AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

June 24, 2016

Andrew M. Slavitt
Acting Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-5517-P, P.O. Box 8016,
Baltimore, MD 21244-8016.

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

Subject: [CMS-5517-P]
Proposed Rule: Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

On behalf of the 18,000 board-certified orthopaedic surgeons who comprise the membership of the American Association of Orthopaedic Surgeons (AAOS) and that of the orthopaedic sub-specialty groups who agreed to sign-on, we are pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule on the Medicare Program's Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models [CMS-5517-P] published in the Federal Register [81 FR 28161; 42 CFR Parts 414 and 495] on May 09, 2016.

The AAOS commends the Administration's efforts for initiating various payment and delivery models under Medicare. This incremental approach is important to allow the development and testing of value-based payment models while enhancing the traditional fee-for-service system. The communication outreach made by the CMS officials through various venues have been informative. Overall these regulations aim to reduce administrative burden on clinicians and introduce greater flexibility in reporting requirements and eligibility rules. However, as surgical specialists, we would like to offer some suggestions to improve the current proposals to better reflect the intent of the Medicare and CHIP Reauthorization Act of 2015 (MACRA) as well as the needs of our surgeons and their patients. The AAOS thanks CMS in advance for its solicitation and consideration of the following comments and concerns.

Merit-based Incentive Payment System (MIPS)

Time frame

AAOS is pleased with the new and more flexible reporting requirements, which streamlines the

multiple Medicare physician quality reporting programs into a single system. However, given that these regulations will not be finalized until the fall of 2016, it will be burdensome, if not impossible, for physicians to get ready for the first performance year of 2017. Hence, we request for 2017 to be treated as a "transition year," when the clinicians start gathering data but are not required to report on those, with the first performance year to be 2018. AAOS is apprehensive that physicians who find this time frame too difficult to comply with may not participate in the MIPS program at all.

Related to this, we believe that the two-year lag between the performance and payment years is problematic for physicians in terms of tracking their performance and managing that performance at required levels with delayed feedback. The intent of the MACRA statute is to affect a change toward value in healthcare. With that time gap, there is no meaningful feedback: payment changes are either a nice "bonus" related to unclear processes or a "punishment" with little clarity as to how the practice could improve. Our suggestion to implement this is to require reporting under MIPS (especially for the active reporting requirement measures) for the first nine months of each year, allowing the last three months for reconciliation of the data such that the performance and payment feedback are available by January of the following year. CMS can use a full year of administrative claims data for the non-reporting measures for a better sample size. This would meet the goals of Medicare by allowing rapid response to physicians at the same time removing the two year lag between performance and payment.

Further, AAOS would request CMS to provide concrete guidelines to clinicians who may find themselves not qualifying for an APM bonus payment in mid-2018 when it might be too late to prepare for participating in the MIPS program as well.

Provision of data to clinicians

In continuation of the discussion above, AAOS would like to emphasize its request for real-time provision of clinician/practice data instead of the lagged feedback system across all the elements of this new proposed program. Access to timely data reflecting the performance scoring of clinicians is essential for the success of the Quality Payment Program (QPP): while historical data could be provided as a guide to clinicians, provision of real time data on a quarterly basis could better inform clinicians. AAOS believes that small and even medium sized physician practices will not be able to participate effectively without quarterly feedback on their performance. [Please note that there are more detailed comments on this topic in the Qualified Clinical Data Registries (QCDR) section below.]

Size and characteristic of physician practice

AAOS appreciates the financial investments in education and technical assistance of small and solo practices as well as the embedded flexibilities in these proposed rules for such practices. Nevertheless, AAOS suggests two different low volume thresholds – one for primary care and

one for specialist clinicians. Also, since specialty charges are typically higher, we request CMS to raise the current proposed low volume threshold exclusions for specialists (proposed as less than or equal to $10,000 in Medicare charges and less than and equal to 100 Medicare patients) to $20,000 in Medicare charges and 200 patients. Another suggestion is to use percentage of Medicare patients to define the threshold levels. In addition including exceptions for rural practitioners (who may be the sole provider in a given area) and practitioners in other underserved areas should be considered by CMS.

With reference to Table 63 (MIPS Proposed Rule Estimated Impact On Total Allowed Charges By Specialty: Mid-Point Estimate), it is quite evident that specialty physicians are more likely to have an aggregate negative adjustment on their charges. Moreover, the data in Table 64 (MIPS Proposed Rule Estimated Impact On Total Allowed Charges By Practice Size) show that physician practices of less than 10 clinicians would account for almost 70 percent of the MIPS penalties in 2019, it is even worse for solo practices with 87 percent of the penalties. According to Table 64, for practices with two to nine clinicians, the aggregate dollar amount of potential penalties for not submitting claims is $279 million, compared to 100 or more clinicians at $57 million. For solo clinicians, it is $300 million. AAOS is concerned that even the biggest practices have less than 100 orthopaedic surgeons and thus orthopaedic practices across the country are estimated to be adversely affected under the MIPS Proposed Rule. This is a serious concern in spite of the recent communication from CMS that the data presented in these tables are dated and could be updated in the final rule.

The AAOS believes that the new scoring design will disproportionately disadvantage the solo, small and even medium-sized practices. For example, per the proposed rule, the threshold for successfully submitting claims based on measures has been increased from 50 percent under the Physician Quality Reporting System (PQRS) to 80 percent for Part B claims and 90 percent for registries and electronic health records. Smaller practices will find it extremely difficult, if not impossible, to report under these complicated guidelines and may not be able to reach these higher thresholds, both of which will result in penalties under the MIPS program.

In addition, a uniform definition of small practices will be helpful. Currently, the rule considers a practice of 10 clinicians as eligible for some exclusions and a group of 15 clinicians for others. We request CMS to use the same uniform definition for exemption from the MIPS program requirements.

Weighting of performance categories

We are concerned that the Quality and Resource Use performance category relative weights vary over time, increasing the emphasis on Cost and decreasing the weight on Quality. By Year 3, the weights on Quality and Resource Use categories become the same. This design assumes that the cost data is fully under the control of and available to practicing physicians. In reality, resource use is under the control of a plethora of providers including physicians, other clinicians, facilities

and payers. We would urge CMS to not increase the weighting on resource use until such cost data is more reliably verified and tracked and their underlying methodology is transparent and provided to participating clinicians.

MIPS performance category: Quality

It is encouraging to note that CMS proposes to make some significant changes from the current Physician Quality Reporting System (PQRS) by reducing reporting burden, providing greater flexibility and by allowing multiple reporting vehicles. The number of measures to be reported under this category are reduced (from nine to six), with no domain requirement along with flexible scoring that recognizes all of a MIPS eligible clinician's efforts above a minimum level of effort and rewards performance that goes above and beyond the norm. However, physician specialties that lack currently validated outcome measures or "high priority" measures are likely to be at a disadvantage under this category. For example, it is widely known that orthopaedic surgery lacks validated patient reported outcome based 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, CMS and the specialty societies agree on non-validated measures through a consensus process. Moreover, as in the past, AAOS is eager to work with CMS and other collaborative measure development bodies to increase the volume, validity, and applicability of PRO-PMs, as well as develop more process measures for musculoskeletal care.

The threshold for successfully submitting claims based measures has been increased from 50 percent under the PQRS to 80 percent for Part B claims. Moreover, CMS proposes to use administrative claims based population measures that were previously part of the Value-based Payment Modifier program. These measures were developed for use at the facility (hospital) and community level and have low reliability and relevance when applied at the clinician level (both individual and group). AAOS requests CMS to keep the threshold at the current 50 percent level for quality reporting for the first performance year and then use a stepped increase in threshold as individual clinician level measures are developed. For example, the threshold level could start at the current 50 percent and increase biannually to reach an 80 percent level finally. AAOS would also request for expansion of exemptions and for development of payment modifier measures that have higher reliability at the clinician level.

MIPS performance category: Advancing Care Information (ACI)

The AAOS commends CMS for reducing the number of required measures and for introducing greater flexibility in the ACI performance category (80 points) for specialist physicians and practices of varying sizes. The allowance of an additional bonus point for reporting to public health registries is encouraging in terms of the Secretary's overall goals of "Better, Smarter, Healthier." However, we have concerns, below, especially on issues of interoperability and infrastructure readiness.

The proposed rules change the scoring methodology without changing the actual measures. The base performance (50 points) would continue to have a pass/fail element including a requirement for a security risk analysis which has proven to be challenging for most physicians. Continuing a "pass/fail" scoring contradicts the overall aim of removing the "all or nothing" approach. Also, the expansion of the 90-day reporting period to a full calendar year is problematic for new participants. Overall, the new ACI performance category regulations are complex and may not fit well within the larger MIPS program scoring methodology.

The focus of measurement should not be limited to "meaningful Electronic Health Records (EHR) users," as defined (eligible professionals, eligible hospitals, and critical access hospitals that attest to meaningful use of certified EHR technology under CMS' Medicare and Medicaid EHR Incentive Programs), and their exchange partners. The populations and measures should be consistent with Office of the National Coordinator for Health Information Technology's (ONC) plans to measure interoperability per the Interoperability Roadmap.[1] For example, consumers, behavioral health providers, and long-term care providers would be included in the Interoperability Roadmap's plans to measure progress; however, these priority populations for measurement are not specified by §106(b)(1)(B)(i) of the MACRA proposed rules.

Eligible professionals under the MIPS program and those who qualify for participation in APMs need certified technology that can process performance measures and exchange normalized data to meet §1848(q) of the Social Security Act, as added by §101(c) of the MACRA. AAOS is concerned that the proposed measures of interoperability (electronically sending, receiving, finding and integrating data from outside sources, and subsequent use of information electronically received from outside sources) per §106(b)(1) of the MACRA may not be adequate. In keeping with the current move towards "patient centeredness," patient and other stakeholder input should be include in interoperability measures.

True exchange of information must be secure, useful, and valuable to the patient and the provider. The reality of the environment is that much of medical documentation outside of laboratory data is qualitative (such as narratives and reports) but is important and useful for the care of patients. Furthermore, imaging files, for example, comprise of essential data for care delivery in certain specialties such as orthopaedics. Although there are established DICOM imaging standards in common use, proprietary extensions and customization, along with data transmission and storage barriers, have perpetuated a high level of friction in the system. This results in the frequent and inefficient duplication of diagnostic imaging studies, and the continued use of physical medium (data discs) that must be manually handled and transported outside the electronic health records (EHR). Quantitative measures of data exchange should not

[1] DeSalvo, K.B. & Galvez, E. (2015). Interoperability to help achieve better care, smarter spending, and healthier people. Available at: http://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/interoperability-electronic-health-and-medical-records/interoperability-roadmap-standards-advisory/

overshadow the clinical role of high value qualitative data such as free-text. Medically informed free-text (e.g. case summaries, operative report descriptions, and decision explanations, etc.) should be preserved and shared in conjunction with more structured data to enhance individualized and holistic patient care. Therefore, Application Programming Interfaces (APIs) need to be available not only for quantitative data but also for various types of unstructured/qualitative data reports that are still vital to good patient care.

AAOS is concerned that true interoperability is not a current possibility for most private practitioners or even employed physicians. As of now, the installed technology is not fully ready and open APIs for the bidirectional free flow of data needs to be encouraged to meet the goal of interoperability. We request CMS and ONC to develop metrics on API usage and for exchange of information to help define, quantify, and improve interoperability. Further, such interoperability measures must have an API requirement from the EHR vendors and the providers. Until the time such metrics and pre-requisites are developed, it is worth considering a single data source for consistency. The only single data source that is found in both eligible and non-eligible providers is ICD-10 CM, ICD-10 PCS, and CPT coding and it is the most granular. Since these are required for billing, these claims data are ubiquitous among all providers in all settings. In addition, if the Z-code section had more wide use among providers, the risk assessment on claims data could be more complete.

Please note that AAOS has provided more detailed comments to the ONC on their "Request for Information Regarding Assessing Interoperability for MACRA" (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-08134.pdf).

MIPS performance category: Resource Use

Again, the AAOS commends the new regulations that states that this category will use administrative claims data and would not have additional reporting requirements for clinicians. However, while this reduces the reporting burden on physicians, the cost data is not readily available to physicians. As discussed above, resource use is under the control of a plethora of providers including physicians, other clinicians, facilities and payers. Thus, without transparency and the ability to control all the moving parts that are reflected in the administrative claims data, it is unfairly burdensome on physicians to be rated on resource use.

While we support using episode groups to assess physician cost/resource use, many of the episodes mentioned in Table 4 of the proposed rule [TABLE 4: Proposed Clinical Condition and Treatment Episode-based Measures Developed Under Section 1848(n)(9)(A) of the Act (Method A)] are not fully developed. We have commented on what methodological improvements are necessary to fully develop the care episode groups, patient condition groups, and patient relationship categories and codes. In February of 2016, we had submitted comments on episode groups and on specific clinical criteria to classify patients into care episode and condition groups (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-

Based-Programs/MACRA-MIPS-and-APMs/Episode-groups-summary.pdf). There are limited orthopaedic episodes that are being considered and the episodes that exist do not fully consider the longitudinal care that orthopaedic surgeons often provide. Moreover, based on the very limited existing musculoskeletal episodes, AAOS is seeking clarification on how Resource Use would be calculated (at least for performance year 2017) for orthopaedic surgeons who provide services other than total joint arthroplasty or spinal fusion (such as the care provided by foot & ankle orthopaedic specialists). Also, physician leadership of the clinical episodes and risk sharing are essential for better patient outcomes. We understand that attribution is a complex process. Unless clear attribution models are developed, there may be opportunities to measure unique aspects of a certain episode but not necessarily the episode in its entirety as the conditions in tables 4 and 5 are complex and require numerous stakeholders with not a single party able to control all aspects of resource utilization.

Concurrently, AAOS is preparing comments in response to CMS' Request for Information on patient relationship categories to be submitted by August 15, 2016 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes.pdf). However, as we await the recommendations from HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) study on the issue of risk adjustment for socioeconomic status on quality measures and resource use as required by section 2(d) of the IMPACT Act, we urge CMS to publish the patient relationship codes as early as possible so that physicians can have a better idea of how their resource use will be scored. More sophisticated risk-adjustment and more detailed attribution methods that are applicable across specialties are required to fully implement the principles of this performance category such that physicians caring for higher risk patients are not disproportionately penalized.

MIPS performance category: Clinical Practice Improvement Activities (CPIA)

Clinicians participate in various clinical improvement activities even without incentives and thus it is helpful to be incentivized for such activities. AAOS is interested in the proposal of an annual call for activities to build the CPIA inventory and that of conducting a study to understand the diversity of CPIA across practice size and location. However, such a study should be designed as inclusive of a variety of practices not just to a "limited number of MIPS eligible clinicians and groups in rural and non-rural settings." More than two specialist groups of MIPS eligible clinicians should be included to reflect the diversity of practices and focus within specialist groups. The application period to participate in the study needs to be extended beyond just the month of January 2017 to enable an easier application process especially for practices that do not have the resources to manage all the application requirements and yet will be valuable participants given the stated goals of such a study. The current rules propose that eligible participants will be approved on a first come, first served basis, we would request for a bigger pool of participants randomized on the basis of their practice characteristics, clinical specialty and geographical location.

Alternative Payment Models (APMs)

Comprehensive Care for Joint Replacement Model (CJR) as an Advanced APM

As a physician specialty group involved with a number of demonstrations under Center for Medicare and Medicaid Innovation (CMMI) authority, AAOS is disappointed that the proposed rules do not list either the Bundled Payments for Care Improvement (BPCI) models or the Comprehensive Care for Joint Replacement Model (CJR) as Advanced APMs (A-APMs) at least in the first performance year. In particular, the exclusion of BPCI and CJR models while including programs that haven't even been initiated (such as the Oncology two-sided risk model), seems inconsistent with the intent of the MACRA legislation and the goals spelled out by the Agency. With the Agency's goal to facilitate and reward participation in high value care, it does not make sense for the Agency to exclude these new models of care. For example, in BPCI, over 3,000 orthopaedic surgeons are managing episodes of care at full risk, are being reimbursed based on quality and are, also, using certified EHR technology – the three statutory criteria required to be considered an "eligible alternative payment entity". We therefore urge CMS to provide, for physician groups participating in BPCI orthopaedic bundles, a pathway for qualification as A-APM. Further, we strongly urge CMS to include CJR, mandatory in 67 Metropolitan Statistical Areas (MSAs), as a designated A-APM for FY 2019 and to automatically qualify all participating physicians under the A-APM pathway for the 'Quality' performance category.

AAOS appreciates CMS requesting for comments on redesigning CJR into an A-APM and we appreciate the consideration of CMS toward further refining CJR. We will repeat our response to the CJR Proposed Rules (CMS-5516-P) that physician (i.e. orthopaedic surgeon) leadership and double-sided risk-bearing by physicians is possibly the only way that CJR can be re-designed to become an A-APM.

Moreover, as we had highlighted in our comments to the CJR Final Rule (CMS-5516-F), it has been corroborated by recent research that the needs for medical services during hospitalization and post-acute care for total hip arthroplasty (THA) post a fracture may be different than the needs after an elective THA performed for osteoarthritis (OA). The current Medicare Severity Diagnosis-Related Groups (MS-DRG) system does not distinguish the complexity, resource use and other characteristics between these two kinds of THA performed for fracture and OA.[2] Thus, separate bundles will need to be developed elective and non-elective hip fractures to redesign the current CJR model. As always, AAOS is willing to work closely with CMS on this issue and has

[2] Schairer, W. W., Lane, J. M., Halsey, D. A., Iorio, R., Padgett, D. E., & McLawhorn, A. S. (2016). The Frank Stinchfield Award. Total Hip Arthroplasty for Femoral Neck Fracture Is Not a Typical DRG 470: A Propensity-matched Cohort Study. *Clinical Orthopaedics and Related Research*, 1-8. DOI: 10.1007/s11999-016-4868-2

already communicated that through various venues.
With these comments in mind, AAOS believes that due to their inclusion of quality measures, advancing care information requirements, clinical improvement activities, and risk bearing requirements, the CJR and BPCI models already qualify as A-APMs and should be included with the other models deemed automatically eligible. We urge CMS to make this adjustment to the MACRA final rule, while simultaneously revising CJR for future implementation years. Further, in later years, CMS should consider developing non-total joint procedure APMs.

Onerous qualification thresholds for specialists

The revenue and patient thresholds for eligible clinicians to become qualifying providers (QPs) is quite onerous for specialty physicians. The rule proposes that in 2019, 25 percent of Medicare payments and 20 percent of patients are qualifying thresholds to receive the increased APM bonus. However, these patient count and payment thresholds are very high for specialty physicians and most of them are likely to not qualify on these levels. While there are some exceptions on threshold requirements for specialists who participate in multiple APMs, AAOS would like to note that these requirements are restrictive.

It is heartening to note that MIPS APMs will have their resource use component weight reduced to zero with the 10 percent reassigned to increase weights for CPIA and ACI thereby creating a pathway of qualification from MIPS APMs to Advanced APMs (A-APMs). Nevertheless, in the spirit of the MACRA legislation, the AAOS has consistently requested reductions in unnecessary and burdensome requirements to qualify for A-APMs that cause resources to be spent on administrative costs rather than patient care. We have also requested for a clear pathway for rapid approval and implementation of physician-focused APMs.

Impact on specialty physicians

As discussed earlier, per the results published in Table 63 of these proposed rules, surgical specialties do worse whereas primary care and specialties are projected to do better under MIPS. Given that Medical Homes and Accountable Care Organization models qualify right away, the AAOS would argue that this is a reallocation of resources away from surgical and other such specialty physicians to enhancing primary care services in this country. We would like to see more details on the actuarial projections that are used to develop these data published in Tables 63 and 64.

In these proposed rules, the definition of Medical Home Models focus on primary care and accountability of empaneled patients across the care continuum. We would urge CMS to consider an alternative definition of Medical Home Models such that specialty physicians and clinicians are correctly attributed to their patients, especially when they play the role of the primary physician consultant and accordingly receive incentives. Surgical homes will be important in that the episode of care is best understood by the physician (surgeon) that is

following the patient post-operatively. Currently there is no financial incentive for the surgeon to monitor total cost of care and level of care that is needed by an individual patient.

State-based Medical Homes

There are a number of State-based Patient Centered Medical Home (PCMH) models currently underway[3] many of which include multi-payer programs. These state-based models do not currently qualify for A-APMs under the proposed rule. In the spirit of the overall objectives of the QPP program and the future goal of including multi-payer claims data in the QPP pathways, the state based models should be actively considered for A-APM qualification thereby incentivizing physicians to participate in these models.

Definition of total risk

The definition of total risk is very complicated for individual clinicians to comprehend and plan their finances. The proposed rule states that to qualify as an A-APM, the total risk borne by the APM entity (i.e., the maximum amount of losses possible under the A-APM track) must be at least 4 percent of the APM spending target. Since clinicians will not have access to information on the percentage of the APM's spending on other providers (such as hospitals, post-acute care providers, skilled nursing facilities, etc.) and other resources, clinician practices will not know the amount of potential losses at the end of the year. Moreover, as discussed above, clinicians do not have any, or extremely limited, control over cost and resource use by other partners within an A-APM. Thus, AAOS requests CMS to reconsider the definition of nominal total risk. One suggestion may be to limit the maximum amount of losses to 4 percent of professional services directly attributable to the physician, at least for performance year 1.

Qualified Clinical Data Registries (QCDR)

AAOS strongly supports the use of Qualified Clinical Data Registries (QCDRs), Qualified Registries (QRs) and Certified EHR Technology. Registries provide the data collection platform that allows for benchmarking, linking measurement to performance and the improvement of quality of care.

Real time access to Medicare claims data

Under §105(b) of the MACRA statute, Congress explicitly directed CMS to provide Medicare claims data to QCDRs for quality improvement and patient safety purposes. CMS instead chose not to adopt policies and procedures to implement this provision, claiming that the process for

[3]National Academy for State Health Policy "Medical Homes & Patient- Centered Care Maps." Available at: http://www.nashp.org/medical-homes-map/

accessing Medicare claims data outlined on the Research Data Assistance Center (ResDAC) website are already available to QCDRs. The ResDAC process, which was established to respond to discrete requests for Medicare data from researchers, is inadequate to meet the continuous and comprehensive access to Medicare claims data required by QCDRs for purposes of linking outcomes data to claims data in support of their quality improvement efforts. There is also a time lag in the data acquired through ResDAC apart from the considerable time and resources needed to complete the data acquisition process. The AAOS recommends that CMS initiate additional notice and comment rulemaking to establish a process for QCDRs to access Medicare claims data for quality improvement purposes in addition to the procedures available through ResDAC.

Weighting of QCDR activities

All QCDR activities in the CPIA category have been weighted as medium. AAOS commends CMS for encouraging the use and participation of QCDRs but with QCDR data submission activities being weighted as medium it will be difficult for small groups (15 or fewer clinicians) and eligible clinicians and groups located in rural areas to obtain 60 points in the CPIA category for participating in/or using a QCDR. AAOS recommends that registry related activities be weighted as high (20 points) so that clinicians are able to get the highest possible weight for registry related activities which will lead to increased participation and use of QCDRs. AAOS would, also, like to recommend the use of QCDRs for identifying and tracking future potential CPIAs. Allowing registries and health IT vendors to submit data for all MIPS performance categories would help to streamline the reporting requirements and remove the administrative burden from practitioners. This by default adds value to the healthcare system by unbridling practitioners from non-patient-care activities.

Expansion of QCDR activities

AAOS agrees that CMS should expand the capabilities of QCDRs to allow reporting for all MIPS performance categories. This alleviates the need for individual MIPS eligible clinicians and groups to use a separate mechanism to report data for these performance categories. Further, CMS proposes that data inaccuracies including (but not limited to) TIN/NPI mismatches, formatting issues, calculation errors, data audit discrepancies affecting in excess of 3 percent of the total number of MIPS eligible clinicians submitted by the QCDR may result in notations on CMS qualified QCDR posting of low data quality and would place the QCDR on probation. It would be virtually impossible for most QCDRs to meet the 3 percent error rate requirement. AAOS recommends that CMS review this proposal and adopt an error rate that is more feasible for QCDRs to achieve.

New proposed terms

Finally, a plethora of new terms and definitions have been introduced as part of the new

legislation and regulation that can be inaccessible and confusing for practicing clinicians and their non-clinician administrative support staff. For example, clinicians participating in Medicare are now familiar with electronic health records (EHR) and Meaningful Use (MU) programs. Per the proposed rule, these programs have undergone some changes, is collectively known as Advancing Care Information (ACI), and is an important MIPS performance category. There are other such examples: MIPS APMs versus Advanced APMs, Qualifying APM Participant and Partially Qualifying APM Participant, APM Entity or Entity Group, Affiliated Practitioner. AAOS would propose a reduction in the number of new terms for the well-established concepts and in new similarly sounding terms so as to improve communication and comprehension for participating clinicians and their patients.

In conclusion, AAOS and our co-signing orthopaedic specialty groups appreciate the stated goal of moving to value-based payments in Medicare and commend CMS on this voluminous rules document. We are thankful for the opportunity to comment on some of the proposals, as above, and look forward to engaging with CMS especially on developing outcome based measures for musculoskeletal care as well as on redesigning innovative payments models such as the CJR. Further, we would like to reemphasize that the guiding principle in the final rule should be simplification of administrative requirements and a focus on improving patient care.

Sincerely,

Gerald R Williams Jr, MD
President, American Academy of Orthopaedic Surgeons (AAOS)

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

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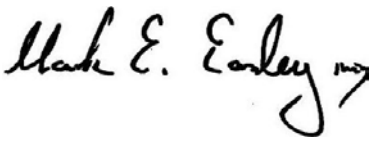
President, Orthopaedic Trauma Association (OTA)



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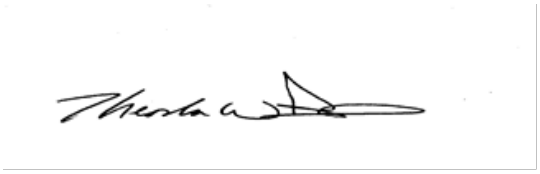

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