AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA REGULATIONS.GOV

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program

The American Association of Hip and Knee Surgeons ("AAHKS") appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") on proposed updates to the Merit-Based Incentive Payment System ("MIPS") and Alternative Payment Models ("APMs") as established under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") (hereinafter referred to as "QPP proposed rule").

AAHKS is the foremost national specialty organization of more than 3,000 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 ensure Medicare payment reforms benefit from our expertise and experience in TJA procedures.

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

MERIT-BASED INCENTIVE PAYMENT SYSTEM

I. Low-Volume Threshold - Sec. II.C.2.c.

CMS proposes to exempt clinicians from MIPS in 2018 if they have less than $90,000 in Medicare Part B revenue or care for fewer than 200 Medicare patients in the year. This would be a change from the 2017 policy exempting physicians with less than $30,000 in Medicare Part B revenue or fewer than 100 Medicare patients in 2017.

AAHKS Comment: We endorse the proposed lowering of the threshold for a physician to quality for a MIPS exemption based on low-volume. AAHKS appreciates the efforts of CMS to reduce clinician burden of MIPS and this certainly encompasses exempting those small physician

practices and those practices in rural regions and Health Professional Shortage Areas that lack the capacity or patient volume to have a realistic opportunity to succeed under MIPS.

II. Virtual Groups – Sec. II.C.4.

There are generally three ways to participate in MIPS in 2018: (1) individual-level reporting; (2) group-level reporting; and (3) virtual group-level reporting. CMS proposes to allow solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, to come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year. Generally, clinicians in a Virtual Group will report as a Virtual Group across all 4 MIPS performance categories and will need to meet the same measure and performance category requirements as non-virtual MIPS groups. Virtual Groups would need to exceed the low-volume threshold at the group level, regardless of location or specialties.

AAHKS Comment: AAHKS appreciates the efforts of CMS to reduce clinician burden and to promote widespread clinician participation under MIPS, particularly with respect to small physician practices and those practices in rural regions and Health Professional Shortage Areas. Virtual Groups are an important part of that effort, but more of the policies in the QPP Proposed Rule should be expanded upon.

The option of forming Virtual Groups will help small and rural practices, but the burdens of establishing a Virtual Group will be substantial for many of the smaller practices in most need. The identification of and agreement among prospective group partners combined with the legal and operational steps necessary to form a group and its tracking and reporting systems are one reason why CMS anticipates only 765 physicians will participate in 16 Virtual Groups in 2018.[1]

There is simply insufficient time remaining in 2017 for prospective Virtual Group participants to prepare for 2018. CMS can best view 2018 as a demonstration test of Virtual Groups in order to inform a process for 2019 that can more realistically serve physicians. One example is to provide technical assistance and guidance for physicians contemplating forming Virtual Groups. CMS analysis projects an annual total financial burden of $832 per Virtual Group, which includes the cost to prepare a formal written agreement and to undergo analysis of the group post-election to verify eligibility.[2] This seems to be a very low estimate to us. CMS can help move the actual financial burden closer to its estimate by providing frequent webinars and other technical assistance to walk physicians through the necessary steps towards becoming a Virtual Group.

Further, CMS should weight the cost performance and clinical practice improvement categories to zero for the first two years of operation in order to allow a Virtual Group time to develop systems to coordinate and improve performance in these categories.

[1] See CMS 10652 – Supporting Statement – Part A.
[2] Id.

CMS should work with the HHS Office of the Inspector General and the Department of Justice to develop and disseminate guidance regarding safe harbors for Virtual Groups from anti-kickback, physician self-referral, civil monetary penalties, and other fraud and abuse laws.

III. Data Completeness Criteria - Sec. II.C.6.b.(3)(b)

CMS proposes to continue to award small practices with 3 points for quality measures that are submitted but do not meet the data completeness criteria, whereas others that do not meet the data completeness criteria will only receive 1 point.

AAHKS Comment: We support the continuation of a 3 point quality measure award for small practices that submit quality measures that do not meet data completeness standards. AAHKS appreciates the efforts of CMS to reduce clinician burden and to promote widespread clinician participation under MIPS, particularly with respect to small physician practices and those practices in rural regions and Health Professional Shortage Areas.

IV. Substantive Changes to Measures - Background and Policies for the Call for Measures and Measure Selection Process – Sec. II.C.6.c.(1)

In Table A of the QPP Proposed Rule Appendix, CMS lists the quality measures proposed for inclusion in MIPS for the 2018 performance period and future years. This includes changes to existing measures, such as changes made to Quality Measures #375 and #376. These CMS steward measures assess the percentage of adult patients who complete baseline and follow-up functional status assessments following TKA and THA procedures.

AAHKS Comment: We thank CMS for making the substantive changes to these measures as requested by AAHKS. It is important that the initial general health survey be conducted prior to surgery.

V. Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices – Sec. II.C.6.f.(7)(a)(ii)

CMS proposes a new hardship exception for clinicians in small practices under the Advancing Care Information performance category. For clinicians that qualify for the exception, CMS will reweight the Advancing Care Information performance category to 0 and the Quality performance category to 85%.

AAHKS Comment: We support the reweighting of the Advancing Care Information performance category to zero for small practices. AAHKS appreciates the efforts of CMS to reduce clinician burden and to promote widespread clinician participation under MIPS, particularly with respect to small physician practices and those practices in rural regions and Health Professional Shortage Areas.

VI. Small Practice Bonus – Sec. II.C.6.g.(4)(c)

CMS proposes to add a 5 point bonus for clinicians, group practices, virtual groups, or APM Entities that consist of 15 or fewer clinicians that participate in MIPS by submitting data on at least one performance category in the 2018 performance period.

AAHKS Comment: We support the small practice bonus, particularly due to the likelihood of the covered small practices serving a disproportionately high number of complex patients. AAHKS appreciates the efforts of CMS to reduce clinician burden and to promote widespread clinician participation under MIPS, particularly with respect to small physician practices and those practices in rural regions and Health Professional Shortage Areas.

VII. Quality Performance Improvement Score – Sec. II.C.7.a.(1)(i)

CMS proposes to add an improvement scoring standard to the MIPS quality and cost performance categories. Starting for the 2020 MIPS payment year, CMS will measure improvement at the performance category level for the quality performance category score. The improvement score will be awarded based on the rate of increase in the quality performance percent score of individual clinicians or groups from the current performance period compared to the score in the year immediately prior to the current performance period. CMS will add an explicit regulatory provision that an improvement percent score cannot be negative. To calculate the quality performance category percent score, the total measures achievement points would be summed with the total measure bonus points and then divided by the total available measure achievement points. The improvement percent score would be added to that calculation. The resulting quality performance category percent score cannot exceed 100 percentage points.

AAHKS Comment: We support the creation of a quality improvement score. This proposed policy may (1) recognize and encourage achieving higher standards of quality among all providers, (2) increase opportunities for providers to succeed under MIPS in light of challenges with cost performance measures, and (3) increase opportunities for providers to succeed under MIPS in light of the challenges associated with serving patients with high social risk factors.

AAHKS is encouraged by reported results of Medicare ACOs in consistently achieving positive scores for quality improvement in certain clinical areas, which demonstrates that CMS may structure such measures in an achievable manner. This is very important in light of the inadequacies with evolving cost performance measures, particularly for episode cost performance. This mirrors what is observed in the Medicare Shared Savings Program in which quality improvement is manifested before significant cost improvement, leading some analysts to question the impact of value based care in reducing costs.[3] Quality improvement measures

[3] See Kocot, S., and White, R., *Medicare ACOs: Incremental Progress, But Performance Varies*, HealthAffairs Blog (Sept. 21, 2016) at http://healthaffairs.org/blog/2016/09/21/medicare-acos-incremental-progress-but-performance-varies/

should continue to be a significant element of MIPS scoring until such time as the potential to achieve and measure cost reduction is better understood.

VIII. Cost Performance Category Weights – Sec. II.C.7.b.(3)(d)

For the 2020 payment year, based on the 2018 performance year, CMS proposes to weight the cost performance improvement category at zero which will therefore not impact a clinician's ultimate score. CMS will calculate a cost improvement score only when data sufficient to measure improvement is available, that is when a clinician participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods.

AAHKS Comment: We support this proposed policy. We encourage CMS to weight the cost measures at zero for the the 2020 payment year because existing total cost and spending per beneficiary measures are poor tools to capture the complexity of the spending and its assignation. AAHKS has explained in prior comment letters its concerns with current cost performance measures as applied to TJA procedures. The episode-based measures used by CMS and developed for the Supplemental Quality and Resource Use Report have never been used for payment adjustment before. There are too few episode groups available to ameliorate the inadequacies of the total cost and cost per beneficiary measures.[4] While MACRA requires the weighting of 30% starting with the 2021 payment year, CMS should examine its authority to adjust weighting beyond that time frame for the purposes of transitioning certain small and rural providers with fewer means available to perform under MIPS.

IX. Incentives to Use CEHRT To Support Quality Performance Category Submissions – Sec. II.C.7.a.(2)(g)

CMS is proposing no changes to the awarding of bonus points for using CEHRT for end-to-end reporting. However, CMS is seeking comment in general on the use of health IT in quality measurement and how HHS can further encourage the use of certified EHR technology in quality measurement.

AAHKS Comment: CEHRT compliance remains prohibitively costly for many small groups and individual providers. Without sufficient incentives, we may see small specialty practices declining Medicare patients or being forced to join larger groups. If there is interest in preserving small practices as a resource to serve Medicare beneficiaries, incentives and inducements from CMS for CEHRT use will be necessary. One option is to provide MIPS credit for partial years of compliance while practices transition into use through a given year.

[4] We are aware that CMS has proposed to develop new episode-based measures for future performance periods, and to do so through increased clinician input. AAHKS continues to support such an approach and our members are prepared to offer their technical expertise at various stages of the process.

X. Accounting for Risk Factors – Considerations of Social Risk – Sec. II.C.7.b.(1)(a)

CMS continues to seek comment on whether MIPS should account for social risk factors, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include:

- adjustment of MIPS eligible clinician scores (for example, stratifying the scores of MIPS eligible clinicians based on the proportion of their patients who are dual eligible);
- confidential reporting of stratified measure rates to MIPS eligible clinicians;
- public reporting of stratified measure results;
- risk adjustment of a particular measure as appropriate based on data and evidence; and
- redesigning payment incentives (for instance, rewarding improvement for clinicians caring for patients with social risk factors or incentivizing clinicians to achieve health equity).

CMS is also seeking comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to the following: dual eligibility/low-income subsidy; race and ethnicity; and geographic area of residence.

AAHKS Comment: We believe that Medicare/Medicaid dual eligibility status is a simple and effective means to risk adjust for socioeconomic factors.

Providers of all types have become more aware of the impact of socioeconomic factors on clinical outcomes. Health status, stage of disease, genetic factors, local demographic and socioeconomic factors significantly impact the quality and outcomes of surgeries performed. Without properly adjusting for all of the factors that impact quality, physicians will be subject to payment adjustments that are reflective of the patient population and not reflective of the actual quality of care provided.

AAHKS acknowledges the concern expressed by some that the use of socioeconomic risk factors could lead to disparate levels of care for vulnerable populations. Nevertheless, the literature demonstrating the impact of socioeconomic factors on outcomes across multiple specialties is growing. The mere perception of higher risks could lead to providers avoiding vulnerable populations through various means. The access to quality care by vulnerable populations with socioeconomic risk factors should not be put at a disadvantage due to insufficient reimbursement to providers for factors outside their control.

We are concerned that MIPS will fail to incentivize better care if physicians find the measurement of quality dependent on factors outside the control of these physicians, and may in fact disincentivize care for those who are most in need. Dual eligibility status is one currently available means to approximate the risk of these socioeconomic factors, though we acknowledge that it is imperfect. CMS could also use patient zip code as a surrogate for income

status, which may in turn be a surrogate for socioeconomic risk factors. We believe CMS has observed this correlation in prior data pulls.

XI. Complex Patient Bonus – Sec. II.C.7.b.(1)(b)

While work on risk adjustment for social factors is ongoing, CMS proposes an interim adjustment for patients with numerous, complex factors that impact health outcomes. CMS will calculate the average Hierarchical Conditions Category ("HCC") risk score for a clinician or group by averaging the HCC risk scores for beneficiaries cared for by the clinician or group. Clinicians will then be awarded 1 to 3 bonus points if their patient population is deemed particularly complex. CMS seeks comment on any alternative complex patient methodologies, under which a bonus would be applied based on the ratio of dual eligible patients.

AAHKS Comment: We support this complex patient bonus. AAHKS has been consistently raising the need for adequate risk adjustment in all value based care models and programs. We are grateful that CMS continues to work toward risk adjustment and we appreciate the complex patient bonus as an interim measure. As CMS evaluates the best data proxy for socioeconomic risk factors above, consideration should also be given to awarding the complex patient bonus to dual eligible patients in addition to and apart from the awarding of HHC risk scores.

ALTERNATIVE PAYMENT MODELS

I. Advanced APM Policies

a. Advanced APM Nominal Risk Standard

To be considered an Advanced APM, an APM must either require that participating providers bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model. Currently, the total potential risk that an APM must bear must be equal to at least: either 8% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APMs for the Medicare QP Performance Periods (from January 1 to August 31) in 2017 and 2018 (the revenue-based standard), **OR** 3% of the expected expenditures that an APM is responsible for under the APM for all performance years (the benchmark-based standard).

CMS proposes to extend the 8% revenue-based financial risk standard established for 2017 and 2018 to the Medicare QP Performance Periods in 2019 and 2020. CMS asks if it should consider a lower or higher revenue-based standard for the 2019 and 2020 Medicare QP Performance Periods.

AAHKS Comment: CMS should move to a lower percentage revenue-based risk standard. The current required level of 8% risk for a provider is so high that it discourages provider participation in Advanced APMs. The over-arching purpose of the MIPS and APM incentives in

MACRA and the QPP is to drive Medicare providers into Advanced APMs in order to achieve higher quality for beneficiaries, reduce variability in costs, and create savings for the Medicare program. One of the most significant factors attracting physicians to Advanced APMs is the 5% bonus for participation. If CMS sets potential losses at a level above 5%, the incentive for physician participation is reduced.

When the 8% risk standard is combined with only one currently available Advanced APM for TJA (under which physicians have no input or control over the episode), surgeons specializing in TJA procedures see little incentive for Advanced APM participation.

II. Other Payer Advanced APM Policies

a. Nominal Risk Standard

CMS had previously adopted a nominal risk standard for Other Payer Advanced APMs requiring: marginal risk of at least 30%; a minimum loss rate of no more than 4%; and total risk of at least 3% of the expected expenditures that the APM Entity is responsible for under the payment arrangement. CMS proposes to add a revenue-based standard of 8%, as an alternative to the benchmark-based standard.

AAHKS Comment: We support the addition of a revenue-based standard for the purpose of measuring nominal risk for the designation of an Other Payer Advanced APM, however CMS should move to a lower percentage revenue-based risk standard. As discussed above in our comment on the Advanced APM nominal risk standard, 8% is so high that it discourages provider participation. One of the most significant factors attracting physicians to Advanced APMs is the 5% bonus for participation. If CMS sets potential losses at a level above 5%, the incentive for physician participation is reduced. An 8% risk standard would lessen the incentive for providers to participate in Other Payer Advanced APMs.

b. Identification of Other Payer Advanced APMs

CMS proposes to allow only certain payers to request that CMS identify a model as an Other Payer Advanced APM for the 2019 performance year. Those payers would be Medicare Advantage plans, Medicare-Medicaid plans, 1876 and 1833 cost plans, and Programs of All Inclusive Care for the Elderly ("PACE") plans, and payers with payment arrangements in CMS Multi-Payer Models (including the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model). CMS proposes that other payer types, including commercial and other private payers, would be able to request that CMS identify a model as an Other Payer Advanced APM starting with the 2020 performance year.

AAHKS Comment: In the interest of promoting wider availability of Advanced APMs and greater opportunity to achieve QP status, CMS should allow all commercial payers to request that CMS identify their models as Other Payer Advanced APMs for the 2019 performance year. In light of

the cancellation of the Medicare EPM models, and the continued acceleration of private bundled payment models, this would be a realistic and appropriate path to QP status. Further, as there may be some transition for plans to successfully develop models that qualify as Other Payer Advanced APMs, the submission and evaluation process should start as soon as possible for as wide a number of payers as possible.

c. QP Determinations and Threshold Scores

CMS proposes the methodology through which it will determine if clinicians qualify as a QP through the All-Payer Combination Option. Beginning in performance year 2019, a clinician may qualify as a QP through the All-Payer Combination Option. To become a QP through the All-Payer Combination Option, a clinician must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM. For an eligible clinician, CMS will conduct QP determinations sequentially, so that CMS first looks at a clinician's participation in a Medicare Advanced APM (the Medicare Option), and then the clinician's participation in both a Medicare Advanced APM and an Other Payer Advanced APM (the All-Payer Combination Option).

AAHKS Comment: The All-Payer Combination Option, like the Advanced APM option is becoming a diminishing opportunity for providers. In light of the recent cancellation of the Medicare Episode Payment Models (EPMs), the narrowing of the CJR, and the slow pace of Medicare Advanced APM development, we fear that the All-Payer Combination Option will be relevant for very few providers.

In order for a physician to take advantage of the All-Payer Combination Option, the physician must participate in a Medicare Advanced APM and have 25% of Medicare revenue associated with participation in the Medicare Advanced APM. CMS needs to accelerate the development of Advanced APM options through the Innovation Center in order for physicians to be able to benefit from the arrangements that they have in place with commercial payers.

Further, as a part of QP determination, CMS whether virtual groups may contract for shared risk under and Advanced APM and how CMS will make QP determinations for physicians engaging in such APMs through such virtual groups

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

Sincerely,

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