AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

September 2, 2014

SUBMITTED VIA ELECTRONIC FILING AND REGULAR MAIL

Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-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 2015

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 2015" published in the Federal Register as a proposed notice on July 11, 2014. 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) Validating RVUs of Services; (5) Payment for Secondary Interpretation of Images; (6) Physician Compare Website; (7) Electronic Health Records (EHR) Meaningful Use (MU) Incentive Program; (8) Physician Quality Reporting System; and (9) 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 (CF) for CY 2015 would be reduced, beginning on April 1, 2015, by over 20 percent. The CF for the first three months of the year is proposed at $35.7977 (compared to the CY 2014 conversion factor of $35.8228), 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 formula and has submitted numerous comments to Congress supporting its legislative reform proposals (H.R. 4015/S. 2000). To access the Academy's comments on SGR repeal visit: http://www.entnet.org/content/permanent-repeal-sgr-formula. We hope lawmakers

will continue to prioritize this on the legislative agenda and welcome efforts by CMS to work with Congress to achieve full repeal of the SGR formula during any lame duck session, or at a minimum, prior to the April 1, 2014 expiration of the current SGR patch.

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

A. Changes to Direct PE Inputs for Specific Services – Conversion from Film to Digital

Within the NPRM, CMS proposes to accept the RUC recommendation to remove the 30 film supply and equipment items associated with film technology (listed in Table 6 of the proposed rule) since these are no longer a typical resource input in providing digital imaging services. CMS acknowledges that this negatively affects portable X-ray suppliers, diagnostic testing facilities, and interventional radiology. The RUC also recommended that the Picture Archiving and Communication System (PACS) equipment be included for these imaging services since these items are now typically used in furnishing imaging services. However, since CMS did not receive any invoices for the PACS system, it proposes to allocate minutes for a desktop computer (ED021) as a proxy for the PACS workstation as a direct expense. CMS adds that for the 31 services that already contain ED021, it proposes to retain the time that is currently included in the direct PE input database. For the remaining services that are valued in the nonfacility setting, CMS proposes to allocate the full clinical labor intraservice time to ED021, except when there is no clinical labor, in which case CMS proposes to allocate the intraservice work time to ED021. For services valued only in the facility setting, CMS proposes to allocate the post-service clinical labor time to ED021, since the film supply and/or equipment inputs were previously associated with the post-service period.

CMS notes that the RUC exempted certain procedures from its film supply and equipment recommendation because (a) the dominant specialty indicated that digital technology is not yet typical or (b) the procedure only contained a single input associated with film technology, and it was determined that the sharing of images, but not actual imaging, may be involved in the service.

CMS, however, rejects the RUC recommendation based on dominant specialty input, arguing that migration to digital technology will be typical for most if not all imaging services before the proposed change to digital inputs would take effect beginning January 1, 2015. CMS also proposes to remove film supply and equipment inputs from 56 codes not covered by the RUC recommendation. This proposal impacts several ENT services, including:

CPT Code	**Descriptor**	**Current Film Related PE Inputs to be Removed**	**CMS Suggested New Input for CY 2015**
61580	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	SK013 Computer Media, DVD	ED021 desktop computer
61581	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	SK013 Computer Media, DVD	ED021 desktop computer
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	SK013 Computer Media, DVD	ED021 desktop computer

92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	SK013 Computer Media, DVD	ED021 desktop computer
92524	Behavioral and qualitative analysis of voice and resonance	SK013 Computer Media, DVD	ED021 desktop computer
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	SK014 Computer Media, floppy disk 1.44mb	ED021 desktop computer
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	SK014 Computer Media, floppy disk 1.44mb	ED021 desktop computer
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	SK013 Computer Media, DVD	ED021 desktop computer
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	SK013 Computer Media, DVD	ED021 desktop computer
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	SK013 Computer Media, DVD	ED021 desktop computer
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	SK013 Computer Media, DVD	ED021 desktop computer
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	SK013 Computer Media, DVD	ED021 desktop computer
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	SK013 Computer Media, DVD	ED021 desktop computer

Regarding the codes outlined above, the Academy believes the crosswalk selected by CMS of ED021 Desktop Computer is appropriate and will sufficiently meet the needs of otolaryngologists and their clinical staff for the purposes of these procedures. Further, we believe the reimbursement amount assigned to ED021 as part of the direct practice expense inputs/formula is sufficient to cover the costs of this item as part of the overall direct practice expense included in providing the service.

B. Using OPPS and ASC Rates in Developing PE RVUs

Within the proposed rule, CMS revisits their CY 2014 proposed policy to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount

that Medicare would pay for the same code in the facility setting. CMS adds that it is not proposing a similar policy for the CY 2015 PFS and that if it did do so in the future rulemaking, it would consider all of the comments received previously. CMS notes, however, that it continues to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated**.** CMS adds that section 220(a) of PAMA, Publ. L. 113-93, provides them with the authority to exploring ways of collecting better and updated resource data from physician practices, including those that are provider-based, and other non-facility entities paid under the PFS, and that using this information does not detract from the statutorily required "relativity" of the MPFS. CMS says that such efforts will be challenging given the wide variety of practices and likely impose some burden on EPs. CMS notes that through a validation contract, it has been gathering time data directly from physician practices, from which it has learned much about the challenges of gathering data directly from physician practices.

CMS further notes that section 220 of PAMA provides authority to use alternative approaches to establish PE RVUs, including the use of data from other suppliers and providers, and that the agency is exploring how best to exercise this authority. CMS seeks comment on the possible uses of the Medicare hospital outpatient cost data in potential revisions of the PFS PE methodology, as means to validate or, perhaps, in setting the relative resource cost assumptions within the PFS PE methodology. CMS is particularly interested in comments identifying other broad-based, auditable, mechanisms for data collection.

The Academy has some concerns in response to CMS' inquiries related to the use of hospital data to compare costs for direct practice expense inputs to that of the RUC database or society presented PE direct input data/invoices. Specifically, that hospitals have much greater buying and negotiating power as compared to physician practices given that hospitals are often purchasing equipment and supplies in larger quantities, and more frequently, than physician practices or solo-practitioners. This affords them leverage in negotiating prices with manufacturers and industry partners that is not available to physician practices purchasing equipment once every few years, or in single quantities. Thus, we would caution that CMS only use hospital cost data submitted to them under the Hospital Outpatient Prospective Payment System (OPPS) as a comparator for invoices submitted via the RUC process by physician practices and specialty societies, and not as a measuring tool or concrete cost data for setting supply and equipment rates under the direct input portion of PE within the PFS.

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

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. Specifically, as stated in our comments from last year's rulemaking cycle, 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 this option, as proposed by CMS.***

In contrast, we have commented previously that of the suggestions made in last year's proposed rule by CMS, we would support the option to require a new place of service (POS) code for "off-campus departments" to be used on the 1500 claim form as 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.

3. POTENTIALLY MISVALUED SERVICES UNDER THE PHYSICIAN FEE SCHEDULE

In CY 2013, CMS finalized their policy to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2015 proposed rule two codes were nominated by the public as potentially misvalued / requiring review. Notably, one was CPT 41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session, which was nominated by the Academy during 2014 notice and comment periods. ***The Academy appreciates CMS' responsiveness to our request based on last year's comments. This proposal was made by the Academy based on input from our clinical experts that two of the practice expense inputs in the existing code had become outdated and required refinement based on current pricing and technology utilized for this procedure. Since the submission of our comments, however, the practice expense for this service was reviewed as part of the AMA RUC OPPS Cap screen during the April 2014 RUC meeting. Recommendations were made to CMS to refine the values of those inputs, accordingly, and therefore we do not feel further review of this code is necessary at this time.*** This is consistent with the comments we have provided via the NPRM Requests screen which will be reviewed by the RAW at the September 2014 RUC meeting.

Additionally as part of the misvalued codes initiative, CMS proposed a new screen which captures approximately 65 codes as potentially misvalued and prioritized a subset of codes that account for the majority of spending under the physician fee schedule. Specifically, they note that within their usual identification process for capturing potentially misvalued codes it is possible to miss certain services that are important to a segment of Medicare practitioners and beneficiaries because the specialty that typically furnishes the service does not have high volume relative to the overall PFS utilization. To capture such services in developing this list, they began by identifying the top 20 codes by specialty in terms of allowed charges. They excluded codes from our proposed potentially misvalued list that we have reviewed since CY 2009, with fewer than $10 million in allowed charges, and that describe anesthesia or E/M services. They believe that a review of the codes in Table 10 is warranted to assess changes in physician work and to update direct PE inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties, as discussed previously. For these reasons, CMS proposes the codes listed in Table 10 as potentially misvalued. The codes relevant to Otolaryngology are listed below in the abbreviated table:

TABLE 10: Proposed Potentially Misvalued Codes Identified Through High Expenditure Specialty Screen – Impacted Otolaryngology Services

14060 Tis trnfr e/n/e/l 10 sq cm/<
31575 Diagnostic laryngoscopy
31579 Diagnostic laryngoscopy
92557 Comprehensive hearing test
95004 Percut allergy skin tests
95165 Antigen therapy services

The Academy understands, and appreciates, CMS' efforts in regards to identifying potentially misvalued codes within the PFS in an effort to conserve resources across the RBRVS payment system. To that end, we have indicated interest on all of the codes in the table above via the RUC review process and will be developing action plans accordingly for the September RUC meeting. While we understand CMS' intent behind these new and additional screens, we have concerns about the use of a blanket "high expenditure" screen without thought towards why a code may be high volume or high expenditure. Specifically, for diagnostic screening tools used by one or multiple specialties, we think it is vital that CMS take into consideration the downstream costs saved by performing the initial diagnostic study. Given the usefulness of these diagnostic exams, we believe CMS should

exempt services that are high volume or high expenditure from these screens unless they have not been RUC reviewed (also known as Harvard valued) and/or if they have not been RUC surveyed in the past 10 years. This will ensure that high volume / high expenditure diagnostic services remain accurately valued, but are not subject to multiple screens on a yearly basis, due solely to the fact that they are high volume or high expenditure, without the acknowledgement that they are medically necessary and save downstream health care costs by being performed initially to fully evaluate the patient.

Additionally, we encourage CMS to consider different types of screens to achieve their goals of identifying misvalued codes in scenarios, such as the one outlined above, where a code will always be high volume because it is useful diagnostic tool and saves downstream costs. In these cases, we believe a screen for codes that have increased a certain percentage over a set period of time (e.g. codes that have increased more than 30% over five years) should be captured, not just codes that are over a certain total utilization. This would identify areas of growth in high volume codes, rather than repeatedly capturing the same high volume codes, and requiring their re-review, when in many cases the high volume may be entirely appropriate.

A. Improving Valuation of the Global Surgical Package

In the CY 2012 rulemaking process, CMS proposed and finalized consolidation of the five-year review and the potentially misvalued code activities into an annual review of potentially misvalued codes. Under this process, CMS issues interim final RVUs for all revaluations and new codes in the PFS final rule with comment period and payments are based on those values during the CY covered by the final rule. CMS considers it appropriate to establish interim values for new, revised and potentially misvalued codes because of the timing incongruities between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process.

CMS notes that their recent revaluation of several code families have raised concerns from stakeholders with the existing process based on the reductions in payment for those services. Specifically, that they did not receive notice of the possible reductions before they occurred, CMS notes that stakeholders should be aware of changes because either CPT has made changes or CMS has identified the codes as potentially misvalued, and representatives of the affected specialties are participating in the RUC meetings. Commenters have asserted, however, they are not aware of RUC recommendations, they have no opportunity to respond to RUC recommendations and not all suppliers are permitted to participate in the RUC process. Additionally, some stakeholders objected to interim final decisions because they do not have an opportunity to meaningfully comment before the values are implemented in the next year's final rule.

i. CMS' Proposal to Modify the Rulemaking Process for Establishing Interim Values for Services

After weighing various options, CMS proposes the following:

- Include proposed values for all codes for which CMS has complete RUC recommendations by January 15th of the preceding year.
- For the CY 2016 rulemaking process, CMS would include in the proposed rule proposed values for all services for which they have a RUC recommendation by January 15, 2015.
- For codes where CMS does not receive a RUC recommendation by January 15th of a year, CMS would delay revaluing the code for one year (or until they receive the RUC recommendation for the code) and include proposed values in the following year's rule.
- CMS notes there might be some circumstances where the RUC recommendation is received by January 15th but CMS is not able to propose values in that year's proposed rule and CMS would treat these codes as if they have not received recommendations before January 15th.
- CMS proposes to adopt coding policies and payment rates that conform, to the extent possible, to the policies and rates in place for the previous year.

- For codes that were revised or deleted as part of the annual CPT coding change and when the changes would affect the value of a code, CMS proposes to create G-codes to describe the predecessor codes. If CPT code revisions did not affect the resource inputs, CMS proposes to use the revised codes and continue to pay at the same rate.
- For new codes that describe completely new services, CMS proposes to work with the RUC to ensure recommendations are received in time to include proposed values in the proposed rule. If RUC recommendations were not received in time and CMS determines it is in the public interest to use a new code, CMS proposes to establish values for the code's initial year using the current policy of considering RUC recommendations if available for the final rule and proposing interim final values. CMS also notes that when it would not be appropriate to establish interim final values, CMS would have contractors price the code for the initial year.

Overall, the Academy is supportive of CMS' proposals to make the assignment of RVUs for new and revised services more transparent via the rulemaking process. Specifically, we support, and have been supportive via sign on letter efforts earlier this year, the concept of publishing the revised RVUs for services within the NPRM rather than within the final rule each year. This gives the public an opportunity to comment in advance of the final rulemaking by CMS, and also allows specialties time to educate their members and the general public when services are anticipated to receive a substantial reduction in reimbursement for the coming calendar year. ***Despite our support for the concept of this proposal and its intended transparency, we do have some concerns regarding how CMS is proposing to operationalize the policy change which is outlined below. We also would like to respond to CMS' specific queries within the NPRM on this subject.***

CMS requested comments on the following:

- Is this proposal preferable to the present process? Is another one of the alternatives better?
- If this proposal was implemented, should it be implemented in CY 2016 or is more time needed? What factors should CMS consider in selecting an implementation date?
- Are there alternatives other than the use of G-codes to allow CMS to address the annual CPT changes through notice and comment rather than interim final rulemaking?

A. Better Alternatives to CMS' Proposal

Regarding CMS' query as to whether any better alternatives exist than that proposed by CMS within the NPRM, the Academy would reiterate our suggested alternative which was outlined in greater detail within a sign-on letter sent to CMS on August 13, 2014. This proposal, developed by the AMA, was also noted in a sign-on letter sent to CMS earlier this year which was signed by 25 specialty societies.

B. Timing of Implementation

In response to CMS' question related to timing of implementation, we would encourage CMS to delay from the proposed 2016 implementation date, as we believe it is premature and would have a serious impact on the development of new technology and new code bundles which is already underway for the Current Procedural Terminology (CPT®) 2016 code set. The cycle for the CPT 2016 code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014 and will conclude on February 7, 2015. We believe that it would be inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial process for the 2016 cycle will already be nearly complete by that date and requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first *CPT 2017* deadline of February 13, 2015. ***Thus, we urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 MPFS.***

C. Use of G Codes for codes not finalized by the release of the NPRM

We strongly urge CMS to adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner. If CMS adopts the AMA proposal, this will eliminate the need for CMS to create G codes which essentially duplicate the CPT codes and would unnecessarily add to the administrative burden of physicians, non-physician practitioners, and providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Further, we are concerned that in the event private payers do not implement G codes consistent with Medicare, this will cause even greater confusion for providers in reporting their services.

B. Elimination of Refinement Panels

CMS proposes to eliminate the Refinement Panel process currently utilized. For nearly two decades, the CMS Refinement Panel Process was considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, a specialty related to the commenter and the commenting specialty. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most recently, CMS modified the process to only consider codes for which new information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to actually finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value.

While we agree that as this system has evolved and changed it has become less meaningful as a realistic method to appeal what stakeholders believe to be misvalued codes, we still feel strongly that some sort of appeals process is necessary regardless of whether CMS publishes proposed values in the NPRM. For example, in cases where a value is published in the NPRM that stakeholders disagree with, they will have the opportunity to comment and discuss further with CMS during the comment period and prior to the publication of the final rule, however, if additional data or information is needed it may not be realistic to gather that for CMS during the short comment period. In cases where those values are finalized, we believe stakeholders should still have the opportunity to appeal the finalized value in a fair, objective, and consistently applied appeals process that would be open to any commenting organization.

C. Concerns with 010 and 090 Globals

Within the 2015 NPRM, CMS proposes a major change to reporting global surgical procedures by suggesting a two year transition of all 010 and 090 global services to a 000 global. Specifically, they note their belief that in the context of the misvalued code initiative, they believe it is critical for the RVUs used to develop PFS payment rates reflect the most accurate resource costs associated with PFS services. To address this, CMS proposes to retain global bundles for surgical services, but to refine bundles by transitioning to all 000 globals over a two year period. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. They propose to make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes. CMS believes that transitioning all 10- and 90-day global codes to 0-day global codes would:

- Increase the accuracy of PFS payment by setting payment rates for individual services based more closely upon the typical resources used in furnishing the procedures;
- Avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period;
- Eliminate disparities between the payment for E/M services in global periods and those furnished individually;

- Maintain the same-day packaging of pre- and post-operative physicians' services in the 0-day global; and
- Facilitate availability of more accurate data for new payment models and quality research.

CMS notes that if they adopt this proposal, they intend to monitor any changes in the utilization of E/M visits following its implementation and seeking comment on potential payment policies that will mitigate such a change in behavior. CMS also states that given their proposed timeline, it does not seem practical to survey time and intensity information on each of these procedures. Absent any new survey data regarding the procedures themselves, they believe that data regarding the number and level of post-service office visits can be used in conjunction with other methods of valuation.

CMS seeks input on the best approach to achieve this proposed transition from 10- and 90-day, to 0-day global periods, including the timing of the changes, the means for revaluation, and the most effective and least burdensome means to collect objective, representative data regarding the actual number of visits currently furnished in the post-operative global periods. They also seek comment on whether the effective date for the transition to 0-day global periods should be staggered across families of codes or other categories. For example, while CMS is proposing to transition 10-day global periods in 2017 and 90-day global periods in 2018, they seek comment on whether they should consider implementing the transition more or less quickly and over one or several years. Last, they seek feedback regarding the appropriate valuation of new, revised, or potentially misvalued 10- or 90-day global codes before implementation of this proposal.

The Academy appreciates CMS's effort to propose solutions that will increase the accuracy of reimbursement for physician's services across the RBRVS payment system. Further, we believe conceptually, that proposing a transition of all 010 and 090 global surgical codes to a 000 global may have merit and could potentially be valuable as we explore alternative payment systems such as episodes of care and bundling initiatives. We do, however, have serious concerns regarding how this proposal would be operationalized, and are unclear of the full implications to reimbursement for surgical specialties at this time. To that end, we are undertaking efforts to conduct modeling and data analysis to better understand the impact transitioning to all 000 globals would have on Otolaryngology, but given the vast scope of this project, we are unable to obtain the necessary data within the 60 day notice and comment period of the NPRM. As a result, we would ask that CMS delay this proposal to allow the Agency, specialty societies, and public stakeholders sufficient time to conduct a thorough analysis of the policy implications of this proposal. Some of our specific concerns related to this proposal, are outlined below:

Unintended Consequences

Removing post operative visits and simply substituting with the general E/M office visit codes will have unintended negative consequences to surgical specialties given that current post operative visits include direct practice expense inputs specific to that specialty. For example, a typical ENT office may have an exam chair, SMR cabinet, xenon light, etc. built into the post operative visit because this equipment is typical in the ENT office and used in all post operative visits. The regular E/M visits of course, do not include these specific pieces of equipment. Thus, in reporting the E/M visit codes, surgeons will no longer be able to cover the costs of their office supplies and equipment for the direct practice expense inputs unless a higher paid E/M code set is created, or modifiers are utilized to denote the higher cost practice expense items commonly utilized by surgical specialties.

On an unrelated, but equally important note, we are concerned about the impact to patients should this policy be finalized. Specifically, the impact on patient care that may arise when patients' are asked to pay separate co-pays for all follow up visit care. This may serve as a disincentive for patients to come in for medically necessary post-operative follow up care which could result in negative patient outcomes and additional downstream costs to the health system. This is a real concern that we believe should be carefully considered if a move towards all 000 globals is implemented.

Last, we are concerned that requiring providers to report E/M codes for all post operative care will significantly increase the number of claims MACs are required to process, which may overload claims processing systems and cause unintended administrative burdens for both MACs and providers, as this would also likely result in delays in processing and payment for physician practices.

Implementation / Valuation of 000 Global Codes

CMS asks for direction regarding how to accurately value the surgical procedures once the post operative visits are removed. As CMS acknowledges in the NPRM, surveying all of the surgical codes is an impractical option due to the administrative and cost burden it would place on surgical specialties and the AMA RUC process. Despite this, we are concerned that there are many surgical procedures that are currently undervalued and if post operative visits were removed, this would only serve to further exacerbate that issue. Further, the suggestion to value one code in a family and extrapolate that value, using magnitude estimation, to other codes in the family is equally disconcerting if the procedure code valued is undervalued and used as a basis for valuing the surrounding codes in the family. Last, given that global codes and E/M visits have different values, backing out post operative care will not only impact practice expense for services, but also PLI. ***Given all of these factors, we again reiterate the need for additional time to fully vet and analyze the impact of this proposed policy change on surgical services prior to proceeding. To that end, we encourage CMS to convene town halls and other stakeholder meetings to gather input from all necessary parties and allow stakeholders a meaningful voice in implementation of this proposal, prior to moving forward in future rulemaking.***

D. Modification to the Time File for Missing Hospital and Discharge Day Management Visits.

As we noted in our comments on the 2014 MPFS, the Academy supports the proposal, based on information from the AMA RUC, to modify the time file to correct missing hospital and discharge management services included in the global period for surgical codes where the visits were inadvertently removed. We again support this proposal to correct these omissions for CY 2015.

4. VALIDATING 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 2013 proposed rule CMS informed the public of their intent to, "enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, both for new and existing services."*** Both contracts will extend over a 2 year period. More details were released regarding these contracts in the 2015 NPRM, including the first

interim report from the Urban Institute. 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 model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results.

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. Urban Institute will use a variety of approaches to develop objective time estimates, depending on the type of service, which will be a very resource-intensive part of the project. Objective time estimates will be compared to the current time values used in the fee schedule. The project team will then convene 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. Additional detail on both projects can be found here.

Given the initial difficulties outlined by both contractors during the initial phases of their validation projects, the Academy would urge CMS to consider other methods by which they might be able to validate services within the PFS moving forward. Specifically, we would urge CMS to consider the use of specialty society registries, or collaboration with specialty societies to create a more robust general registry should CMS find that more beneficial, to review and analyze practice patterns and intensity/complexity of services across medical specialties. The Academy, like many other specialties, is currently exploring registry options, however, due to the large upfront cost; this is a somewhat daunting task. If CMS or CMMI were willing to contribute funding to support specialties in registry development, we believe this could be a partnership opportunity that would benefit both specialty societies and the Agency as a whole.

5. PAYMENT FOR SECONDARY INTERPRETATION OF IMAGES

Within the NPRM, CMS seeks comment to assess whether there is an expanded set of circumstances under which it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, and whether such a policy would be likely to reduce the incidence of duplicative advanced imaging studies.

The Academy would like to respond to CMS' specific inquiries in turn, below:

- **For which radiology services are physicians currently conducting secondary interpretations, and what, if any, institutional policies are in place to determine when existing images are utilized?**

The services for which physicians are conducting secondary interpretations within the otolaryngology community are: CT temporal bone, neck, sinus; MRI neck, and IAC/brain. At this time we are not aware of written institutional policies to determine when existing images are utilized. It is the opinion of our imaging experts, who hold experience and training from large quaternary medical centers and tertiary centers, that the delivery of care in tertiary facilities receiving patients who arrive with existing, available images, focus on high quality care and place the needs of the patient first. The integrity and professionalism of physicians caring for the patient in these settings prevents additional, unnecessary imaging from being performed. If the existing images are sufficient quality and provide the necessary information, they are used. If imaging is not sufficient or poor quality, they are repeated as needed.

Our experience suggests that physicians are not ordering duplicative images upon receiving patients transferred from outside hospitals in order to bill for primary interpretation of imaging. Rather, if high quality images are available, they review the images, seek out prior documentation and document the E/M services as an appropriately higher service level.

Therefore, we believe it is important to allow for payment for a secondary interpretation of imaging, where medically necessary. Tertiary radiologists and neuroradiologists frequently read/re-read such images from outside hospitals, as previously discussed. This is the most common example our imaging experts see in their practices. We believe radiology input is essential, and thus, their work should be compensated. Should another specialist make the second reading, they too should be compensated.

- **Should routine payment for secondary interpretations be restricted to certain high-cost advanced diagnostic imaging services?**

The Academy does not believe secondary interpretations should be restricted to specific high-cost advanced diagnostic imaging services. Two interpretations of any imaging can be helpful for patient care. Given that the specialist is responsible, and held liable, for such secondary interpretations, we believe it is reasonable they be compensated for this work and time in interpreting all images.

- **How should the value of routine secondary interpretations be determined? Is it appropriate to apply a modifier to current codes or are new HCPCS codes for secondary interpretations necessary?**

In response to this inquiry, we defer to radiology in cases where the secondary read of images is performed by a radiologist. In cases where a surgeon is re-reading the image, we would agree that appending a modifier to indicate the secondary interpretation is reasonable as a method of tracking these trends by physicians.

- **Is there a limited time period within which an existing image should be considered adequate to support a secondary interpretation?**

We felt it was difficult to define a set time period within which an image could be considered "adequate" and do not support the use of generic time frames in this regard. We believe these decisions should be left to the independent clinical judgment of the physician and will vary based on clinical condition and specialty.

- **Would allowing for more routine payment for secondary interpretations be likely to generate cost savings to Medicare by avoiding potentially duplicative imaging studies?**

We are concerned that this question presumes that many additional studies are ordered merely to generate a bill for interpretation, and therefore, are not medically necessary. While we understand CMS' concern in this regard, and support their efforts to eliminate unnecessary medical imaging, we urge CMS not to implement generic guidelines that will hamper independent clinical judgment as it relates to critically important diagnostic imaging tools. We believe the decision as to whether a prior MRI brain or sinus CT scan was appropriate, and whether correct anatomy was imaged, is a critical piece of this discussion. In order for secondary interpretation to be valuable, rapid review of images and reports would need to be available. Currently, mechanisms to do this are often inadequate and delay timely diagnosis and delivery of care.

- **What operational steps could Medicare take to ensure that any routine payment for secondary interpretations is limited to cases where a new imaging study has been averted while minimizing undue burden on providers or Part B contractors (such as restricting physicians' ability to refer multiple interpretations to another physician that is part of their network or group practice, requiring physicians to attach a physician's order for an averted imaging study, or requiring physicians to identify the technical component of the existing image supporting the claim)?**

We suggest the requirement of including a single line within the dictation/documentation in the medical report stating: "the secondary interpretation is done with the benefit of EITHER averting a new imaging study; OR is necessary for specialized patient care, in which case a description of the lesion/pathology reviewed is provided".

6. PHYSICIAN COMPARE

Within the NRPM, CMS reiterates that the goal of Physician Compare to create a website to aid patients in making informed decisions when choosing physicians and other healthcare professionals enrolled in Medicare.

The Academy fully supports providing patients and beneficiaries with information that allows them to make the best decisions possible regarding their clinical care, but we fear many of the previous final rules, and current proposals, fail to advance the intended goals. Specifically, we believe information published on Physician Compare must be presented in the manner that not only is easily understood by patients, but also is derived from sources that adequately and appropriately demonstrate the quality of care provided. ***Given the complexity of data proposed for public display in the coming years, we urge CMS to reconsider publishing specific performance data derived from CG-CAHPS, PQRS, and other reporting initiatives, as patients are highly unlikely to be aware of the variances, potential inaccuracies, and other key issues associated with the programs as they currently stand.***

A. CG-CAHPS versus S-CAHPS Survey Information

For example, the CG-CAHPS survey does not appropriately capture patient experience associated with surgical procedures, yet this data is published for group practices of 25 or more EPs reporting CG-CAHPS. To ensure patients are provided with the most accurate and relevant data, we encourage CMS to allow surgeons to utilize the AHRQ approved Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS) to evaluate the patient experience associated with surgical care for purposes of posting this information on the Physician Compare website. We believe the use of the S-CAHPS survey will further CMS' goal to obtain more accurate and meaningful quality data to share with patients because it more closely assesses the relevant patient experience during surgical care. The publishing of CG-CAHPS survey data for surgeon specialists, such as otolaryngologist – head and neck surgeons, limits a patient's ability to effectively and judiciously select a providing surgeon because the information provided is derived from a source that does not appropriately evaluate patients' experience with surgeon specialists in the first place. ***To that end, we would be happy to work alongside CMS, and other surgical specialties who have been heavily involved, to discuss how best to operationalize the inclusion of the S-CAHPS survey for future quality reporting years. The Academy views the availability of this survey as key to surgical specialists' successful participation in CMS quality incentive programs, and welcomes the opportunity to discuss this further with CMS staff.***

As an additional alternative, should CMS determine that they are not able to incorporate the S-CAHPS survey for future PQRS use, we would recommend that CMS only report survey responses for the section "your care from this provider during your most recent visit" (questions 14-26 on the visit-specific survey), as we believe these questions are pertinent to overall quality of care and universally relevant, regardless of physician specialty.

B. General Concerns with Posting Provider Specific Data

Similarly, while we appreciate the desire to provide patients with information on providers' quality program participation to aid them in selecting a physician, we remain concerned with CMS' decision to publish specific performance data for providers. As CMS knows, many aspects of the quality incentive programs have yet to be finalized and currently require regular stakeholder feedback to address problems that have arisen as the programs unfold. Because of such, ***we urge CMS to reconsider its proposals to: publish additional specific performance data (e.g. publicly reporting all 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims), accelerate the timeline for publishing, and to include calculated benchmarks; until the programs are more developed and greater opportunities for specialist participation have been afforded. To do so any earlier is an unfair burden on providers, and a disservice to patients, as it fails to ensure the information provided adequately and appropriately reflects the provider's quality of care.***

It is also unclear how information on the specific quality measures will be used by patients who: 1) likely do not know what the program entails, and 2) do not understand the requirements for successful participation. Again, while we fully appreciate CMS' goal to provide information which helps patients find and make informed decisions, but ***we urge CMS to be mindful about what information is necessary and meaningful to patients, and avoid inundating them with information derived from programs not yet fully developed. By only posting successful participation of providers for the quality programs at this point-in-***time, CMS limits the opportunity

for patients to misinterpret or misconstrue the information provided while still advancing the intended goals of the program.

C. Concerns related to Accuracy of Data

Finally, concerns remain regarding the accuracy of the information posted, which only further inhibits patients' ability to make informed decisions based on this data. As we've noted in previous comments, review of several of our physician leader's information uncovered several errors in information, such as physicians being listed as affiliated with hospitals they have never worked in, or have languages listed which they do not speak. When our members attempted to correct their information listed on the website, they were asked for PECOS login information which many times is not immediately available, and were told that it would take up to 6 months for the information to be corrected. The inability to correct incorrect information in a timely manner not only unfairly punishes providers, but it also may have the unintended consequence of limiting patient choice. ***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, and meaningfulness to patients related to, the 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.***

7. ELECTRONIC MEDICAL HEALTH RECORDS (EHR) MEANINGFUL USE (MU) INCENTIVE PROGRAM

The Academy appreciates the willingness of CMS, within the NPRM, to incorporate greater flexibility into the EHR MU Incentive Program by allowing providers that are unable to have CEHRT that is tested and certified to the most recent version of the electronic specifications for CQMs, the ability to not recertify their product and only report the most recent version of the electronic specifications for the CQMs. While we are pleased that CMS has chosen to revisit this requirement, we remain concerned additional flexibility has not been proposed.

The goal of incentivizing the meaningful use of electronic health records emphasizes greater efficiency in health care, decreased costs of providing medical care, and improving the clarity and legibility of medical information as it is shared between providers, regulators, and public health agencies. Unfortunately, many of these requirements are having the opposite effect. In fact, often times the requirements decrease the efficiency of healthcare visits. CMS has incorporated additional flexibility for 2015 with this proposal, but flexibility beyond 2015 and recertification requirements are essential to obtaining the envisioned goals of the EHR MU program. ***CMS could achieve this increased flexibility in a number of ways, including: creation of alternative reporting options; alignment between the various quality initiatives; and more flexible reporting criteria.***

A. Timeline for Stage 2

The Academy applauds the role the EHR MU Incentive Program has played in advancing and promoting adoption of the health information technology (HIT) across the country, we remain troubled by the stringent timing requirements of program, especially in light of the lack of flexibility afforded to providers (as mentioned above). ***To that end, we previously requested an extension of Stage 2 for providers who need extra time to meet Stage 2 requirements and would like to reiterate this request.***

Many of our members have been under significant time pressures to meet the 2014 requirements, resulting in progression to Stage 2 being virtually impossible. The inability to successfully adopt, implement or upgrade to the 2014 Edition CEHRT further exacerbated such pressures, by affording providers even less time than originally anticipated to properly adjust workflow changes and receive additional training on the new software before progressing to Stage 2, and 2015 requirements. These significant burdens and lack of feasibility are especially prevalent for small and rural specialists who lack the resources of large practices, and who are likely not vendors' top priorities. ***A delay of Stage 2 for providers would further the goals of the EHR program, whereas a failure to extend may have the unintended effect of stifling innovation and increasing medical error. Allowing for sufficient time to ensure a safe and orderly transition through Stage 2 is critical to the long-term success of EHR MU Incentive Program and is of great importance to our specialists.***

B. Stage 3 Requirements

We also remain concerned that specialists, such as otolaryngologists – head and neck surgeons, will only continue to have difficulty meeting the increased thresholds in Stage 3. As previously stated, while we are supportive of the stated goals of HIT, and the vision of Stage 3 which includes a "collaborative model of care with shared responsibility and accountability," we are concerned that Stage 3 includes higher objective thresholds with increased penalties. This will only increase pressure on small specialty practices that have encountered problems successfully meeting MU Stage 1 and/or 2 requirements. Stage 3 is scheduled to begin in 2017 and we believe that coupled with decreasing reimbursement and other potential penalties, these increased thresholds could continue to hinder not only HIT adoption, but also patient access to quality care.

Thus, the need for additional flexibility is particularly true in light of the lack of interoperability of EHR systems. Many of the program's requirements depend upon interoperability of EHR systems which has not yet been realized except within health systems sharing the same software. These limited networks decrease patient access to care, choice, and timely specialty availability, thwarting many of the overall objectives intended by the program. For example, a requirement of order tracking will provide an incentive to limit consultations to systems that share a similar EHR. Improved interoperability must precede some standards. ***As such, we encourage CMS to carefully consider these potential roadblocks to successful implementation of the coming stages, as well as consider the aforementioned solutions.***

8. PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

A. Approval of New Measure Groups

Within the NPRM, CMS proposed the addition of two new measure groups, Sinusitis and Acute Otitis Externa (AOE). ***The Academy is extremely grateful to CMS for including these proposed new measure groups within the NPRM, particularly given the amount of time and effort our specialty, in concert with CMS staff, have dedicated to the development of these new measure groups. We are confident the inclusion of these new groups will encourage greater PQRS participation within the otolaryngology community. We look forward to continued collaboration with CMS in the future, to develop additional measure groups which are broadly applicable to our highly subspecialized field of physicians.***

B. Increase in Number of Measures Reported in Measure Groups

The Academy supports CMS' proposal within the NPRM to increase the number of measures that may be included in a measures group from a minimum of 4 measures to a minimum of 6. While we recognize that this will add additional work, to include two (or more) measures to existing measure groups, we believe this is outweighed by the benefit to providers and our members as it allows them access to meaningful quality measure groups to achieve successful PQRS reporting.

C. Deletion of Measures for CY 2015 Reporting / Measure Maintenance

Within the NPRM, CMS proposes to delete the Perioperative care measures group for CY 2015 reporting because they feel this measures group does not add value to the PQRS and EPs are consistently meeting performance on this measure, with performance rates close to 100 percent.

The Academy is concerned about this proposal from CMS and urges the Agency not to delete this measures group for CY 2015 reporting. Specifically, we are concerned regarding CMS' comment that because providers are performing well on these measures, that they do not "add value to the PQRS". Rather than assess a high performance rate on this measures group as lacking value due to high performance, we believe high performance is an indication that providers in the surgical community are performing well, and providing high quality care, to their patients during the perioperative period. As such, we believe surgeons should be rewarded for their high quality care and should be allowed to report on measures, even in cases where they are already performing at a high level. Further, we believe for many providers just beginning PQRS reporting, this is a good measure group for them to report on, as it provides a baseline for quality of care related to all

surgical procedures. We also believe that removing measures due to providers' "high-performance" assumes that the group of EP's is static and has reached sustainability, however, often times that is not the case as most groups of providers change over time, making these measures meaningful on an ongoing basis.

Further, the Academy would urge CMS to consider a transition period, for instances in future rulemaking, when they propose to delete measures from the PQRS program. This would allow specialties with limited measures, and measure groups, time to evaluate additional or new measures they may need to utilize given a proposal to delete a measure previously reported. We do not believe the period between the proposed rule and final rule is sufficient to allow practices to evaluate and modify their plans, in terms of measures to report, and thus, urge CMS to operationalize a transition period/process in cases where they propose to delete individual measures or measure groups in future rulemaking.

CMS also proposes to remove the Sleep Apnea measures group from reporting in the PQRS beginning in 2015 because, for a number of measures included in this group, the measure steward has indicated they will no longer maintain those measures. Those measures and their associated measure groups are proposed for removal from the program. As a result, the measures group would have less than the 6 measures proposed to be required in a measures group.

As indicated by CMS in the NPRM, should a new entity offer to serve as the measure steward for this measure group, and agree to develop an additional 2 measures to complete the measure group based on the new proposed requirement of 6 measure per measure group, CMS would be willing to retain the measure group for CY 2015 reporting. The Academy believes this is an important measure group to retain given that sleep medicine is a subspecialty of otolaryngology. Further, given that sleep medicine is such a specialized area of practice, we remain concerned that if this measure group were deleted many of our members would lose a vital measure group that allows them to participate in the PQRS program. Therefore, the Academy would like to volunteer to become the measure steward for the sleep apnea measure group for CY 2015 and would like to collaborate with CMS to develop the additional 2 measures that will likely be required for CY 2015 reporting of measure groups.

D. New Cross-Cutting Measures Requirement for Claims and Qualified Registry Reporting

Another change proposed by CMS, within the NPRM, is to add the requirement of reporting on two "cross-cutting" measures for providers reporting on individual measures via claims or traditional registries (such as the PQRS Wizard). This is required in cases where providers conduct at least one "face-to-face" encounter with a Medicare beneficiary, defined as an EP billing for services under PFS associated with encounters such as general office visits, outpatient visits, and surgical procedures.

While the Academy understands the intent behind this recommended proposal, and supports the concept of increasing measures that are useable across medical specialties, we have some concerns regarding this specific proposal by CMS. Most notably, the burden on physicians and their practices in terms of quality reporting is already quite high in that they are expected, as of CY 2015 reporting, to report on 9 individual measures across three quality domains to achieve successful reporting. We believe increasing the burden, to include additional 2 cross-cutting measures, is overly burdensome and will result in surgical specialties, who already have a very limited number of measures to report, being unable to achieve successful reporting.

Additionally, it is unclear how these new cross-cutting measures will be applied to the Measure Applicability Validation (MAV) process and/or how physicians will be evaluated on their performance related to these new cross-cutting measures. Should CMS finalize this proposal for CY 2015, we urge the Agency to provide additional detail necessary for specialties and practices to prepare for this additional reporting requirement.

E. Suggestions for including S-CAHPS Survey for Future GPRO Reporting

The proposed rule also addresses the Consumer Assessment of Healthcare Providers Surgical Care Survey (S-CAHPS). CMS says that "at this time, due to the cost and time it would take to find vendors to collect S-CAHPS data, it is not technically feasible to implement the reporting of the S-CAHPS survey measures for the 2017 PQRS payment adjustment. CMS seeks comments on how to allow for reporting of the S-CAHPS survey measures for the 2018 PQRS payment adjustment and beyond.

As the Agency is aware, and as discussed within our comments on Physician Compare, the Academy has routinely and consistently supported the notion of including the S-CAHPS survey as part of the various CMS quality incentive programs, as we were one of the groups who not only participated in the development of the survey, but also tested it through our practice-based network. We believe this survey tool would more accurately reflect the level of care patients are receiving related to surgical services, as compared to that of the CG-CAHPS currently in use for PQRS. In terms of operationalizing the use of S-CAHPS, the Academy understands that CMS has been actively engaged in discussions with some surgical specialties that are committed to the use of S-CAHPS for future reporting years, including the AOA and ACS. To that end, the Academy would like to volunteer to participate in any future workgroups or town hall meetings around this issue, as we believe the inclusion of S-CAHPS would only further the ability of otolaryngologists to meaningfully participate in quality incentive programs, as well as accurately reflect their quality of care.

F. Extension of Reporting Deadline for Qualified Registries

The Academy also supports CMS' proposal to push back the reporting deadline from the last Friday of February, following the applicable reporting period, to March 31 (for example, March 31, 2016 for the reporting periods ending in 2015). We believe this will allow providers more time to successfully report their PQRS data and will result in an overall positive trend towards greater PQRS participation, and more successful reporting.

G. Change in GPRO Registration Date

With respect to the Group Practice Reporting Option (GPRO), CMS proposes an earlier deadline for registering to participate in the GPRO, June 30 of the year in which the reporting period occurs (that is, June 30, 2015, for reporting periods occurring in 2015), rather than the current September 30. This is being proposed because CMS believes there is benefit in providing timelier feedback reports. CMS seeks comment on whether to allow more frequent submissions of data through the GPRO Web interface.

While we understand CMS' rationale in proposing this change to the GPRO reporting option, we are concerned that in the initial year of this policy change practices may have difficulty transitioning to the earlier deadline. Given this, we believe CMS should retain the concept proposed, but delay the implementation of the change until CY 2016 to allow groups to more fully prepare for the earlier deadline.

H. Provider Ability to Report Data more Frequently

Within the NPRM, CMS questions whether commenters would be supportive of the ability for providers and/or groups to report PQRS data on a more regular basis. ***The Academy supports this concept and would encourage CMS to finalize the ability for providers reporting via Qualified Registries to report data on a more regular and ongoing basis throughout the year. Specifically, we believe it would make it much easier to submit data when measures are ready, rather than once a year.***

9. VALUE BASED PAYMENT MODIFIER PROGRAM (VM)

A. Expansion of the VM to all Physicians, Non-physicians, and groups of physicians by CY 2017

CMS proposes that beginning with CY 2017, the VM would be applied to physician and nonphysician EPs in groups with 2 or more EPs and to solo practitioners based on the CY 2015 performance period. CMS estimates that this proposal will affect approximately 83,500 groups and 210,000 solo practitioners (as identified by their

TINs) that consist of approximately 815,000 physicians and 315,000 nonphysician EPs.

CMS proposes that physicians and nonphysician EPs would be subject to the same VM policies established in earlier rulemakings. The quality of care composite would be based on the quality data submitted under the PQRS at the group or individual level in accordance with PQRS policy. The cost composite would be based on the beneficiary attribution methodology and if a cost composite cannot be calculated for a group or solo practitioner, CMS proposes to classify the group or solo practitioner's cost composite as "average".

While the Academy understands and supports CMS' goal of incentivizing higher quality care, we would caution that transitioning a program as large and complex as the VM over such a short period of time could be crippling to the success of the program's overall goals in the long term. Specifically, we believe that transitioning this program not only to all physicians by CY 2017 (reporting year of 2015), but also to all nonphysicians and solo practitioners, is extremely aggressive and may result in many providers being adversely affected by the VM simply due to a lack of time to prepare and analyze quality resource use reports (QRURs) prior to the performance year. As such, we urge CMS to delay application of this program to nonphysicians and solo practitioners until at least CY 2018 (reporting year of 2016), if not a later date, to allow for adequate preparation and adjustment to practice patterns such that practices can avoid penalties resulting from this program.

B. Quality Resource Use Reports

Further, in keeping with our concerns outlined above related to expanding the VM to all non-physicians for CY 2015 reporting, we are also concerned that while CMS plans to provide physician feedback, via their QRURs, in late summer to all physicians, these reports will NOT include information on performance (quality or cost) for non-physicians in the TIN. Thus, while we agree with CMS' aims to encourage coordination of care by applying the VM to all providers (physicians and non-physicians), we are concerned that practices may be penalized by the program before they have all the necessary information to fully evaluate the performance of all members of their practice, physicians and non-physicians alike. ***Thus, we propose that if CMS wishes to include non-physician providers in the VM program and count them towards both the group's cost and quality scores, that CMS wait to implement this change until practices have received QRUR reports that reflect quality and cost metrics for all members of their practice (physician and non-physicians) so they are fully informed, and can modify their practice patterns as necessary, to improve quality of care and to avoid penalties under the VM and PQRS quality incentive programs.***

Additionally, while we are pleased that QRURs will be provided to ALL PHYSICIANS this summer, we are concerned that the pending QRURs that will be released to providers will contain 2013 performance data which is not particularly meaningful given the scope of changes to the PQRS reporting requirements for CY 2014. Specifically, to avoid PQRS penalties based on the CY 2013 performance period, practices could report using the administrative claims option and report on only one quality measure. For CY 2014, that was modified to require reporting on up to 9 quality measures across 3 domains. Thus, the data contained in the 2013 QRUR reports will likely do little to inform practices and/or individual physicians how they will fare under the substantially heightened reporting requirements for 2014, and beyond. While we understand that CMS is limited in the information they can provide in these reports, and are appreciative of the steps taken thus far to enhance the usability of the QRUR reports, ***we would urge the Agency again, not to apply penalties to groups or providers (non-physicians) that have not had the chance to meaningfully evaluate their performance and/or to modify their practice patterns to avoid penalties under these programs.***

C. Payment Adjustment Amount under the VM

Additionally within the NPRM, CMS raises the payment risk under the VM from the previous +/- 2.0% to +/- 4% for CY 2017 (based on performance year of 2015). CMS states, however, that only groups of 10 or more EPs will be subject to upward, neutral, or downward adjustments. Groups of 2-9 will only incur upward or neutral adjustment, in essence, they will be held harmless from a penalty under the VM for CY 2017. Quality tiering will

now become mandatory for all providers, despite smaller groups being held harmless from penalties. Groups and solo practitioners are eligible for an additional +1% if their average beneficiaries' risk score is in the top 25% of all beneficiary risk scores nationwide (i.e. if their patient population is "high risk").

In keeping with our comments outlined previously, the Academy is troubled by the proposal to double the payment risk under the VM within one calendar year. We believe the total risk, when combined with the payment penalties from PQRS and the EHR MU Incentive program; represents an extreme reduction in reimbursement that would be unsustainable by most physician practices if levied in one year (a potential total reduction of almost -10%). While we support the concept of aligning these quality programs, and the goals of improving quality of care and achieving cost efficiencies, we believe more time is needed for physicians and practices to prepare for the requirements of these programs. ***Along these lines, we appreciate CMS' proposal to "hold harmless" smaller groups and solo practitioners, and urge them to finalize this proposal in the CY 2015 final rule. In fact, we urge CMS to expand the group of providers that are held harmless to groups of 2-25, rather than just groups of 2-9 providers.***

Additionally, given our concerns outlined above, we do not believe it is reasonable to double the financial risk to practices without providing the data to them in advance to fully evaluate how their practice/TIN is operating as a whole under the VM cost and quality methodologies. Thus, we recommend that CMS delay any increase to the financial benefit or risk from the current +/-2%, until such a time that practices can fully evaluate their performance based on data for all providers, and modify it accordingly in order to avoid potential payment penalties under the VM.

D. Expanding the Informal Inquiry Process to allow for Corrections

For the CY 2015 payment adjustment period, to align with PQRS, CMS is proposing to expand the established informal inquiry process and establish an initial corrections process that would allow for some limited corrections. CMS notes there would be no administrative or judicial review of the determination resulting from this expanded informal inquiry process.

- CMS is proposing a deadline of January 31, 2015 for a group to request correction of a perceived error made by CMS in the determination of the CY 2015 CV payment adjustment. CMS seeks comment on an alternative deadline of no later than the end of February 2015, the deadline for the PQRS informal review process.
- For the CY 2015 payment adjustment period, CMS proposes to classify a TIN as "average" quality if they determine that they made an error in the calculation of the quality composite. CMS states that they do not anticipate it would be operationally feasible for them to fully evaluate errors with regard to quality measures for the CY 2015 payment adjustment period.
- CMS proposes to recompute a TIN's cost composite if they determine they made an error in the calculation.
- CMS proposes to adjust a TIN's quality tier if they make a correction to a TIN's quality and/or cost composites as a result of this initial corrections process.

CMS proposes to continue the expanded informal inquiry process for the CY 2016 payment adjustment period (CY 2014 performance period). CMS anticipates having the necessary operational infrastructure to support this process and proposes:

- A 30-day period that would start after the release of the QRURs for the applicable period for a group or solo practitioner to request correction of a perceived error in the VM for that payment adjustment period.
- Recompute a TIN's quality composite and/or cost composite when CMS determines an error was made in the calculation. If CMS lacks the operational infrastructure to allow this recomputation, CMS proposes to continue the CY 2015 proposals.

The Academy appreciates and supports CMS' efforts to expand the informal inquiry/review process as it relates to the VM program. On the whole, we support the proposals as put forth by CMS, with one exception related to

the timeline for requesting a correction. We believe the 30 day window may be too brief to allow practices to carefully review their data and submit a request for a correction within that time frame. Notably, the clock starts ticking on the 30 day window once the QRURs are released, so in cases where reports are lost or delayed due to delivery errors or problems that are not the fault of the practice and the practice is penalized by the short timeframe within which to request review. To avoid these issues, we would suggest that CMS consider extending the timeframe to 60 days following the release of the QRURs so that no one is unintentionally disadvantaged by the timeframe to request review.

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

David R. Nielsen, MD, FACS
Executive Vice President and CEO