AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for FY 2020; Changes to Part B Payment Policies; Medicare Shared Services Program; and Medicaid Promoting Interoperability 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 its Medicare physician fee schedule (PFS) proposed rule for fiscal year 2020 (hereinafter referred to as "FY 2020 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,000 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. 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 FY 2020 PFS proposed rule:

I. Identifying and Reviewing Potentially Misvalued Services Under the PFS – Sec. II.E.2

We suggest new criteria regarding transition to value-based care that should be routinely included in CMS's evaluation of public nomination of potentially misvalued codes and subsequent evaluation of recommendations from the AMA RVS Update Committee (RUC). Our suggestions here are informed by CMS's decision in 2018 to refer CPT codes 27447 and 27130 for review as

potentially misvalued codes following a public nomination.[1] Under the *established* process, CMS evaluates public nominations of potentially misvalued codes that include documentation of any of the following:

- Peer reviewed medical literature or other reliable data that demonstrate changes in physician work due to one or more of the following: Technique, knowledge and technology, patient population, site-of- service, length of hospital stay, and work time
- An anomalous relationship between the code being proposed for review and other codes
- Evidence that technology has changed physician work
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases
- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation
- Prices for certain high cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information. Analyses of work time, work RVU, or direct PE inputs using other data sources
- National surveys of work time and intensity from professional and management societies and organizations, such as hospital associations[2]

Following CMS evaluation, CMS then determines whether or not to refer the codes to the AMA RUC for its annual review process. The nomination and referral in 2018 of 27447 and 27130 (the CPT codes, respectively, for total knee arthroplasty (TKA) and total hip arthroplasty (THA)) illustrates a central and relevant characteristic of nominated codes that is not included in CMS's list of factors for evaluation: namely, *the degree to which performance of the procedure may be in transition due to it being thrust into value-based care*.

Misvalued code evaluations may be of limited accuracy or appropriateness for procedures in the midst of rapid and wide-ranging transition. Data reviewed by CMS and the AMA RUC capture only a cross-section moment in time and cannot predict the nature of how TJAs may be performed in five or even two years during this current transition. The following are some of the most high-profile policies that significantly alter the landscape in which TJA procedures are performed:

- TJA procedures were the first to be subjected to a mandatory bundled payment model, the Comprehensive Care for Joint Replacement Model (CJR)
- The CJR is about to undergo alteration through the proposed rule, *Comprehensive Care for Joint Replacement Model Three Year Extension and Modifications to Episode Definition and Pricing* (CMS-5529-P)
- TKA was made available for Medicare reimbursement in outpatient facilities beginning in 2018

[1] 83 FR 59502 (Nov. 13, 2018).
[2] See 84 FR 40516 (Aug. 14, 2019).

- CMS seems poised to make THA available for Medicare reimbursement in outpatient facilities beginning in 2020
- CMS seems poised to make TKA available for Medicare reimbursement in Ambulatory Surgery Centers (ASCs) beginning in 2020
- CMS proposes not accepting RUC-recommended valuation updates of global surgery periods
- CMS is proposing a new MIPS Value Pathways system for 2021

The national variation in site of care, admission status, services bundled, and gain-sharing incentives, calls into question to what degree current limited procedural data can be representative of the procedures in all settings. It would be more appropriate to defer misvalued code evaluation for TJA procedures until practice of the procedure can stabilize after several more years of experience with outpatient Medicare delivery and stable bundled payment models.

AAHKS recognizes CMS's goal of site-based payment neutrality in Medicare. Our members also have been at the forefront of the transition to value-based care. As practitioners of a high-volume, high-value procedure, we appreciate the potential benefit of value-based care to Medicare beneficiaries, providers, and the Medicare program itself. This involvement is most apparent in our involvement in the first mandatory bundled payment model as well as the Bundled Payments for Care Initiative (BPCI) Advanced models. In 2015, AAHKS even convened with CMS and others the *Patient Reported Outcomes (PROs) Summit for Total Joint Arthroplasty* that led to coordination on PROs that could be used in public and private bundled payment models.

Nevertheless, the combination of the Medicare program putting TJA procedures at the forefront of value-based and site-neutral care and simultaneously threatening a potential PFS reimbursement reduction for these procedures cannot help but create an impression among orthopaedic surgeons that their profession is under assault. In effect, the Medicare program is encouraging orthopaedic surgeons to take on more risk under alternative payment models, but simultaneously threatening to reduce overall reimbursement, leaving our members with more at risk for a smaller reimbursement.

When reviewing public nominations for misvalued codes and when evaluating AMA RUC recommendations regarding those nominations, CMS should take into account other factors impacting providers in question, such as overall status of the procedure transitioning to value-based care, and what other CMS-directed initiatives are changing practice patterns and demanding greater surgeon attention,focus, and time.

II. Office/Outpatient Evaluation and Management (E/M) Visit Coding and Documentation – Sec. II.P.3.a

In 2019 PFS proposed rule, CMS emphasized that coding, payment, and documentation requirements for E/M visits are overly burdensome and no longer aligned with the current

practice of medicine. To alleviate and mitigate the burden, CMS proposed changes for 2021; more specifically CMS proposed collapsing the office based and outpatient E/M payment rates, documentation requirements, and create new add-on codes to better capture the differential resources involved in furnishing certain types of E/M visits.

Now CMS is proposing to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA; we believe it would accomplish greater burden reduction than the policies it finalized last year and would be more intuitive and consistent with the current practice of medicine. Under the new policy, history and exam would no longer select the level of code selection for office/outpatient E/M visits. Rather, for levels 2 through 5 office/ outpatient E/M visits, the code level reported would be decided based on either the level of MDM (as redefined in the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to- face and non-face-to-face time).

AAHKS supports the proposed new documentation standards for office/outpatient E/M visits. We appreciate CMS allowing physicians to determine the level of service based on the total time personally spent by the reporting practitioner on the day of the visit or medical decision-making, which we believe is more representative of the complexity presented to a physician by our patient population. E/M visits would include a medically appropriate history and exam, when performed. This option resonates with the experience of many of our members who believe that the intensity of medical decision-making is the factor that most distinguishes one patient visit from another. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam would no longer apply, and these components would only be performed when and to the extent that they are medically necessary and clinically appropriate.

III. Office/Outpatient E/M Visit Revaluation – Sec. II.P.3.b

In April 2019, the RUC provided CMS with results of its review, and recommendations for work RVUs, practice expense inputs and physician time (number of minutes) for the revised office/outpatient E/M code set. This would include separate payment for five levels of office/outpatient E/M visit CPT codes as revised by the CPT Editorial Panel, resurveyed by the AMA RUC, with minor refinement, including deletion of CPT code 99201 (Level 1 new patient office/outpatient E/M visit) and adoption of the revised CPT code descriptors for CPT codes 99202-99215.

CMS notes that for some codes, the total of time associated with the three service periods (component) did not match the RUC recommended total time. CMS asks how it should address the discrepancies in times. AAHKS recommends that CMS use the RUC recommended total time in 2021 as it pertains to recommendations for work RVUs, practice expense inputs and physician time for the revised office/outpatient E/M code set. We suggest the use of the RUC recommended times because it preserves payment stability. Further, MedPAC already has expressed long-standing concerns the office/outpatient E/M services are undervalued because

values of these codes have remained unchanged. Adopting the RUC recommended times would ensure a consistent CMS position on reforming E/M codes to better reflect the way services are provided.

IV. Simplification, Consolidation and Reevaluation of HCPCS Codes GCG0X- – Sec. II.P.c

CMS believes that there are three types of office outpatient E/M visits that differ from the typical office/outpatient E/M service: (1) separately identifiable office/outpatient E/M visits furnished in conjunction with a global procedure, (2) primary care office/outpatient E/M visits for continuous patient care, and (3) certain types of specialist office outpatient E/M visits. Further, CMS states that some revalued office/outpatient E/M code sets still do not appropriately reflect these differences in resource costs.

As such, CMS proposes a new add-on code that consolidates the two add-on codes GCG0X (complexity inherent to non-procedural specialty care including hematology/oncology, urology, interventional pain management and etc.) and GPC1X (complexity inherent to primary medical care services that service as a focal point for all needed health care services) into one code.

AAHKS welcomes CMS efforts to acknowledge the resource costs associated with complex office/outpatient E/M visits. We support this proposed change because GPC1X does not prevent certain specialists from using the code when they experience additional resource costs due to complexities. The 2019 final rule codes only included a small subset of specialists. Furthermore, we support the RVU increase from 0.25 RVU at 8.25 minutes in the 2019 proposed rule to 0.33 RVU at 11 minutes in this proposed rule.

Generally, the reduction of coding and documentation burdens for physicians is a guiding principle for AAHKS and thus we support the use of one code instead of two. However, despite GPC1X encompassing more specialties and the simplification to one code instead of two, we believe CMS should proceed with caution. We do not support the simplification of E/M documentation now to be used in the future as justification to reduce reimbursement.

V. Valuation of CPT Code 99xxx (Prolonged Office/Outpatient E/M) - (Section II.P.d)

The RUC recommended a new CPT code to account for prolonged office/outpatient visits. CPT code 99xxx (*Prolonged office or other outpatient evaluation and management services beyond the total time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 mins*) The RUC recommended 15 minutes of physician time and a work RVU of 0.61. CMS is proposing to delete the HCPCS add-on code finalized last year and adopt this one.

We recommend CMS use the 2019 PFS final rule valuation for the prolonged office services code. AAHKS supports the creation of the prolonged services code. The creation of the prolonged services code acknowledges the additional time physicians may need to provide

patients with optimal care. In the 2019 final rule, CMS suggested a 30-minute prolonged services code with a work RVU of 1.17, which was equal to half of the work RVU assigned to CPT 99354.

Alternatively, the RUC recommended 15 minutes of physician time at a RVU of 0.61. We believe that CMS should use the 2019 final rule code valuation. First, the 2019 valuation encourages more time and communication with patients, which ultimately improve the quality of care. Second, the 2019 RVU valuation of 1.17 is not baseless. The 2019 final rule RVU is based on an existing CPT code 99354 and should be seriously considered as a valid RVU for the prolonged office services code.

VI. Global Surgical Packages – Sec. II.P.f

The AMA RUC also recommended adjusting the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. This included procedures with a 10- and 90-day global period within which post-operative visits are included in their valuation. CMS proposes to not apply the RUC-recommended changes to global codes, thus creating a discrepancy within E/M visit valuation between accepted RUC recommended levels and codes without RUC recommended levels.

In 2014, CMS proposed transforming all 10- and 90-day global surgery packages to 0-day global packages. In 2015 Congress legislatively blocked CMS from implementing this proposal and instead directed CMS to collect data on the number and level of post-operative visits to enable CMS to assess the accuracy of global surgical package valuation. CMS then collected data on pre- and post-operative services through claims and direct survey of 5,000 practitioners, stratified by specialty, geography, and practice type, with at least 311 (high volume utilizers) reporting practitioners from each specialty. CMS is only now releasing three reports prepared based on that data collection.

Since the inception of the PFS, each time that CMS increased payments for new and established office visits, CMS also increased the bundled payments for these post-operative visits in the global period. CMS is not transparent or explicit that it is changing that long-standing practice. By proposing to change the values for some E/M services, but not others, CMS would disrupt the required relativity across codes in PFS. CMS is statutorily prohibited from paying physicians differently for the same work, and the "Secretary may not vary the…number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."[3] Accepting the RUC recommended updates for some codes but not for the global codes amounts to paying some doctors less for providing the same E/M services.

It is true that Congress required CMS to survey the global codes, but that requirement and any CMS findings from its recent release of the three reports, does not obviate the need to maintain relativity across codes. CMS states that it "will give the public and stakeholders time to

[3] 42 U.S. Code §1395w-4(c)(6

study the reports we are making available along with this rule and consider an appropriate approach to revaluing global surgical procedures." CMS should give stakeholders time to evaluate these reports and approach to valuation. CMS should not preemptively devalue the global codes in the interim by failing to accept the RUC recommended values.

VII. Episode-Based Cost Performance Measures for the 2020 Performance Period - Sec. III.K.3.c.(2)(b)(iii)

Following work of a measure development contractor, which included the input of a Technical Expert Panel and a clinical subcommittee, CMS proposes to add 10 newly developed episode-based measures to the cost performance category for the 2020 performance period. Episode-based measures compare clinicians on the basis of the cost of the care clinically related to their initial treatment of a patient and provided during the episode's timeframe. The 10 newly developed cost performance measures include one procedural measure: **Elective Primary Hip Arthroplasty.**

AAHKS supports the development of Elective Primary Hip Arthroplasty as a procedural measure. We believe that the creation of the procedural measure provides our members the ability to collaborate with CMS to improve the quality of care while earning performance-based payments in MIPS. We suggest that CMS consider working with specialty societies such as AAHKS as it begins to implement this performance measure in 2020.

VIII. MIPS Value Pathways - Request for Information – Sec. III.K.3.a

CMS states an intention to move toward "a more streamlined MIPS program." To advance this goal for the 2021 MIPS performance period, CMS intends to reduce reported complexities with data submission, confusion surrounding measure selection, and lower barriers to APM participation through a new framework called MIPS Value Pathways (MVPs).

The most significant change under MVPs is that eventually all MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Rather, measures and activities in an MVP would be connected around a clinician specialty or condition and encompass a set of related measures and activities. CMS would no longer require the same number of measures or activities for all clinicians but focus on what is needed to best assess the quality and value of care within a particular specialty or condition. The unified set of measures and activities would be layered on top of a base of population health measures, which would be included in virtually all of the MVPs.

CMS discusses a very loose framework of what MIPS Value Pathways may be for 2021 and seeks public input on a number of questions. AAHKS's responses are included below.

a. MVP Definition, Development, Specification, Assignment, and Examples – Sec. III.K.3.a(3)(a)

CMS proposes four guiding principles to define MVPs:

- MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.
- MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.
- MVPs should include measures that encourage performance improvements in high priority areas.
- MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement

AAHKS recommends that several additional principles guide CMS in defining and developing MVPs. First, MVPs should move the Medicare program away from, not closer to, measurements of performance based on administrative data sets. Rather, MVPs should seek new ways to utilize existing registry data to the maximum extent possible.

Second, under measurements based on procedural data, CMS should incentivize more universal acceptance of specialty society accepted registries such as the Society of Thoracic Surgeons (STS National Database) and recognize their data collection.

Third, CMS should recognize that certain specialty societies do not recognize certain administrative data based MIPS performance measures as acceptable. We appreciate that CMS is attracted to measurement based on administrative data sets for measurement because they do not create a new burden on physicians of collecting and reporting. However, we believe that many administrative data sets are plagued by errors that impact their accuracy.

Fourth, CMS should recognize that physicians may be willing to undertake the burden of collecting and reporting quality data, if they have a role in developing the quality measures. This has been the case in the adoption of patient reported outcome measures (PROMs) specific to joint arthroplasty, the collection of which has been mandated through the CJR with a generally successful surgeon response

Fifth, physicians should have a choice in measurement/payment methodology. Physicians can be motivated to effectively embrace MVPs with new incentives for capturing PROM data and cost data.

Sixth, CMS should not feel rushed to implement MVPs in 2021. Rather, CMS should take the time necessary to implement MVPs correctly, to "get it right", so that there is not a need to reform MVPs in four years.

b. MVP Approach, Definition, Development, Specification, Assignment, and Examples – Sec. III.K.3.a(3)(a)(i)

How should CMS best engage stakeholders in the development of MVPs?

CMS should engage stakeholders by involving them in the earliest design of the key elements of a value-based payment system. Namely, physicians should be involved in determining which measures would be used under each MVP, and involved in the development of the measures in question. This is preferable to using contractors with limited stakeholder outreach that simply develop a measure that is then pushed into the field. Measure development within MVP should be a true partnership between CMS, its contractors, and the physician groups.

How would stakeholders like to be engaged in MVP development? What type of outreach would be the most effective in gathering the voice of the patient in the MVP concept and the selection of measures?

Physician stakeholders should be invited to participate in transparent processes to develop new measures from their earliest inception. We recommend the engagement methods used by Acumen to develop several episode cost measures. It is possible to identify physicians for participation who may share the perspective either of capturing the nuances of outcomes in quality measures or of considering patient interests in what is represented in each individual MVP.

For quality measures, should CMS initiate a ''Call for MVPs'' that aligns with policies developed for the Call for Measures and Measure Selection Process, or should CMS use an approach similar to the process used to solicit recommendations for new specialty measure sets and revisions to existing specialty measure sets?

CMS should establish the infrastructure to solicit through both approaches. In fact, there are practices, societies, and other stakeholders who have valuable input, but who have the sophistication to submit prepare input only through a Call for Measures-type process or specialty measure set input. Understanding the operational lift on CMS, the more democratized pathways for stakeholder input allowed, the more substantively informative input will be received.

Another important guiding principle is that CMS should decidedly reduce the barriers to measure development and make the alternative pathways to measure endorsement more robust. We appreciate the steps CMS has taken to initiate and expedite new measure development when a gap exists. This should be taken to the next level as the more CMS can ease the process of measure development, the more individual MVP measures will be able to reflect the quality of the underlying procedures.

How should MVPs be organized, for example, around specialties and areas of practice? Alternatively, should MVPs be organized to address a small number of public health priorities, for example, HIV care or healthcare-associated infections?

Either approach may be appropriate in different situations, so long as the included services are homogenous and there is a defined set of providers. For many specialties, it makes most sense to organize and MVP around a procedure or practice area. Some fields of primary care may be organized around disease states or chronic care population management.

How can CMS ensure the right number of MVPs that result in comparable and comprehensive information that is meaningful for the clinicians, patients, and the Medicare program? How should CMS limit the number of MVPs? Should each specialty have a single MVP?

CMS must solicit input from all professional societies and associations to learn what number of MVPs each believes is necessary to capture the different services within their fields. Regardless of the number of MVPs, each MVP must contain at least homogeneous procedures, a defined set of providers, a measureable financial impact on the Medicare program, and an ability to measure volume of procedures. It should not be presumed that every specialty will have an MVP.

How should CMS further Promoting Interoperability objectives, while linking the 4 categories within MVPs? How could CMS best promote the use of health IT and interoperability in practices not yet using electronic health records?

From the perspective of specialty societies, the current promoting interoperability financial incentives should be increased for successful interface with potentially universal specialty registries. This would make meaningful data collection more efficient and routine. A successful example is the STS registry mentioned above.

How can MVPs effectively reduce barriers to clinician movement into APMs, such as practice inexperience with cost measurement and lack of readiness to take on financial risk?

From the perspective of specialty societies, the final steps to participating in an Advanced APM will be more likely if CMS can lower the burden and financial barriers of interface with registry data and enable access to that data on a more routine basis. The degree to which both MVPs and Advanced APMs use common measures will also speed migration to the latter.

c. Selection of Measures and Activities for MVPs – Sec. III.K.3.a(3)(a)(ii)

What feedback can be shared on Table 34, providing an illustrative example of a Major Surgery MVP?

We accept the TKA cost measure under Major Surgery as effective. None of the other major surgery measures listed are adequately risk adjusted, and none have been tested in an arthroplasty procedure. CMS should recognize that current and proposed measures in arthroplasty are inadequately risk adjusted and have validation deficits.

Should MVPs include only required measures and activities, or a small list of quality measures and activities from which clinicians could choose what to report?

A required set of measures is more operationally feasible for both physicians and CMS, which will mean a greater likelihood of success. However, this approach is only valid if stakeholders are included as partners in measure development.

What criteria should be used for determining which measures and activities should be included in an MVP, such as prioritizing outcome, high priority and patient-reported measures; limiting the number of quality measures to 4, including only cost measures that align with quality measures, etc.? How should performance categories and associated measures and activities be linked (e.g., quality measures aligned with cost measures)?

Ideally, patient reported outcome measures should carry the greatest weight. Quality measures should continue to be included if they are adjusted to accept and align with the improved exclusion criteria. Procedure-specific cost measures are also valuable to include if they are appropriately risk adjusted.

CMS is interested in feedback on whether improvement activities should focus on improving the quality and cost measures within an MVP or be much broader including any improvement activities that are relevant to the practice.

The improvement activities should be focused on improving the collection of data and transmission to registries with QCDR functionality because such information is what makes the MVP quality and cost measures more effective.

For the quality measures, should clinicians and groups be required to use a certain collection type (eCQMs, MIPS Clinical Quality Measures [MIPS CQMs], CMS Web Interface, or QCDR measures) in order to have a comparable data set in the MVPs? What will clinicians' administrative burden be for changing to a new, specific collection type for a measure, for example, changing from MIPS CQM to an eCQM?

For some clinicians it will not increase because of current involvement with registry collection and the need for patient reported outcome measures within the CJR. If some physicians or specialties are not ready for a required specific measure collection method, that should not prevent CMS from advancing the quality of procedure specific measure data collection through specific collection methods for specialties with relatively more experience with registries.

Currently CMS has similar measures addressing the same clinical topic, with different collection types (for example, eCQMs, MIPS CQMs, QCDR measures, etc.) that have different specifications and separate benchmarks. What methodology could be used to develop a single benchmark when multiple collection types are used? Should CMS require a single collection type in order to ensure comparable measure data?

A single collection type would be ideal, specifically a required registry with QCDR. The STS National Database is the best example. However, as the cost of establishing such registries is prohibitive for many societies, CMS should provide funding or financial incentives for the development of needed registries in key practice areas.

Should QCDR measures be integrated into MVPs along with MIPS measures, or should they be limited to specific MVPs consisting of only QCDR measures? How should CMS continue to encourage clinicians to use QCDRs under MVPs?

CMS can encourage use of QCDRs by making use of the applicable associated registry mandatory for participation in the MVP.

Should improvement activities in MVPs be restricted to activities directly related to the clinical outcomes of the quality and cost measures in the MVP? Should attestation to participation in a specialty accreditation program satisfy the improvement activities performance category requirements for an MVP? Should this option be available for all MVPs or limited to specific MVPs, such as particular specialties for which accreditation programs are available? What criteria should CMS use to identify such programs?

Attestation to participation in a specialty accreditation program should be permitted to satisfy the improvement activities performance category requirements. For example, it would be acceptable to allow a surgeon to show recognition of his/her main hospital as a Joint Commission center of excellence for the surgeons practice area, such as arthroplasty, and have that apply.

d. MVP Assignment – Sec. III.K.3.a(3)(a)(iii)

How should CMS identify which MVP(s) are most appropriate for a clinician? Would it be based on the clinician specialty as identified in PECOS or the specialty reported on claims? If CMS assigns an MVP, how would CMS be able to verify the applicability of the assigned MVP?

There will not be one standard answer for this question. It will depend on different practice areas and specialties. Fortunately, identification will be relatively simple for some procedures. For arthroplasty, an average more than 50% of an arthroplasty specialist's overall billed CPTs are arthroplasty related. Identifying this through claims would pose the least burden to practitioners.

Should CMS provide clinicians and groups more than one applicable MVP and allow clinicians to select their MVP(s) from those identified? What tools would be helpful for clinicians to understand what MVP(s) might be applicable, for example NPI lookup, measure shopping cart, etc.?

For surgeons, the MVP should be limited to that part of the surgeon's practice that accounts for more than 50% of the billed procedures.

e. Transition to MVPs – Sec. III.K.3.a(3)(a)(iv)

What practice level operational considerations does CMS need to account for in the timeline for implementing MVPs?

The ramp-up and prep time necessary for a practice to be able to collect PROMs is comparable to the 12-18 month lead time hospitals and practices needed to ramp-up for mandatory participation in the CJR.

f. Adjusting MVPs for Different Practice Characteristics – Small and Rural Practices – Sec. III.K.3.a(3)(b)(i)

How should CMS structure the MVPs to provide flexibility for small and rural practices and reduce participation burden? What MVP related policies could best assist small and/or rural groups when submitting measures and activities? Should CMS have alternate measures and activities submission requirements for small and/or rural practices? For example, should small and/or rural practices be allowed to report fewer measures and activities within an MVP?

Separate, scaled-down versions of MVPs should be available for small/rural practices.

How can CMS mitigate challenges small and/or rural practices have in reporting? What types of technical assistance would be most helpful to help small and/or rural practices to have successful participation in MVPs?

CMS should implement the concept of "virtual" practice associations to create economies of scale, including the ability of a virtual group to participate in an Advanced APM.

g. Adjusting MVPs for Different Practice Characteristics – Multispecialty Practices – Sec. III.K.3.a(3)(b)(ii)

CMS is considering a requirement in future years that multiple specialty types within a group report relevant MVPs to provide more comprehensive information for patients. CMS seeks input on whether it can use the MVP approach as an alternative to sub-group reporting to more comprehensively capture the range of the items and services furnished by the group practice. For example, would it better for multispecialty groups to report and be scored on multiple MVPs to offer patients a more comprehensive picture of group practice performance or for

multispecialty groups to create sub-groups which would break the overall group into smaller units which would independently report MVPs? How should CMS balance the need for information for patients on clinicians within the multispecialty practice with the clinician burden of reporting?

CMS should use the same process that allows for removal of those participating within an Advanced APM to not count toward the MIPS score of the overall TIN.

What criteria should be used to identify which MVPs are applicable to multispecialty groups? For example, should it be based on the number or percentage of clinicians from the same specialty in the group? Should a group be able to identify which clinicians will report which MVP?

There should be an established minimum number of clinicians from the same specialty as a baseline for any group to report under an MVP.

Should a group be able to identify which clinicians will report which MVP?

A group should be able to identify, and patients should be able to learn, which clinicians report which MVPs.

Should there be a limit on the number of MVPs that could be reported by a multispecialty group?

No. Such a limit would be become an artificial barrier on the growth and evolution of practice within a group.

What mechanisms should be used to assess a group's specialty composition to determine which MVPs are applicable? For example, would groups need to submit identifying information to assure that measure MVPs aligned with the number or percent of clinicians of different specialties within a group? Is there information (such as specialty as identified in PECOS or the specialty reported on claims) CMS could leverage to ensure the appropriateness of MVPs for groups?

Keep the MVP process focused on key limited high cost/high volume procedures only.

h. Scoring MVP Performance – Sec. III.K.3.a(3)(d)

Should CMS align Shared Savings Program quality reporting requirements and quality scoring methodology with MIPS. As MIPS transitions to MVPs and addresses multispecialty practices, what MVP policies should be applied to MIPS APM participants?

The most important and valuable action to promote transition to Advanced APMs is to adopt aligned quality metrics between the AAPMs and related MVPs.

How should CMS score multispecialty groups reporting multiple MVPs? Should scores be consolidated for a single group score or scored separately (and with separate MIPS payment adjustments) for specialists within the group? Alternatively, should CMS have an aggregate score for the multispecialty group?

Scores should be scored separately for specialists within the group.

i. Clinician Data Feedback – Sec. III.K.3.a(5)

CMS would like to ultimately provide meaningful clinician feedback on administrative claims-based quality and cost measures. As clinicians and groups move towards joining APMs, is there particular data from quality and cost measures that would be helpful?

It would be most helpful to drive positive changes in practice habits of clinicians and groups were provided with details of both quality and cost measures with comparisons to regional and national performance.

Would it be useful to clinicians to have feedback based on an analysis of administrative claims data that includes outlier analysis or other types of actionable data feedback? What type of information about practice variation, such as the number of procedures performed compared to other clinicians within the same specialty or clinicians treating the same type of patients, would be most useful? What level of granularity (for example, individual clinician or group performance) would be appropriate?

Feedback based on analysis of administrative claims data to show outlier status would be useful. As CMS understands from its current work to prepare outlier reports on opioid prescribing, identifying outliers in a useful way is very difficult. Some of the same issues apply here, such as ensuring comparison account for differences in patient population, geographic area, and health care resources available in a region.

j. Enhanced Information for Patients – Patient Reported Measures – Sec. III.K.3.a(6)(a)

What patient experience/satisfaction measurement tools or approaches to capturing information would be appropriate for inclusion in MVPs? How could current commercial approaches for measuring the customer experience outside of the health care sector (for example, single measures of satisfaction or experience) be developed and incorporated into MVPs to capture patient experience and satisfaction information?

For arthroplasty, specialty societies have gone to great lengths to assess and endorse HOOS JR, KOOS JR, PASS score, and GCAHPS as most appropriate and valid.

What approaches should CMS take to get reliable performance information for patients using patient reported data, in particular at the individual clinician level? Given the current TIN

reporting structure, are there recommendations for ensuring clinician level specific information in MVPs? Should clinicians be incentivized to report patient experience measures at the individual clinician level to facilitate patients making informed decisions when selecting a clinician, and, if so, how?

Yes, primarily through incentives to use registry QCDR and allow interoperability and improvement scores to reflect improvements in capturing such data.

How should patient-reported measures be included in MVPs? How can the patient voice be better incorporated into public reporting under the MVP framework, in particular at the individual clinician level?

CMS should mirror the utilization of PROMs as already established in the CJR, wherein CMS has shown the ability to capture and data-warehouse such data.

k. Enhanced Information for Patients – Publicly reporting Performance Information – Sec. III.K.3.a(6)(b)

What considerations should be taken into account if CMS publicly reports a value indicator, as well as corresponding measures and activities included in the MVPs?

CMS should account for the adequacy of risk adjustment in the underlying measures, and if not modelled, reporting of socio-economic status risk burden.

If CMS develops a value indicator, what data elements should be included? For example, should all reported measures and activities be aggregated into the value indicator?

In terms of aggregations into a value indicator, CMS consider and utilize methodology similar to that being used by the Physician Compare website.

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

Sincerely,

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