

October 3, 2016

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5519-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Advancing Care Through EPMS; Cardiac Rehabilitation Incentive Payment Model; and Changes to the CJR - Proposed Rule

The American Association of Hip and Knee Surgeons (“AAHKS”) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) Center for Medicare and Medicaid Innovation (“CMMI”) on its proposed rule for Episode Payment Models (“EPMS”), the Cardiac Rehabilitation Incentive Payment Model, and changes to the Comprehensive Care for Joint Replacement Model (“CJR”) (hereinafter referred to as “proposed rule”).

AAHKS is the foremost national specialty organization of 2,900 physicians with expertise in total joint arthroplasty (“TJA”) procedures. Many of our members conduct research in this area and are experts on the evidence based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS offers these comments in anticipation of continued close collaboration with CMS to develop value-based care models that benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of the proposed rule:

FUTURE DIRECTIONS FOR EPISODE PAYMENT MODELS

I. Refinements to the BPCI Initiative Models - Sec. II.3.a

CMS states that “building on the BPCI initiative, [CMMI] intends to implement a new voluntary bundled payment model for CY 2018 where the model(s) would be designed to meet the criteria to be an Advanced APM.” This will mean that the new model must meet the three requirements of Advanced Alternative Payment Models (“APMs”): require participants to use certified electronic health record technology (“CEHRT”), provide for payment for covered

professional services based on quality measures that are comparable to those in the quality performance category under the Merit-based Incentive Payment System (“MIPS”), and either require that the participating APM entities bear more than nominal risk for financial losses under the APM.

AAHKS Comment: We understand from conversations with CMMI officials that this to-be-developed “BPCI-like” model presents an opportunity to test incentives and financial arrangements specific to TJA that are not encompassed by the CJR. AAHKS strongly endorses such a model to be developed and announced by CMMI in 2017 as an important opportunity to test various arrangements which may allow for value-based TJA models to be further expanded nationally in the future. While we concede there may be a limitation on what CMS can test and accomplish through the CJR at this time, this new “BPCI-like” model can address numerous outstanding issues and identify how the CJR may be improved upon. A number of these issues follow.

Episode Conveners - The CJR model does not allow for physicians to manage care provided under the bundled payment. CMS should allow physicians with requisite qualifications to participate in the ‘BPCI-like” program as episode initiators and conveners. Also, CMMI should continue the practice allowed under the BPCI of allowing non-physician organizations to serve as “conveners”. This will prove especially necessary to allow for novel Advanced APM participation for groups or physicians that otherwise lack the size and economies of scale to bear risk or provide the necessary infrastructure.

Defining the Episode – The “BPCI-like” program should allow providers to offer and test the provider’s ability to engineer change in the way care is delivered to the patient when episodes are defined differently. This is an excellent opportunity for CMS to compare the CJR to episode models with alternative TJA episode definitions, such as limiting cases to elective TJA due to osteoarthritis. Elective procedures are a comparatively controlled clinical event, more subject to provider influence and care, unlike fracture cases that are currently included in the CJR model. Episodes could also be tested to include more or fewer TJA-related services than the CJR.

Quality Measures – To qualify as an Advanced APM, a model must provide for payment for covered professional services based on quality measures that are comparable to those in the quality performance category under MIPS. The “BPCI-like” program should allow for TJA specific models to incorporate measures beyond the two facility-based measures that are currently included in the CJR model: the hospital-level risk standardized complication rate following elective primary THA and/or TKA measure and the Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”) survey measure. We are interested in the use of physician-reported measures, orthopedic surgery measures specific to THA and TKA that are a better indicator of outcomes and the performance of the clinical team. Other orthopaedic quality measures could be ready by late 2017 for use in the model.

Risk Adjustment – We understand that CMS has struggled to incorporate a risk and severity adjustment method into the CJR model, so that hospitals, physicians, and post-acute providers treating high risk patients are rewarded when they achieve the same quality as those taking on only low risk patients. AAHKS believes that the “BPCI-like” model presents an opportunity to test novel risk-adjustment arrangements, such as risk stratification, to allow for more accurate reimbursement of the true cost of complex TJA procedures as impacted by socioeconomic factors. For example, we look forward to discussing with CMMI the potential role in the new model of the risk-adjusted Cost of Episode of Care of Joint Replacement performance measure developed by Yale Center for Outcomes Research & Evaluation (“CORE”).

AAHKS will reach out to CMMI in the near future to share more details of recommended model parameters to expand what can be learned about successfully managing Medicare TJA episodes.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT

I. Advanced Alternative Payment Model Considerations - Sec. V.O.1

CMS proposes a path by which the CJR and its participant hospitals would meet the criteria for Advanced APMs as defined in the MACRA Proposed Rule. With the CJR as a CMS-designated Advanced APM, those eligible surgeons performing TJA procedures in CJR participant hospitals could be considered Qualified Professionals (“QPs”) under MACRA and thereby be eligible for a five percent annual lump sum bonus payment and exclusion from the MIPS Program.

AAHKS Comment: We strongly support this proposal and urge its adoption in the final rule. Upon the release of the MACRA proposed rule, the limited number of Advanced APMs was its greatest deficiency. In the MACRA proposed rule, CMS identified only six existing models and demonstration programs being tested through CMMI, excluding CJR, which would be considered Advanced APMs under the established criteria. Given the importance of APM participation to both the practice and reimbursement of Medicare physicians, AAHKS’ position has been that access to Advanced APMs should be attainable for all physicians.

The case for an expanded number of Advanced APMs has been strongest for those in CJR, CMMI’s only mandatory participation payment model. If the facilities in which they perform TJAs were selected for the CJR, surgeons effectively had no freedom to enter into an Advanced APM and would have been forced to participate in MIPS. Congress intended physicians to have a choice under MACRA to practice under MIPS or APMs. Participation in Advanced APMs not only allows physicians to strive for improved efficiency and practice, but also includes financial incentives that avoid the potential penalties associated with MIPS.

By making the CJR an Advanced APM, as is proposed, CMS allows most surgeons performing TJA procedures in CJR facilities the ability to choose between MIPS and the APM bonus. This will expand the positive impact of the CJR on quality and efficiency.

II. CJR Participant Hospital Tracks - Sec. V.O.2

CMS effectuates the Advanced APM designation by creating two tracks for participant hospitals under the CJR. To be considered an Advanced APM, the APM must require participants to use CEHRT, which the CJR currently does not do. CMS proposes that all CJR participant hospitals would choose whether to meet the CEHRT use requirement. Participant hospitals that do not meet and attest to the CEHRT-use requirement would be in Track 2 of the CJR model. Participant hospitals selecting to meet the CEHRT use requirement would be in Track 1 of the CJR model and would be required to attest in a form that their use of CEHRT meets CMS Advanced APM standards. Participant hospitals in Track 1 would therefore be deemed Advanced APMs.

AAHKS Comment: We support this proposed method of designating Advanced APMs. This approach recognizes that CJR participant hospitals have different timelines in which they can require all participating providers to use CEHRT. Those hospitals that are not currently prepared can work towards CEHRT adoption and integration and attest to Advanced APM status as soon as ready.

We recognize that this necessarily means that surgeons in any Track 2 hospitals will still be unable to access Advanced APMs on their own timelines and will therefore be subject to MIPS. We trust that the prospect of Advanced APM status will motivate physicians nation-wide to encourage CEHRT adoption by any outlier facilities and that CMS will continue to assist hospitals in CEHRT adoption. If experience in over the next few years shows that a significant number of CJR hospitals are not adopting CEHRT, then AAHKS will advocate that CMS develop relief for participating surgeons to achieve the five percent APM bonus sum.

III. Clinician Financial Arrangement Lists Under the CJR model - Sec. V.O.3

In order to make determinations as to eligible surgeons who may be considered QPs based on CJR participation, CMS will require information about eligible surgeons who enter into arrangements to support the participant hospitals' cost or quality goals under the CJR. Such arrangements could be CJR collaborators engaged in sharing arrangements with a CJR participant hospital; physician group practice ("PGP") members who are collaboration agents engaged in distribution arrangements with a PGP that is a CJR collaborator; or PGP members who are downstream collaboration agents engaged in downstream distribution arrangements with a PGP that is also an ACO participant in an ACO that is a CJR collaborator.

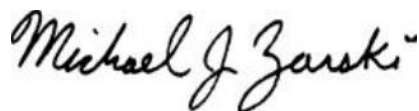
A list of surgeons and other these arrangements could be used to make determinations of who would be considered for a QP determination based on services furnished under the CJR model. CMS proposes that each participant hospital that chooses to meet and attest to the CEHRT use requirement must submit to CMS a clinician financial arrangements list in a form and manner specified by CMS on a no more than quarterly basis.

AAHKS Comment: We support this proposed method as likely the most direct and least burdensome means to accurately identify QPs participating in an Advanced APM. We acknowledge that CJR hospitals could modify their contractual relationships with their CJR collaborators and require those collaborators to include similar requirements in their contracts with collaboration agents and in the contracts of collaboration agents with downstream collaboration agents.

CMS states that “those physicians . . . who are included on the Affiliated Practitioner List as of December 31 of a performance period would be assessed to determine whether they qualify for APM Incentive Payments.” We interpret this to mean that physicians who had a partial year arrangement with a CJR hospital would be on the Affiliated Practitioner List as of December 31, and not that a physician would have to still be an Affiliated Practitioner on December 31 in order to qualify. Our understanding is further supported by the fact that the proposed reportable information includes the start and end date of the physician arrangement.

AAHKS appreciates your consideration of our comments. If you have any questions, you can reach me at mzarski@aaahks.org; or you may contact Joshua Kerr at jkerr@aaahks.org.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Zarski". The signature is written in a cursive, flowing style.

Michael J. Zarski, JD
Executive Director
AAHKS