



AMERICAN ACADEMY OF  
ORTHOPAEDIC SURGEONS

AMERICAN ASSOCIATION OF  
ORTHOPAEDIC SURGEONS

August 30, 2017

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1678-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

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

**Subject: (CMS-1678-P)  
Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical  
Center Payment Systems and Quality Reporting Program**

Dear Administrator Verma:

On behalf of over 18,000 board-certified orthopaedic surgeons represented by the American Association of Orthopaedic Surgeons (AAOS) and the orthopaedic specialty societies that agreed to sign on, we are pleased to provide comments on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment and Ambulatory Surgical Center(ASC) Payment Systems Proposed Rule published in the Federal Register on July 20, 2017.

We commend CMS on its efforts to improve care quality and access. The Proposed Rule touches on several issues that directly affect our membership and we sincerely hope you will take our comments into consideration as you move forward on these changes in policy.

### **Removal of Total Knee Arthroplasty (TKA) from the Inpatient-Only List (IPO)**

Total knee arthroplasty (TKA) or total knee replacement (CPT 27447- Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing) has traditionally been an inpatient surgical procedure. In this proposed rule, CMS has solicited comments on the removal of TKA from the IPO list and whether it meets the criteria for an ASC procedure. AAOS supports the removal of TKA from the IPO list contingent upon several issues.

CMS rightly defers to providers for developing patient selection and exclusionary criteria for identifying appropriate patients for an outpatient TKA procedure. The determination of how to best provide adequate and timely care to a Medicare beneficiary should fall under the purview of

the patient-surgeon relationship, as these are the individuals who shoulder the risk of these procedures. A shared decision-making model requires the primacy of the doctor- patient relationship. Ultimately, the surgeon must be the final arbiter of the appropriate site for the surgical procedure. We ask that this be explicitly stated in the final rule.

The AAOS calls for clear criteria for surgical site selection. Not all ASCs nor outpatient departments are the same. Further, local ASCs have their own criteria for whether a particular patient may have surgery at their facility. CMS must ensure that patients rejected by an ASC have other local inpatient hospital or HOPD options. The determination of surgical site selection must be weighed in light of local conditions to assess basic patient safety. In addition to the capabilities of a specific facility to treat certain orthopaedic conditions, after care must be available. That being said, rigid criteria for a patient being done as an outpatient or in the ambulatory setting may not meet these local conditions. Should home care or transportation be unavailable, the ambulatory option should not be pursued. Otherwise, the patient may be forced into a distant and unfamiliar care setting, thus obviating the advantages of the outpatient or ambulatory care.

Another unintended consequence of forcing care into the outpatient setting becomes apparent when commercial payers follow CMS, the healthcare market leader. These payers will have considerable power to drive patient care to specific facilities and restrict patient access to ASCs based on cost alone. Forcing care to the outpatient or ambulatory setting could result in significant further stresses in isolated rural care settings. To this end, the AAOS requests patient selection and risk stratification protocols that will harmonize the differing criteria of hospital outpatient departments and ASCs.

An outpatient TKA procedure would be appropriate only for carefully selected patients who are in excellent health, with no or limited medical comorbidities and sufficient caregiver support. It is important to note that the less invasive unicondylar arthroplasty, or partial knee replacement (CPT 27446), currently performed successfully in the outpatient setting, is not entirely similar to total knee arthroplasty. There are significant differences between partial and total knee arthroplasty, particularly when patellar resurfacing is performed as part of a TKA. Aside from requiring a larger incision for greater exposure, TKA is a significantly more invasive procedure with a greater risk of complications, such as bleeding, deep vein thrombosis, and pulmonary embolism. Best practices for lowering the incidence of adverse events will require a more comprehensive and extensive perioperative plan than for unicondylar replacement. For instance, post-operative limitations for those undergoing TKA necessitate physical therapy and pain management leading to greater use of ancillary services in the postoperative and preoperative periods.

The AAOS is currently developing outcomes measures to assist optimal selection of the ideal candidate for these procedures. The medical specialty societies engaged in such activities are best positioned to develop evidence-based patient selection and exclusionary criteria for

determining the clinical acceptability of performing TKA as an outpatient procedure. As there are no validated orthopaedic outcome performance measures at present, time will be required to incorporate performance measures into practice and publish peer-reviewed data optimizing patient selection. AAOS suggests that a stepwise approach to transitioning to the Ambulatory Surgical Center (ASC) will require one – two years of TKAs in the outpatient departments of hospitals. The data collected in a joint registry will inform the best practices and the safe transition to the ASC. Systematic data collection is necessary for developing adequate risk adjustment and exclusion criteria for all arthroplasty procedures, regardless of the surgical setting (i.e., hospital inpatient, outpatient or ASC). CMS has the opportunity to define best practices by sharing data and lessons learned from the Bundled Payment for Care Improvement (BPCI) demonstration for public analysis, in peer reviewed medical literature as called for in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation.

We appreciate that CMS proposes to prohibit the Recovery Audit Contractor (RAC) from denying a hospital claim for patient status for TKA procedures performed in the inpatient setting for a period of 2 years. This will allow time to gain experience in performing TKA in the outpatient setting. However, the AAOS echoes previously highlighted concerns about the effects of removing the TKA procedure from the IPO list on the BPCI and Comprehensive Care for Joint Replacement (CJR) Medicare payment models.

In connection with the proposal to remove TKA from the inpatient-only list, we strongly urge CMS to coordinate with CMMI on the development and implementation of the next iteration of the BPCI initiative. In the current BPCI initiative's Model 2, episodes can only be triggered by a hospital admission. Should CMS subsequently allow for joint replacements in the outpatient setting and the next BPCI program require an inpatient trigger, hospital or physician group Episode Initiators (EIs) in the new BPCI would be at a significant disadvantage. Specifically, these EIs will likely be left to manage only the most medically complex and likely higher costing Medicare patients, as opposed to the more highly optimized or less comorbid beneficiaries who are viable candidates for an outpatient procedure. While risk stratification may be employed in this context, given the dearth of historical cost data establishing sound target pricing within the IPPS- v. OPSS-eligible patient population, viable target pricing for these episodes early in the program's development, will be challenging. As we have seen in the current initiative, in the face of unrealistic or vastly unpredictable target pricing, EIs will exit the program.

The AAOS believes that payments for TKA should remain site neutral. By moving a procedure to the outpatient setting, Medicare will benefit from substantial inpatient savings. Moving TKA out of the IPO should not lead to reevaluation of the entire family of joint replacement codes. In fact, providers should be compensated for the additional work they will perform to optimize care in the outpatient and ASC settings. As previously mentioned, an outpatient procedure would require considerably more physician work and care coordination, both in surgical planning, and throughout the perioperative period. Perioperative support services, traditionally provided by hospital staff, will fall to the provider. This includes care coordination, such as arrangement of

physical therapy, transportation, and home services. The development and provision of preoperative education programs (e.g., Joint School), which has become standard of care, is labor intensive and, both, financially and logistically burdensome.

### **Removal of Partial Hip Arthroplasty (PHA) and Total Hip Arthroplasty (THA) Procedures from the IPO List**

The AAOS offers the following comments on whether partial and total hip should also be removed from the inpatient only list and added to the ASC Covered Surgical Procedures List.

We believe clarification of “Partial Hip Arthroplasty (PHA)” is necessary. The procedure performed under CPT code 27125, commonly called hemiarthroplasty, is primarily for treatment of fragility hip fractures in the elderly. It is not an elective procedure and has very narrow indication criteria. It would not be safely performed on an outpatient basis. Unlike total and partial knees, which are elective and require differing levels of invasiveness, THA and hemiarthroplasty are equally invasive procedures. In fact, patients requiring a hemiarthroplasty for fragility fractures are by nature higher risk, suffer more extensive co-morbidities and require closer monitoring and preoperative optimization. It would not be medically appropriate to remove CPT code 27125 from the IPO.

Most outpatient departments are equipped to provide THA to some Medicare beneficiaries. The AAOS believes it is appropriate to remove THA (CPT code 27130) from the IPO, as well as add it to the ASC list, with the same caveats as TKA. In fact, all of our previous comments on TKA would apply to THA. While technically dissimilar, these procedures would have parallel perioperative requirements.

### **Further Recommendations for Removal from IPO and Addition to ASC Covered Surgical Procedures**

The AAOS requests that CMS consider removing several additional procedures from the IPO, as well as add them to the ASC list. We believe these procedures satisfy most, if not all, of the criteria for consideration of removal.

- CPT 27702 Total Ankle Arthroplasty (TAA) or Total Ankle Replacement (TAR)
- CPT 27703 Revision Total Ankle Arthroplasty
- CPT 23472 Total Shoulder Arthroplasty
- CPT 23470 Shoulder Hemiarthroplasty

A recent study in the *Journal of Bone and Joint* compared total shoulder replacement (TSA) among Medicare beneficiaries in the inpatient and outpatient setting. “After controlling for age, gender and medical conditions, patients who underwent TSA as outpatients had lower rates of 30- and 90- day re-admission and a lower rate of complications than inpatients.” (*Bone Joint*

J2017;99-B:934-8). Assuming proper patient selection, similar findings could be expected for ankle arthroplasty patients.

### **Payment Changes for X-rays Taken Using Computed Radiography (CR) Technology**

AAOS believes that the reduction in payments for services utilizing computed radiography technology is unreasonable. Providers who offer in-office services to improve access and convenience to patients should not be penalized for using this time-tested technology. In fact, CR is preferable to Digital Radiography (DR) in certain instances. For example, a full spine radiograph for scoliosis evaluation and scanograms for leg length inequality are ideally performed using CR. DR requires a “stitching” together of separate views, introducing measurement errors and sub-par studies. The quality of DR in these setting is sub-optimal. While some hospitals may be better positioned to make high fixed-cost investments, digital upgrade of a radiology suite is a financial barrier for others, including most individual and small practices. Decreasing payments furnished during CYs 2018 through 2022 by 7 percent, and 10 percent thereafter, will force many orthopaedic providers to cease offering these services. To incentivize upgrades to DR, AAOS recommends offering bonus payments analogous to the currently proposed 2015 Certified Health Record Technology (CEHRT) bonus under the Quality Payment Program (QPP) Year 2. Additionally, the CPT modifier requirement should fall on the provider using DR, particularly in light of higher reimbursement.

### **Accounting for Social Risk Factors and Risk Stratification**

We commend CMS for addressing the complicated issue of social risk factors within each of its quality programs. Social factors are well-studied determinants of health and are fundamental to understanding and measuring quality. In addition to the standard socio-economic covariates, such as education, marital status, and employment status, there are functional issues that affect outcomes, particularly with respect to orthopaedic conditions. Patients lacking family assistance or those having to navigate stairs at home tend to require more services, including longer length of stay, inpatient rehabilitation, or home care services. Additionally, distance and transportation to the site of care have a direct effect on outcomes and functional improvement. Consider the patient who does not have a means of transportation to a physical therapy facility after knee replacement surgery. Without extended home physical therapy services, this patient might develop significant post-operative scarring, a painful and restrictive condition, often requiring additional corrective surgery. It is clear that social needs are powerful drivers of care provision. Accounting for these factors can illuminate the cause and legitimacy of cost variation. Programs should be designed to enable teams of providers to redesign care in ways that reduce or eliminate avoidable spending, while ensuring that patients with greater needs have access to increased levels of care.

Risk stratification and adjustment are equally significant components of valid quality assessment. Outcome measures are only reliable in a relative sense, as a means to compare baseline and post-

care status. Comorbidities, functional impediments, and cognitive limitations must be accounted for when assessing quality and costs. Importantly, the effects of multiple co-morbidities and social factors are often synergistic. Providers should not be financially penalized when caring for patients with greater needs. This could potentially discourage providers from performing certain procedures or lead to restriction of warranted care.

#### Priority List of Risk Variables

- Body Mass Index – The actual height and weight should be recorded. The BMI should not be captured from the administrative data. The height and weight are currently being recorded in many electronic health records.
- Race/Ethnicity – Race/ethnicity should be a patient-reported variable and may be recorded in the EHR.
- Smoking Status – Smoking status may be reported through administrative data but additional information may be provided from the EHR.
- Age – Age is reported in administrative data.
- Sex – Sex is reported in administrative data.
- Back Pain – Back pain would be a patient-reported variable and recorded in the EHR. It has been noted to influence outcomes of joint replacement patients.
- Pain in Non-Operative Lower Extremity Joint – Pain in a non-operative lower extremity joint would be a patient-reported variable and recorded in the EHR. It has been noted that pain in other extremities can influence the outcome of a total joint replacement.
- Health Risk Status – The actual comorbidities that should be included need further investigation. Both the Charlson morbidity index and the Elixhauser morbidity measure may identify appropriate comorbid conditions. In order to identify the patient's comorbid conditions, it is recommended that all inpatient and outpatient diagnosis codes for the prior year be evaluated.
- Depression/Mental Health Status – The PROMIS Global or VR-12 will collect this variable, as well as the administrative data.
- Chronic Narcotic or Pre-Operative Narcotic Use – These variables affect patient outcomes and requires additional consideration. The information should be available in the EHR.
- Socioeconomic Status – This variable affects patient outcomes and requires additional consideration. Further evaluation is required regarding how the data could be collected.
- Pre-Procedure Ambulatory Status.

#### Future Desired List of Risk Variables

- Literacy
- Marital Status
- Live-in Home Support
- Family Support Structure

- Home Health Resources

#### Risk Variables to Not Include

- ASA Score
- Range of Motion (ROM)
- Mode of PROM Collection

#### **Physician-Owned Hospitals**

Physician-owned hospitals (POH) have been shown to provide higher quality care at lower cost compared with those run by non-physicians or appointed boards. A higher percentage of POHs have received the top 5-Star Rating by CMS than non-POH hospitals, which have considerably higher risk of complications. With physician- controlled operations, these hospitals are more agile. They are able to shift focus and address frontline issues without the administrative red-tape that cripples larger hospital systems. They contribute to local economies and meet a growing demand for health care services, especially in rural areas. Concerns that POHs could have an incentive to serve only the most profitable patients have been proven baseless. A comprehensive peer-reviewed study published by the British Medical Journal found that, overall, “physician-owned hospitals have virtually identical proportions of Medicaid patients and racial minorities and perform very similar to other hospitals in terms of quality of care.”

We encourage the Secretary to explore all regulatory avenues to lift the arbitrary ban on new and expanding POHs. The Secretary has broad authority in creating a new demonstration project through the Center for Medicare and Medicaid Innovation for POHs which would include a waiver or exemption that would allow POHs to expand if they are accepted into the program. We also encourage the Secretary to explore a defined process for states to waive the Affordable Care Act’s provisions on POHs through state and regional waivers. Based on legal analysis of the relevant statutes, regulations, and guidance regarding state section 1115 waivers and the POH restrictions, the Secretary has broad authority to modify section 1877 and lift the POH moratorium.

Additionally, the Stark Law, which has not been updated statutorily for more than two decades, limits the full potential of Alternative Payment Models (APM) and POHs as innovative health care delivery models. Its implementation has not realized the goal of decreasing medical costs. Rather, it has resulted in large hospital systems that disincentivize competition. These hospital systems are absorbing surrounding medical practices, becoming functional HMOs and multi-specialty practices. Further, as rural hospital pressures accelerate, physicians (or physician-led groups) should be allowed to partner in a joint venture with the current management structure. This is just another way to preserve access to rural medical care while driving down costs and

increasing quality care. The local medical market should dictate the structure of the medical services available.

### **ASC Payment Reform**

Payments for ASCs continue to be updated annually based on the Consumer Price Index, while the HOPD update is based on the “hospital market basket.” The Consumer Price Index for All Urban Consumers (CPI-U) is not a good indicator of costs of goods affecting ASCs. The use of the CPI-U methodology results in a more volatile update factor that does not accurately predict ASCs costs. Accordingly, AAOS continues to urge CMS to use the hospital market basket, aligned with the HOPD productivity adjustment, to update the ASC payment system.

The AAOS also wishes to express ongoing concern that the relationship between ASC and HOPD rates continues to diverge with these proposed rule policies. The gap between the two payment systems is creating financial incentives to use the HOPD rather than the ASC setting in more competitive metropolitan areas.

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

The AAOS agrees that implant costs may be an issue when moving certain procedures to the outpatient setting. As implant costs and purchasing power vary widely across individual facilities, careful evaluation is necessary before moving these procedures to the ASC Covered list. We agree with the device-intensive designation for 27179, 27279, 27415, 27438, 27440, 27442, and 27446 and request analysis of device offset for ankle and shoulder arthroplasty implants. Likewise, ancillary services must be examined in this setting.

### **ASC-17**

CMS proposes to introduce new measure ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures beginning with the CY 2022 payment determination. This measure will use claims data to capture seven-day unplanned hospital visits. The AAOS believes in the importance of measures that can validly demonstrate quality. That said, the assumption that a hospital visit within 7 days of ASC procedure is a sign of poor quality is not well proven, particularly if “all-cause” conditions are applied. Successful application of risk stratification methods must be accomplished before using such data. This is particularly important if we are to continue to move traditionally inpatient procedures to the outpatient and ambulatory setting. During such a transition, there is greater likelihood and expectation of overutilization of unplanned hospital visits. The ASC-17 should not be tied to payment or measure procedures



until after the first year of provision in the ASC setting. Doing so at the outset would not accurately reflect quality and risks incentivizing hospital services over ASCs.

### **Health Care System Flexibilities and Efficiencies**

The AAOS commends the Administration's efforts to initiate various payment, quality, and delivery models under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We support the commitment of all stakeholders to develop and evaluate payment methodologies that incentivize coordination of care and curb health care inflation. Admittedly, these programs have wrought significant administrative strain. We appreciate that in recent rulemaking CMS has been so forthcoming in its pursuit of stakeholder input for ameliorating the burdens associated with these changes.

#### **Hardship Exceptions**

We thank CMS for the introduction of hardship exceptions for small practices and believe that additional exceptions should be extended to rural practices, low-volume physicians (as with MIPS) and similarly situated physicians with significant barriers to participation (i.e., physicians without expectation of extended future practice). Further, hospital-based physicians who are captured through facility reporting should not be required to duplicate that effort. The AAOS is encouraged by CMS proposing to allow voluntary participation in the CJR payment model and hope further exceptions will be offered.

#### **EHR**

Payment and quality programs are designed to improve care and control costs. Unfortunately, current electronic health records were primarily developed for billing purposes. Expanding dependence on financial technology for quality reporting and patient care has not been a simple transition. We have seen utilization of EHR diminish the provider-patient relationship and we must ensure that this does not continue. Neither CMS nor providers have the ability to streamline CEHRT functionality and must rely on EHR vendors to support this effort. To this end, we thank CMS for its justifiable suspension of the requirement for providers to upgrade to 2015 Edition CEHRT, as most EHR developers have not yet met the 2015 CEHRT requirements. Only 96 of the more than 3,800 EHR products are currently certified and posted on the Certified Health IT Product List (CHPL). Further the vendor should shoulder the burden of not meeting CMS / ONC standards, not the physician. With the proposal to move total joint replacements to the ASC list, it is important to note that ASCs do not currently have available CEHRT.

#### **Medicare Claims Data**

Quality improvement and patient safety dictate robust use of all data sources to meet the goals of the National Quality Scheme. Adequate risk adjustment is evolving and comprehensive registry data requires the merging of real-time Medicare claims data. The AAOS is deeply concerned about CMS's continued refusal to implement Section 105(b) of

the MACRA statute. The law included a provision, Section 105, “Expanding the Availability of Medicare Data,” which was to have taken effect on July 1, 2016. Unless QCDRs can validate their data with real-time Medicare and non-Medicare claims data, their findings exist in a virtual vacuum and are of little benefit. Both the patient and the medical device itself require surveillance throughout the medical system in order to meet goals of both CMS and FDA. Presently, the medical record is discontinuous and held by various providers and institutions utilizing unique identifiers. Despite calls for interoperability, there is no easy way to reconcile an individual’s record from different facilities. Thus, a failed device would elude identification. Real time data from Medicare claims is a minimum requirement for solving this essential function. With validation, QCDRs can provide CMS with information that can both save lives and incur significant cost savings for the Medicare program. AAOS urges CMS to implement Section 105(b) of MACRA and grant QCDRs access to real-time Medicare claims data.

#### Non-mandatory bundles

We thank CMS for responding to our concerns regarding the Surgical Hip and Femur Fracture Treatment (SHFFT) by cancelling the model before it was to begin. We also thank CMS for decreasing the number of mandatory Metropolitan Statistical Areas (MSA) for the Comprehensive Care for Joint Replacement (CJR), but continue to believe that CJR should be voluntary in all MSAs until such time as public reporting and best practices have been identified. Currently, many surgeons and facilities are forced into models, though they lack the familiarity, experience, and/or proper infrastructure required to support care redesign. This aggressive model is counter to the spirit and letter of MACRA which calls for public reporting, peer reviewed publication and association analysis to identify best practices prior to widely implementing a model. Further, the AAOS agrees with the proposal allowing voluntary participation in CJR through an opt-in election. This will decrease the reporting burden, particularly for low-volume and rural providers. We also look forward to the new voluntary bundled payment models that will be available for 2018.

#### Advanced Alternative Payment Models (APMs)

CMS has proposed to broaden the scope of eligible clinicians attaining Qualifying Participants (QP) status for the CJR Advanced APM. We appreciate the move towards allowing a greater number of providers to participate in an orthopaedic Advanced APM. We look forward to the next iteration of the BPCI initiative models that will qualify as Advanced APMs for 2018. BPCI is a proven model for expanding care for both physician groups and hospitals in large and small markets and, as such, can be built upon and expanded. Without the BPCI models, the CEHRT/Advanced APM track in CJR would be the only opportunity for orthopaedic surgeons to participate in Advanced APMs. Thus, we continue to urge CMS to expand on specialist-focused Advanced APMs that will allow for greater participation by specialists.

We support the proposal to reconsider the Metropolitan Statistical Area (MSA) selection criteria used earlier and decrease the mandatory MSAs to 34 of the original 67. The current voluntary BPCI initiative is already a nationwide program, without the MSA restrictions or eligible case thresholds. This design has enabled the expansion of care redesign for elective and trauma cases well beyond the limits of major metropolitan areas.

#### Physician Leadership

We would like to echo our earlier recommendation to explicitly place a surgeon as head, or co-head, of episodes-of-care, which would significantly reduce barriers to achieving high quality patient outcomes. It is the orthopaedic surgeon who is involved in the patient's care throughout the episode-of-care. No other party in the total episode-of-care is as involved in all aspects of the patient's care, and no other party is as important to the final patient outcome, as the operating surgeon. Therefore, it is logical that all episodes treated under the program be overseen by orthopaedic surgeons, rather than an acute care hospital facility. In addition, we believe the surgeon bears the most risk and, ultimately, is best able to discern the optimal means to improve quality and efficiency. We recommend that CMS create a mechanism for a surgeon or physician group to participate with a third party who manages the episode, payments, and "shared savings" distributions.

Finally, the AAOS recommends that CMS eliminate all limits on gainsharing among providers to allow flexibility for allocating CMS payments across program teams in ways that maximize incentives. While we support measures to disincentivize overprovision of services, there should be no restriction on payment for cost-controlling services within an episode.

#### Code Errors

The AAOS is concerned about the requirement that all providers use G-codes for all post-operative patient encounters. In addition to being unnecessarily burdensome, this will most likely result in inaccurate data. While reviewing the requirements for reporting post-operative visits (99024), we have uncovered many errors in the long descriptors on the code list published on the CMS website. We identified a ***26 percent error rate*** in the long descriptors for just the musculoskeletal codes (20000 series). For example, the long descriptor listed for code 29822 is arthroscopy, shoulder, surgical; capsulorrhaphy. This descriptor is incorrect and should read arthroscopy, shoulder, surgical; debridement, limited. These errors are not insignificant and are causing tremendous confusion for providers in an already demanding reporting environment. The AAOS believes these errors will cause the data collected to be incorrect and requests that the mandatory reporting period scheduled to begin on July 1, 2017, be postponed until the corrections can be made and provider education efforts reinstated with the corrected information.

#### Independent Payment Advisory Board (IPAB)

While largely an effort that must be undertaken by Congress, the AAOS opposes the IPAB and supports repeal of this entity. IPAB's mandate to contain Medicare costs will likely subject physicians to unfair cuts in reimbursement. IPAB is severely constrained in what it can recommend to slow the pace of Medicare spending growth. IPAB recommendations cannot increase beneficiary premiums or cost-sharing, cannot reduce benefits in any way, and cannot increase taxes. The only options available are adjustments to what Medicare pays for various medical services. Since hospitals are exempt from cuts until 2020, the burden of payment reductions will fall heavily on physicians.

#### Accrediting Organization Publication of Plans of Correction

We appreciate the decision not to pursue the publication of quality improvement surveys and plans of correction by accrediting organizations (AO) in current form. Quality Assurance (QA) committees and documentation have been held as non-discoverable in medico-legal actions by most states in an effort to promote disclosure. Proposal of publication would go against QA activities across health systems in most states (Kentucky being a notable exception).

#### Opioids

Orthopaedic surgeons are intimately aware of the difficulties of providing pain relief amidst the opioid crisis. Many orthopaedic conditions require narcotic pain management for weeks or months, particularly those involving trauma or aggressive post-surgical physical therapy. We continue to utilize multimodal pathways for pain control, thus decreasing the need for oral pain medication.

We believe that payment incentives for higher scores on the Pain Management dimension of the HCAHPS survey may have created the unintended consequence of overprescribing opioids in the inpatient setting. This scoring system of "Pain as a Fifth Vital Sign" has also created a culture of opioid demand among patients which has made discontinuation of narcotics challenging. We appreciate the change in the Pain Management category of HCAHPS, but it is important to clarify the difference between prescribing appropriate narcotics for acute pain related to injury or surgery and prescribing behavior which promotes dependence. For example, states are restricting narcotics (i.e., the 7-day rule, required E-prescribing) and have mandated DEA logging for each narcotic prescription. These stop-gap regulations place extraordinary burden on patients and physicians treating acute pain in the post-operative period, when narcotics are necessary and warranted. Pain medication dosing is often increased as patients become more active in the days following hospital discharge. This leads patients to prematurely complete the 7-day supply. As can be expected, it is not uncommon for patients to suffer weekends without pain medication in the days following surgery when physicians lack access to the EMR.

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We appreciate CMS's continued efforts to reduce the burden on clinicians and to introduce

greater flexibility. Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' suggestions. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

A handwritten signature in black ink that reads "William J. Maloney". The signature is written in a cursive style with a large, sweeping loop at the end.

William J. Maloney, MD  
President, AAOS

Cc: David A. Halsey, MD, First Vice-President, AAOS  
Kristy L. Weber, MD, Second Vice-President, AAOS  
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS  
William O. Shaffer, MD, Medical Director, AAOS

This letter has received sign-on from the following orthopaedic specialty societies:

Alabama Orthopaedic Society  
American Alliance of Orthopaedic Executives (AAOE)  
American Association of Hand Surgery (AAHS)  
American Association of Hip and Knee Surgeons (AAHKS)  
American Orthopaedic Society of Sports Medicine (AOSSM)  
American Shoulder and Elbow Surgeons (ASES)  
American Spinal Injury Association (ASIA)  
Cervical Spine Research Society (CSRS)  
Limb Lengthening and Reconstruction Society (LLRS)  
Musculoskeletal Infection Society (MSIS)  
Musculoskeletal Tumor Society (MSTS)  
Scoliosis Research Society (SRS)  
Florida Orthopaedic Society  
Georgia Orthopaedic Society  
South Carolina Orthopaedic Association  
The Hip Society (HIP)  
The Knee Society (KNEE)  
The OrthoForum