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

March 1, 2016

VIA E-MAIL FILING

CMS MACRA Team
[Attn: Eric Gilbertson]
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 240
Phoenix, AZ 85016-4545

RE: CMS Quality Measure Development Plan

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

AAHKS is the foremost national specialty organization of 2,710 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 physician payment reforms benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of the Quality Measure Development Plan ("MDP"):

I. Applicability of Measures Across Healthcare Settings

CMS will consider recommendations from recent publications and gather stakeholder input related to measures that are applicable across settings of care and types of clinicians. Options may include adapting specifications for measures developed for a different setting or level of care and using measures that may not be specific to a care setting.

AAHKS Comment: We support CMS' work to consider the latest measures that are applicable across settings of care. This is consistent with overall trends in health care to increase parity in

treatment and reimbursements, where appropriate, across various care settings. Such measures are increasingly applicable to bundled payments offered by public and private payers.

However, measures implemented through the MDP will ultimately be applied to care provided on a fee-for-service basis. In such cases where there is no bundled payment across care settings, or when multiple providers are not jointly at risk for outcomes, CMS must ensure that measures applicable across care settings are not imposed upon providers who lack realistic influence or control over the care or outcomes.

The scope of applicable measures should recognize the continuing influence that the patient's care team can have on process, outcomes, and resources at different points as a patient moves from acute inpatient care to post-acute care and beyond. We recognize that such measures are meant generally to encourage collaboration and coordination across care settings. However, as separate measures exist specifically for care coordination, we urge that the MDP ensure providers are only measured on the factors which they have the power to influence.

We additionally urge that the MDP incorporate truly adequate risk adjustment, ensure that measures are readily deliverable by the average surgeon to whom they may apply, and finally that measures not be solely process focused. For example, the AHIP-CMS Core Quality Measures Collaborative recently endorsed NQF measures 1550 and 1551 addressing complications and readmission following TJA procedures. Insufficient risk adjustment models in each measure, that have yet to improve beyond "C" statistics of 0.65, may threaten access to care for certain condition classes. Such concerns are in addition to the risk of surgeon dislocation secondary to the perceived need to leave areas of more challenged socioeconomic communities that have no risk adjustment at all.

II. Reducing Provider Burden of Data Collection for Measure Reporting

CMS strives to minimize provider burden by collecting data that are part of the existing clinical workflow. CMS also prioritizes the development of measures based on data from EHRs that can decrease the data collection burden while maintaining measure validity. CMS collaborates with EHR vendors and frontline providers during the measure development process to maximize the use of existing clinical workflows to capture information required for quality measurement. CMS solicits comments on the viability of this approach.

AAHKS Comment: We strongly support this strategic approach by CMS in addressing this challenge. There is great potential to develop clinically meaningful measures by collecting data directly from the patient or caregiver. At the same time, CMS' work with EHR vendors and others is essential to minimize the additional time and burdens placed on providers to collect or populate data for quality measures. Most AAHKS members are in independent practice and lack the resources of a large health system to enable significant data collection outside the clinical workflow. Collecting information retrospectively or outside of the clinical workflow will impair the utilization and value of any measure.

III. Clinical Practice Guidelines

CMS seeks comments on its Clinical Practice Guidelines recommendations as well as new approaches to aligning clinical practice guidelines with measure development. CMS recommends that "Measure developers and stewards should be cognizant of Medicare covered services when creating or maintaining measure specifications."

***AAHKS Comment*:** We appreciate the standard for inclusion of clinical specialty societies whose participation is essential. In addition to being informed by Medicare covered services, measure developers should ensure they consider coverage and benefit management standards of commercial payers as well.

Many commercial insurers increasingly institute pre-certification programs and other benefit management tools, particularly for highly complex, high-value procedures. These programs can influence treatment decisions and the timeliness of care provided. In the interest of furthering the multi-payer applicability which is a key strategic approach of the MDP, clinical practice guidelines is a topic where it is important for measure developers to account for commercial payer standards. Otherwise, adoption of clinical practice guidelines will be slowed and resisted to the degree that providers are measured on clinical process standards that run counter to requirements of commercial contracts.

Additionally, most clinical guidelines should be recognized, however, as being overall guidelines without the precision to direct care for the individual patient that presents with a constellation of conditions and risks. Guidelines should not be quoted verbatim in terms of measure development or coverage policies, and AAHKS continues to champion the need for autonomy in decision making between the surgeon and his/her patient.

IV. Patient and Caregiver Experience Measures

CMS seeks comments and suggestions for the development and selection of measures within each of the seven stated quality domains. CMS further seeks comments regarding the utility of specialty-specific patient experience surveys and whether such surveys exist and are in use in Medicaid or the private sector—through either plans or providers.

AAHKS Comment: We strongly believe that patient reported measures addressing experience and outcomes should be specialty specific. Adoption of such measures may already be occurring faster in some specialties than others.

The validity of patient experience surveys in measuring the quality of patient experiences sub-specialty practices has not been shown, and the risk adjustment in such survey is generally inadequate. Nevertheless, there is still significant value to partnering in the development and

dissemination of such measures as clinical specialty societies have the best insight into which patient outcomes and experiences may be influenced by which providers.

AAHKS already has a track record of partnering with CMS and other payers on the adoption for such measures. On August 31, 2015, AAHKS convened a Patient Reported Outcomes Summit for Total Joint Arthroplasty (the "Summit") with representatives from orthopaedic organizations (AAHKS, American Association of Orthopaedic Surgeons, The Hip Society, The Knee Society, and American Joint Replacement Registry), CMS, Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation ("Yale/CORE"), private payers and other stakeholders. The purpose of the Summit was to obtain a consensus regarding the patient reported outcomes and risk variables suitable for THA/TKA performance measures. The orthopaedic organization participants of the Summit offered joint recommendations to CMS as a part of the AAHKS response to the CMS Comprehensive Care for Joint Replacement ("CJR") proposed rule.

CMS accepted the joint recommendation of the Summit and modified the CJR to require hospitals to use only one of the patient reported general health questionnaires recommended by the Summit participants. CMS also explicitly noted the input from the Summit regarding new data validating shortened versions of voluntary patient reported outcomes data submission instruments in THA/TKA patients.

Therefore, we recommend CMS continue to partner with specialty societies to be informed on the latest developments in specialty-specific patient experience surveys and the need for proper risk adjustment.

V. Adequately Accounting for Risk Variation

The MDP acknowledges the need to adopt statistical risk adjustment models that account for differences in patient demographic and clinical characteristics that may affect the outcome but are unrelated to the quality of care provided. CMS plans to develop risk adjustment models to distinguish performance between providers rather than predict patient outcomes.

AAHKS Comment: We applaud CMS' recognition of the need for appropriate risk adjustment models. This may be the most important issue for AAHKS members. AAHKS members have historically been assessed on readmission, re-operations, cost, and length-of-stay, but these measures often inadequately account for the wide variation among patients and therefore lose their comparative value. Whatever measures are developed or adopted, or quality assessments are used, they must be risk-adjusted for factors such as health status, stage of disease, genetic factors, local demographics and socioeconomic factors. These factors represent real variations in patient need and the costs of care. Therefore, the MDP should make assessment and recommendation of appropriate risk adjustment methods a standard component of each measure's adoption under the MDP.

Development of risk adjustment methods must be done with close consideration of minimizing additional data collection steps for providers. Many important risk factors for adverse patient outcomes currently are either not measurable using available data (e.g., preoperative functional status) or are not consistently reported (e.g., obesity). We understand that incorporating such factors as comorbidities into risk prediction is an evolving science, therefore the MDP and MIPS implementation is an opportunity to significantly advance this field.

We recommend that in this process CMS consider the various methods available in addition to risk adjustment to account for meaningful patient variation. These include risk stratification and exclusion, often used for process measures. Under risk stratification, patients are divided into two or more groups according to their expected risk of the process or outcome of interest. For example, CMS's Nursing Home Compare system includes the "Percentage of High-Risk Long-Stay Residents Who Have Pressure Sores" and the "Percentage of Low-Risk Long-Stay Residents Who Have Pressure Sores" as separate measures. Occasionally, stratification is used to support numerator definitions of process measures that differ according to the patient's risk status. In this case, a broader time window for the process measure is allowed if the patient is classified as low risk.

Another approach is simply to exclude patients who do not qualify for the process of care in question, or for whom the process of care has not been shown to confer a clear benefit. For example, all of The Joint Commission's Core Measures of hospital quality for heart attack, heart failure, pneumonia, and surgical care have carefully defined denominators that exclude patients for whom the therapy in question is documented as medically necessary or appropriate.

***

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,

Michael J. Zarski, JD
Executive Director
AAHKS