even those that are well-developed but do not necessarily have the reporting infrastructure to deliver such frequent feedback. As such, we would ask that QCDRs be required to submit feedback on at least an annual basis, rather than quarterly.

Third, AAOS believes physicians should have the opportunity to request audits of their quality data and be afforded due process to address any data errors. AAOS supports public reporting of provider performance that is appropriately risk-adjusted, thoroughly vetted for accuracy and that offers a reliable and rapid mechanism for challenging and removing inaccurate information from provider profiles.

The AAOS is also concerned about the requirement for QCDRs to report on a minimum of nine measures. Although we are appreciative of the flexibility for these measures to not be limited to those that are NQF-endorsed, we believe that QCDRs should be afforded greater flexibility in the number of measures they report. QCDRs are often conceived and maintained by relatively small organizations that may not be able to implement the minimum number of measures in time to self-nominate. Thus, the AAOS asks that QCDRs be allowed to self-nominate with three clinical measures to encourage early adoption and participation in this new quality reporting modality, and that requirements for a greater number of measures be phased-in over time.

Lastly, the AAOS is concerned that the scope of these new rules seems to be limited to office based registries. Within orthopaedics, a growing number of our surgeons participate in the American Joint Replacement Registry (AJRR) which collects data on joint replacement procedures. The AJRR does not collect this data directly from physicians, instead they establish contractual relationships with hospitals. AAOS
suggests that CMS expand the scope of these rules to include variants of registries that collect data from entities such as hospitals, rather than directly from physicians.

PHYSICIAN COMPARE

The AAOS is grateful for the opportunity given to specialty societies to provide input and feedback on Physician Compare. Public reporting of provider performance is rapidly expanding and the Medicare Physician Compare website is one of the biggest steps in this area. The AAOS supports judicious growth of public reporting that is clinically relevant, reliable, appropriately risk adjusted, and actionable for patients. We are also particularly interested in public reporting that minimizes the burden of data collection on patients, physicians, and hospitals. Lastly, we are appreciative of CMS providing the opportunity for physicians to be involved in the Physician Compare design process, as some physicians from our society have had the opportunity to do in the past year.

We have two concerns with the ongoing expansion of Physician Compare and the integrity and accuracy of the data it presents. First, we urge CMS to ensure that the demographic data on physicians is validated against other sources for accuracy and regularly updated, as need. In addition, we believe providers should have a formal process available to them to audit or challenge their data displayed on Physician Compare.

PHYSICIAN FEEDBACK REPORTS

The AAOS is appreciative of CMS’s proposal to provide feedback reports to eligible professionals reporting individual measures and measures groups via claims for 2012 and beyond. We appreciate the inclusion of solo practices to receive feedback reports along with group practices in the newest proposed rule. These feedback reports will be helpful for physicians to assess their standing in the Value-Based Modifier Program.
VALUE-BASED PAYMENT MODIFIER (VBM) PROGRAM

The AAOS commends CMS on its work developing the value-based payment modifier (VBM) and its commitment to rewarding better value, outcomes and innovations. The AAOS looks forward to working with CMS and other provider organizations on issues related to assessment of physician performance and implementation of the value modifier, including steps for both measurement of performance and application of payment adjustments.

**Proposed measurement period**

CMS has proposed to utilize performance measurement in CY 2014 for payment adjustments in 2016. Although we acknowledge the requisite time needed for CMS to assess claims data and process the payment modification process, we believe that physicians are not yet adequately informed or prepared of the performance measurement process and how they may need to adjust their practice in order to avoid penalties under the VBM program. The AAOS emphasizes that caution and transparency are important in proceeding in this program and, while statutorily mandated, that the program not ignore the diversity of physician practices and the types of patients that they care for. Therefore, we recommend basing the value-based modifier payment adjustments for 2016 on CY 2015.

**Minimum practice size for applicability**

In addition to the proposed timeline, the AAOS also disagrees with the physician group practice size threshold proposed by CMS for VBM payment adjustments. We believe that reducing this threshold to groups with a minimum of 10 physicians by CY 2016 is premature and that the VBM program is still too young to be expanded to well over half of physicians. The AAOS would be supportive of an application option for smaller group practices with fewer than the current 100 eligible professional threshold to participate in the VBM. We believe that more time is necessary to assess the accuracy of the VBM’s methodology, particularly for small groups where heterogeneity in an individual physician’s practice may put the entire group at a disadvantage in the program.

**Proposed “quality tiering” of eligible PQRS participants**

The AAOS has particular concerns about the “quality tiering” effort that CMS has proposed to apply to physician groups that participate in PQRS and are subject to the VBM. Specifically, we are concerned that comparing of groups to national benchmarks of quality and costs may not be accurate and appropriately risk-adjusted, as this represents a highly nuanced assessment of physicians across two quality programs. We believe the measurement of cost and quality in this program
is already delicate and this layer of benchmarking may unfairly penalize certain physician group practices if their particular case mix or practice type is not adequately accounted for.

**LIABILITY FOR OVERPAYMENTS**

The AAOS respects CMS’s need to combat fraud and ensure integrity of the Medicare program. Our organization is also in agreement with CMS’s choosing to waive provider repayment in situations where there is no wrongdoing after a pre-defined look-back period. However, we are concerned that the look-back period is becoming extended to a duration that would make for an onerous and aberrant record-keeping burden on physicians. The proposed five-year look-back period would extend liability further in duration than the three-year look-back periods associated with other program integrity initiatives.

While the AAOS recognizes that CMS has shown latitude in reducing its previously proposed ten-year look-back period to a five-year period, we nonetheless believe that a look-back period beyond those found in other program integrity initiatives will demand highly burdensome record keeping for physicians. We ask that the look-back period remain at three years in duration.

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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,

[Signature]

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

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