Medicare Red Tape Relief Project

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: 8/25/17
Name of Submitting Organization: American Association of Hip & Knee Surgeons (AAHKS)
Address for Submitting Organization: 9400 W. Higgins Rd., Suite 230, Rosemont, IL 60018-4976
Name of Submitting Staff: Josh Kerr, Director of Advocacy and International Activities (DC Contact: David McNitt, National Health Advisors)
Submitting Staff Phone: (DC: 202 496-3459)
Submitting Staff E-mail: jkerr@aahks.org (DC: Dmcnitt@Oldakergroup.com)

Statutory_X_ Regulatory_X_

Please describe the submitting organization's interaction with the Medicare program:

AAHKS is the national specialty organization for physicians that specialize in total hip and knee arthroplasty; providing care to Medicare beneficiaries across the country.

Short Description:

Improvements to the Medicare Comprehensive Joint Replacement Model

Summary:

AAHKS is supportive of exploring new models of value based care and the development of Advanced Alternative Payment Models (A-APMs) under MACRA's Quality Payment Program. Our members have been at the forefront of testing new models of care for the Medicare program such as the Comprehensive Joint Replacement Model (CJR) from CMMI.

AAHKS is dedicated to improving the CJR model, but there are several issues that need to be addressed by CMS or Congress for the model to succeed for patients and physicians:

1) Inadequate Risk Adjustment in Alternative Payment Models: Lack of risk adjustment creates a disincentive for physicians to treat medically complex patients. This is a fundamental threat to the physician-patient relationship that must be addressed for APMs (not just CJR) to succeed. As we move into a value-based health care system, the sickest patients cannot be left behind.

2) Lack of Physician Control in Bundled Payment Models: CJR Model does not have a mechanism to permit physicians to assume the risk of controlling the bundle.

3) Regional/Geographic-Based Episode Target Prices in Bundled Payment Programs: Regional pricing targets provide a disincentive for physicians to treat medically complex patients. Practices that deliver care to high acuity/medically complex patients should not have the same target prices as a practice that provides care to lower acuity/low-risk patients. CJR's episode target prices begin as a blend of 2/3 facility history & 1/3 regional pricing. Eventually the blend shifts to a 100% regional price target, exacerbating inequities between practices based on the

acuity & medically complexity of their patient population.

4) Mandatory & Restrictive CJR Participation: CJR is a mandatory program in 67 MSAs. AAHKS believes that participation in the model should be voluntary. Conversely, there are practices that are interested in participating in the CJR model, but are not located in one of the participating MSAs.

Related Statute/Regulation:

Regulatory: 42 CFR 510 (CJR Model)

Proposed Solution:

1) Inadequate Risk Adjustment in Alternative Payment Models: AAHKS recommends that Congress and/or the Secretary direct the CMS Innovation Center to work with relevant specialties and associations to create appropriate risk adjustment/stratification methodology to accommodate medically complex patients. This consultation should be required for all new APMs, but addressing existing APMs with inadequate risk adjustment should be a top CMMI priority. At minimum, the risk adjustment model used in the Yale/CMS Risk Standardized 90 Day Episode Cost Measure for Total Hip and/or Total Knee replacement should be implemented in CJR and future AAPMs.

2) Lack of Physician Control in Bundled Payment Models: The physician has the most contact with the patient, and the most influence on clinical outcomes. Under a bundled payment model, it is imperative that the physician be afforded the opportunity to lead the effort to ensure the patient is receiving the right care, at the right time, in the right setting in order to meet bundled payment benchmarks. AAHKS supports flexibility in bundled payment programs to allow physicians to control the bundle and share risk if they so choose. Evolving concepts like the BPCI Facilitator Convener is also a positive step.

3) Regional/Geographic-Based Episode Target Prices in Bundled Payment Programs: We recommend the CJR model maintain the 2/3 historical episode blend as described in 42 CFR 510.300(b)(2)(i) for all performance years as an immediate step, and then allow for the development of risk adjustment methodology to appropriately account for medically complex patients.

4) Mandatory & Restrictive CJR Participation: We recommend that the participation criteria under the CJR regulations be expanded to permit broader voluntary participation in CJR. Permitting physicians interested in participating in CJR to do so will allow more practices to test the model, and provide offsetting participation for removing mandatory participation requirements. NOTE: AAHKS will be providing official comments to the recent proposed rule reducing the number of mandatory MSAs and creating criteria to make participation voluntary for certain MSAs and eligible participants.

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Short Description:

Discharge Planning Flexibility

Summary:

Current Medicare discharge planning requirements restrict the kind of information that can be given to patients. These restrictions can frustrate both patients, physicians and discharge planners as they seek to help the patient understand their post-acute options.

Physicians know the post-acute providers from which their patients receive the best outcomes. They should be allowed to impart that knowledge to help their patient navigate their rehabilitation. Managing a patient's treatment across the continuum of care is a core element of health reform, and the interests of the patient and physician are aligned for achieving the best possible outcomes.

Related Statute/Regulation:

Regulatory: 42 CFR 482.43

Proposed Solution:

We recommend that Congress or HHS provide flexibility to make recommendations to their patients regarding post-acute providers. The Home Health Compare and Nursing Home Compare tools are helpful, but clarifying a safe harbor that allows for a more involved discussion with patients about the best post-acute options would be a major improvement.

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Short Description:

Elimination of unnecessary face-to-face requirements

Summary:

Medicare Face-to-Face requirements for home health and certain DME cause a significant documentation burden on physicians, and are duplicative in some cases (e.g. Form CMS-485, Home Health Certification and Plan of Care). Even in cases when a non-physician practitioner can perform the F2F encounter, the physician must still certify that the encounter occurred and prepare the documentation.

Related Statute/Regulation:

Medicare Home Health Face-to-Face Requirement
Regulatory: 42 CFR 424.22(a)(1)
Statutory: 42 U.S.C. 1395f(a)(2)(C)

Medicare DME Face-to-Face Requirement
Regulatory: 42 CFR 410.38
Statutory: 42 U.S.C. 1395m (a)(11)(B)(ii)

Proposed Solution:

In the short term, HHS could suspend enforcement (MAC, CERT etc) of the F2F requirements, but ultimately we recommend that Congress repeal these face-to-face requirements.

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Short Description:

Improving Prior Authorization Programs

Summary:

Prior Authorization programs in Medicare Advantage are applied too broadly; raising the administrative burdens on both physicians and MA. These programs should be targeted to identify truly unnecessary care, instead of being a blunt obstacle for necessary care. An improper initial denial of coverage is a frustrating and all-too-common experience for our members. These denials are frequently overturned, but that process requires a time consuming peer-to-peer review consultation. Additionally, peer-to-peer consultations are not always done by a physician in a relevant specialty.

Related Statute/Regulation:

Regulatory: 42 CFR Part 422

Subregulatory: Medicare Advantage Plans, Managed Medicaid Contractors

Proposed Solution:

We recommend that Congress and CMS encourage an approach to prior authorization programs that focuses on physicians who have high historic denial rates, and exempt the majority of responsible physicians from constant administrative headaches.

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Short Description:

Inflexible Medical Necessity Requirements

Summary:

The Medicare requirements to satisfy medical necessity for total joint arthroplasty (TJA) is incompatible with some patient cases, and can delay necessary care.

For example, current medical necessity requirements demand that 3 months of conservative treatment be attempted and failed before Medicare covers TJA. A physician can determine in some of these cases, that 3 months of conservative treatment will 1) be ineffective, 2) put the patient through undue suffering, 3) delay patient care, and 4) waste medical resources. In these cases the 3 month requirement can cause additional suffering for the patient and incur unnecessary expense for the Medicare program.

Related Statute/Regulation:

Subregulatory - MAC coverage determinations

Proposed Solution:

We recommend that either 1) the Secretary provide for consultations with the appropriate specialty organizations to establish criteria for medical necessity or 2) Congress formally establish a mechanism for such consultations. This would allow for a process to refine coverage requirements to benefit Medicare beneficiaries who are harmed by inflexible Medical Necessity Requirements, including providing flexibility for cases where 3 months of conservative treatment is not an appropriate pre-requisite for coverage of TJA.

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Short Description:

Reasonable Meaningful Use Criteria

Summary:

Meaningful Use of electronic health records is an important tool in modern medicine. AAHKS also appreciates the flexibility afforded to physicians in MACRA's quality payment program. However, the requirements of Stage 3 Meaningful Use are too burdensome for most providers. Small practices already struggle to dedicate resources to MU compliance, however Stage 3 requirements are unattainable for even the most sophisticated and resourced health systems.

Related Statute/Regulation:

Regulatory: 42 CFR 495

Proposed Solution:

We recommend that the Secretary use Stage 2 Meaningful Use criteria for all relevant federal programs, and that Stage 3 Meaningful Use be shelved permanently instead of simply delayed. Furthermore Stage 2 should be evaluated to make sure that its criteria are making technology work for physicians, instead of physicians working for technology.

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Short Description:

Medicare Signature Requirements

Summary:

Medicare mandates that the practitioner must sign and document directly in order to submit a claim for medical services and supplies. CMS guidance, for example, states that for a signature to be valid, "Services that are provided or ordered must be authenticated by the ordering practitioner".

Medicare requirements for physicians to be directly involved with administrative tasks reduces time they should be spending with their patients.

Related Statute/Regulation:

Subregulatory - Medicare Program Integrity Manual, (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4.

Other subregulatory guidance: Medicare Learning Network Fact Sheets (ICN 905364)

Statutory: This is an element of the CMS Comprehensive Error Rate Testing (CERT) Program as established in the Improper Payments Elimination and Recovery Improvement Act (IPERIA) (31 U.S.C. 3321)

Proposed Solution:

AAHKS recommends that flexibility be added to Medicare signature requirements to allow a surgeon to supervise a team that collectively documents and signs for them.

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Short Description:

Modernize Stark Law

Summary:

Stark Law has become an obstacle course on the pathway to value-based care and care coordination efforts across settings. Ambiguity in the law provides too many pitfalls for providers to safely navigate, and even technical violations of the law are associated with disproportionate penalties. The prevalence of waivers in alternative payment models is evidence of the incompatibility of current law with new health reform models, and the different requirements and criteria for those waivers create even more complexity in the system. It is time to review and modernize Stark law to facilitate, instead of impede, health reform.

Related Statute/Regulation:

Statutory: 42 U.S.C. 1395nn

Proposed Solution:

We recommend that Congress and HHS engage in an open stakeholder process to modernize Stark Law (and Antikickback, Civil Monetary Penalty and 503c law) to clarify safe harbors and exemptions. AAHKS looks forward to engaging in a deliberative and iterative policy process that protects Medicare program integrity while paving the road towards value based care.

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Short Description:

Three-Day Inpatient Hospital Stay Requirement for Care in a Skilled Nursing Facility

Summary:

Currently, Medicare requires that a patient spend three days as an inpatient in a hospital for their stay in a skilled nursing facility to be covered. This law limits patient ability to access rehabilitative services, regardless of the clinical need. It also places improper incentives on providing services on an inpatient vs. outpatient/observation basis.

Value based reimbursement models like CJR and Medicare Next Gen ACO provides for a waiver of the 3 Day requirement; displaying that the policy is not necessarily in the patient's interest, or in the interest of the Medicare program.

Related Statute/Regulation:

Statutory: 42 U.S.C. 1395x(i)

Proposed Solution:

We recommend that Congress repeal the 3 day inpatient requirement for SNF coverage, and allow that decision to be made on the basis of what is most clinically appropriate for the patient.

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Short Description:

Streamline Quality Measures Development

Summary:

The difficulty of getting quality measures through the NQF process has contributed to the dearth of specialty quality measures. With the implementation of the MIPS track in the Medicare Quality Payment Program, the need for meaningful measures is more acute than ever. The MIPS track is currently not a good option for AAHKS members because there are not enough approved quality measures that accurately reflect the quality of care delivered by our surgeons, or capture the nature of their practice. While MACRA's attention to a quality measures development plan is greatly appreciated, we remain concerned about all AAHKS members who may find themselves reporting measures that do not articulate the quality of their practice in the early years of QPP.

Related Statute/Regulation:

Subregulatory: CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Regulatory: 42 CFR 414.90 (PQRS)

Statutory: 42 USC 299b–31 (AHRQ-NQF)

Statutory: 42 U.S. Code § 1395w–4 (q)(2) (MIPS)

Statutory: 42 U.S. Code § 1395w–4 (s)(Measure development plan)

Proposed Solution:

We recommend that Congress and HHS seek a direct pathway for approving specialty society endorsed measures for reporting and incentive programs. This process should prioritize specialties without meaningful quality measures for the MIPS track.