AAHKS
AMERICAN ASSOCIATION OF
HIP AND KNEE SURGEONS

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ORTHOPAEDIC SURGEONS
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November 17, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 1753-P
Baltimore, Maryland -21244-1850

Submitted electronically to CMSOrthopedicsMeasures@yale.edu

RE: Project Title: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measures (PRO-PMs)

To Whom It Concerns,

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the development of a clinician-level and clinician group-level THA and TKA PRO-PM.

CMS seeks stakeholder feedback on the Project which has a goal to assess the quality of care provided to Medicare beneficiaries by clinicians and clinician groups performing elective primary THA and/or TKA procedures using patient-reported outcome (PRO) data.

Overall, AAHKS supports the re-specification of the Hospital THA/TKA PRO-PM as a clinician-level and clinician group-level measure for the Quality Payment Program but believes that it is premature to introduce this measure at this time. PROs are the best available means for a patient-centered measurement of functional status improvement, the ultimate objective of arthroplasty; however, AAHKS has the following concerns.

I. Whether it is preferable to report measures at the clinician-level or clinician group-level or both, and why?

   AAHKS supports reporting at both the clinician-level and clinician group-level. The opportunity to report as either a clinician or a clinician-group maximizes the opportunity for participation in the measure. However, the creation of sub-group reporting as a goal in 2026, as stated in the 2022 final PFS, will require new processes not currently in place.

II. Preferences for approaches to transmitting patient-reported outcome measure (PROM) data for this measure to CMS (e.g., via a clinical registry, third party vendor)

   AAHKS supports use of clinical registry submissions as a method for transmitting PROMs and believes that this is an opportunity to further encourage provider utilization of QCDRs, such as the American Joint Replacement Registry (AJRR) which is the registry primarily used for physician-level reporting for CJR, BPCI-A, and MIPS. PROM collection itself can be costly and time consuming and

participation in data submission through a third party vendor will result in additional costs to the clinician/clinician groups whose hospitals have chosen to not participate in a clinical registry. This presents a barrier to participation for those without infrastructure or hospital support for PROM collection and transmission. The same barrier exists for patients who are HOPD THA/TKA and those whose care is completed at an ASC.

III. Optimal minimum response rate for measure calculation and/or future reporting

The target for minimum response rate has no basis at this time. The CJR experience is not appropriate for determining collection rate targets given that there was significant incentive provided in terms of collection targets being met. Studies evaluating PROMs have demonstrated significant variation in response rate based on numerous demographic factors. Ideally data collection during voluntary collection with incentivization for high collection rates would precede final determination.

IV. Any additional input on the measure for future implementation planning

AAHKS supports clinician-level and clinician group-level PRO-PM for QPP, but believes that it is premature to introduce the measure at this time without having an appropriate benchmark for response rate. AAHKS recommends the initial implementation of the clinician-level and clinician group-level PRO-PM as a voluntary quality point rewarded structural measure to assess the viability of collection of PROMs by clinician and clinician groups which would then be used as a means of establishing the expected response rate. Stratified process targets starting at low levels would provide a minimum basis to establish the expected response rate and could be raised to find any potential ceiling.

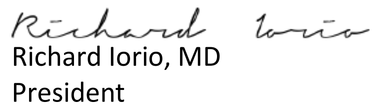
PROM collection and reporting is valuable and appropriate, but it is nevertheless an administrative burden on multiple parties that make a PROM capture rate of 60-70% a challenge. In particular, AAHKS is concerned for individual practitioners and small groups who will need additional time to develop policies and procedures to collect and report these data. Therefore, AAHKS recommends delaying inclusion of this measure in the QPP for 2 years to monitor and assess its use at the hospital level before expanding to the clinician level.

AAHKS welcomes the risk model developed for this measure but believes that ongoing evaluation of the risk factors in the model is required to ensure that the risk factors identified from CJR patients are appropriate when applied to the entire Medicare population. AAHKS has long favored the inclusion in risk adjustment of sociodemographic factors of patients. AAHKS recognizes that the statistics on the sample population of CJR patients did not demonstrate an influence on the PRO-PM, however, to mitigate even the perception of sociodemographic risk, AAHKS recommends stratification by proportions of dual-eligibility similar to what is now used by the CMS Readmission Reduction Program.

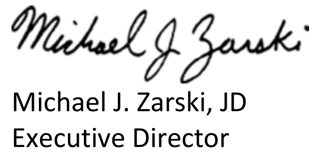
If and when CMS proposes to formally add this PRO-PM to QPP, AAHKS supports an incentive for the collection PROMs. The development of a new E/M code to support collection of PROMs would support clinicians and clinician groups to develop infrastructure for data collection and support participation in registries for data submission. Once a target response rate has been established, an incentive program providing additional Quality Points for high performers will encourage C/CGs to improve systems for collection and submission making the measure more meaningful as response rates improve.

AAHKS appreciates consideration of its comments. If you have any questions, please contact Michael Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

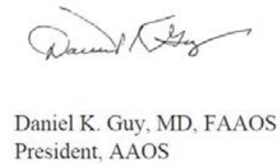
Sincerely,



Richard Iorio, MD
President



Michael J. Zarski, JD
Executive Director



Daniel K. Guy, MD, FAAOS
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