
August 17, 2023**VIA REGULATIONS.GOV FILING**

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5540-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information: Episode-Based Payment Model

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to offer input regarding the design of a future episode-based payment model. AAHKS is the foremost national specialty organization of more than 4,600 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.

I. AAHKS' Overarching Principles for Value-Based Care

Due to the high volume and high value of TJA, no other clinical specialty is as deeply involved in both mandatory and discretionary Medicare episode-based payment models. 50% of AAHKS members have participated in an alternative payment model (APM). AAHKS is guided by four principles:

- Payment reform is most effective when physician-led;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for the high-risk, and physician incentives must remain a focus.

Our comments on the RFI are as follows:

II. Care Delivery and Incentive Structure Alignment: If Model Participation Leads to Further Medicare Physician Reimbursement Reductions for TJA, Health Care Consolidation Will Accelerate – (Sec. A)

It is a challenging proposition for policy makers to ask that physicians carry the burden of Medicare expenditure reductions while hospital payments continue to increase, especially given the fact that the physician fee accounts for less than 6% of the overall episode of care cost.

Reduced reimbursement prevents surgeons from sustaining independent practices, which may lead to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care, particularly in rural and underserved areas. Reduced reimbursement for THA/TKA also leads to surgeons shifting their focus to other procedures and conditions for which they have trained, despite the accelerating need for joint replacement in the Medicare age eligible population.

While payments under the Inpatient Prospective Payment System (IPPS) and Physician Fee Schedule (PFS) may be calculated according to separate statutory formulas, CMS and Congress should be alarmed at the divergent trends in facility and surgeon reimbursement for arthroplasty. Medicare reimbursement to physicians for TJA has been cut 11% from 2020-2024. Over that same period, the Medicare payment to facilities for the same procedure has increased 10% for standard cases and increased 23% for those with major complications. Due to the lack of an MEI or other inflationary index in the PFS reimbursement to physicians for TJA, adjusted for inflation, has ben cut 57% in 30 years.

We have commented previously that CMS should explicitly state whether it believes Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for arthroplasty paired with severe cuts to the professional services for those procedures, and if so, why. In light of President Biden's *Executive Order on Promoting Competition in the American Economy*¹, CMS should evaluate whether its proposed reductions in Medicare physician rates promote competition in health care or facilitate consolidation.

Because of these concerns, AAHKS is optimistic for the future passage of H.R. 3284, the *Providers and Payers COMPETE Act of 2023*, which recently was reported out of the House Committee on Energy & Commerce by a vote of 49-0. HR 3284 would require the Secretary of the Department of Health and Human Services (HHS) to assess and report to Congress on the impact of any Medicare reimbursement or regulatory changes on consolidation of healthcare providers and payers. Such reporting is an important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates.

III. Clinical Episodes: A 30-day Episode May Diminish Incentives to Prevent Costly Adverse Effects in the 31-90 Day Timeframe – (Sec. B)

We agree with the factors that CMMI presents to be considered when deciding which clinical episodes a model can realistically test: Clinical homogeneity; Spending variability; Episode volume; Quality impacts; Episode overlap alignment. There is no question that TJA has been and remains an ideal procedure for episode-base payment models. We have concerns with the proposal of a 30-day episode for TJA, as that timeframe may not incentivize the best care for the patient or most efficient use of resources.

¹ EO 14036 (July 9, 2021).

For TJA patients who have not been provided appropriate preoperative management of underlying conditions, many of the complications and associated costs will arise in the 31-90 days window. This includes leg swelling, pain, and erythema that we find more likely 31-90 days after surgery and which often lead to costly ER admissions.

A surgeon who does not sufficiently manage the patient in the preoperative period may demonstrate savings in the 30-day timeframe but the adverse impacts and costs would arise after that point. Most TJA surgeons will still continue to perform the necessary preoperative patient management in the 30 days prior to surgery which lead to better short- and long-term patient outcomes, but a 30-day episode would remove an important incentive for surgeons who would not otherwise work to minimize adverse effects in the 31-90 day timeframe.

We hope CMMI in the future should offer a range of episode lengths for the same procedure in order to test the impact of episode duration on providers' ability to improve outcomes and efficiencies. We believe that, while they may not be appropriate for a national, mandatory model, longitudinal condition-based episodes should continue to be explored for conditions like osteoarthritis. Such longitudinal, chronic conditions may present a greater role for coordination with ACOs than a 30-day episode for TJA.

IV. Participants: Savings and Patient-Centered Decision Making are Maximized When the Physician Manages the Bundle – (Sec. C)

CMMI should replicate the participant model of BPCI-A to ensure robust availability of physicians leading as initiators and conveners. Episode payment models without physician leadership increase the risk of significant decisions being made based on factors other than patient care. There is a greater potential for savings and for patient-centered decision-making when the surgeon manages the bundle. In contrast, it has been the experience of many AAHKS members that not all facilities participating in the CJR have coordinated with surgeons on care planning and management or even on offering gain sharing.

There is a role for non-physician organizations to serve as conveners in situations where groups or physicians wish to direct the clinical coordination but that otherwise lack the size and economies of scale to bear risk or provide the necessary infrastructure. We believe the need for non-physician conveners decreases as CMMI makes more technical assistance, financial support, and risk bearing options available to physicians in the future, as discussed below.

We remind CMMI of AAHKS' long-standing position that participation in Medicare episode payment models should be voluntary. Mandatory models are imposed unequally on providers with different levels of experience and preparedness for them. We appreciate that CMMI is evaluating additions to model programs to ease integration for providers with little or no experience in value-based care. However, the best means to accommodate different types of providers under mandatory models may be a range of models, or at least a range of risk sharing options, to accommodate providers of different size or sophistication.

V. Health Equity: Experience with the CJR Demonstrates that a Strong Risk Adjustment Model is Necessary to Prevent Adverse Selection or a Two-tiered Healthcare System - (Sec. D)

AAHKS believes that adequate risk adjustment is the essential component to a successful APM. Without properly accounting for the clinical, cost, and quality variations among patients with different health and socioeconomic (SES) characteristics, incentives exist for a two-tiered health care system to emerge. Effective risk adjustment or stratification can significantly improve physicians' willingness to participate in models on what they see as fair ground. The prospect of being held accountable for factors not within their direct control is among the most demoralizing aspects of other value-based payment models.

We note that a CMMI evaluation released last year found that, because earlier studies show that “compared with White patients, Black and low-income patients are more likely to be discharged to post-acute care following surgery” [which is associated with increased odds of 30-day hospital readmission and higher spending], an “opportunity for bias” exists in CJR as “providers could make fewer offers of joint replacement surgery to Black and low-income individuals in an effort to keep spending below the CJR target price and generate savings under the model”. The evaluation found that beneficiaries receiving joint replacements at participating hospitals while the CJR program was in effect were less medically complex than those receiving joint replacements at those same hospitals before the CJR implementation began. Beneficiaries receiving joint replacements in the CJR were also less likely to be dually eligible for Medicaid and Medicare than those not in CJR. Revising the CJR risk-adjustment formula to include dual-eligibility status beginning in 2022 (as AAHKS long-advocated for) is a step towards addressing this concern.

Providers of all types have become more aware of the impact of SES on clinical outcomes. Health status, stage of disease, genetic factors, local demographic and SES factors significantly impact the quality and outcomes of surgeries performed. CMS has received numerous comments from AAHKS on risk adjusting for poverty and other SES factors. In such cases, it is preferable to account for dual eligible status as well as geographic location (zip code estimation of income and/or the AHRQ poverty index) across the relevant patient population. The dual eligibility status alone is overly narrow in the scope of what it may represent for a particular facility or jurisdiction. A patient's dual eligibility status is not necessarily a reflection of the economic status of a local population. Patients without dual eligibility status may still come from a severely economically depressed neighborhood. In short, adding geographic location to the assessed SES factors allows for measurement of the overall community effect, which helps to account for the unique nature of urban social topology. Supporting literature demonstrates that when poverty is controlled, race/ethnicity is less of an influence on cost or efficiency.

We acknowledge the concern expressed by some that the use of SES risk factors could lead to disparate levels of care for vulnerable populations. Nevertheless, the literature demonstrating the impact of SES 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.

Risk stratification designed by clinical experts for different procedures may prove most effective. On June 27, 2017, AAHKS presented to the CMMI Patient Care Models Group its detailed proposal for TJA risk stratification based on clinical risk factors. We are happy to continue work on these suggestions with CMMI.

VI. Quality Measurement and Multi-Payer Alignment: Close Coordination with Specialties is Needed to Identify the Least Burdensome Measures that Actually Assess Patient Outcomes – (Sec. E.)

Quality measurement should focus on meaningful measures for patient experience and outcomes. Historically, AAHKS members have been assessed on readmission, re-operations, cost and length-of-stay. Most importantly, whatever quality and cost assessments are used, they must be risk-adjusted or else the measures lose their comparative value. Factors such as health status, stage of disease, genetic factors, local demographic and SES factors significantly impact the quality and outcomes of surgeries performed. These factors must be reflected in quality assessments to accommodate real variations in patient need and the costs of care.

In our experience, the direct CMMI coordination with specialty societies offers the best chance to identify existing measures that assess real patient impact and that are not overly burdensome for providers and patients. For example, the AAHKS Quality and Patient Safety Summit convened in Baltimore on August 31, 2015 to bring together the American Association of Orthopaedic Surgeons, The Hip Society, The Knee Society and the American Joint Replacement Registry with CMS, Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation (Yale/CORE), private payors and other stakeholders. Summit attendees reached consensus regarding patient-reported outcomes and risk variables suitable for total hip and knee arthroplasty performance measures and have collaborated on a comment letter sent to CMS and issued the PRO Summit Report 2015. These consensus measures were used in the CJR and have since been adopted within other public and private models.

VII. Payment Methodology and Structure: Target Prices Must Recognize the Differences in Savings Potential for Providers Who are Already Efficient – (Sec. F)

It is important to note and be completely transparent about the role of episode payment models in driving down Medicare FFS provider payment rates. We offer a reminder of the developments around TJA RVUs since the institution of the CJR and BPCI models as the following scenario could be repeated again for specialties participating in CMMI models. In the previous case, a for-profit commercial insurance company manipulated CMS' public nomination process in 2018 for potentially misvalued codes to be reviewed by the AMA RUC. The insurer's intention was to ultimately drive down reimbursement to their contracted physicians who are paid a percentage of Medicare rates.

The subsequent AMA RUC evaluation of the TJA codes noted a reduction in physicians' post-operative time due to emerging efficiencies under value-based care arrangements but did not recognize corresponding increases in physicians' pre-operative time which is necessary to secure improved clinical outcomes for hip and knee replacement patients. Nevertheless, CMS chose to accept the RUC recommendations to reduce wRVUs in 2021, proving that participating providers are not merely at risk within a single model, but that they also face a long-term risk that the underlying rates will be reduced because of efficiencies achieved for patients and the Medicare program.

Such a reduction broadcast a strong, chilling message to all physicians participating in—or considering participating in—APMs: when providers in the vanguard of value-based care and bundled payments begin to achieve some efficiencies in the delivery of care, CMS will use those positive developments as a justification to cut fee-for-service reimbursement. In the future, CMMI should analyze this long-range impact when conducting economic analysis of new proposed models.

The recent Medicare FFS physician payment reductions attributable to the conversion factor, the TJA wRVU reductions above, and the potential for further rate reductions driven by episode model participations are all reasons why there is little or no capacity for providers to participate in models with benchmarks and performance targets that set unrealistic performance targets or reimburse providers below the true cost of care. BPCI-A provides little opportunity for a reduction in cost to offset a reduced Target Price for efficient providers who are challenged by the program's application of trend and efficiency factors that presumes their cost reduction can continue to decline at the same rate as non-efficient providers.

The many participants who were driven to exit the BPCI-A due to unrealistic targets is the latest example of this phenomenon. For example, as of 2019, 16% of BPCI-A participants from all specialties had withdrawn from the program.² The BPCI-A target pricing was particularly insufficient for groups participating in the Lower Extremity Joint Replacement program, where a withdrawal rate of 85% of participants was observed from 2019-2020.³ Our members observed a further 21% reduction in hip and femur replacement participation in that timeframe.

Models must be realistic for small practices as well as large systems. As noted in Health Affairs, "more studies are needed to increase our confidence that these models do not unintentionally lead to provider consolidation."⁴ Until that time, CMMI should offer smaller and less sophisticated practices increased levels of technical assistance to launch participation. Also, a system providing participants with limited risk as they build experience over several

² See *BPCI Advanced Down to 1,295 Providers as 252 Drop Out*, Healthcare Finance (Mar. 19, 2019); available at: <https://www.healthcarefinancenews.com/news/bpci-advanced-down-1295-providers-252-drop-out>

³ See *Medicare bundles for arthroplasty; A Journey Back to Fee for Service?*, Bone Joint J 2021;103-B(6 Supple A):119–125.

⁴ *Have Alternative Payment Models Led to Provider Consolidation?*, Fang He, Health Affairs, (April 28, 2023).

performance years, as is done in the ACO program, would ease more providers into episode payment models with a real chance to succeed.

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

Sincerely,



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