AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

September 6, 2013

SUBMITTED VIA ELECTRONIC FILING AND REGULAR MAIL

Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Schedule & Other Revisions to Part B for CY 2014" published in the *Federal Register* as a proposed notice on July 19, 2013. Our comments will address the following issues, in the order in which they appear in the proposed rule: (1) Sustainable Growth Rate (SGR); (2) Resource Based Practice Expense (PE) Relative Value Units (RVUs); (3) Potentially Misvalued Services Under the Fee Schedule; (4) Requirements for Billing 'Incident To' Services; (5) Physician Compare Website; (6) Quality Reporting Initiatives; and (7) Value Based Payment Modifier and Physician Feedback Program.

1. SUSTAINABLE GROWTH RATE (SGR)

Over the past decade, the AAO-HNS and others in the physician community have repeatedly advocated for the reform and full repeal of the unstable and unsustainable Medicare physician payment formula. The failure to enact permanent reform has created an instability and uncertainty that undermines the ability of physicians to plan for the future, to provide for their employees, and to make investments to improve the quality and efficiency of the care they provide. In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) estimates that under current law, the conversion factor for CY 2014 would be reduced by 24.4 percent to $26.8199 (compared to the CY 2013 conversion factor of $34.0230), but emphasizes that the Agency is committed to working with Congress to permanently reform the SGR methodology for MPFS updates. ***The Academy applauds CMS for recognizing that the SGR formula must be eliminated, and we appreciate CMS' commitment to work with Congress to resolve the issue. The Academy continues to advocate for permanent repeal of the SGR, and has submitted numerous comments to the U.S. House of Representatives' Energy & Commerce and Ways & Means Committees, as well as the Senate Committee on Finance, regarding their draft repeal legislation and proposals. To access the Academy's comments on SGR repeal visit:*** http://www.entnet.org/Practice/members/Advocacy.cfm***. We appreciate the efforts of lawmakers in this regard over recent months and welcome***

efforts by CMS to work with Congress to achieve full repeal of the SGR formula by year's end.

2. RESOURCE BASED PRACTICE EXPENSE (PE) RELATIVE VALUE UNITS (RVUS)

A. Reduction to Office PE RVUs that Exceed OPPS/ASC Facility Payment Rates

Within the proposed rule, CMS proposes a major change to the methodology for setting practice expense RVUs for services under the PFS. Specifically, they propose that for PFS services provided in the physician offices setting whose payment rates exceed those for the same procedure when performed in a facility (hospital outpatient department (HOPD) or Ambulatory Surgical Center (ASC)), CMS would use current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services in the office under the PFS. In setting PFS rates, they would compare the PFS payment rate for a service furnished in an office setting to the total Medicare payment to practitioners and facilities for the same service when furnished in a HOPD setting. For services on the ASC list, they would make the same comparison except they would use the ASC rate as the point of comparison instead of the OPPS rate. **They propose to limit the office PE RVUs for individual codes so that the total office PFS payment amount would not exceed the total combined amount Medicare pays for the same code in the facility (hospital) setting.** To maintain the greatest consistency and transparency possible, they propose using the current year PFS conversion factor and current year OPPS or ASC rates for this comparison.

CMS proposes to exempt several categories of codes from this proposed policy, including:

- those without separate OPPS payment rates;
- those subject to the DRA imaging cap;
- those with less than 5% total volume in the OPPS setting,
- those with ASC rates that are based on the PFS payment rates;
- those paid in the facility at the non-facility PFS rates; and
- those with PE RVUs developed outside the PE methodology.

The Academy is extremely concerned about CMS's proposal to limit the office PE RVUs for individual codes under the NPRM, so that the total non-facility (office) payment would not exceed the total combined payment amount Medicare pays for the same service in the hospital or ASC settings. Of note, this proposal has a direct impact on our specialty and captures 13 CPT codes where Otolaryngology is the dominant provider, and 10 additional services commonly provided by Otolaryngologists. For these services, reductions in payment under the MPFS for 2014 range from 14-60% as compared to 2013. For 11 of the Otolaryngology services captured by this policy, the payment rate in the ASC setting is significantly *below* the cost of the direct costs incurred by physician offices in the private practice setting. Undoubtedly, this will cause Otolaryngologists to discontinue theses services in the physician office, as the reimbursement is no longer sufficient to cover the direct costs incurred by the practice to furnish the service. Thus, this policy will only serve to shift services into the hospital outpatient setting where coinsurance for beneficiaries is higher and access to care for many patients is restricted due to lengthy travel time to the nearest hospital. Specific examples of this are outlined below in section iii of our comments.

Further, tying fee schedule payment to the hospital outpatient prospective payment and/or the ambulatory surgical center payment systems (OPPS/ASC) will result in increased instability in reimbursement which causes uncertainty for physician offices from year to year. Given that OPPS and ASC rates evolve and change each year based on the cost data submitted by hospitals, and its impact on the cost to charge ratios (CCRs) within ambulatory payment classifications (APCs), tying policy under the relatively stable fee schedule (absent the annual SGR concerns) to the unpredictable OPPS payment system creates an overly

complicated fee schedule, as well as instable payment rates for physician practices, many of whom have already invested in devices and equipment required for services likely to be impacted by this new policy on a rolling basis.

In addition to the general, over-arching concerns noted above, we'd like to specifically respond to several of CMS' assertions related to this policy proposal within the NPRM, our comments are outlined in turn below.

i. **Reliability of Hospital Cost Data**

First, we note our concerns that currently the HOPPS cost data is NOT publicly available which makes it virtually impossible for specialty societies and the general public, to obtain the data, let alone analyze it thoroughly during the short 60 day comment period for the NPRM. ***To that end, we strongly urge CMS to be as transparent as possible moving forward and to make all data (which is not proprietary in nature) upon which their policy proposals in the NPRM are based, publicly available. This will allow the public to provide the most well-thought-out and accurate feedback on policy proposals as possible when commenting to CMS.***

Further, we believe there is no clear rationale provided by CMS in the NPRM to believe that the OPPS and ASC payment rates, and related cost data, should be presumed to be the gold standard in reliability. Particularly when many of the Otolaryngology services capped by the ASC rate under this policy are not performed in the ASC setting (or are performed less than 1% in an ASC) and ASCs are not required to supply cost data to CMS. In addition, hospital cost data in and of itself is often unreliable as hospitals have free reign over assigning costs to cost centers and the CCR process and associated charge compression often results in diluting the actual equipment and supply costs associated with procedures such that it is not accurately captured by the final APC payment rate for a given service. Even more concerning is the fact that high cost devices and supplies are typically packaged under OPPS policies, and therefore do not receive separate payment. This results in many hospitals not even reporting the associated supply code for the item, which means it's not possible to track the cost for those individual items under the OPPS system. Thus, tying fee schedule payment to the OPPS and ASC payment systems does not achieve the result CMS hopes (providing more reliable PE data); rather it further complicates and dilutes the actual costs of direct PE inputs under the MPFS.

Finally, in many cases specialties dispute the assignment of services to various APC groups and may be working to resolve these concerns with the Hospital Outpatient APC Panel. Given real concerns that many APC assignments, or associated payment rates for services, may be too low and not reflective of the true cost incurred to provide a service, tying MPFS payment to the OPPS payments will only broaden the number of services for which reimbursement is inappropriate or inaccurate.

ii. **Reliability of MPFS PE Data / Reliability of the RUC PE Process**

As outlined above, we believe there are many concerns with the way hospital outpatient cost data is submitted and utilized within the OPPS payment system. In contrast, we believe the process implemented by the AMA Relative Update Committee (RUC) is a very sound process, and would like to take the opportunity to address CMS' concerns in the NPRM that PE for services under the MPFS are often based on one invoice or quote, and are therefore, unreliable. First, we would note that many specialties participating in the AMA RUC process submit multiple invoices to the RUC as part of their PE presentation for new or revised CPT codes. In addition, specialty society recommendations are based on the firsthand experience of experts in the relevant medical field rather than subjective cost center data provided by hospitals. Further, PE under the RBRVS is carefully vetted by the RUC's Practice Expense Subcommittee, which is overseen by CMS representatives who attend the meetings, and is often reduced

and reviewed in excruciating detail – delving into nuances such as how many Band-Aids are required for a procedure. ***Therefore, we believe this process is much more detailed and carefully vetted, than that of the OPPS payment system's methodology for assigning payment rates and should continue to serve as the sole method for assigning practice expense direct costs for services under the MPFS.***

iii. Impact to Otolaryngology under this Proposal

As noted in the introduction of this section, this policy has a broad impact on Otolaryngology services if finalized for CY 2014. Thus, we are providing specific examples of the impact to our specialty to illustrate flaws in the proposed methodology. As a result of these perceived flaws, for which there are dozens of other examples across all impacted specialties (See AMA sign on letter related to this issue), we urge CMS to reconsider this policy and rescind its proposal within the CY 2014 final MPFS rule.

Example 1:

Code 31295 Sinus endoscopy w/balloon dilation, which is paid at $2229.87 in CY 2013 under the PFS, is part of APC0075 which has a payment rate of $1137.31 when performed in an ASC in 2013. Code 31295 is only done 19.87% of the time in the outpatient setting and 3.7% of the time in the ASC, so it has little impact in the calculation of the APC payment rate which is driven primarily by all the other surgical procedures in the APC, all of which are not performed in the physician office and are done only under general anesthesia in the facility setting. Code 31295 has invoiced/ CMS-priced direct expenses of $1408.50, including a sinus surgery balloon kit (maxillary, frontal, or sphenoid) valued at $1299.93, which **exceeds** the total APC/ASC payment in CY 2013 under the proposed OPPS cap policy.

Example 2:

Code 30903 Control of Nosebleed, which is paid at $216.39 in CY 2013 under the PFS, is part of APC0250 which has a payment rate of $43.82 when performed in an ASC in 2013. Code 30903 is only done 2.40% of the time in the outpatient setting and 0.19% of the time in the ASC, so it has little impact in the calculation of the APC payment rate which is driven primarily by 41250 Repair of Tongue Laceration which is paid at $284.77 under PFS, as well as a wealth of unlisted codes whose costs and payments will vary drastically depending on the comparator code used by the physician when submitting their claim. Code 30903 has invoiced/ CMS-priced direct expenses of $83.38, including an epistaxis balloon valued at $43.06. Thus, the 2013 ASC payment of $43.82 leaves $0.76 cents to cover the remaining $39.56 of overhead the physician must expend to provide this service in their office.

In addition, CPT 30903 is only performed 2.4% in the outpatient setting, so per the CMS proposed exceptions which require 5% utilization in the hospital outpatient setting, it shouldn't be included at all under this policy. Further, given that virtually all the codes in this APC are unlisted codes, the data and costs are completely unreliable and will vary drastically depending on the comparator code the physician uses to set their RVUs and costs on their claims when reporting unlisted codes. Thus, payment rates for this APC are completely unpredictable and unstable, and should not be utilized in setting payment rates under the MPFS.

Finally, procedures such as 30903, 30905 and 30906 are emergent procedures and are not services that can be scheduled and moved to the outpatient setting, as is often done with planned surgical procedures. Cutting reimbursement so drastically for these services in the physician office setting will result in practices having to eliminate the provision of the service in their office, which is especially problematic in rural settings where physician practices are utilized as outpatient/emergency clinics for emergent procedures such as control of nosebleed. Given the distance patients would have to travel to get to the

nearest outpatient or emergency department, applying this policy to emergent procedures that are frequently performed in physician offices will present a serious access to care for patients in rural locations who have serious medical problems that require immediate resolution.

iv. Alternatives to this Policy Proposal for CY 2014

Given our concerns stated above, the Academy would like to offer some alternative solutions for CMS' consideration. First, we understand why, on its face, it may seem unreasonable for payment for a service to be higher in the physician office versus the hospital outpatient setting. In light of that, we believe it is reasonable for CMS to ask specialties to justify scenarios where this perceived anomaly exists. ***To that end, we propose that in lieu of their proposed policy to apply a OPPS/ASC cap to the practice expense of services under the MPFS, that CMS consider adding a screen to their misvalued code initiative through annual rulemaking, which would capture "all services where total payment in the non-facility setting exceeds total payment in the hospital outpatient setting".*** This would allow CMS to monitor services in this category which they perceive as misvalued and also allow specialty societies and stakeholders to bring the codes forward in a thoughtful manner through the Relativity Assessment Workgroup (RAW) Subcommittee of the RUC and identify areas where revisions to the code may need to be made, where additional coding education may need to take place, or where identification of codes for resurvey by specialties is necessary to improve accuracy of valuation. ***We believe this alternative would implement a more thoughtful and deliberate process whereby CMS' concerns about this group of services is addressed, but payments for services are not arbitrarily reduced based on a OPPS or ASC capitation policy.***

Another option CMS could consider within the confines of the already existing RUC PE review process is to require multiple paid invoices, or additional types of cost data, when codes are presented to the PE Subcommittee. This would result in a much less onerous method by which to obtain additional cost data to assuage the Agency's concerns that PE in the MPFS is based on inaccurate information.

v. Exceptions CMS Should Consider if They Proceed with this Policy

In the event CMS elects to proceed with this policy for CY 2014, the Academy also has some recommendations regarding other exceptions CMS should consider, in addition to those they have proposed in the NPRM. ***Specifically, we suggest that for services captured on the list by CMS in the NPRM, that any service which has been RUC reviewed, or has had its PE reviewed, within the last 5 years be removed from the list and presumed valid and accurately valued given the recentness of the RUC review, and subsequent acceptance of valuation by CMS.*** In reviewing the Otolaryngology services impacted by this policy, we note that four services have had their practice expense inputs reviewed, and five of the 13 services for which Otolaryngology is the dominant specialty, have undergone full RUC review in the last five years. ***Thus, we believe there is no reason to arbitrarily cut the reimbursement for these services which have been recently RUC reviewed, as we believe the RUC values (which are approved by CMS) should be presumed valid and appropriate.***

vi. Areas Requiring Clarification Under this Policy

In addition, we are perplexed and concerned regarding the 5% threshold CMS has elected to use in this policy proposal. First, it is unclear why such a low threshold selected by the Agency rather than a higher requirement such as 50 – 90 % utilization in the OPPS/ASC setting which would produce much more robust and reliable data to base payment rates upon. In addition, it is unclear why CMS has not implemented a similar exception to the OPPS 5% threshold for services capped by the ASC payment rate (i.e. requiring a 5% utilization in the ASC setting in order to cap a payment rate at the ASC rate). Virtually all of the Otolaryngology services captured under this policy are capped by the ASC rate, but

almost none of them are performed in the ASC setting more than 5% of the time. In fact, many of them are only performed in an ASC less than 1% of the time, which raises concerns about the accuracy of payment in the ASC setting and why CMS would choose to tie payment to such a small and unreliable subset of data. Further, for two codes on the list, 92583 and 92596, neither is performed in the OPPS setting at all, so it is unclear to us why these services have been captured by this policy. ***Thus, we seek clarification from CMS on their decision to utilize a 5% threshold, as well why they are not applying that threshold requirement in the ASC setting for services that would be capped at the ASC rates under this policy.***

In sum, we appreciate CMS' concerns regarding accurate valuation and reimbursement for services, particularly related to direct practice expense inputs under the MPFS. We also appreciate the Agency's desire to use the most accurate data possible in assigning direct PE inputs for the PFS. We do not believe, however, that this policy, as proposed, will accomplish those goals, and instead, have concerns that it will only serve to further complicate, and dilute the accuracy of services under the MPFS. To that end, we appreciate CMS' consideration of our comments and alternative suggestions as outlined above.

B. Direct PE Input Refinements based on Routine Data Review

The Academy supports this proposal by CMS to apply consistent standards for moderate sedation across all codes for which it is inherent in the nonfacility setting, and thus, we support the adjustments to time as proposed for the 18 codes impacted by this policy services.

C. Adjustments to Pre-Service Clinical Labor Minutes

The Academy supports CMS' proposal, based on an AMA RUC recommendation, to cap all 000 global CPT codes pre-service clinical labor time at no greater than 30 minutes within the 2014 NPRM. We would note that this proposal is consistent with the current RUC standard for 000 and 010 global procedures, which recommends that for services with "Extensive Use of Clinical Staff Time" a standard of 18 minutes for procedures performed in the office setting, and 30 minutes for procedures performed in the facility setting, is appropriate. For all other 000 and 010 globals that require standard use of staff, the typical pre-service time is 0 minutes. ***Thus, we believe CMS' proposal to accept the AMA RUC's recommendation to cap all clinical staff pre-service time at 30 minutes for 000 global services is consistent with RUC policies and is appropriate.***

D. Academy Requests for Changes to CPT 31231 PE in 2013 MPFS Final Rule

Related to modifications to practice expense inputs, the Academy is disappointed that CMS did not accept any of our recommended revisions to the direct practice expense inputs, specifically the allocation of time to several pieces of equipment, for CPT 31231 Nasal Endoscopy, Diagnostic. While the Agency accepted the errors we noted in our comments on the 2013 Final MPFS, none of our requests for additional minutes assigned to the equipment for this service were accepted and no rationale for the decision was provided.

To that end, we encourage CMS to continue their efforts to clarify (via the RUC Practice Expense Subcommittee process and spreadsheet) their formula for assigning minutes to equipment inputs presented by specialty societies at AMA RUC meetings, so that specialty societies can more accurately prepare their presentations, and avoid significant changes at the table to their recommendations, for equipment time. ***There have been several changes to the line items on the practice expense spreadsheet utilized by the RUC and CMS over the past few years, and therefore, we recommend CMS provide, either via the final 2014 MPFS or during the October 2014 RUC meeting,***

documentation which clearly outlines which clinical staff activity line items they believe <u>should not apply to the equipment for a service</u> and those that are applicable. AMA RUC staff has been working to include notes in the PE spreadsheet to reflect this information, however, it seems new requirements come up at each meeting, and thus, we respectfully request that CMS provide documentation in this regard.

E. Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments

Within the NPRM, CMS draws attention to the recent trend, in literature and in practice patterns, across the U.S. of providers moving from the private practice/office based setting to an integrated model where they practice in an off-campus hospital setting that looks very much like a private practice. CMS expressed concern in the proposed rule that current requirements do not mandate that hospitals seek a CMS determination of provider-based status for a facility that is located off campus, nor is there a formal process for gathering information on the frequency, type and payment for services provided in off-campus provider-based departments of a hospital. In order to better track this trend, CMS proposes three options:

1) Using a claims-based approach, requiring a new place of service code for off-campus departments to be reported on the 1500 claim form;
2) Creating a HCPCS modifier that would be reported with every code for services furnished in an off-campus department on the 1500 claim form and the UB-04 hospital outpatient claim form; or
3) Asking hospitals to break out the costs and charges for their provider-based departments into an outpatient service cost center on their Medicare hospital cost report form.

While the Academy understands CMS' desire to track and analyze the perceived trend of physicians moving away from private practice into an employment relationship with hospitals where they practice in an off-campus hospital provider-based department, we have some concerns about the administrative burden CMS' proposals above would impose on both providers and their hospital billing departments. Of the options put forward by CMS, we believe that option one, to require a new place of service (POS) code for "off-campus departments" to be used on the 1500 claim form is the best of the alternatives aimed at tracking the site of service in which providers are rendering services to Medicare beneficiaries. ***Given that providers already have to select a POS code for the 1500 claim, simply adding a new option to denote an "off-campus department" will not place any additional burden on the physicians or their billers, and therefore, we support this as the least burdensome means of tracking this issue.***

Regarding option two, we believe requiring the use of a HCPCS modifier to be reported with every code billed for services furnished in an off-campus department would be extremely onerous to providers and billing departments. Further, we have concerns that in cases where a provider or biller failed to report the modifier, due to simple error or oversight in implementing the new coding requirement, claims would be denied solely on this basis and then require additional time and efforts to reprocess all as a result of attempted tracking of services by site of service. ***Thus, we do not support option two, above, as proposed by CMS.***

Finally, regarding option 3, the Academy does not support this proposal as it is burdensome for hospitals to break out costs and charges for these departments and could result in inaccurate cost data given that hospitals are not used to reporting costs using specific cost centers for provider-based departments.

3. POTENTIALLY MISVALUED SERVICES UNDER THE PHYSICIAN FEE SCHEDULE

A. Use of Medicare Contractor Medical Directors to Identify Potentially Misvalued Codes

Within the 2014 proposed rule no codes were nominated by the public as potentially misvalued/requiring review, so CMS elected to broaden the process of identifying potentially misvalued codes by soliciting feedback from Medicare Contractor Medical Directors (CMDs) to develop a list of potentially misvalued codes for the 2014 NPRM. CMS states that CMDs are able to offer a unique perspective on the Medicare program as they "administer the program in their assigned geographic areas, are physicians themselves, and are on the front line of administering the program and serve as the first point of contact for any provider with questions regarding coverage, coding and claims processing."

While we appreciate the importance of ensuring proper valuation and reimbursement for Medicare services, and the role that identification of misvalued services under the MPFS plays in that regard, we are concerned about CMS' proposal to utilize Medicare CMDs for this purpose. Specifically, while we agree that CMDs are able to offer a unique perspective on the Medicare program, we are concerned about the lack of transparency provided by CMS and the CMDs in selecting codes they believe are potentially misvalued for CY 2014. In fact, the NPRM provides little to no insight as to how CMDs selected the services for review beyond stating that they felt "the code(s) may be overvalued." ***Thus, we respectfully request that in the event CMS continues to utilize feedback from CMDs to identify potentially misvalued codes under the MPFS, that CMS provide a detailed rationale from the CMDs as to why the code is perceived as "misvalued" and that CMS subsequently publish that rationale as part of annual rulemaking. This will allow stakeholders and specialty societies who are directly impacted by these recommendations, and who may be required to expend time and money to survey the identified services via the AMA RUC process, to provide input and potentially useful background to CMS for consideration through rulemaking. We also encourage CMS to avoid automatic acceptance of recommendations from the CMDs regarding potentially misvalued codes and instead, urge them to perform an internal review of the CMDs rationale for potential misvaluation prior to including a service on the potentially misvalued list within the proposed rule.***

B. Improving Valuation of the Global Surgical Package

In the CY 2013 proposed rule, CMS sought comment on methods of obtaining accurate and current data on Evaluation & Management (E/M) services furnished as part of a global surgical package. Commenters provided a variety of suggestions, including comments from the AMA RUC noting that the hospital and discharge day management services included in the global period for many surgical procedures may have been inadvertently removed from the time file in 2007. CMS reviewed this file and agreed that the data were deleted from the time file due to an inadvertent error as noted by the AMA RUC. In response, CMS proposes for CY 2014 to replace the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA-RUC. Nine of the 117 CPT codes noted by the AMA RUC are provided by Otolaryngology. ***Thus, the Academy appreciates CMS' attention to detail as part of the 2013 and 2014 rulemaking process. We supported the AMA RUC's comments on this issue within our 2013 comments and are pleased that CMS has reviewed the information provided by the RUC and agrees that inadvertent errors were made in the time file. Given that several services impacted by this proposed correction impact our specialty, we appreciate and support CMS' proposal to revise the CPT codes for which post-operative hospital E/M visit time was accidentally omitted.***

C. Validation of Relative Value Units (RVUs) for Services

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. ***In the CY 2014 proposed rule CMS provided additional details on the contractors (RAND and Urban Institute) they have engaged as well as the types of studies they will be undertaking.*** Specifically, CMS noted that the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The Urban Institute will focus on the central role of time in establishing work RVUs and the concerns that have been raised about the current time values. A key focus of the project is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. The project team will include groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time.

While the Academy understands that CMS is statutorily obligated to develop a method to validate potentially misvalued codes based on the language in the ACA, ***we remain concerned about the Agency's engagement of outside contractors to perform this function, as well as the perceived lack of transparency that may occur during these projects.*** As stated in previous comments, the Academy continues to believe the AMA RUC process is a sound and reliable process for evaluating and valuing physician services to Medicare beneficiaries. ***Notably, since 2006, the AMA/Specialty Society RVS Update Committee (RUC) has identified over 1,500 potentially misvalued services through objective screening criteria and has completed review of approximately 1,300 of these services. The RUC's efforts for 2009-2013 have resulted in $2.5 billion in redistribution within the MPFS.*** We believe the physician component is a critical piece of the valuation process, as they have first-hand knowledge and expertise which cannot be replicated or supplanted by methodologies developed by outside contractors who are not familiar with the clinical services they are valuing.

In fact, valuation of physician services without the input of physicians could result in the misvaluation of services across the physician fee schedule. While we appreciate CMS sharing additional details on the contractors they will be working with, as well as the study designs they will be undertaking, ***we urge CMS to ensure that these projects be conducted in an open and transparent manner to keep specialty societies apprised of the process and the methodology that will be used to validate the RVUs for these services, as well as which services (and associated CPT codes) are being utilized by the contractors for time and intensity comparisons. It is also critical that any methodology used to review CPT codes include input from practicing physicians who are knowledgeable about the specific services. To that end, we understand both projects will incorporate specialists or an expert panel to some degree. We urge CMS and its contractors to allow for specialty society involvement in those panels/review boards, as we believe physicians are uniquely positioned to provide input and expertise on intensities and complexities involved in provide patient care. Finally, we strongly encourage CMS to use restraint in the utilization of the results of these studies and respectfully request that the Agency continue the use of the AMA RUC as the primary method of validating RVUs for physician's services.***

4. REQUIREMENTS FOR BILLING "INCIDENT TO" SERVICES

Within the NPRM CMS proposes to revise its regulations to require that the individual performing "incident to" services meets any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished. CMS says that this will not only provide health and safety benefits to the Medicare patient population, but also assure that federal dollars are not expended for services that do not meet the standards of the states in which they are being furnished. This change will also allow CMS to recover federal government funds paid where services and supplies are not furnished in accordance with state law. ***The Academy supports this proposal by CMS and believes it will only serve to increase quality of care and safety for Medicare beneficiaries.***

5. PHYSICIAN COMPARE WEBSITE

Recently, CMS released a redesigned Physician Compare website[1]. Information currently reflected on the site includes a provider's business address, education, ABMS board certification information, hospital affiliations, and language skills. By statute, CMS is required to post the names of eligible professionals (EPs) who satisfactorily report under PQRS as well as those who are successful e-prescribers under the Medicare eRx Incentive Program. CMS states that all information posted on the website is derived from the PECOS system, and is verified by claims. CMS will also place a check mark for any individual who has earned a Maintenance of Certification additional Incentives starting with data reported in CY 2013. CMS also plans to post PQRS GPRO measure performance data on the website in 2014 and will post data from the Clinical and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for group practices of 100 or more EPs reporting data under the GPRO in 2013, and for ACOs participating in the Medicare Shared Savings Program (MSSP), as early as 2014.

While the Academy supports providing patients and beneficiaries with information that allows them to make the best decision possible regarding their clinical care, we have continued concerns regarding CMS' proposals related to Physician Compare. Despite the recent revisions and re-launch to the website, there remain many problems with the Physician Compare Website. For example, upon review of several of our physician leader's information following the website re-launch, we noted that many physicians are listed as affiliated with hospitals they've never worked in, or have languages listed which they don't speak. Further, our members reported that when they attempted to correct their information listed on the website, they were asked for PECOS login information they did not have readily available or memorized, and were told that it would take up to 6 months for the information to be corrected. ***Therefore, while we believe CMS has made major strides in improving the usability of the Physician Compare website, we remain concerned about the accuracy of information posted on the website and urge CMS not only to improve the accuracy of physician information, but also to streamline the process by which providers can correct their information and the time within which corrections are posted.***

Further, while we appreciate the desire to provide patients with information on provider's quality performance to aid them in selecting a physician, we reiterate that CMS should be mindful as to what provider information is necessary and meaningful to patients, and avoid over-saturating them with too much information. For instance, it is unclear how information on PQRS quality measures (for groups of 100 or more in 2014 and for smaller groups and individuals in future years) will be used by patients who likely do not know what the PQRS program is. ***In addition, we believe that it is too early for CMS to begin posting PQRS GPRO measure data and CG-CAHPS data for large groups and ACOs in 2014. Specifically, we are concerned that for surgical specialists, the CG-CAHPS survey is not applicable to their patients and may not accurately reflect the quality of care received. As such, we urge CMS to allow surgical specialties to use the AHRQ approved Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS) for patients over 18 in the hospital setting in lieu of the CG-CAHPS, to better reflect the quality of surgical services provided.***

Similarly, CMS suggests posting provider involvement with the Choosing Wisely® Program within the NPRM. While we think identifying providers as members of medical specialties who have engaged in the Choosing Wisely® Program is an excellent way to identify a specialties' commitment to improved quality of care, we caution that this information may be confusing to patients who are unfamiliar with the program. Given that Choosing Wisely® is not a program that individual physicians pledges or commits to follow the principles of, there is no way to know whether providers within specialties who have joined the

[1] www.medicare.gov/physiciancompare

program are actually adhering and committing to the principles of the program. If a pledge option were available in the future to show a provider's commitment to the principles, this is information we think would be very useful for the website, and could potentially be very meaningful for patients seeking high quality care. ***Thus, we urge CMS to consider a user-friendly way to convey quality performance which is accurate, but also useable by patients in selecting their care.***

In regards to future reporting, CMS seeks input on posting information on patient experience measures for both for group practices and ACOs and for group practices of 25 or more professionals who choose to voluntarily report CG-CAHPS data as part of their participation in the PQRS GPRO. ***In regards to this information, the Academy's concerns are the same as outlined above as we do not feel the CG-CAHPS survey appropriately captures the quality of care associated with surgical procedures, and instead, we encourage CMS to allow surgeons to utilize the S-CAHPS survey to evaluate the patient experience associated with surgical care for purposes of posting this information on the Physician Compare website***.

6. QUALITY REPORTING INITIATIVES

A. Physician Quality Reporting System

The Academy appreciates CMS' continued willingness to enhance the Physician Quality Reporting System (PQRS). We are also pleased with CMS' efforts to streamline the reporting periods and requirements across the PQRS, Value Based Payment Modifier, and Electronic Health Reporting (EHR) programs for CY 2014 reporting. In respect to CMS' stated goal of improving participation within PQRS for future years, the Academy has several comments below which address questions and issues in the proposed rule.

i. Changes to PQRS Measures in CY 2014

The Academy is pleased to see that CMS has proposed 47 new measures and 4 new measure groups for CY 2014. Specifically, we are thrilled that CMS has proposed to include four of our nine recommended Adult Sinusitis Measures created through the Physician Consortium for Performance Improvement (PCPI) process and endorsed by the Academy. The four measures proposed for inclusion were:

Measure Title	**CMS Proposed Reporting Method**	**PCPI Recommended Data Source**
Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse)	Registry	Claims, EHR or Registry
Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Registry	EHR or Registry
Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	Registry	EHR or Registry
Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Registry	EHR or Registry

While we greatly appreciate CMS' decision to propose inclusion of these four measures for CY 2014 reporting, there are several areas where we would like to we request clarification. First, CMS proposed

these measures for use in registry reporting only, despite PCPI's recommendations that they be utilized in EHR or registry reporting (and for claims for the first measure). ***Thus, we respectfully request that CMS provide additional detail on their rationale for limiting the use of these measures to registry reporting only, as only allowing the measures to be reported via one method will limit the utilization of the measures by our specialty.***

In addition, we respectfully request the rationale for CMS' decision to only accept four of the nine measures put forward by the Academy and the PCPI for inclusion in the 2014 PQRS measure set. Specifically, it would be helpful to know why CMS chose not to include the five additional sinusitis measures below. We believe additional background on the Agency's decision making process in this regard will serve to inform us as we work to develop new Otolaryngology-Head and Neck Surgery measures in the future. We believe the Agency's feedback and criteria is critical as specialties spend time and resources on the development of future measures.

Measure Title	**PCPI Recommended Data Source**	**Specifications included in call for measures**
Adult Sinusitis: Accurate Diagnosis of Acute Sinusitis: Distinguishing Viral vs. Bacterial Sinusitis	Claims, EHR or Registry	Claims/registry specifications; Data requirements table for EHR
Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table submitted for EHR consideration
Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (underuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table for EHR
Adult Sinusitis: Watchful Waiting for Acute Bacterial Sinusitis: Initial Observation Without Antibiotics for Patients With Mild Illness (Appropriate Use)	EHR or Registry	Data requirements table for EHR/Registry
Adult Sinusitis: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis (Overuse)	EHR or Registry	Data requirements table for EHR/Registry

CMS also proposes to eliminate two measures which were previously reportable by Otolaryngologists under the PQRS program. These are the Preventative Care and Screening: Unhealthy Alcohol Use-Screening and Hypertension: Blood Pressure Management measures. We are disappointed that CMS has chosen to eliminate these measures for CY 2014, particularly in light of their proposal to increase the number of measures required for successful reporting from 3 to 9 in 2014 (see further discussion on this issue below). ***Even in light of the four sinusitis measures proposed for inclusion in the 2014 PQRS program, specialties such as Otolaryngology, with a large number of subspecialties, remain limited in terms of measures they are able to report. In addition, given that CMS proposes to delete 46 measures for CY 2014, any elimination of useable measures increases the difficulty of participation for our specialty. Therefore, we respectfully request that CMS retain these two measures for the 2014 PQRS reporting period.***

ii. Changes to Reporting Requirements to Avoid the 2016 Penalty Adjustment

The Academy is extremely concerned with CMS' proposal to increase the number of measures required for satisfactory reporting from 3 (required in 2013) to 9 for CY 2014. As outlined above, given the limited number of measures reportable by Otolaryngologists, increasing the requirements for reporting

from 3 measures to 9 will make it extremely difficult for members of our specialty to successfully report. This is true even in light of the four new sinusitis measures CMS has proposed for CY 2014. During the quality briefing hosted by the AMA on August 1, 2013, the Agency requested viable alternatives to the proposed increase of measures to 9 measures and noted their goal was continue to enhance the reporting requirements as the PQRS program becomes more familiar to providers and more EPs participate.

In response to this request by CMS, the Academy has two alternative suggestions for CMS' consideration both of which we believe will allow increased participation over the 9 measure requirement proposed within the NPRM. ***First, CMS could consider a tiered approach as an alternative to the proposed 9 measures required for CY 2014 reporting. Such an approach could be modeled after the EHR Meaningful Use Program and require that in a EPs first year of participation in PQRS they are required to report on 3 measures. In their second year, 6 measures, and in their third year (and each year thereafter) EPs would be required to report on 9 measures.*** The rules regarding individual EPs reporting via claims who indicate less than the required number of measures applicable to them would still apply, and they would be subject to the Measures Applicability Validation (MAV) process to determine if they were correct in their assessment that they could not report on a sufficient number of required measures. ***We believe this tiered approach would allow EPs time to adjust to the PQRS reporting requirements and process, and would also achieve CMS' goals of increased participation and reporting in future years. Further, this approach would allow specialties time to develop the necessary number of measures to allow increased reporting in the future.***

A second alternative CMS could consider is eliminating the requirement for reporting on a specific number of measures, and simply require that providers report across a set number of domains. For example, CMS could retain their 3 domain requirement from the NPRM, but allow providers flexibility to report on as few or as many measures across three domains as they wish. This too would allow additional flexibility as providers become more familiar with the quality reporting process and develop additional measures, across various domains, related to their specialty.

We are appreciative of CMS' exception to the 9 measure reporting requirement, which allows EPs who report via claims on 3 measures to avoid the 2016 payment penalty, and argue that EPs falling under this exception should not qualify for a 2014 incentive payment. ***While we appreciate CMS' flexibility in allowing EPs to report less than 9 measures, we continue to be concerned that this exception was not clearly delineated in the NPRM, and would urge CMS to explicitly state any exceptions to the 9 measure reporting requirement (if finalized) in the final 2014 rule this fall to ensure clarity among providers.***

Similarly, we are concerned with CMS' proposal to expand the number of measures in a measure group from 4, in 2013, to 6 in 2014. Given the requirement that individuals reporting via measure groups must report on **ALL** the measures in a measure group, the Academy is concerned that by increasing the number of measures in a measure group, CMS is only making it more difficult for individuals to successfully report via measure groups. ***Therefore, we recommend that CMS either retain the previous measure group size of four measures, or allow more flexibility in expanding the size of measure groups and only require individuals to report on 4 of the 6 measures in a measure group. We also urge CMS to consider allowing group practices to report via measure groups, as we believe this would allow an additional method by which groups could achieve satisfactory reporting.***

iii. Administrative Claims Reporting

The Academy is disappointed that CMS has proposed the elimination of the Administrative Claims reporting option for CY 2014. We believe this reporting option served as a hold harmless for those practices that were simply not equipped to begin participation on PQRS for CY 2013, and likewise,

should remain an option in CY 2014 for groups that have started reporting, but simply cannot meet the 9 measures across 3 domain requirement that CMS has proposed. ***Thus, we strongly encourage CMS continue the Administrative Claims reporting option for the CY 2014 reporting period to allow all EPs sufficient time to prepare to report on quality measures under the PQRS program.***

iv. Reporting Mechanisms for Group Practices

CMS maintains their policy that all group practices of 100+ professionals report via the GPRO web-interface for satisfactory reporting to avoid the 2016 payment adjustment. Due to the limited number of quality measures applicable to Otolaryngology in the two outlined reporting mechanisms, ***the Academy urges CMS to expand the available reporting mechanisms for group practices of 100+ professionals to include claims, registry, qualified clinical data registry (QCDR), and EHR based reporting.*** Allowing large group practices to report via these additional methods will improve our specialties participation and ability to satisfactorily report in PQRS.

CMS also proposes to allow all groups to report on CG-CAHPS to meet 3 of their 9 measure requirements for satisfactory reporting. These groups would then have to also report 6 measures covering at least 2 National Quality Strategy domains using registry, EHR, or GPRO web interface reporting (depending on their size). ***The Academy appreciates CMS providing this new option to groups of 25+ to satisfy some of their reporting requirements via the CG-CAHPS survey measures, however, we continue to have concerns that these surveys are not particularly applicable to specialists. While we encourage CMS to continue all efforts to expand flexibility for groups to meet PQRS reporting requirements, we want to ensure that the data reported is meaningful for specialties and groups reporting. Thus, we continue our recommendation from 2013 for CMS to utilize or in cases where groups of 25+ are paying to utilize a survey to meet reporting requirements, that CMS allow, the S-CAHPS survey tool for surgical specialty groups reporting under PQRS for CY 2014.***

Last, we understand from the AMA quality briefing mentioned previously, that it was an oversight on behalf of CMS not to include the new Qualified Clinical Data Registry reporting option as available to groups for CY 2014. To that end, we request that CMS clarify their intent as it relates to this new reporting option and its applicability to groups reporting in CY 2014 within the final rule, and encourage CMS to allow groups to report via this method, as it is more likely that large group practices will be best positioned to meet the requirements of the new QCDR reporting option by the March 2014 deadline.

v. New Qualified Clinical Data Registry Reporting Option (QCDR)

The Academy is pleased with CMS' decision to introduce the new qualified clinical data registry reporting option for CY 2014 within the NPRM. We believe this new reporting option will provide much needed flexibility to the PQRS program and will allow the implementation and utilization of new and meaningful quality measures to be utilized by specialties given that QCDR's are not required to have their measures endorsed by PQRS or the National Quality Forum (NQF). ***Therefore, the Academy applauds CMS for proposing this new reporting option for CY 2014.***

We do, however, have some concerns regarding the requirements and timeline for this new reporting option. Specifically, groups must self-nominate by January 31 to report under this method. While we understand that groups may dually identify as a registry and a QCDR, we are skeptical that any existing registry will be adjusted and ready for reporting based on the proposed QCDR requirements, by the January 2014 nomination deadline. CMS is also requiring descriptions for the measures that the QCDR will report by March 31, 2014, which may not be feasible. ***To that end, we request that CMS provide further clarification on what the process will be for groups who dual identify as a registry and a QCDR***

for CY 2014 reporting, but do not end up meeting the requirements for the QCDR by the March 31, 2014 deadline for descriptions of measures which the QCDR will report.

We also seek clarification from CMS on who will be responsible for "deeming" a registry a qualified QCDR moving forward. Specifically, whether this is a process CMS intends to undertake or will some other authorizing body such as the AMA PCPI, NQF, or other quality group be responsible for this? We believe it is critical that this process remain unencumbered and streamlined to allow the flexibility it is intended to create, and urge CMS to implement a clear process for nominating, and submitting measure information for the Agency's review in a timely manner that promotes efficient and flexible reporting of quality data.

vi. Changes to Measure Groups in 2014

Within the NPRM, CMS proposes changes to the following measure groups reportable by ENTs:

- Perioperative Measure Group: Added #130 *Documentation of Current Medications in the Medical Record* and #226 *Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention, and Patient-Centered Surgical Risk Assessment and Communication: The Percent of Patients who underwent Non-Emergency Major Surgery Who Received a Preoperative Risk Assessment for Procedure Specific Postoperative Complications using a Data Based, Patient Specific Risk Calculator, and who also Received a Personal Discussion of Risks with the Surgeon*
- Asthma Measure Group: Added #110 *Preventative Care and Screening: Influenza Immunization* and #130 *Documentation of Current Medications in the Medical Record*
- Sleep Apnea Measure Group: Added #128 *Preventative Care and Screening: BMI Screening and Follow-Up*, #130 *Documentation of Current Medications in the Medical Record*, and #226 *Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention*

The Academy is concerned that these changes to measure groups reportable by Otolaryngologists create additional confusion for providers reporting on the measure groups. Specifically, it is unclear how patients who underwent non-emergency major surgery will be defined. In addition, it is unclear what the patient specific risk calculator will look like. To that end, we encourage CMS to provide clarification to providers regarding measure applicability as well guidance on which measures they believe are best suited for groups and individual EPs to report on.

vii. PQRS Reporting Periods in 2014

The Academy strongly supports the proposed additional six month reporting period (July 1- December 31) for the reporting of measure groups via registry for 2014. Additional reporting periods are extremely helpful in allowing EPs to successfully report quality measures to avoid payment reductions in 2016 and we appreciate CMS' inclusion of this new reporting period for 2016. We also appreciate CMS' decision to align the reporting periods for all other reporting options (including a secondary option for EPs reporting via registry) to a 12 month reporting period. We believe unified reporting periods across all reporting methods avoids confusion for participation EPs and group practices.

B. EHR Reporting Requirements for PQRS

We appreciate CMS' efforts to further integrate quality reporting options under the PQRS and EHR Incentive Programs through the continued integration of e-specified clinical quality measures. The continued alignment of these quality reporting programs will help to increase participation and assist in the collection of data.

In the NPRM, CMS states it will require providers to use the most recent version of the electronic specifications for Clinical Quality Measures (CQMs) or report via attestation if using older versions of e-CQMs. While we understand it may not be technically feasible for CMS to accept data that is reported according to specifications of the older versions, the requirements in the proposed rule will place an increased reporting burden on physicians and their staff. By requiring EPs and their staff to use the most up to date versions, and ensure their EHR technology has been tested and certified with the most recent versions, CMS places the onus on providers to ensure their technology has the capacity to successfully report for PQRS. This creates an undue administrative burden and results in additional cost to practices, which serves as a deterrent and barrier for participation in the PQRS program. ***As such, the Academy recommends that rather than forcing EPs and their staff to ensure they are using the correct versions of e-CQMs, CMS should work with vendors to ensure only the most up to date e-specified CQMs are available to providers and their staff for reporting via EHR systems.***

7. VALUE-BASED PAYMENT MODIFIER (VM) AND PHYSICIAN FEEDBACK PROGRAM

A. Physician Feedback Program / QRUR Reports

As part of the value based purchasing program, CMS began issuing Physician Feedback reports (or Quality Resource Use Reports (QRURs)) to physicians in fall of 2011 (sent to groups of physicians who participated in the PQRS GPRO) and again in March of 2012 (sent to all physicians in four states). These reports were intended to provide confidential reports to physicians that measure the resources and quality of care involved when furnishing care to Medicare beneficiaries. CMS has stated they intend to continue distribution of these reports to physicians and will distribute reports this fall on September 16 to groups with 25 or more EPs (this does not include non-physician health care providers) which will be based on 2012 PQRS quality data.

While the Academy appreciates CMS's tremendous work in this complex area, we remain concerned with the aggressive timeline for roll-out of this program. We recognize that statue requires the value based payment modifier (VM) to apply to all physicians enrolled in the Medicare program by January 1, 2017, however, we fear that physicians are just beginning to understand the incentive/penalty structure for other quality programs, such as Meaningful use of EHRs, eRx incentives, and PQRS, which have been in place for several years now. To add an additional quality program, which is even more complex in nature, is certain to cause increased difficulty in preparing our members to meet the requirements of these programs.

In addition, we feel there is much to learn from the prior distribution of these feedback reports to physicians in 2010, 2011 and 2012; particularly given that CMS has acknowledged that physicians receiving the reports would most likely be penalized by the program if it were applicable today. ***Based on this, we encourage CMS to continue refining the way information is relayed to physicians to ensure that it is timely and frequent enough to allow physicians and groups for which the VM will apply, to adjust their practice patterns, if needed based on feedback from these reports, to avoid the VM penalty.*** We understand that CMS has taken large strides to improve the clarity and usability of the QRUR reports to present cost and quality performance in a meaningful and clear way to providers, and to that end we appreciate CMS' efforts with stakeholders. ***We urge the Agency to continue these efforts and recommend that it reconvene the stakeholder workgroup they previously worked with to continue the enhancement of these feedback reports for 2014 and future years.***

B. Value-based Payment Modifier: Expanding to groups of 10+ for CY 2014

The Academy recognizes CMS' urgency to begin expanding the VM program to meet the 2017 statutory deadline for phasing in all physicians enrolled in Medicare, however, we have concerns regarding CMS'

proposal to expand the VM program to all groups of 10+ for CY 2014. Specifically, we are concerned that under previous rulemaking, CMS elected to send QRURs to groups of 25+ in September of this year. That data will be based on a group's performance in PQRS in CY 2012. Thus, this prior policy decision now creates a gap in information for groups of 10-24 EPs who will not receive any feedback on their 2012 PQRS performance related to cost and quality, but will be subject to the VM in CY 2014. ***Thus, we recommend that CMS either find a method to convey feedback on performance to groups of 10-24 prior to applying the VM to them for 2014 reporting, or that CMS revise their proposal and only apply the VM to groups of 25+ for CY 2014 reporting.*** We understand that CMS selected the 10+ size groups for 2014 as a way to integrate 60% of Medicare providers at the half-way point of the VM program rollout, however, we believe this proposal would disadvantage groups of 10-24 who will not have performance metrics or feedback reports to work off of to prepare for participation in the VM program in CY 2014.

C. New Reporting Mechanism for CY 2014: 70% of EPs Reporting Individually

The Academy is pleased with CMS' decision to provide an additional method of reporting for groups under the VM program for CY 2014 reporting. Specifically, we appreciate the flexibility provided to groups by allowing them to report on PQRS measures as individuals and so long as 70% of the EPs in the practice report successfully, this will be deemed sufficient to meet the reporting requirements for the VM program. ***We applaud CMS for providing this additional reporting option, and urge them to do provider education around this option, as it has the potential to be confusing for practices and groups in the first year of applicability. We are concerned, however, that the percentage threshold may be too high under the NPRM and suggest that CMS utilize a tiered approach of requiring 25% in the first year, 50% in the second year, and 75% in the third year (and years thereafter) in order to allow more groups to be successful in reporting under this option for CY 2014.***

In the same vein, and as mentioned previously in our PQRS comments, we are disappointed that CMS has decided to eliminate the administrative claims reporting option for 2014, and urge them to extend this reporting option for 2014. We also urge CMS to consider allowing EPs to report via the new QCDRs, for purposes of the VM program, in future rulemaking.

D. New Cost Measure for CY 2014

For CY 2014, CMS is proposing a new cost measure as part of the VM program. Specifically, they propose to add a cost measure for Medicare spending per beneficiary measures (3 days prior and 30 days after an inpatient hospitalization) attributed to all groups providing a Part B service during hospitalization.

The Academy is concerned with this new cost measure as proposed by CMS. Specifically, we do not agree that it is appropriate to attribute patients to surgical specialists for 30 days after a hospital procedure as the majority of inpatient work done by Otolaryngology is consultative or an isolated procedure such as a tracheotomy. Under the proposed structure of this cost measure, excessive costs will be applied to our specialty without any way to individually attribute patient care and costs that are within the purview or control of the surgeon. In addition, surgeons cannot manage or control a beneficiary's other chronic conditions during the 30 days following a surgical procedure, which also increases the risk under this cost measure that high patient costs, unrelated to the surgery, will be attributed to surgical specialists. Thus, we believe E&M services post-discharge that do not fall within a procedure's global period should be separated out and attributed to the provider rendering that care and only costs for surgical procedures and their associated global period post-operative care should be assigned to surgical specialists.

E. Cost Benchmarking in CY 2014

CMS creates a cost composite for each group of physicians by calculating a standardized score for each cost measure and then places the measures into one of two equally weighted domains: (1) the total per capita costs for all attributed beneficiaries domain and (2) the total per capita costs for attributed beneficiaries with specific conditions domain. To calculate the standardized score for each cost measure, CMS compares the performance for each group's cost measure to the benchmark (national mean of the performance rate among all the groups of physicians) of other groups subject to the payment modifier (peer group) for the same performance year. CMS discusses two methods for the CY 2016 value-based payment modifier (based on 2014 reporting) to account for the group practice's specialty composition.

The **first method, "specialty adjustment"** accounts for the specialty composition of the group prior to calculating the standardized score for each cost measure. Each cost measure would have its own set of specialty-specific expected costs.

The **second method, "comparability peer grouping"** creates peer groups for each physician group practice by identifying group practices with the nearest comparable specialty mix. Using this methodology, CMS would calculate a benchmark for the peer group and then use the benchmark to calculate the group's standardized score for that measure. For this method, CMS would need to develop a transparent way to define which groups of physicians are similar enough to be included in each group's peer group. CMS also notes that this approach creates a different benchmark for each group of physicians, which may make it more difficult for groups to understand how their costs are benchmarked.

Beginning with the CY 2016 value-based payment modifier, CMS proposes to use the first method, the specialty benchmarking method, to calculate the standardized score for each group's cost measures. CMS proposes to identify the specialty for each EP based on the specialty that is listed on the largest share of the individual's Part B claims. CMS will continue to monitor the effects of this policy and may consider changes through future rulemaking.

i. Specialty Adjustment Method

Of the options proposed, the Academy favors the specialty adjustment method; however we remain concerned that under this method CMS will identify a provider's specialty based on specialty listed on the majority of the individual's claims. Using this method to assign a specialty could be fraught with error in cases where the PECOS designated specialty is incorrect for a provider or in cases where their specialty mix is even but one designation is associated with higher cost services than another. Rather, we encourage CMS to assign specialty designations for cost benchmarking purposes under the VM program based on a claims analysis to identify the services most typically provided by the individual (i.e. the top 15 services the provider renders based on submitted claims) and assign their specialty based on the care they are most frequently providing.

ii. Comparability Peer Grouping Method

The Academy does not support this method as proposed by CMS. Notably, we are concerned with CMS' ability to identify peer groups, as defined within the NPRM, for all provider groups such that benchmarks are consistent and equitable across specialties and practices under the VM program.

F. Mandatory Quality Tiering in CY 2014

The Academy understands that based on feedback in 2013 rulemaking, providing group practices with the option to elect quality tiering was unlikely to be an effective method to incentivize group participation in this portion of the VM program. To that end, we can appreciate CMS' decision to mandate quality tiering for all groups under the 2014 reporting year for VM program. We also applaud CMS for proposing a "hold harmless" provision of sorts, which will allow groups of 10+ to avoid a VM payment penalty in 2016 so long as they participate in PQRS for CY 2014 reporting. Despite this provision, however, we remain concerned that groups of 100+ will not know that they are automatically subject to quality tiering and will potentially be subject to a 2016 payment penalty if they perform poorly as compared to their peers on quality and cost metrics. ***To that end, we urge CMS to conduct large scale educational efforts, including provider calls, MLN Matters articles, webinars, etc., and to collaborate with specialty societies to provide materials they can share with their members, to prepare groups of 100+ for this policy change in CY 2014, if finalized.***

G. Increased Payment Risk in CY 2014

For CY 2014, CMS proposed increasing the potential payment risk to groups of 100+ from -1% in payment year 2015, to -2% for payment year 2016. Due to the large number of total penalties potentially facing providers in CY 2016, based on CY 2014 reporting, as a result of the various quality programs they must comply with; we urge CMS to refrain from increasing the potential penalty under the VM program from the -1% in 2013 to -2% in 2014. ***Rather, we suggest that CMS retain the 2013 payment penalty of -1% for high cost/low quality groups, and utilize a -0.5% penalty for average cost/low quality or high cost/average quality groups, for CY 2014 reporting.***

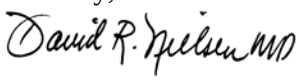
H. Quality Measures

Again, the Academy thanks CMS for attempting to ease provider confusion by coordinating the various quality reporting program measures. While we appreciate the attempt to align the quality programs by using the PQRS measures as the means for measuring a provider's quality of care under the physician feedback and value based payment modifier programs, ***we have continued concern regarding the limited number of measures relevant for our specialty to report on in both programs. Thus, we encourage CMS to continue adding measures to the PQRS system, as they have begun to do by proposing the Academy-PCPI Adult Sinusitis measures for CY 2014, which allow meaningful reporting options for all specialties and providers (see PQRS comments above for more detail).***

Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. If you have any questions or require further information, please contact Jenna Kappel, MPH, MA, Director of Health Policy at jkappel@entnet.org or 703-535-3724. Thank you.

Sincerely,



David R. Nielsen, MD, FACS
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