AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

OFFICE: 847.698.1200 • FAX: 847.698.0704 • WEB: aahks.org
9400 W Higgins Road, Suite 230 • Rosemont, IL 60018-4976

October 16, 2017

**VIA E-MAIL FILING**

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5524-P
P.O. Box 8011
Baltimore, MD 21244-1850

**RE: Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model**

The American Association of Hip and Knee Surgeons ("AAHKS") appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") on its proposed rule, "Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models: Changes to the Comprehensive Care for Joint Replacement Payment" ("proposed rule").

AAHKS is the foremost national specialty organization of more than 3,200 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 anticipates continued close collaboration with the Administration and Congress to advance payment reform to best serve beneficiary access and outcomes. In all of our comments, AAHKS is guided by its three principles:

- Payment reform is most effective when physician-led;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus

Our comments focus on the following provisions of the proposed rule regarding the Comprehensive Care for Joint Replacement Payment Model ("CJR"):

## I. Proposed Voluntary Participation Election (Opt-In) for Certain MSAs and Low-Volume and Rural Hospitals – Section III.B.1.

CMS proposes to continue the mandatory CJR model in approximately half of the originally

selected geographic areas (34 of the 67 selected geographic areas) with an exception for low-volume and rural hospitals. In the 34 areas where participation of the CJR model would be mandatory, CMS would exclude and automatically withdraw rural and low-volume hospitals. Some rural and low-volume hospitals may want to continue their CJR model participation and therefore CMS would provide a one-time voluntary participation election period.

**AAHKS Comment:** We applaud and support CMS's proposal to reduce the number of hospitals, and thereby physicians, that are mandated to participate in the CJR Model. AAHKS has enjoyed a close working relationship with the CMS Center for Medicare and Medicaid Innovation ("CMMI") regarding episode payment models, but we have long stated that participation in Medicare episode payment models should be voluntary. Otherwise models are imposed unequally on facilities with different levels of experience and preparedness for them.

Further, introducing CJR first through a mandatory requirement for certain geographic areas seemingly violates the limitations on CMMI's authority to expand models. Under section 1115A(c) of the Social Security Act, the Secretary's authority to impose mandatory participation models "through rulemaking," exists only after a new models has been tested and formally evaluated.

We further support CMS's proposed exception for low-volume and rural hospitals in the ongoing mandatory geographic areas. Recognizing the value of evaluating the impact of the CJR on Medicare spending and beneficiary outcomes, we encourage CMS to consider further narrowing the mandatory nature of the CJR.

## II. Comment Solicitation: Incentivizing Participation in the CJR Model – Section III.B.3.

CMS solicits comments on ways to incentivize eligible hospitals to continue participating in the CJR model for the remaining years of the model and further incentivize all participant hospitals to advance care improvements, innovation, and quality for beneficiaries throughout TJA episodes.

**AAHKS Comment:** In order to promote a higher volume of participation in the CJR, we urge CMS to adopt those proposals previously recommended by AAHKS and other medical specialty societies.

***Risk Adjustment/ Risk Stratification*** - The lack of risk adjustment/stratification in the CJR penalizes the hospitals and surgeons that treat the sickest patients. Furthermore, as CJR shifts towards regional benchmarking, hospitals and TJA practices that disproportionately care for medically complex patients will be in direct competition with those that treat a healthier patient base. AAHKS advocates that risk adjustment encompass the sociodemographic factors or patients as well as their orthopaedic complexity.

In spite of positive CMS proposals to reduce the scope of mandatory CJR involvement, without incorporating risk adjustment, the CJR, or any other APMs created by CMS, will create a reimbursement environment that increasingly incentives cherry-picking and lemon-dropping. At minimum, it would seem consistent and appropriate to use the exclusion criteria and risk adjustments already being used in the CMS hospital-level, risk-standardized payment measure that is capturing 90 day total joint costs for all hospitals.

We seek continued CMS cooperation to create risk adjustment methodology that accounts for treating high risk patients based on the quality of care delivered. AAHKS has shared with CMMI four possible risk stratification methodologies. We firmly believe that this is an important component of new payment models that will help to prevent potential barriers to access of care for high risk patients.

***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 CJR as episode initiators and conveners. Also, CMMI should utilize the practice allowed under the BPCI of allowing non-physician organizations to serve as "conveners". Such measures would make participation by physicians more likely which increases the likelihood that they those physicians can successful advocate within their facilities for CJR participation.

## III. Proposed Adjustment to the Pricing Calculation for the CJR Telehealth HCPCS Codes to Include Facility PE Values – Section III. E.

Under CJR, CMS established nine HCPCS G-codes to report home telehealth evaluation and management ("E/M)" visits provided under the CJR telehealth waiver. Pricing for these codes is updated each calendar year to reflect the relative value units ("RVUs") for the comparable office and other outpatient E/M visit codes on the Medicare Physician Fee Schedule, with the exception of comparable practice expense ("PE") RVUs which CMS assumed to be marginal.

CMS now concedes that the zero PE value assigned to these telehealth codes leads to inaccurate pricing. Therefore, CMS proposes to use the facility PE RVUs for the analogous services in pricing the nine CJR HCPCS G-codes.

**AAHKS Comment:** We support the proposal to more fully recognize the costs associated with telehealth E/M visits. Although the use of facility PE values is not perfect, it serves as a feasible placeholder proxy that will help hospitals and physicians in the short term. AAHKS looks forward to CMS efforts to develop the appropriate RVUs for the CJR telehealth model services.

## IV. Clinician Engagement Lists: Proposed Clinician Engagement List Requirements – Section III.F.2.

Under the Quality Payment Program, the Advanced APM track of the CJR model does not include eligible clinicians on a Participation List; rather the CJR Advanced APM track currently

includes eligible clinicians on an Affiliated Practitioner List. CMS uses this list to identify the eligible clinicians to be assessed as Qualifying APM Participants ("QPs") for the year. CMS then makes QP determinations individually for these eligible clinicians. CMS set in regulation that a list of physicians, nonphysician practitioners, or therapists in a sharing arrangement, distribution arrangement, or downstream distribution arrangement, as applicable, would be considered an Affiliated Practitioner List of eligible clinicians who are affiliated with and support the Advanced APM Entity in its participation in the Advanced APM for purposes of the Quality Payment Program ("QPP").

CMS states that stakeholders have called for model changes that would also include in the clinician financial arrangement list physicians, nonphysician practitioners, and therapists without a financial arrangement under the CJR model, but who are affiliated with and support the hospital in its participation in the CJR. CMS agrees that these practitioners should have their contributions to the hospital's participation in the CJR recognized under the QPP.

CMS proposes that each physician, non-physician practitioner, or therapist who is not a CJR collaborator during the CJR model performance year but does have a contractual relationship with a participant hospital based at least in part on supporting the participant hospital's quality or cost goals under the CJR model would be added to a clinician engagement list.

**AAHKS Comment:** AAHKS appreciates CMS's proposal to expand the opportunities to qualify as a QP, there by earning the 5% payment bonus and exclusion from MIPS. One of AAHKS's foremost goals is to increase its members' ability to achieve QP status under the CJR. This proposal would appropriately create more paths to recognize a physician's contribution to and role in support of value based care.

Furthermore, CMS solicits comments about approaches that would minimize the reporting burdens on hospitals when submitting both an Affiliated Provider List and a Clinician Engagement List. In order for physicians to be recognized in the CJR model, or any AAPM, hospitals must be able to efficiently and effectively report and submit their information free of undue burdens. AAHKS has learned that some hospitals struggle with reporting and the burdensome information submission process. As such, we appreciate CMS's request for information to minimize reporting burdens on hospitals. We encourage CMS to closely consider feedback from hospitals about reducing the administrative burdens associated with submitting and reporting clinician engagement lists. Ultimately, reducing reporting and submission burdens will result in more physicians accurately being designated as QPs.

***

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

Sincerely,

Mark I. Froimson, MD
President

Michael J. Zarski, JD
Executive Director
AAHKS