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September 2, 2014

SENT VIA ELECTRONIC MAIL

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1612-P
Box 8013
7500 Security Blvd.
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Administrator Tavenner:

The North American Spine Society (NASS) appreciates the opportunity to comment on the 2015 Medicare Physician Fee Schedule Proposed Rule. NASS is a multispecialty medical organization dedicated to fostering the highest quality, evidence-based, ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 8,000 physician and non-physician members from several disciplines, including orthopedic surgery, neurosurgery, physiatry, pain management, neurology, radiology, anesthesiology, research, physical therapy and other spine care professionals.

Improving the Valuation and Coding of the Global Package

CMS proposes to transition all 10-day and 90-day global codes to 0-day global codes by 2017 and 2018, respectively, based on concerns that global packages may not accurately reflect the typical post-operative care currently provided. Additionally, CMS notes difficulties in obtaining data to verify the number, level, and costs of post-operative visits included in the global packages.

While NASS is supportive of efforts to ensure payment accuracy, we are concerned that the proposed changes would not accurately account for the physician work, practice expense, and malpractice risk involved in services performed during the post-operative period. Furthermore, NASS has significant concerns about the potential impact of the proposal on patient care as well as the administrative burdens that would be placed on patients, physicians, and insurers.

Impact on Patient Care

NASS is very concerned about the potential impact of CMS' proposal on quality patient care. Unbundling post-operative services would result in patients being required to pay separate co-payments for every

visit instead of one bundled payment at the outset of care. Many Medicare beneficiaries are socioeconomically disadvantaged and requiring multiple co-payments would be a financial burden. It is likely that some of these patients would forego medically necessary follow-up care due to the increased out-of-pocket costs. This would have a significantly detrimental impact on continuity of care. For example, patients who don't return for all of the necessary post-operative care may not receive appropriate wound treatment, potentially leading to advanced complications including, sepsis and wound breakdown requiring removal of implants.

Post-Operative Services

In addition to hospital visits, office visits, critical care visits and discharge day management, there are other post-operative services bundled into the 10-day and 90-day global packages, including the following:

- Dressing changes
- Local incision care
- Removal of operative pack
- Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints
- Insertion, irrigation and removal of urinary catheters
- Routine peripheral intravenous lines
- Nasogastric and rectal tubes
- Changes and removal of tracheostomy tubes

If the global periods are eliminated, these physician services would need to have their physician work, practice expense and malpractice risk separately paid using either new or existing CPT/HCPCS codes.

Post-Operative Visit Levels

Typically, the existing global surgical packages have lower levels of office and hospital visits relative to separately-reported E/M visits. Therefore, CMS should consider the upward shift in the level of post-operative E/M reporting that would be likely to occur if post-operative care is unbundled. The median established office visit in a global surgical package is a 99212, whereas the median level for separately-reported visits is a 99213. Only 1% of all established patient office visits in 10-day and 90-day global surgery packages have a visit level above a 99213, whereas 43% of all separately-reported E/M visits are reported as a 99214 or 99215.

CPT Code	2013 Surgical Global E/M Utilization Percentage (010-day and 090-day)	2013 Separately Reported E/M Utilization Percentage
99211	0.39%	2.84%
99212	56.83%	7.70%
99213	41.52%	45.70%
99214	1.23%	39.58%
99215	0.03%	4.19%
TOTALS	100.00%	100.00%

The median hospital visit in a global surgical package is a 99231, whereas the median level for separately-reported hospital visit is a 99232. 57% of hospital visits in a global package have a hospital visit level of 99231, whereas only 12% of all separately-reported hospital visits are reported as a 99231.

CPT Code	2013 Global Surgical E/M Utilization Percentage	2013 Non-Global E/M Utilization Percentage
99231	57.25%	12.31%
99232	29.73%	56.89%
99233	9.99%	24.82%
99291	3.03%	5.98%
TOTALS	100.00%	100.00%

Administrative Burdens

An additional significant area of concern NASS has with CMS’ proposal is the potential administrative burdens on physicians, Medicare Administrative Contractors (MACs), and CMS. The number of claims submitted for processing would increase substantially as there would be separate claims for every post-operative service provided. NASS urges CMS to review whether the MACs have the capacity to handle such an increase in claims prior to implementation of any change. Furthermore, while most private payers may follow CMS in eliminating global service packages, some may choose to retain them or transition on a different timeline, resulting in additional administrative burdens and confusion for the patients and providers as well as for the payers.

Finally, CMS’ proposal would increase the need for physician documentation for separate billing of every post-operative service, which would not improve patient care and would add any additional burden to physicians. Documentation of E/M services for subsequent inpatient care requires face-to-face evaluation or care spent at the bedside and on the patient’s hospital floor or unit. Currently, a significant portion of post-operative care takes place away from the patient’s hospital floor or unit as it involves phone calls to nurses for medication, to therapists for a physical therapy plan, to social workers to discuss placement, and reviewing post-operative films in radiology or PACs.

Proposed Timeline

NASS is extremely concerned that the proposed timeline to transition codes from 10-day and 90-day global periods to 0-day global periods is not feasible and would result in inaccurate payments relative to the rest of codes in the fee schedule. To maintain appropriate relativity, each of the over 4,000 codes with a 10-day or 90-day global period would need to be surveyed and reviewed individually, an enormous and time-consuming undertaking for the specialty societies, the RUC, and CMS that could not be completed in less than the two years allowed for in CMS’ proposed timeline. Simply backing out the values of the bundled E/M services from the existing values would be inappropriate and not in keeping with the RUC’s use of magnitude estimation to value all physician services.

Conclusion

Based on the issues addressed above, NASS recommends that CMS work with the RUC in its ongoing efforts to review data to validate the post-operative services currently included in the global periods and make the appropriate modifications rather than eliminating the global periods altogether.

Valuing New, Revised, and Potentially Misvalued Codes

While NASS supports efforts to improve transparency in the CPT code valuation process through publication of new, revised, and potentially misvalued services in the annual fee schedule proposed rule rather than in the interim final rule, we have concerns about how this change will be implemented. CMS proposes this transition to begin for the calendar year 2016 rule. However, development and review of new codes for 2016 are already underway and changing the review process at this point would have a negative impact on the process. New codes for 2016 will be nearly complete by publication of the final rule in 2014. Requiring that these codes be held for publication in the 2016 proposed rule will delay their implementation. NASS urges CMS to begin implementation of any timeline for the 2017 fee schedule as that will allow full notice for all codes beginning the process with the 2017 CPT cycle.

CPT/RUC Timeline

To accommodate publication of proposed values for new, revised, and potentially misvalued codes as addressed in the section above, CMS is proposing that all RUC recommendations be submitted by January 15 of each year. For the 2016 fee schedule, this would mean that the May 2014 CPT/September 2014 RUC meeting would be the only opportunity for consideration of new technology codes as the next RUC meeting will not convene until January 29, 2015. This proposal would lengthen the time required to develop and value a code from 22-30 months from the time of application, whereas under the current system the time required is 14-22 months from the time of application. This proposal would further impede the implementation of new technology.

NASS is supportive of the alternate proposal submitted by the American Medical Association that would expedite review of new, revised, and potentially misvalued services and we urge CMS to adopt this proposal.

Refinement Process/Appeals Process

CMS is proposing to eliminate the Refinement Panel process currently used as an appeals process for interim values for codes in the fee schedule. Refinement Panels were organized and composed by CMS, consisting of members from the primary care organizations, contractor medical directors, a specialty related to the commenter, and the commenting specialty. For many years, CMS typically deferred to the Refinement Panel's vote in finalizing values. Recently, CMS modified the process to only consider codes for which new clinical information was provided. CMS also began to independently review each Refinement Panel decision in deciding on final values. In many cases, the Refinement Panel supported the original RUC recommendation, yet CMS chose instead to implement their original proposed value. NASS is concerned that CMS' proposal to completely eliminate the Refinement Panels will result in a lack of an organized and objective appeals process for code valuation decisions. NASS recommends that CMS re-consider its proposal and maintain an objective and consistent appeals process that is transparent and open to all interested parties.

Physician Compare

NASS thanks CMS for its continuing work to improve the accuracy and presentation of the data reported on Physician Compare. This most recently includes the announced quarterly enhancement of a reordering of the physician search options to ensure that the specialties most relevant to the search term appear first, additional labeling of each section to help further clarify the results list for site users,

and refining the “Is this you?” link to assist physicians in updating their information on Physician Compare. NASS also had the opportunity in 2014 to work with CMS’ vendor to help refine and expand search terms and their relationships to various specialties within spine to help further improve site accuracy. We have noted in the past that public reporting of more complicated quality measure data cannot be supported until more basic identification issues are resolved, and we appreciate CMS’ effort to move in that direction.

Nevertheless, we still have concerns about the rapid pace at which CMS plans to publicly report performance data, particularly data related to individual physicians. In this rule, CMS proposes to move up the date by which it would publicly report on 20 PQRs individual measures collected through a registry, EHR, or claims from late 2015 to early 2015 and to report on 2013 data rather than 2014. CMS also proposes to publicly report all 2015 PQRs measures for individual EPs by late 2016 based on 2015 data. CMS is only first starting to publicly report on very limited performance data on a very selective population in 2014 (i.e., 5 Diabetes Mellitus and Coronary Artery Disease measures collected via the Web Interface for group practices with a minimum sample size of 25 patients and Shared Savings Program ACOs). Also included in this rule, CMS proposes to remove 73 measures from PQRs for the 2015 reporting year, many of which are measures that specialists report. Removal of these measures will not only have a significant impact on the physician’s ability to successfully report, but also on the physician’s performance rates that are proposed to be publicly reported on Physician Compare. Furthermore, aiming to report on all data by 2016, including data submitted by smaller groups and individuals, is an aggressive goal.

We greatly appreciate CMS’ intent to work with specialty societies to ensure all publicly reported measures remain clinically relevant and accurate, and to use concept testing with consumers to assess how well they understand each measure. However, two years is simply not enough time for CMS to properly evaluate the strength of the methodologies used to produce performance scores and benchmarks, and which public reporting formats are most meaningful to both patients and physicians. A recent poll by the Associated Press-NORC Center for Public Affairs Research found that while 6 in 10 people say they trust physician recommendations from friends or family, and nearly half value referrals from their regular physician, far fewer trust quality information from online patient reviews, health insurers, ratings web sites, and the government. Before expanding publicly reported data, CMS must carefully evaluate to what extent patients are actually visiting Physician Compare and whether they find this data meaningful and useful for healthcare decision-making.

CMS also seeks comments on including specialty society measures on Physician Compare and/or linking Physician Compare to specialty society websites that publish non-PQRs measures. NASS appreciates the flexibility that this option would offer in terms of allowing professional societies to choose measures that are most relevant to their specialty. We would support this proposal so long as there is a mechanism in place to ensure that measures are supported by scientific evidence, developed by relevant specialty societies, have been comprehensively vetted and tested, and are trusted by the physician community. If this proposal is finalized, we urge CMS to include a disclaimer on the Physician Compare website informing the public of the limitations of the PQRs measure set and that in certain cases, specialty-selected measures may provide patients with more relevant and meaningful information. The disclaimer should also note that if a specialty does not have measures, this is not a negative reflection on the specialty or its physicians.

In 2016, CMS proposes to include an indicator on the Physician Compare website that reflects successful participation in the EHR Incentive Program based on 2015 data. Given the low participation rates and

ongoing barriers to successful participation, including difficulty in selection and functionality of EHRs and limited ability to implement core measures, we urge CMS to include a disclaimer next to the indicator explaining these barriers and that successful participation in the EHR Incentive Program is only one of various ways to demonstrate an investment in higher quality care.

CMS also proposes to calculate and post composite scores for select measures groups in 2016 based on 2015 data. While none of the measures groups are directly relevant to our members, we caution against this aggressive timeline. CMS should not publicly report composite scores until it has carefully evaluated the validity and reliability of composite methodologies and shared these results confidentially with physicians through the Quality and Resource Use Feedback Reports (QRURs).

We also oppose the public reporting of CAHPS measures for PQRS and ACOs due to the subjective nature of these measures. Additional comments detailing these concerns are offered further below.

CMS also proposes to develop and publicly report on benchmarks in 2016 for 2015 PQRS GPRO data (calculated based on 2014 data) using a benchmark methodology that is similar to that used under the Medicare Shared Savings Program (MSSP). Benchmarks would be established for each percentile. A group practice would earn quality points on a sliding scale based on performance: performance below the 30th percentile for a measure would receive zero points; performance at or above the 90th percentile would earn the maximum points available. CMS proposes to do the same for individual measures in the future. While we appreciate CMS' effort to provide patients with a tool to accurately interpret performance data, it is unclear exactly how these benchmarks will be calculated. NASS seeks clarification on whether the benchmarking methodology used is the same as or different than the methodology applied under the Value-Modifier. Under this methodology, will groups be arbitrarily placed into score brackets or does the sliding scale offer flexibility when calculating the group practice's final score? Care should be taken so that benchmark cut-offs are not arbitrary in nature and that data are appropriately risk-adjusted.

NASS appreciates that for all measures posted on Physician Compare, data must meet the minimum sample size of 20 patients and prove to be statistically valid and reliable. Regarding the physician preview period, the period where physicians are able to view their measures as they will appear on Physician Compare prior to being published, NASS recommends that CMS increase the period from 30 to 60 days. The additional time will allow physicians more time to interpret and digest data and ensure their practice is fairly represented on Physician Compare. We again urge CMS to implement a formal appeals process. CMS notes that any data found to be invalid, inaccurate or that fails to adhere to sample size requirements will not be publicly reported. However, without an appeals process, physicians will only be able to request changes in measure display, not accuracy, which is of greatest value to consumers. In the Value Modifier section of this rule, CMS proposes to expand its informal inquiry process starting with the 2015 payment adjustment period to establish an initial corrections process that would allow for some limited corrections to be made to cost measure determinations. However, CMS notes that it is not operationally feasible to evaluate errors with regard to quality measure data by that time. Measure performance data should not be used for accountability purposes-- whether payment penalties or public reporting--until CMS has the capability to evaluate and correct calculation errors.

Physician Quality Reporting System (PQRS)

NASS is deeply concerned about CMS' proposal to increase the requirements for successful PQRS reporting, while decreasing the number of measures available to report on. As a result of these proposals, including the removal of the Back Pain Measures Group and the Perioperative Measures Group in 2015, spine care providers will find it very challenging to meet the reporting requirement of 9 measures across 3 National Quality Strategy domains. For those who do, many will be forced to report on peripherally relevant measures simply for the sake of satisfying the reporting requirement and not because they are truly relevant to their patients. If CMS' true goal is to improve patient care without creating an undue administrative burden on physicians, it should either lower the reporting threshold or, at the very least, maintain the measures proposed for removal for another 1 to 2 years. This transition period, which should apply to any measure proposed for removal in the future, would give physicians time to identify alternative reporting mechanisms or for specialty societies to develop additional measures.

The inclusion of cross-cutting measures, which many spine care providers will have to use to meet the reporting requirement, emphasizes the dearth of measures for specialists in general and highlights the fact that creating cross-cutting sets fails to recognize the differences between primary care providers and specialists and the nuances in care provided to specialty patients. NASS is also concerned about the proposed requirement that a qualified registry have the ability to collect and transmit to CMS data on ALL 18 of the proposed cross-cutting measures when physicians are only required to report on 2 of these measures. CMS claims this will give registry participants the flexibility to choose among the full set of cross-cutting measures. However, specialty societies are best equipped to determine which of these 18 measures are most relevant to their registry participants. For many specialties, the majority of these 18 measures are not relevant and therefore, qualified registries should not be required to have the capability to report these data elements.

We also seek clarification from CMS as to how the cross-cutting measure set will affect the measure-applicability validation (MAV) process. The MAV is determined by how an eligible professional codes and whether their coding matches up with the measure numerator and denominators. An eligible professional is subject to the MAV process when they fail to meet PQRS reporting requirements. Through the MAV process, CMS will determine if there were applicable measures that eligible professionals could have reported, but didn't. It is very possible that there are instances where a measure, specifically those in the cross-cutting measure set, is neither relevant nor appropriate to report, but is captured in the MAV due to the eligible professional's billing and CMS' arbitrarily created clusters. As discussed throughout this letter, specialty societies are best equipped to determine which measures are most relevant to specialists. Therefore, NASS strongly recommends that CMS create a mechanism whereby specialty societies may review and comment on the MAV algorithm to ensure that eligible professionals are not inappropriately targeted and unfairly penalized.

NASS does note the addition of two measures related to spine: average change in functional status following lumbar spine fusion surgery; and avoidance of inappropriate use of imaging for adult ED patients with traumatic low back pain. The average change in functional status following lumbar spine fusion surgery measure is currently proposed as a new measure for the 2015 Minnesota Statewide Quality Reporting and Measurement System (SQRMS). According to measure specifications outlined in their [proposal](#), pilot reliability testing results will not be available until fall 2015. While NASS appreciates CMS' proposal to include measures relevant to spine surgeons, we recommend that CMS delay incorporating this measure until MNMCM has fully tested and vetted this measure. NASS seeks

clarification on whether this measure would be reportable within any registry system or would be required to be reported to Minnesota's SQRMS.

We urge CMS to maintain the current definition of measures groups, ie, measures groups contain a minimum of four measures rather than the proposed six. The development process for one measure is challenging enough let alone that for a measures group. Increasing the minimum measures will only hinder measures groups development especially among specialties with limited resources and scientific evidence to support creation of measures. Additionally, last year, CMS finalized its proposal that measures groups would only be reportable via registry and no longer via claims. While we appreciate CMS' recognition of the value of registries and its effort to move away from claims-based measures, we feel that CMS should not limit reporting options. For some EPs, claims-based reporting may be the only option available to participate in PQRS, especially for those who do not have access to a qualified registry. We urge CMS to maximize program flexibility by including as many reporting options as possible, including claims-based measures group reporting, at least for the next year.

As we have stated in the past, NASS does not believe that pairing an increased reporting burden with penalties will encourage participation in the PQRS, a program that already suffers for participants. Instead, it will breed frustration and skepticism and potentially encourage providers to opt out of Medicare over questions regarding the true value of federal quality initiatives.

Clinician Group (CG) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

In this rule, CMS proposes to further incorporate CG-CAHPS survey measures into its federal quality initiatives. In late 2014, CMS will publicly report on CAHPS performance reported by groups of 100 or more, but by 2015, it will report on CAHPS performance for groups of 25 or more and in 2016, it will report on performance for groups of 2 or more. While reporting the CAHPS measures would be optional for groups with 2-99 EPs for the 2017 payment adjustment, CMS proposes that beginning with the reporting period for the 2018 PQRS payment adjustment (i.e., 2016), group practices with 25+ EPs participating in GPRO would be required to not only report on, but to also bear the cost of using a certified vendor to collect the CAHPS survey measures.

As NASS has stated in the past, we are opposed to including patient experience measures in federal quality improvement programs. These measures have to be considered carefully in light of the specialty being evaluated. While it is important to understand patient experience in the care setting, patient experience/satisfaction should not be a required element of reporting for providers since these are often subjective in nature and not directly under the control of the physician (e.g., physician wait times in a hospital setting). In spine care, patient experience measures can be dangerous and inappropriate and there is no direct correlation between higher patient experience scores and better clinical outcomes. Spine care providers see many patients with chronic pain. Some patients that are in pain do not have surgically correctible or other remedial pathology or have significant secondary gain issues, which make certain treatments futile. Appeasing any patient in the name of patient satisfaction rather than providing clinically effective, evidence-based care can be dangerous and costly. When used for accountability purposes, patient satisfaction measures can incentivize bad medicine and discourage clinically and cost effective strategies. We fully recognize the need to evaluate and ensure high standards in regards to patient experience. However, this could be accomplished most effectively through confidential feedback to physicians.

We appreciate that CMS proposes to make the reporting of CAHPS measures in 2015 for purposes of the

2017 VM optional for groups with two or more EPs. However, CMS' other proposals related to CAHPS measure reporting seem to indicate the agency's desire to make patient experience measures a required component of federal quality initiatives in the future, including the VM and Physician Compare. Because of the perverse incentives that may result from patient satisfaction measurement, we urge CMS to focus on evidence-based, physician-driven clinical quality measures for accountability purposes and to retain patient experience measures for internal quality improvement purposes only.

Qualified Clinical Data Registries (QCDRs)

NASS strongly supports the QCDR reporting mechanism since it gives specialty societies the flexibility to report on measures that are most relevant and meaningful to their members and to make use of data they may already be collecting for other purposes. We very much appreciate changes proposed by CMS that would give entities more flexibility or otherwise ease the requirements of becoming a QCDR. These include the proposal to increase the number of non-PQRS measures that QCDRs can include from 20 to 30, to extend the deadline by which QCDRs must submit quality measure data to CMS to March 31 of the year following the reporting period, to permit QCDRs to use an external organization for data collection/data transmission, and to recognize entities that have broken off from a larger organization for purposes of QCDR qualification.

However, we have concerns about other proposals that seem to place an unreasonable burden on QCDRs and may limit the extent to which entities can take advantage of this reporting option. Our biggest concern has to do with CMS' proposal to require QCDRs to publicly report performance data by April 31 of the year following the reporting period. Many specialty society registries are relatively new with analytics that are still in the development stage. While they may be collecting valuable data on quality and outcomes, this data must be collected over time before quality variables most likely to determine patient outcomes can be defined and meaningful performance benchmarks can be developed. Furthermore, registry participants need a chance to become used to reporting to the registry and to make improvements based on feedback. The practical and economic burdens of physician participation in a registry, particularly in the early stages, are significant.

Given these considerations, we strongly believe it is premature to require the public reporting of QCDR performance data. The necessary processes and safeguards required to make public reporting meaningful for physicians, patients and the public requires time, resources and careful consideration. Therefore, NASS recommends that CMS implement a scaled approach to QCDR reporting that establishes criteria for moving toward accurate and meaningful public reporting of performance information over time and with experience. This will allow specialties in various stages of registry development to take advantage of the QCDR reporting mechanism in a meaningful manner and ensures that consumers would receive accurate and reliable information

NASS also believes the requirement that QCDRs report on 50% of all applicable patients seen for each measure (Medicare and non-Medicare) may disproportionately burden high volume physicians. NASS requests that CMS require only that physicians report on a statistically valid sample of patients. NASS also continues to support its concerns about the disqualification of QCDRs as stated in its comments last year. CMS previously finalized that if it finds, pursuant to an audit, that a registry has submitted inaccurate data, the registry would be disqualified from PQRS participation for the following year. The inaccurate data submitted for eligible providers would also be discounted for the reporting year. NASS finds the automatic disqualification of the registry and exclusion of reporting data to be very unfair, especially while CMS, registry vendors, and eligible providers are familiarizing themselves with

this reporting option. Instead of automatic disqualification during these crucial early learning years, NASS urges CMS to allow for an appeals process so that vendors and eligible providers can determine the causes of the inaccurate data and make corrections when issues are identified, while still remaining in the program. In most situations, NASS believes that the inaccurate submission will not be fraudulent in nature, but rather caused by issues that can be easily rectified.

QCDRs will also be expected to include three outcomes measures (or two outcomes measures and one resource use, patient experience or efficiency measure) instead of one outcomes measure. There are specialties for which outcomes measures are still not readily available. With the many modifications already required for QCDRs and PQRS, NASS would ask CMS to allow use of a single outcomes measure for those specialties in which those measures are not yet available.

VALUE-BASED PAYMENT MODIFIER (VM)

NASS continues to have serious concerns about the pace at which CMS has chosen to roll out the VM. In coming years, physicians may be at risk for losing over 10% of their Medicare payments given upcoming penalties related to the PQRS, VM, and EHR Program. We request that, where feasible, CMS use its authority to lessen the immediate impact of the program, especially on smaller group practices and individuals, and to maximize the time over which it can evaluate the accuracy of cost measure calculations and the overall practice of tying physician payments to performance. While NASS understands that CMS is statutorily obligated to apply the VM to all physicians by 2017, there are many other aspects of the program over which CMS has broad discretion.

For instance, CMS has the authority to set the maximum penalty under the VM each year. For 2015, it finalized a 1% penalty that will apply to groups with 100 or more EPs that fail to participate in PQRS. A maximum downward adjustment of 1% could also apply to groups that elect to be held accountable under the quality tiering calculation, but that decision is voluntary for 2015. For 2016, CMS finalized that the VM will apply to groups with 10 or more EPs, the penalty for non-participation will increase to 2%, and that the quality tiering calculation will be mandatory, but that groups with 10-99 EPs will be held harmless from a downward performance-based payment adjustment. For 2017, CMS is now proposing to apply the VM to all groups, to double the non-participation penalty to 4%, to maintain the mandatory quality tiering calculation and to hold groups with 2-10 EPs and solo practitioners harmless from downward performance-based payment adjustments. This would mean that in 2017, the first year that groups with 10-99 EPs could be subject to downward performance-based adjustments, they could be penalized up to 4%. This also means that during the very first year that the VM applies to the smallest of practices (2-10 EPs), they will be subject to a non-participation penalty that is two times as large as the penalty applied to larger practices (10-99 EPs) and four times as large as the penalties initially applied to the largest of practices (100+ EPs).

It is simply unfair to subject smaller practices to such a higher penalty during their first year of this relatively new program. Smaller practices face greater challenges participating in federal quality reporting programs and if anything, should be subject to the same or lower penalties as larger practices (who have greater resources to dedicate to a program), at least initially as they become accustomed to the reporting requirements. We recommend that in addition to holding smaller groups harmless from performance-based downward adjustments during the initial year, that CMS also subject them to a lower penalty for non-participation. In the second year, when these groups are no longer held harmless

from downward adjustments, they should also be subject to a lower initial penalty, preferably -1% or -2%.

A more gradual roll out of the penalties is also critical in terms of giving CMS more time to evaluate and make improvements to the program. There is much that CMS and the public still needs to learn about the validity of cost measures, the accuracy of patient attribution and risk adjustment methodologies, the reliability of composite scores, the significance of benchmarks, and the overall value of performance data to both physicians and patients.

NASS also requests that CMS consider revising the quality (and potentially cost) scoring strategy to recognize and reward not only physicians that meet a certain benchmark, but those that make year-to-year improvements in performance scores, as CMS is proposing for MSSP ACOs. Furthermore, we oppose CMS' decision to not apply socioeconomic status adjustments to cost measures under the VM. A large body of evidence demonstrates that sociodemographic factors such as income and insurance status affect many patient outcomes, including readmissions and costs. Failing to adjust measures for these factors can lead to substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes.

Finally, we appreciate CMS' efforts to expand the informal inquiry process in regards to performance calculations. Under current policy, a group of physicians is simply given the option to contact CMS after receiving its annual Physician Feedback report to inquire about the report and the calculation of the VM. In this rule, CMS proposes a more formal process for groups to request a correction of a perceived error. NASS supports giving groups until at least February 2015 to request a correction for the 2015 payment adjustment. Not only is CMS' proposal of January too short of a deadline, but the February deadline aligns with the PQRS informal review process. CMS would recompute the group's cost composite and readjust its tier accordingly if the agency determines it made an error in the cost calculation for 2015. However, CMS claims it is not technically feasible to do the same for quality composite errors in 2015 and would instead classify a TIN as "average quality" in those cases. It is not fair to hold practices accountable for performance without a mechanism in place to ensure corrections to that data. It seems inappropriate to deem a group "average quality" simply because CMS does not have the capacity to correct its own errors, especially if an "average quality" rating could potentially lead to penalties.

For the 2016 and 2017 payment adjustments, CMS proposes to establish a 30-day period that would start after the release of the QRURs for the applicable reporting period for a group or individual to request a correction of a perceived error related to the VM calculation. By 2016, CMS claims it would be able to recompute a TIN's quality composite. NASS supports a 60-day period for physicians to request a correction. Physicians have reported difficulty accessing the Feedback Reports and since many are still unfamiliar with both the reports and the VM, they will need more time to sift through this complex set of data and to really understand what they are looking at, let alone identify potential errors.

PHYSICIAN FEEDBACK PROGRAM

NASS urges CMS to continue to evaluate and refine the annual QRURs in an iterative, ongoing manner, working closely with specialty societies. The accuracy, format, and usability of these reports will be increasingly important going forward since they will include critical information about how physician

payments will be affected under the VM and how quality and cost determinations are translated into such payment adjustments.

CMS also discusses its ongoing work related to the development of episode groupers for purposes of evaluating resource use. The 2012 Supplemental QRURs include 26 condition and procedural episode types, including lumbar spine fusion/re-fusion. NASS has commented in the past on the broad nature of the total per capita cost and MSPB measures, as well as concerns about their attribution methods, which often result in a physician being held accountable for care outside his/her their control. We are also concerned that these cost measures do not align with the quality measures used to calculate the VM. As such, we appreciate CMS' effort to move towards more clearly defined episodes of care. While we support this more focused approach to cost measurement, it is important that CMS not use episodes for accountability purposes until it can marry these resource use measures with relevant quality measures—whether from the PQRS set or more homegrown measures developed through specialty societies and collected via QCDRs.

NASS appreciates the opportunity to comment on this proposed rule. If you have any questions or need additional information, contact Allison Waxler, Director of Regulatory Affairs at 630-230-3683 or awaxler@spine.org.

Sincerely,

A handwritten signature in black ink that reads "W.C. Watters MD". The signature is fluid and cursive, with a large loop at the end.

William Watters, MD
President