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American Association of Oral and Maxillofacial Surgeons

November 12, 2013

The Honorable Max Baucus, Chair
The Honorable Orrin Hatch, Ranking Member
Senate Finance Committee
912 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Dave Camp, Chair
The Honorable Sander Levin, Ranking Member
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

RE: SGR Repeal and Medicare Physician Payment Reform Discussion Draft

Dear Chairmen Baucus and Camp and Ranking Members Hatch and Levin,

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional association that represents more than 9,000 oral and maxillofacial surgeons in the United States, I commend the commitment by Congress, and your committees in particular, to repealing and replacing the flawed SGR update mechanism. The AAOMS appreciates the opportunity to provide the following comments with regards to provisions outlined in the October 30, 2013 SGR Repeal and Medicare Physician Payment Reform Discussion Draft. Some of these policies will have a significant impact on Medicare beneficiary's access to care should the proposal result in increased administrative burdens and low reimbursements on solo or small physician practices.

Section I – SGR Repeal and Annual Updates

The AAOMS supports the Committees' proposal to permanently repeal the SGR update mechanism and reform the fee-for-service (FFS) payment system through greater focus on value over volume, and encourage participation in alternative payment models (APM). The AAOMS supports rewarding physicians participating in Advanced Alternative Payment Models with

annual two percent increases, while providing annual updates of one percent to all other Medicare providers. However, the AAOMS does not support freezing physician reimbursement until the year 2024. Medicare physicians have not experienced an increase in Medicare reimbursement in over 10 years, which has resulted in mass numbers of physicians opting out or terminating their participation. Opportunities for incentives and bonus payments must be implemented sooner to ensure beneficiaries' ample choices of participating providers and specialists.

II. Value-Based Performance (VBP) Payment Program

The AAOMS supports the proposal's efforts to sunset the current incentive programs and streamline the program into a single budget-neutral incentive payment program. Having one Value-Based Performance (VBP) Payment Program to concentrate upon reduces the duplicative efforts and onerous guidelines of participating with the three current incentive programs.

Professionals Eligible for the VBP Program

The AAOMS also strongly supports the proposal's recommendation to exclude from the VBP those providers who treat few Medicare patients as well as those who receive a bulk of their revenue from advanced APM(s). However, the AAOMS requests clarification as to how providers who treat few Medicare patients will be defined. Furthermore, oral and maxillofacial surgeons (OMSs) frequently treat Medicare patients but the majority of services provided are not considered Medicare covered benefits. The AAOMS additionally recommends not only excluding those who treat few Medicare patients, but also those who render services that are infrequently covered by Medicare, perhaps by establishing a claims or revenue threshold.

Assessment Categories

The AAOMS also requests further explanation as to how providers are to indicate their specific role in treating Medicare beneficiaries (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) on the claim form. Since payment reductions would apply to those who fail to provide such information, ample time must be provided to properly educate Medicare providers.

Clinical practice improvement activities

The AAOMS supports in concept the establishment of clinical practice improvement activities to prepare providers in transitioning to an advanced APM(s). However, the AAOMS is concerned that the proposal only provides those primary care and specialists practicing in a certified medical home with the highest possible score. OMSs may not have the opportunity to join a medical home in some regions because they are considered a "dental specialty" which therefore eliminates the option to participate in this sort of APM and its associated incentives. Furthermore, some OMSs have encountered Accountable Care Organization's (ACOs) that exclude them from participation due to their type of specialty. OMSs provide high quality care to trauma patients suffering from facial injuries, fractures, or pain, as well as other Medicare

patients in need of oral cancer treatment and treatment of tumors and cysts of the jaws and other reconstructive procedures. Exclusion from these types of APMs eliminates the choice for an OMS to participate in the VBP or APM program. For this reason, the programs must either be enhanced to allow unique specialties providing equally important care the opportunity to participate and earn incentives, or exclude them from program requirements without penalty.

Performance Assessment
The AAOMS does not support tying the VBP incentive payment to a provider's single performance composite score. While it is understood that the VBP is a budget neutral program in which payment increases for high performance scores would be offset by payment reductions for poor performing professionals, concessions must be considered based upon lack of patient compliance, the number of Medicare patients seen as well as the number of Medicare covered services rendered. As mentioned earlier, the majority of services provided by OMSs are not covered by Medicare; therefore, the number of cases in which quality measures may be reported may be few. If a surgeon fails to report accurately on those few cases, his or hers composite score may be low which may provide the false assumption to Medicare as well as a Medicare patient, that particular OMS is not providing high quality care.

III. Encouraging Alternative Payment Model Participation

The AAOMS supports efforts to encourage APMs; however, we believe that successful participation in an APM by 2016 may not be feasible for small practices or specialties that treat few Medicare beneficiaries due to limited opportunities and lack of knowledge of such programs. Therefore, making the requirement to receive at least 75 percent of Medicare revenue through an advanced APM or receive at least 75 percent of their total, all-payer revenue through an advanced APM, including at least 25 percent of their Medicare revenue, virtually impossible. If specialties such as ours are unable to participate in an APM or a VBP due to the lack of performance measures to report, we may be left out of receiving any any positive updates.

IV. Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

The AAOMS supports the proposal to establish payment for one or more codes for complex chronic care management services, beginning in 2015.

V. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule

The AAOMS does not support the proposal's recommendation to solicit information from selected Medicare providers to assist in accurate valuation of services nor do we support providing a ten percent payment reduction to those who do not provide the requested information, despite the fact that practices with ten or fewer providers would be exempt. The AAOMS

believes that it is the AMA's Relative Value Update Committee's (RUC) responsibility to ensure the global payment for the work component of surgical procedures accurately reflects the average number/type of visits following surgery. If CMS were to solicit such information, the AAOMS requests clarification as to the credentials and experience of those analyzing the data and recommends that in the event a panel is formed to review such data, a specialist licensed in the same specialty as the supplier of information be responsible for valuing such services. Only one licensed in that same specialty will completely understand the time, work and effort associated with a procedure.

VI. Recognizing Appropriate Use Criteria

The AAOMS supports the proposal's suggestion to encourage (?) development and endorsement of specialty-specific appropriate use criteria. Specialty input is imperative to determining the most appropriate criteria and ample time must be provided to develop such clinical support decision tools.

VII. Expanding the Use of Medicare Data for Performance Improvement

The AAOMS has concerns with the proposal's intent to expand the use of Medicare data for performance improvement and requests further explanation of the type of data to be used and how it would be used to assist in quality improvement activities.

VIII. Transparency of Physician Medicare Data

The AAOMS also opposes the proposal's call for the Department of Health and Human Services (HHS) to publish utilization and payment data for physician and other practitioners on the Physician Compare website, in addition to the quality and resource use information that would be posted through the VBP program. The AAOMS believes that disclosing annual Medicare reimbursement payments to individual physicians may violate privacy interests of both physicians and their patients. If reimbursement data is reported by each patient interaction or event, sophisticated information analyzers could use payment date and codes to speculate on the disorders for which the patient is being treated even if the patient's information is not identifiable. Disclosure of gross payment information (i.e., total Medicare payments per month) also has drawbacks. Patients could improperly imply that a physician incorrectly submitted a claim simply because the gross amount seems large in their opinion. Furthermore, reporting a total amount to the public would not provide an audit path to insure that billing was correct. We support efforts to individually audit suspicious cases and announce convictions as a more effective way to prevent fraud and abuse that preserves the privacy of the compliant majority than the gross release of individual doctor-patient financial data.

Should CMS decide to release individual physician payment information, the AAOMS believes that such information should be aggregate only and should include the total number of hours worked by the physician to provide the billed services so that patients can appreciate an hourly compensation rate. Furthermore, we recommend that publically disclosing such data should also be done first as a pilot project, in select areas, with an outcomes assessment, comparing cost and efficacy of such published methods to conventional audits before deciding to move forward with implementing on a national basis. The AAOMS also requests that providers be given the option to opt-out of their data being released without ramification.

Again, the AAOMS appreciates both the committees' efforts to tackle the long overdue issue of repealing the Medicare SGR formula and reforming Medicare physician reimbursement as well as the opportunity provide comments on your draft proposal. Please contact Patricia Serpico, manager of the AAOMS Department of Reimbursement at 800/822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

Eric T. Geist, DDS
AAOMS President