AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

April 26, 2017

Thomas E. Price, MD
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Ms. Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Price and Administrator Verma:

On behalf of over 18,000 board-certified orthopaedic surgeons represented by the American Academy of Orthopaedic Surgeons (AAOS), we appreciate the Administration's emphasis on reducing regulatory burdens and would like to offer some suggestions to address the needs of our surgeons and thus improve patient care. We urge the Administration to consider the recommendations listed below.

2016 PQRS & MU Reporting Relief
The AAOS commends the Administration's efforts for initiating various payment, quality and delivery models under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We appreciate your aim to reduce the administrative burden on clinicians and to introduce greater flexibility in reporting requirements and eligibility rules. There have been challenges for providers in meeting the requirements of Physician Quality Reporting System (PQRS) and Meaningful Use (MU). We urge the Centers for Medicare & Medicaid Services (CMS) to change 2016 PQRS requirements by reducing the number of measures for success to six measures. This would be consistent with the Merit-based Incentive Payment System (MIPS) and would enable more physicians to succeed. In addition, we urge CMS to substantially expand the hardship exemption criteria for 2016 MU to include older physicians, low volume physicians (similar to MIPS), hospital based physicians, rural practices and small practices.

MACRA: MIPS
We are pleased that CMS agreed to our request for 2017 to be treated as a "transition year," with a gradual buildup starting in 2018, although we believe the transition should be complete with no penalties for failing to report, as opposed to the minimum reporting requirements in the final rule.

AAOS encourages removal of the requirement to report on all patients going forward. It is widely known that orthopaedic medicine lacks validated patient reported outcome based

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performance measures (PRO-PM) and has few process measures. AAOS suggests that in areas where there are no validated clinician level quality measures, and until the time these are developed, those physicians be allowed to participate in MIPS voluntarily.

MACRA: APM demonstrations

We appreciate that CMS has delayed the effective start date of the Surgical Hip Femur Fracture Treatment (SHFFT) model. We would like to thank CMS for considering additional review and comment rule-making to modify the policy. The AAOS strongly supports *voluntary* bundled and episode-of-care payment models. The CJR model and the SHFFT models' mandatory participation requirement for all surgical episodes triggered by MS-DRGs 469-470 and MS-DRGs 480-482 respectively in each of the 67 randomly selected Metropolitan Statistical Area (MSA) is flawed and should be replaced by a voluntary payment model for providers and facilities. In effect, any provider practicing in these designated MSAs will be mandated to participate in these programs. This will force many surgeons and facilities who lack familiarity, experience, or proper infrastructure to support care redesign efforts into these bundled payment models.

The proposal to include all episodes and all providers and facilities will severely disadvantage those surgeons, non-physician providers, and facilities that either do not have the proper infrastructure to optimize patient care under episodes-of-care payment models and/or lack adequate patient volumes to create sufficient economies of scale. A voluntary program that allows surgeons, facilities, and non-surgical providers to tailor their episode-of-care models to their particular patient population would lead to far better patient care as well as more accurate and efficient payments.

We strongly urge CMS to revise the mandatory nature of the proposals and instead create incentives for interested participants that would reward innovation and high quality patient care. We believe the programs should be voluntary for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, coordinated, and lower costs for musculoskeletal care and who have the infrastructure necessary to carry out an episode of care approach to payment and delivery. Specifically, we recommend that CMS require that any participating entity have verifiable interoperability, infrastructure, and agreements between all necessary entities.

Furthermore, our recommendation to explicitly place a surgeon as head, or co-head, of episodes 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, from the pre-operative workup, to the surgery itself, to inpatient post-operative care, to the post-operative care provided in rehabilitation facilities, at home, and in the physician's office. 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 and not

an acute care hospital facility. In addition, we believe an orthopaedic surgeon bears the most risk throughout the episode-of-care and ultimately has the most insight into the best pathways to improving patient care quality and efficiency and should therefore lead the bundled payment initiative.

We recommend the operating surgeons and physician groups have the ability to be in charge of the bundle, or explicitly create a mechanism allowing the surgeon or group to participate with a facility or third party to manage the episode, collect payments, recoup overpayments, and return "shared savings" across the spectrum of care. Having the hospital in charge of the bundle provides the hospital inappropriate leverage over surgeons and other participants and could allow some hospitals to exclude surgeons and other care providers if those parties don't wish to meet the hospital's terms.

AAOS recommends that CMS eliminate all limits on gainsharing among providers to give providers flexibility to allocate the CMS payment among the members of program teams in ways that maximize incentives for each specific team, as opposed to a one-size-fits-all model. Prohibiting compensation to any provider designed to reward them for increases in the number of procedures they perform must continue, but there would be no ban on payments that help control costs within a CMS episode.

2015 Edition CEHRT

We strongly urge the Administration to remove the requirement for providers to upgrade to 2015 Edition Certified EHR Technology (CEHRT). The most recent requirements for CEHRT were approved in 2015, but most EHR developers have not yet met them. Only 54 of the over 3,700 EHR products are currently certified and posted on the Certified Health IT Product List (CHPL). Physicians should not be subject to financial penalties under the Quality Payment Program (QPP) and MU because vendors have not certified their 2015 Edition products in a timely manner. CMS should continue to allow the use of both 2014 and 2015 Editions and permit participants to meet modified Stage 2 MU and Advancing Care Information (ACI) measures.

Global Codes Reporting and Data Collection

The AAOS is concerned that the steps proposed by CMS, particularly the requirement that all providers use G-codes for all post-operative patient encounters, are unnecessarily burdensome for physician and physician practices. This will most likely result in inaccurate data, and represents an overreach according to the language in MACRA calling for CMS to collect data on resources used in the post-operative global period. While AAOS acknowledges CMS' response to our comments in this regard, even requiring mandatory reporting from all providers furnishing global surgery services in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island will be unduly burdensome for providers. AAOS strongly urges CMS to significantly revise their proposed methodology to not use the G-codes as proposed, to not make the claims reporting universal to all Medicare providers using global period codes, and to utilize representative samples of services and other approaches that are likely to yield more

reliable and accurate data without imposing major burdens on hundreds of thousands of providers.

Translation & Interpreting Services
The AAOS urges the Administration to remove the burdensome requirements in the Affordable Care Act (ACA) for insurers and the healthcare industry to provide translation and interpreting services for limited English proficiency (LEP) individuals. In certain settings, such as rural areas, it is difficult to procure translation and interpreting services.

IPAB Repeal
AAOS opposes the Independent Payment Advisory Board (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 and cannot reduce benefits in any way. IPAB cannot recommend tax increases. The only options available are adjustments to what Medicare pays for various medical services. Because hospitals are exempt from cuts until 2020, the burden of payment reductions will fall heavily on physicians.

The AAOS recognizes the importance of lowering health care costs and we are committed to improving the value of health care. Medicare payment policy requires a broad and thorough analysis of the effects on all providers and beneficiaries. Unfortunately, the IPAB threatens unnecessary and harmful cuts to physicians causing undue burden on physicians and their practices.

We recognize that CMS has recently released Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information CMS-1677-P, which welcomes feedback on positive solutions to better achieve transparency, flexibility, program simplification and innovation. We will provide additional comments on this proposed rule and RFI to help inform the discussion on future regulatory action.

Thank you for your time and consideration of the American Academy of Orthopaedic Surgeons' suggestions to reduce the regulatory burden on physicians. We appreciate CMS's continued efforts to reduce the administrative burden on clinicians and to introduce greater flexibility. 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,

William J. Maloney, MD
President, American Academy of Orthopaedic Surgeons

cc: Thomas E. Arend, Jr., Esq., CAE, AAOS Chief Executive Officer
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