



AMERICAN ACADEMY OF  
ORTHOPAEDIC SURGEONS

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ORTHOPAEDIC SURGEONS

July 23, 2018

Seema Verma, MPH  
Administrator,  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services,  
Attention: CMS-1689-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

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

**Subject: [CMS-1689-P] Medicare and Medicaid Programs; Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers and Request for Information on Price Transparency: Improving Beneficiary Access to Home Health Agency Charge Information**

Dear Administrator Verma:

On behalf of over 34,000 orthopaedic surgeons and residents 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 Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers and the Request for Information on Price Transparency: Improving Beneficiary Access to Home Health Agency Charge Information included in the Centers for Medicare and Medicaid Services' (CMS) Medicare and Medicaid Program; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements (CMS-1689-P) published in the Federal Register on July 2, 2018.

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## **I. Promoting Interoperability**

AAOS strongly supports the development of interoperability standards for all Electronic Health Records (EHR). We also support the development of appropriate standards for meaningful use of electronic health records by government agencies and private carriers which balance the needs of patients and their families, physicians and their staff, and regulators. We believe these standards

should be collaboratively developed by physicians through their professional organizations in cooperation with government agencies. The process should emphasize the requirements for the highest level of quality patient care while recognizing the limits and clinical specialty focus of physicians who use the systems.

As orthopaedic surgeons, we have been at the forefront of various CMS experiments with episodic bundled payment models. We have been successful in improving the quality of care for our patients as well as in reducing costs for the Medicare program by partnering with post-acute care providers. Post-acute care providers were a major source of efficiencies in the Bundled Payment for Care Improvement (BPCI) Classic. Therefore, we believe that any discussion of interoperability is incomplete without including all providers across the care delivery continuum. Home Health Agencies (HHAs) play a vital role in this space. In this regard, we applaud the announcement of the Data Element Library by CMS which will enable all post-acute care providers to “speak the same language” and exchange patient care information with acute care providers and other primary care providers.

AAOS welcomes innovative solutions to help advance the electronic exchange of information. Moreover, AAOS agrees that physicians need to be able to see and integrate certain key pieces of a patient’s demographics and health history into their EHR from other sources to provide more comprehensive care. However, we recommend setting a standard that only allows stakeholders to participate in data exchange if they can meet minimum standards for data exchange and security.

AAOS also encourages conducting all exchange openly and transparently. We suggest establishing the need for an audit log that is maintained by the data owner, where the record of source is kept, that tracks where the data was sent, who requested the information, and what information was sent. This audit trail can then be made available to the patient upon request.

One 2017 survey on adoption of these technologies concluded that, “[T]hese are organization-wide changes that will make an impact on not only the physicians and care providers but can have long lasting impact on the entire health system.”<sup>1</sup> Accordingly, these changes should be handled cautiously and any changes to current CMS health and safety standards should only implement those solutions recognized to improve patient care and safety.

AAOS continues to support differentiated payments in which bonuses might be paid to incentivize HIT adoption. However, revising CMS’s conditions of participation (CoP), conditions for coverage (CfC), or requirements for participation (RfP) will not overcome the significant challenge posed by information blocking.

As the Office of the National Coordinator explained in its 2015 report to Congress on the subject, providers often have less power to solve this particular obstacle to interoperability. “Having made these investments, providers may be financially and otherwise unable to switch to

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<sup>1</sup> “Why physicians switch electronic health record vendors,” Pete Andresen, et. al., Business & Health Administration Proceedings, 226-134 (March 2013).

superior technologies that offer greater interoperability, health information exchange capabilities, and other features. These switching costs make it easier for developers to engage in information blocking without losing existing customers.”<sup>2</sup> AAOS believes any solution should target intransigent developers but also recognize the cost burden of certain requirements, particularly for small private practitioners, and for practitioners in rural areas.

We appreciate CMS’s decision to establish a ‘Promoting Interoperability’ score of 50 points or more in order to satisfy the requirement to report on the objectives and measures of meaningful use. AAOS agrees that the 50-point minimum score provides the necessary benchmark to encourage progress in interoperability. The reduction in the ‘Provider to Patient Exchange’ objective percentage between 2019 and 2020 is a move in the right direction, but we still believe 35 points on this objective is heavily over-weighted.

In the Proposed Rule, CMS seeks feedback on the question of “identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records.” AAOS agrees that more informed patients produce better outcomes through shared decision-making by both patients and providers. However, we would urge CMS that “directly sharing” records with patients does not always translate into true value for patients. As we have in the past, AAOS continues to support efforts that produce greater transparency and consumer education in this space. However, patient records are just one means by which providers can create a forthright record of patient interactions and evaluations. However, in a number of scenarios, patients’ descriptions to their providers may not always align with providers’ assessments. Due to the legal sensitivities involved with patient records, as well as the substantial risk of contextual misinterpretation, we would caution CMS as it tries to eliminate barriers that prevent patients from being given unfiltered access to and control of their medical records.

## **II. Price Transparency**

AAOS shares CMS’s concern that patients face unwarranted challenges due to insufficient price transparency. As the Medicare Access and CHIP Reauthorization Act (MACRA) envisioned, healthcare in the United States should be oriented toward delivery of high quality and value-based care. Giving patients more information on their healthcare is an important step toward that goal. Yet transparency alone – and relying on the patient to make those decisions alone – will never be enough in the absence of comprehensive work from all stakeholders to move toward value-based care. Relatedly, providing pricing information alone does not help patients understand that information nor does it consider other measures of patient satisfaction. Equally important is preserving the value of physicians’ services for their patients.

One complication to providing greater transparency in healthcare pricing is the unique nature of assessing the quality of healthcare services for many patients. In fact, a study in the *New England Journal of Medicine* has explained that, “Timely and salient comparative quality information is often

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<sup>2</sup> “Report on Health Information Blocking,” Office of the National Coordinator (April 2015), p. 23, [https://www.healthit.gov/sites/default/files/reports/info\\_blocking\\_040915.pdf](https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf).

unavailable, so patients may rely on cost as a proxy for quality. The belief that higher-cost care must be better is so strongly held that higher price tags have been shown to improve patients' responses to treatments through the placebo effect."<sup>3</sup> CMS's movement toward rewarding quality care should not be superseded by hasty price transparency solutions.

Studies have repeatedly demonstrated that simply providing price transparency tools to patients have had mixed results.<sup>4</sup> According to one study, "Price transparency tools may result in lower prices for a selected set of services, but the tools have little impact on overall spending because of the small percentage of people who use them."<sup>5</sup> In addition to the limited use of these tools, patients are also often unwilling to switch providers,<sup>6</sup> and "[u]sing price transparency websites to choose providers is complicated for patients, given the wide array of services a person can receive and the complexity of billing and navigating different types of out-of-pocket spending (that is, deductibles, coinsurance, and copays)."<sup>7</sup>

Giving patients access to median Medicare costs for a particular service would allow this information to be accessible in a single online repository. CMS already has access to this information and could provide sufficient clarity to inquiring patients about their expected portion of the estimated, median cost.

AAOS would like to highlight another impairment to full transparency. Many physicians have multiple contracts with carriers where the actual price for a procedure is unknown as carriers will only supply the surgeon with a sample of the twenty most common procedures. In these circumstances, many surgeons do not actually know what price will be paid for a specific procedure for a specific patient's health plan. This arrangement is, by some carriers', designed so that one surgeon group does not know what another is being paid in a specific region, and it can serve to prevent price-setting. AAOS asks CMS to remain cognizant of such gaps in providers' price knowledge as it works to craft solutions, and recognize the need for an all-inclusive plan that involves participation by all stakeholders.

Payers, including CMS, represent the best resource for patients seeking information about their individual costs. If CMS requires HHAs to make available online a list of charges in machine-readable format, CMS should define "standard" as usual and customary charges by providers in the geographic area before the application of any discounts.

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Thank you for your time and consideration of the American Association of Orthopaedic

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<sup>3</sup> "Increased Price Transparency in Health Care — Challenges and Potential Effects," *The New England Journal of Medicine*, Anna D. Sinaiko, PhD, et. al., 891-894 (March 2011).

<sup>4</sup> "Would Greater Transparency And Uniformity Of Health Care Prices Benefit Poor Patients?" Margaret K. Kyle and David B. Ridley, *Health Affairs*, 1384–1391 (October 2007); "Examining A Health Care Price Transparency Tool: Who Uses It, And How They Shop For Care," Anna D. Sinaiko and Meredith B. Rosenthal, *Health Affairs*, 35:4 (April 2016).

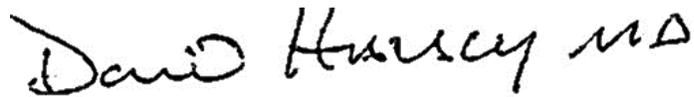
<sup>5</sup> "Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees," *Health Affairs*, Sunita Desai, et. al., 1401–1407 (August 2017).

<sup>6</sup> "Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information," Ateev Mehrotra, et. al., *Health Affairs*, 1392–1400 (August 2017).

<sup>7</sup> Desai (August 2017).

Surgeons' suggestions. We commend CMS on its 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, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

A handwritten signature in black ink that reads "David Halsey MD". The signature is written in a cursive, slightly slanted style.

David A. Halsey, MD  
President, AAOS

Cc: Kristy L. Weber, MD, First Vice-President, AAOS  
Joseph A. Bosco, III, 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:

American Association of Hip and Knee Surgeons (AAHKS)  
American Orthopaedic Society for Sports Medicine (AOSSM)  
American Shoulder and Elbow Surgeons (ASES)  
American Spinal Injury Association (ASIA)  
Arthroscopy Association of North America (AANA)  
Cervical Spine Research Society (CSRS)  
Limb Lengthening and Reconstruction Society (LLRS)  
Musculoskeletal Infection Society (MSIS)  
Ruth Jackson Orthopaedic Society (RJOS)  
American Alliance of Orthopaedic Executives (AAOE)  
OrthoForum