AAOE
American Alliance
of Orthopaedic Executives

September 8, 2018

The Honorable Seema Verma, MPH
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P)

Submitted Electronically at regulations.gov.

Dear Administrator Verma,

On behalf of the 1,500 members of the American Alliance of Orthopaedic Executives (AAOE), the 15,000 physicians they serve, and the 70,000 people they employ, we are pleased to provide comments on the proposed changes to the physician fee schedule and Quality Payment Program (CMS-1693-P). Our experience in orthopaedic practice management has taught us that no matter how well-intentioned, shifts in regulatory policy can produce unintended consequences. In our comments below, we outline our support for and objections to key proposals that impact the management and practice of orthopaedic medicine. Our goal is to assist CMS in limiting the potential for unintended adverse consequences and it is in this spirit that we hope our comments are considered and evaluated.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

AAOE strongly supports the creation of codes GVCI1 and GRAS1. As you know, Medicare payment policy for telemedicine services has lagged behind other payers and as a consequence, the adoption rate of telemedicine in orthopaedics has lagged behind other specialties. In a survey on telemedicine in Orthopaedics conducted in May 2018, 92% of respondents indicated that they are not utilizing telemedicine in their practices. Another 81% of respondents indicated that an expansion of the procedures and services reimbursed by Medicare would prompt their practices to make the necessary investments to provide telemedicine services to their patients.

We believe that the creation of these codes as well as CMS' willingness to use store and forward technology to provide these telemedicine services will provide orthopaedic practices the incentive to begin offering telemedicine services to Medicare beneficiaries. To be clear, we encourage CMS to keep the definition of acceptable telemedicine technology as encompassing and/or accommodative as possible given the array of methods that can be used to deliver virtual care. Patients now have access to a multitude of telemedicine delivery systems including through applications that run on their mobile phones and tablet devices, store and forward technology that does not require the patient to be present during the consultation, kiosks in public locations such as a pharmacy or wellness clinic, and/or the older fixed video teleconferencing systems in an originating site. We expect that the decision to utilize one

communication technology over another will be based largely on patient and clinician preference as well as the severity of the complaint. For instance, a patient with a large bruise on their body may wish to use communications technology with video whereas a patient complaining of symptoms similar to seasonal allergies may simply wish to use audio.

In response to CMS' request for comment on the time frame in which separate reimbursement of these codes would be appropriate, we suggest that adding an artificial timeline at all would be inappropriate, in particular for specialty services. The nature of orthopaedic injuries and disorders means that by the time a patient is able to be seen in the office for an evaluation and management visit that could be tied to the initial telemedicine consult, the patient's complaint may be more complex making the E/M visit a significantly different, and we believe separately reimbursable, visit. We encourage CMS to finalize a policy that would take into account the complexity of the visit to determine if the codes are separately reimbursable.

Furthermore, we do not believe that documenting medical necessity should be a concern for these types of calls. As we understand CMS' proposal, this would be an initial conversation between a provider and patient to determine if an office visit is warranted for a complaint. Only if the provider determines that an office visit is necessary should medical necessity documentation be required. However, medical necessity could be included in the claim by documenting the presenting complaint or documenting the presenting complaint in the patient's medical record.

CY 2019 Identification and Review of Potentially Misvalued Services

CMS indicated in the proposed rule that the agency had received a nomination for total hip arthroplasty (27130) and total knee arthroplasty (27447) as potentially misvalued. AAOE does not believe that any further action on this proposal is warranted. These codes were reviewed by the RUC and CMS in 2013 when the current values were established and there is no data to indicate a change in the work of performing the procedure.

Additionally, we have concerns about the way in which this nomination was included in the proposed rule. Transparency is vitally important in the establishment of these payment policies. In 2014, CMS was rebuked by Congress for not being more transparent in the misvalued codes initiative[1] and we are heartened to see that CMS has been including codes proposed for revision in its proposed rules, however, the opaque nature through which CMS collects these potentially misvalued codes leaves room for error and mischief as we are unable to review the data the original submitter presented with their nomination. We strongly urge CMS to make this a part of the public process of collecting data on potentially misvalued codes.

Global Services Data Collection

AAOE is proud that the orthopaedic specialty had one of the highest reporting rates of any specialty in the nine states required to submit data on procedures furnished during the global surgical period. In order to encourage other providers to report data, CMS could allow professional societies like AAOE to

[1] "Congressional Dear Colleague Letter to Marilyn Tavenner," 17 April 2014.

collect this data and transmit it to CMS on a quarterly basis. Many professional healthcare societies now have registries with the capability of tracking this information and clinicians may be more likely to submit this information to their societies rather than through an added code on a claim form. Keep in mind that a physician is generally not the one submitting their own claims and if the biller or coder does not have the required information or is unaware of the requirement to report certain data on a claims form, the data may not get reported.

If CMS were to use a registry function to collect this data, it would be as simple as pulling the data out of the medical record and uploading it to the registry. We would expect that CMS would standardize the reporting structure for these societies to follow and at the end of each quarter, or another frequency that CMS determines, the societies would submit that information to CMS on behalf of the providers and practices.

As CMS plans to start a separate data collection effort, we encourage the agency to make it optional and as non-invasive as possible. Our members, their staffs, and their clinicians already have plenty to keep them busy as they treat their patients. An additional survey would add more administrative burden to these practices that are already struggling under the existing regulatory burden.

Changes to Direct PE Inputs for Specific Services

AAOE joins other orthopaedic groups in opposing the recently enacted cuts to computed radiography (CR). This 7% reduction to the technical component is having a negative impact on orthopaedic physician offices, where CR is most commonly used. Currently, practice expense (PE) inputs are based on the less costly CR systems but our members have been forced to either upgrade to direct radiography (DR) or accept the 7% cuts and continue to use CR. If CMS presumes that DR is the "standard" x-ray system, we encourage CMS to reflect this in an update to practice expense (PE) inputs that would better reflect the cost of digital systems. This increase should be applied to all x-ray codes, retroactive to January 1, 2018.

Valuation of Specific Codes

- 29105

Under Medicare's proposal, the application of a long arm splint in 2019 would decrease approximately $5. These splints are "constructed" during the application to the patient and require a particular skill set and materials to apply correctly – they are not pre-fabricated products that are just strapped on. We believe that this decrease in valuation is unwarranted and encourage CMS not to finalize the proposed RVUs for this code.

- 20551

This code would see a decrease of approximately $8.57 between CY 2018 and CY 2019. These injections provide significant relief to patients at a relatively low-cost to Medicare and this proposed cut disincentivizes a practice or physician from offering simple, low-cost, and highly effective therapies to the Medicare population. We encourage CMS not to finalize the proposed RVUs for this code.

- 76000

While the proposed decrease in this code is not large, we do believe that it is counter-productive. This service is frequently delivered with epidural steroid injections in both facilities and physician office settings; although it is only separately reimbursable in the office setting despite the additional reimbursement for this service, the overall cost to Medicare when it is provided in a physician's office is less than the cost when performed in a facility. CMS' proposed decrease will disincentivize the provision of these services in physician offices leaving them to be performed in the higher cost settings where Medicare also pays a facility fee. We encourage CMS not to finalize the proposed RVUs for this code.

Evaluation and Management Visits

We appreciate CMS' efforts to reform the documentation guidelines regarding evaluation and management (E/M) visits. These visits are some of the most common types of codes our practices are submitting for reimbursement and the existing guidelines represent one of the greatest burdens to our practices. As you know and have recently stated[2], Medicare's E/M guidelines have not been updated since 1997; a nearly 20-year gap during which technology and the practice of medicine has improved.

We support CMS' proposals to only require time or medical decision making to determine the level of E/M code to report rather than including the patient's history in the documentation, along with time and medical decision making. We agree with CMS that changing this documentation requirement will save clinicians time and improve the beneficiary experience. We are concerned, however, with CMS' parallel proposal to equalize the reimbursement for level two through five E/M codes.

As CMS concedes in the proposed rule, these codes are reimbursed at differing amounts because of the inherent complexity and escalating resource use for higher level E/M codes. The proposed rule leaves little rationale for CMS' reasoning in proposing this change now other than a reference to believing the codes to be misvalued. We would have preferred to see these proposed changes submitted separately from the proposed change to documentation requirements. Both proposals constitute a major shift in policy for CMS and will take significant training and resources to implement at the practice level. When making changes like this, we believe incremental adjustments are always best.

Regretfully, while we recognize CMS' motivation and intent in equalizing code reimbursement for E/M visits, we cannot support this proposal. With the proposed add-on codes for visit complexity and length, CMS fails to acknowledge that the required use of these codes will increase the burden on clinicians having to use them to justify reimbursement for the visit. The absence of a detailed explanation of the required documentation to justify the use of these add-on codes gives us pause as it threatens to undo the reduction in burden that CMS proposed concerning the 1995 and 1997 documentation guidelines.

We are also concerned with CMS' analysis of the data used to determine the change in reimbursement by specialty and CMS' expectations for this policy for the future. Americans are living longer and thus are visiting the doctor with greater comorbidities and other presenting conditions. This longer life-expectancy means that the current usage of level four and five codes will not stay the same year over year and will likely increase, making this proposal a net-loser year-to-year. We recognize that CMS has

[2] "Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session", Medicare Learning Network, 22 August 2018.

proposed to include add-on codes for the delivery of longer or more resource intense E/M visits and that the proposal is not budget neutral but, as we have stated above, the additional burden of justifying the use of these add-on codes negates CMS' original intention of reducing the administrative burden of the 1995 and 1997 guidelines.

We would encourage CMS, rather than making this policy switch entirely, to implement this in a limited setting to test physician, beneficiary, and CMS behavior. As we mentioned above, this is a major policy shift and moves reimbursement of E/M visits away from the Resource Based Relative Value System (RBRVS) that has been in use in Medicare since 1992. Within this demonstration period, we encourage CMS to collect data on provider burden with the additional codes for time and complexity as well as data on patient inconvenience (i.e. returning for a procedure that could have been performed at the initial visit but the provider would not have received fair or adequate compensation for the service under the demonstration codes). We must have more information on the impact of this proposed policy than what has been outlined in the proposed regulation. Indeed, more caution should be used when implementing the wholesale adoption of such an untested policy; a policy that could very well lead to unintended adverse consequences, such as delays in care and beneficiary inconvenience.

Accounting for E/M Resource Overlap

We oppose CMS' proposal of a multiple procedures payment reduction for E/M visits. While there may be duplicative resources used when E/M visits and procedures with global periods are furnished together, we are concerned that this could lead to some physicians requiring patients to schedule a separate E/M visit so that they will be reimbursed the full amount and the MPPR would not be activated. This will lead to an increased volume of E/M services, a greater copayment responsibility for beneficiaries, and decreased access to care for more complex beneficiaries. If CMS is intent on creating an MPPR to account for resource use overlap, we suggest a percentage that is significantly less than 50% which we believe is excessive and needlessly punitive.

Proposed HCPCS G-Code Add-ons to Recognize Additional Relative Resources for Certain Kinds of Visits

If CMS plans to finalize the proposed reimbursement methodology for E/M visits, we encourage CMS to finalize add-on codes to account for the additional resources used that some E/M visits will utilize. While we believe that add-on codes will take away from some of the burden reductions that CMS is attempting to implement with the change to documentation guidelines, these are necessary to ensure that providers are reimbursed a fair amount for the services they supply. We wanted to specifically address the add-on code GCG0X for specialty services.

The *Social Security Act* (the Act) prohibits creating a different payment for a subset of specialties and we oppose any action that would reimburse certain specialists more, merely for the perception of "inherent complexity". CMS does not indicate the criteria for inclusion in this list and does not state the threshold of volume of level four and five codes for inclusion. Orthopaedics has a similar utilization rate of level four and five codes as otolaryngology (see table 1) but orthopaedics is inexplicably left off this list.

Table 1: Level 4-5 E/M Utilization

Orthopaedics		Otolaryngology	
New Patient	**Established Patient**	**New Patient**	**Established Patient**
25%	26%	28%	29%

Proposed HCPCS G-code to Describe Podiatric E/M Visits

We disagree with CMS that podiatric E/M visits are overpaid relative to the services offered and we believe that creating a separate set of codes solely for podiatry would be contrary to CMS' stated intention of reducing the administrative burden of E/M coding. CMS' proposal would serve to provide differential payment for the same E/M services based on specialty. As we have already mentioned, the Act prohibits different payment structures based on specialty and we believe this proposal violates that prohibition. Further, CMS provides no rationale for establishing this separate coding structure for the same services other specialists - MDs and ODs - may be providing their patients.

GPCI Comment Solicitation

In response to CMS' request for comments regarding sources of commercial rent data for use in the next GPCI update, we encourage CMS to turn to our professional societies. Many of these societies, including AAOE, now operate their own benchmarking surveys where data like this is collected. We would recommend engaging these organization, AAOE included, in gathering this information and using it to inform the next GPCI update.

Part B Drugs: Application of an Add-on Percentage for Certain Wholesale Acquisition Cost (WAC)-based Payments

In this proposal, CMS proposes to decrease the add-on percentage for wholesale acquisition cost (WAC) based payments for Part B drugs from 6% to 3%. AAOE strongly opposes this proposal. We understand that the costs of prescription drugs have increased dramatically over the past decade(s) however, we believe that this proposal is targeting the wrong parties. By decreasing the WAC-based payments to 103% of the cost of the drug, CMS will be reducing the reimbursement to the providers and not the parties responsible for the cost increases, the pharmaceutical manufacturers that refuse to or cannot provide the average sales price to CMS. Additionally, 3% above the WAC does not cover the actual fixed costs associated with procuring and administering these drugs. We are concerned that this proposal could see physicians choosing higher cost drugs because average sales price (ASP) data is available and thus would be reimbursed at the higher 6% above ASP just to cover these fixed costs.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

We thank CMS for its proposal that the consultation with appropriate use criteria (AUC) through a qualified clinical decision support mechanism may be performed by clinical staff working under the direction of the ordering professional. We encourage CMS to clarify in the final rule that the definition of "clinical staff" would include credentialed and non-credentialed medical assistants.

Additionally, we fully support CMS' proposal to create a significant hardship exception that would exempt certain providers from consulting appropriate use criteria when they meet said exception

criteria. We would encourage CMS to add additional criteria to the hardship exception that would allow clinicians to claim the hardship exception if, for some reason, there is a lack of AUC for the service(s) ordered and/or the AUC is outdated.

We also thank CMS for its stated intention of soliciting public comment to inform the agency's methodology to identify outlier orderers of advanced imaging. We believe that policymaking is strengthened when the public and/or stakeholders in a given policy are permitted to participate in the process and we look forward to offering our thoughts on this methodology.

The Quality Payment Program

We were disappointed that CMS chose to package the updates to the Quality Payment Program (QPP) with the physician fee schedule proposed rule. Since the implementation of the Quality Payment Program began in 2017, the rulemaking has been done separately from the fee schedule and typically released in April or May. This release date earlier in the year allows for a more thorough understanding of the policies that CMS will likely implement for the upcoming year well in advance of the start of the reporting year.

CMS' delay with this proposed rule has significantly hindered our ability to fully prepare for the 2019 reporting year. For example, for the CY 2019 reporting year, CMS proposes to require the use of 2015 edition certified health IT for the promoting interoperability category of the MIPS track of the QPP. Our members need more than five months[3] to evaluate and implement the new edition of CEHRT. For those who were using a certified EHR product that is not upgrading to the 2015 edition, they must evaluate multiple EHRs just to make a purchasing decision. Had this proposed rule been released in April or May, that would have given us three to two additional months to prepare for this change. Additionally, preparations are more than just upgrading the edition of CEHRT our practices are using, they include training staff on the capabilities of the new edition and revising our clinical and non-clinical workflows.

CMS' delay in releasing this proposed rule is unfortunate and we hope an anomaly in future years.

MIPS Eligible Clinicians

We are not supportive of CMS' proposal to include physical therapists (PTs) and occupational therapists (OTs) in the definition of a MIPS Eligible Clinician for 2019. As it stands now, the number of quality measures available to PTs and OTs are just too few to be relevant for quality measurement and improvement. For years under the Physician Quality Reporting System (PQRS), our surgeons struggled with reporting measures that were unrelated to the clinical quality of care they were providing. We fear that this proposal will lead these clinicians to a similar outcome and further delay clinician buy-in to the program.

CMS should work with stakeholder groups to design outcomes measures for use by PTs and OTs that would be clinically meaningful rather than requiring participation before relevant measures are available.

[3] Historically, the QPP final rule has been released at the beginning of November or, two months before the reporting year begins.

Group Reporting

CMS indicates in the proposed rule that it is considering the use of a sub-group identifier to allow sub-groups within a group practice to report to MIPS in the 4th year of the Quality Payment Program (QPP). We are concerned that the creation of sub-groups would make an already complicated program, even more, complicated and difficult to implement within our practices.

The use of sub-groups would create an added administrative burden through the use of the separate sub-group identifier. We would anticipate that with the sub-groups, not only would the sub-group be required to indicate the TIN of the group they are a sub-group of but also list their separate sub-group identifier at any time they are attempting to report data, view their results, etc. Additionally, we are concerned that allowing the creation of sub-groups within a group practice would create highly granular data that would be useless to the larger group practice for quality improvement, benchmarking, etc.

We encourage CMS to reconsider employing sub-groups as a method of reporting to MIPS. While there are benefits to the use of sub-groups within multispecialty practices, we contend that the costs (in data validity and reliability, and burden on clinic staff) will exceed these benefits.

MIPS Performance Period

We are disappointed that CMS will be prematurely pushing providers to report quality and cost data for a full calendar year. We encourage flexibility during the transition and would urge CMS to adopt a reporting period minimum of 90 continuous calendar days up to a full calendar year for CY 2019. CY 2019 continues to be a transition year and we believe that the reporting should better reflect that by giving providers the flexibility to report as little or as much data as they are able to report.

Additionally, we are not supportive of CMS' proposals related to the 2022 MIPS payment year (2020 reporting year) and future years to set the performance periods at a full calendar year for the cost and quality performance categories. We believe that giving clinicians the greatest flexibility to report data for a minimum of 90 consecutive days up to a full calendar year is the best policy and will allow our clinicians to truly focus on quality improvement in the period in which they're not recording and capturing quality data.

We are, however, supportive of CMS' reiteration in the proposal of the finalized 90 continuous days reporting period for CY 2019 and CY 2020 for the Promoting Interoperability and Improvement Activities performance categories. We encourage CMS to assign a 90 continuous day reporting period to these categories for the life of the MIPS.

MIPS Performance Category Measures and Activities

AAOE supports streamlining and improving the terminology used in the MIPS program and we encourage CMS to expand the use of this terminology program-wide. Additionally, we encourage CMS to identify the types of mechanisms that may be used with each submission type prior to finalization. While we understand that these new terms are meant to steer medical practices away from reliance on a particular

type of technology, we believe that providing examples in the regulation text of the types of mechanisms available would be helpful to administrators and clinicians seeking to report to the MIPS program.

Improvement Activities: Timeframe for the Annual Call for Activities

AAOE strongly supports CMS' proposal that the annual call for activities timeframe be changed to February 1 through June 30th of the year for measures to be considered in the next year's rulemaking. While this will limit the availability of improvement activities for a year, we appreciate the longer window in which to propose new improvement activities.

Promoting Interoperability

AAOE strongly supports the restructured Promoting Interoperability category. The described structure in the proposed rule is simpler, streamlined, and makes more intuitive sense than the Advancing Care Improvement category. While making the category easier to understand, we also believe that CMS' proposal moves the program closer to the intent of the MACRA statute.

While there is much to like about this proposal, we must encourage CMS and ONC to address the concerns of the provider community related to information blocking on the part of EHR vendors and health systems. Only by addressing information blocking in a holistic manner will interoperability be truly achievable. Recent comments made by the Administrator indicate that this administration's enforcement focus will be solely on physicians when data points to the real information blockers being the EHR vendors we rely on for success in this program.[4] In a 2017 study, Adler-Milstein and Pfeifer determined that 83% of survey respondents had witnessed an EHR vendor engaging in intentional information blocking occasionally or routinely; compared to 59% of survey respondents that indicated they had witnessed hospitals and health systems engage in intentional information blocking.[5] Any healthcare provider engaging in intentional information blocking is inappropriate but this study clearly shows that vendors have the perverse incentive to block the free-flow of healthcare-related patient data and are actively doing so.

Small Practice Bonus

In our comments on the CY 2018 QPP proposed rule, we encouraged CMS to adopt policies that would ease the reporting burden of the MIPS program for solo and small practices. As such, we welcomed finalization of the small practice bonus. We were disappointed to see CMS propose in the CY 2019 MPFS proposed rule to reduce the small practice bonus from five to three points. With this proposal, the reduction of the total value of the quality category to 45%, and shifting the total bonus point allocation to a single category, CMS is effectively making the MIPS program more burdensome to solo and small practices.

[4] Seema Verma, MHA, "Speech at Commonwealth Club", San Francisco, CA, July 25, 2018.

[5] Julia Adler-Milstein and Eric Pfeifer, "Information Blocking: Is It Occurring and What Policy Strategies Can Address It?", in *The Milibank Quarterly*, 2017 March, Vol. 95, Issue 1, pp. 117-135.

We encourage CMS to maintain the current small practice bonus and apply that bonus to the Quality category. Alternatively, we would support a small practice bonus applied to all four performance categories.

Qualified Clinical Data Registries

AAOE is staunchly opposed to the proposed requirement for future qualified clinical data registries (QCDRs) that the approved QCDR have clinical expertise in medicine and quality measure development. We are particularly opposed to this proposal because CMS gives no definition of what constitutes "clinical expertise in medicine and quality measure development". AAOE operates a QCDR for the benefit of its members and is one of the most cost-effective options that our members have access to. While we do not offer the use of AAOE developed measures at this time, we do not want to rule out the opportunity to do so in the future. The QCDR is attractive to our membership because we can incorporate non-MIPS measures that may be in use in other programs.

Each year, our quality measurement task force comprised of physicians, practice administrators, and other stakeholders work to select measures that will be included in the AAOE QCDR. We have clinical input within our measure selection process however, we are not a clinical society. We fear that using the blanket definition proposed, CMS will be:

A. Imposing artificial barriers to entry into the market. Instead of placing restrictions on QCDRs, CMS should establish processes for denying applications and/or measures that appear to not have had any clinical influence rather than requiring the entire entity to have "expertise".
B. Dictating who can provide services to our members instead of letting the free market decide. If a QCDR does not have measures that are clinically meaningful and/or relevant to the provider, the clinician can switch prior to the next reporting year. We would encourage CMS to develop a process by which a clinician who feels unsupported by a QCDR can submit information to CMS for further investigation.
C. Discriminating against potential vendors because of a perceived advantage at quality measurement based on education, experience, etc. Clinical quality measurement is still a relatively new field and we do not believe that anyone can rightly claim "expertise" in the field just yet.

At a minimum we ask CMS to avoid finalizing this policy until after the agency has, through notice and comment rulemaking, provided a better description of the proposal; we would expect this description to include a more fully formed definition of "clinical expertise".

We are also concerned with CMS' proposal to require licensing QCDR measures to CMS for the use of all QCDRs. While AAOE has experienced other QCDRs asking for large licensing fees for the use of their QCDR measures, we are concerned with the chilling affect this proposal could have on measure development. We would rather CMS work with QCDRs to devise a compromise proposal that maintains competitiveness while ensuring fair access to developed measures. The current proposal is akin to using a sledgehammer to drive in a push-pin and we do not believe that it will further the goals of meaningful measurement in medicine.

Increasing the CEHRT Use Criterion for Advanced APMs

We are opposed to CMS' proposal that would raise the CEHRT threshold for A-APM status. The 75% proposal is just one more barrier to smaller practice participation in A-APMs. We would encourage CMS to develop a small practice threshold where the CEHRT requirement might be lower if the APM meets a small practice threshold. For example, in CY 2019, an APM might qualify as an A-APM if the APM requires 50% of participants to use CEHRT and 10% of participating clinicians are designated as "small practices". We believe that this would give providers more of an incentive to participate in A-APMs, especially small practices.

CY 2018 Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

AAOE is appreciative of CMS' work to develop and implement innovative models that our members' clinicians may participate in and avoid participating in MIPS.

Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

AAOE supports price transparency but we strongly believe that it is CMS' role to provide Medicare's beneficiaries with cost estimates and/or clinician prices. This can be done via an easy to navigate and access website, mobile application, and/or call center that can discuss beneficiary costs.

CMS is in possession of all Medicare beneficiary cost data. It only makes sense that CMS would be the entity responsible for coordinating and displaying price information to beneficiaries. We would encourage CMS to work with a contractor to develop this system and test it with its beneficiaries.

Should you have any questions concerning AAOE's comments, please do not hesitate to contact AAOE's Manager of Government Affairs, Bradley Coffey, MA at bcoffey@aaoe.net or 317-749-0629.

Sincerely,

Karen Sollar, CMPE
2018-2019 President
American Alliance of Orthopaedic Executives

CC: Addy M. Kujawa, CAE, *Chief Executive Officer*, AAOE
Kitchi Joyce, *2018-2019 President-Elect*, AAOE