

June 13, 2017

**VIA E-MAIL FILING**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1677-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates**

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 hospital inpatient proposed payment systems (“IPPS”) proposed rule for fiscal year 2018 (hereinafter referred to as “FY 2018 IPPS proposed rule” or “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 anticipates continued close collaboration with the Administration and Congress to advance payment reform to best serve beneficiary access and outcomes. 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 2018 IPPS proposed rule:

I. **Hospital Readmissions Reduction Program: Provisions for the Proposed Payment Adjustment Methodology for FY 2019: Proposed Methodology for Calculating the Proportion of Dual Eligible Patients – Section V.I.8.b.**

CMS may group hospitals and apply a methodology that allows for separate comparisons of hospitals within groups in determining a hospital's adjustment factor for payments of discharges beginning in FY 2019. Furthermore, Congress requires CMS to define groups of hospitals, based on their overall proportion of dually eligible individuals. CMS proposes to define the proportion of full-benefit dual eligible beneficiaries as the proportion of dual eligible patients among all Medicare FFS and Medicare Advantage stays. CMS additionally considered defining the proportion of dual eligibles as the proportion among FFS stays only.

**AAHKS Comment:** AAHKS agrees with the proposal to define the proportion of dual eligible as those among both Medicare Advantage and FFS stays. Classifying a hospital's proportion of Medicare Advantage and FFS dual eligible stays more accurately identifies the social risk of the patients a particular hospital serves, compared to classification by FFS population only, which is the intent of the requirement. Furthermore, recognizing the dual eligible served by a hospital through Medicare Advantage is especially important as more and more U.S. jurisdictions are seeing a majority of their Medicare beneficiaries covered by Medicare Advantage. In such jurisdictions, FFS alone cannot be an accurate reflection of the Medicare beneficiary population, its needs, or its impact on regional facilities.

II. **Hospital Readmissions Reduction Program: Provisions for the Proposed Payment Adjustment Methodology for FY 2019: Proposed Methodology for Assigning Hospitals to Peer Groups – Section V.I.9.**

CMS may group hospitals and apply a methodology that allows for separate comparisons of hospitals within groups in determining a hospital's adjustment factor for payments of discharges beginning in FY 2019. CMS considered three alternative methodologies for assigning hospitals to peer groups (two, five, or ten peer groups). CMS's preferred approach is to stratify hospitals into quintiles (five peer groups). CMS seeks public comment on its quintile proposal and alternative considerations.

**AAHKS Comment:** We recommend that CMS use ten peer groups instead of five. As indicated by CMS, the use of ten peer groups is supported by more research, considering the earlier analysis by the Assistant Secretary for Planning and Evaluation ("ASPE") as well as the Medicare Payment Advisory Commission.

CMS notes that "as the number of groupings increase, hospitals became more similar within their peer groups with respect to proportion of dual eligible patients in their patient population. Hence, payment adjustments are more closely related to the proportion of dual eligibles, and to

the possible influence on the likelihood of readmission resulting from small variations in patient populations.”<sup>1</sup> This is correct and a reason in support of using ten peer groups. In the experience of AAHKS, the proportion of dual eligible is a significant predictor of hospital readmissions and recognition of this allows the Readmissions Reduction Program to be better risk-adjusted.

AAHKS takes this opportunity also to call for individual measures under the Readmissions Reduction Program to be risk-adjusted. Data on demographics and social risk factors reported by physicians, including dual status, could allow for risk adjustment of measures and facilitate better public reporting of patient status.

**III. Accounting for Social Risk Factors in Various Programs – Sections V.I.11; V.J.2; V.K.5; IX.A.1.d; IX.B.5; IX.C.2.b.**

CMS acknowledges that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (a.k.a. socioeconomic status (“SES”) factors or socio-demographic status (“SDS”) factors) play a major role in health. CMS further acknowledges its wish to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible. CMS is seeking comments on the best methods or combination of methods of risk adjustment, as well as which measures may be prioritized for risk adjustment.

**AAHKS Comment:** AAHKS believes that adequate risk adjustment is vital to appropriately incentivize providers and educate the public based on the quality of provider performance as opposed to the wide-variation in health status of different patient populations. The Readmissions Reduction Program, Quality Reporting Program, and others will not achieve their objectives to improve clinical care if providers are held accountable for factors not within their direct control.

We have reviewed the two main findings of the December 2016 ASPE report, “Social Risk Factors and Performance Under Medicare’s Value-based Purchasing Programs”:

- Beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they saw, and dual eligibility status was the most powerful predictor of poor outcomes among social risk factors
- Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix

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<sup>1</sup> 82 FR 19796, 19960 (Apr. 28, 2017).

Historically, AAHKS members have primarily been assessed on readmission, re-operations, cost, and length-of-stay. Whatever quality 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, health literacy, local demographic and socioeconomic factors significantly impact the quality and outcomes of surgeries performed by AAHKS members. These factors must be reflected in quality assessments to accommodate real variations in patient need and the costs of care.

One specific suggestion focuses on risk adjusting for a hospital for the SES factors of its patient population, such as poverty. 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 whole population of the hospital. The dual eligibility status is overly narrow in the scope of what it may represent for a particular hospital. 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 additionally look forward to the results of the NQF 2-year trial period in which certain new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for selected social risk factors is appropriate for these measures.

**IV. Refining the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166) Measure for the FY 2020 Payment Determination and Subsequent Years – Sec. IX.A.6.a.**

For the FY 2020 payment determination and subsequent years, CMS proposes to refine the existing HCAHPS Survey by refining the current Pain Management questions (HCAHPS Q12, Q13, and Q14) to focus on the hospital's communications with patients about the patient's pain during the hospital stay, rather than whether or not the patient considered themselves in pain.

**AAHKS Comment:** In the CY 2017 HOPPS proposed rule, AAHKS provided comments in support of CMS's proposal to remove the HCAHPS pain management dimension from scoring in the Hospital VBP Program for FY 2018 and to develop modified pain management questions for the HCAHPS Survey. We believe that pain management is an important dimension of the quality of care a patient receives, but that hospital payment incentives under the Hospital VBP Program should not be structured in such a manner to cause hospitals to change their opioid prescribing

patterns in order to achieve higher scores on the HCAHPS pain management dimension. This is particularly important in light of the present opioid crisis.

AAHKS principles for pain management questions in quality measurement programs are that questions should: (1) focus on communication with the patient regarding pain management rather than pain control, for example through the prescribing of opioids; (2) recognize that pain management takes a variety of forms and is not managed by medication alone; (3) focus on communication with patients about pain-related issues, setting expectations about pain, shared decision-making, and proper prescription practices; and (4) assess and address pain over an entire episode of care, rather than assessing the inpatient experience only. We believe CMS's proposed new questions for FY 2020 satisfy those principles and therefore we support this proposal.

#### **V. Request for Information on CMS Flexibilities and Efficiencies – Sec. XIII.C**

CMS seeks proposals for changes within its authority that can be made to reduce unnecessary burdens for clinicians, other providers, and patients and their families, throughout the Medicare program. Changes can include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences.

In all of our comments which follow, AAHKS is guided by its three principles for payment reform:

- Payment reform is most effective when physician-led
- The burden of excessive physician reporting on metrics detracts from care
- Patient access, especially for high-risk patients, and physician incentives must remain a focus

##### ***a. Limited Availability of Advanced Alternative Payment Models (“APMs”) Under the Quality Payment Program (“QPP”)***

There are numerous reasons why APMs may be a more appropriate choice for specialist surgeons than participation in the Merit-Based Incentive Payment System (“MIPS”), particularly due to the lack of orthopaedic-specific quality measures under MIPS. Unfortunately, very few Advanced APMs have been made available by CMS and few are appropriate for joint replacement surgeries. Some AAHKS members work in hospitals that are mandated to participate in the Comprehensive Care for Joint Replacement Model (“CJR”), which is not

presently an Advanced APM. should focus on making multiple models available so that providers may choose the one that best fits their practice and patients.

In July 2016, CMS issued a proposed rule on Episode Payment Models (“EPMs”) that would establish a path for CJR participation to qualify as Advanced APM participation. CMS also suggested that new Advanced APMs would be designed for 2018. CMS should make available a suite of options for joint replacement surgeons and other specialists to qualify as participating in Advanced APMs, including a specialist-managed episode bundle. CMS has delayed finalization of these changes twice since January 2017. We hope CMS will soon finalize changes to make these models qualify as Advanced APMs.

***b. Improvements to Existing Bundled Payment Models (CJR & BPCI)***

AAHKS is supportive of the existing proposed changes to the CJR, as well as anticipated re-release of the BPCI models as an Advanced APM. However, additional modifications are essential for the success of these models.

The lack of risk adjustment/stratification in the CJR penalizes the hospitals and surgeons that treat the sickest patients. Furthermore, as CJR shifts towards regional benchmarking, TJA practices that care disproportionately for medically complex patients will be in direct competition with those that treat a healthier patient base. Without incorporating risk adjustment, the CJR will create a reimbursement environment that increasingly incentivizes cherry-picking and lemon-dropping. At minimum, it would seem consistent and appropriate to use the exclusion criteria and risk adjustments already being used in the CMS hospital-level, risk-standardized payment measure that is capturing 90 day total joint costs for all hospitals.

AAHKS seeks continued CMS cooperation to create risk adjustment methodology that accounts for treating high risk patients based on the quality of care delivered. AAHKS will be sharing its proposal for an Advanced APM, including four possible risk stratification methodologies. We firmly believe that this is an important component of new payment models that will help to prevent potential barriers to access of care for high risk patients.

***c. Additional Quality Measure Risk Adjustment***

CMS should also ensure that appropriate risk adjustment is implemented into MIPS quality measures so that the shortcomings of CJR are not promulgated throughout MACRA’s QPP. There are improvements that also may be made to measures used in Hospital Quality Programs. For example, the Readmissions Reduction Measure for TJA (NQF #1551) remains un-validated. The measure borrows from a validation study performed on NQF #1550, which is self-refuting. Further, 1550 and 1551 are poorly risk adjusted as the C-statistics for each are only 0.65.

***d. Excessive Physician Reporting***

The administrative burden of reporting requirements under the Medicare program continues to increase, often overburdening physicians who are trying to focus on direct patient care. AAHKS is committed to improving outcome reporting to increase accuracy and utility, such that what is collected is useful to patients and decision makers, but doing so with a decrease in the administrative burdens on physicians. Through development of more accurate and simplified quality measures, including the effective use of endorsed registries such as the American Joint Replacement Registry (“AJRR”), this goal can be achieved.

***e. Opioid Addiction Crisis***

We are grateful for the recent attention of Secretary Price, CMS, and other agencies of the Department of Health & Human Services (“HHS”) to this addiction crisis. As prescribers of pain medications, AAHKS members are aware of the risks and difficult issues faced by treating prescribers. We note that more transparent and thorough coverage of TJA procedures, when medically necessary, by both Medicare and commercial insurers, would reduce the initial need to prescribe pain medication.

AAHKS members are working to reduce opioid use through effective care management. We believe there could be value in developing a MIPS quality measure for opioid-sparing approaches to managing pain. With the opioid crisis in mind, AAHKS intends to develop an opioid-sparing pain management quality measure applicable to total joint arthroplasty. Our overall goal is to develop or identify three processes, three structural and three outcomes measures for the physician to use at their discretion to satisfy various reporting requirements. We would request that these measures be reviewed and validated by appropriate entities within HHS after they are developed.

***f. New Measures for Value Under Hospital Quality Programs and Other Medicare Programs***

CMS earlier sought comment on the existing measures and methodologies which could be used to measure value. There is a limit to how existing Hospital VBP quality and efficiency measures are able to realistically reflect hospital “value,” particularly as some of those surgical procedure measures were never meant to reflect “value.” Therefore, AAHKS strongly urges that any new assessment of “value” under the VBP or any other Medicare payment program be based on new measures. The TJA procedures performed by AAHKS members perfectly illustrate this issue.

The VBP Clinical Care Domain includes NQF # 1550 (Hospital-level Risk Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty), assessing complications following admission for TJA. Complications may include:

acute myocardial infarction, pneumonia, or sepsis/septicemia within 7 days of admission; surgical site bleeding; pulmonary embolism or death within 30 days of admission; mechanical complications; periprosthetic joint infection; or wound infection within 90 days of admission. These factors are important measures of quality, but are far too narrow in scope to capture value of the underlying procedure. Value to the patient undergoing the procedure is measured by the patient with consideration of many more factors, including quality of life, duration of implant, and other issues beyond the 90-day timeframe of NQF # 1550.

Work is needed to develop meaningful measures that capture patient value of TJA procedures. We know that beyond cost-efficiency and short-term quality issues, our patients judge value on long-term quality of life issues such as ease of movement/discomfort, mobility, and the existence of any emerging deficiencies in the joint implant itself. AAHKS therefore recommends that CMS develop new specific measures of value through the measure development process that will eventually be incorporated into the Inpatient Quality Reporting (“IQR”) program and then the VBP program. We understand that it will be a “lengthy process” to develop new measures that appropriately reflect the value to the patient of a TJA procedure over the long-term. It would be expected to be a lengthy process if pursued correctly with input and guidance from specialty societies. We believe there is interest among measure developers to address this next level of TJA measures, drawing from patient-reported outcome measures, the AJRR, and other sources to capture the value to the patient of the full life of a joint implant. AAHKS already has demonstrated experience in partnering with CMS, other payers, and measure developers on the adoption of other consensus outcome measures.

AAHKS opposes using VBP’s existing scoring methodology to account for value based upon some combination of quality and efficiency scores. Existing VBP measures and scoring methodologies are of a limited scope and were not designed to create a quality/efficiency judgment of the value of a hospital’s performance on TJA procedures for patients and payers. An approach that is based only on cost-efficiency and short-term outcomes could incentivize the provision of care that unintentionally leads to longer-term negative outcomes: use of lower-cost/lower-quality implants; decreased length of stay; insufficient use of physical therapy or home health care. This is an issue for all TJA measures and many other measures of specific surgical procedures. Furthermore, it would be a disservice to beneficiaries if publicly available VBP measures of value only reflect the short-term risks to CMS, as a payer, of complications. Again, such measures are appropriate for quality, but are only a portion of the calculations of value to the beneficiary. VBP measures should not inappropriately steer beneficiaries between providers based on a misconception of value to CMS as the payer.

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AAHKS appreciates your consideration of our comments. You can reach me at [mzarski@aaahks.org](mailto:mzarski@aaahks.org), or you may contact Joshua Kerr at [jkerr@aaahks.org](mailto:jkerr@aaahks.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Mark I. Froimson". The signature is written in a cursive style with a long horizontal flourish at the end.

Mark I. Froimson, MD  
President

A handwritten signature in black ink, appearing to read "Michael J. Zarski". The signature is written in a cursive style with a long horizontal flourish at the end.

Michael J. Zarski, JD  
Executive Director  
AAHKS