January 4, 2019

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Public Comment on Hospital-Wide All-Cause Unplanned Readmission Measure and Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty under the Merit-Based Incentive Payment System

The American Association of Hip and Knee Surgeons ("AAHKS") appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") and the Yale New Haven Health Services Corporation - Center for Outcomes Research and Evaluation ("CORE") regarding the draft clinician quality measure for complications following elective primary total hip arthroplasty ("THA") and/or total knee arthroplasty ("TKA") (hereafter "THA/TKA complication measure").

AAHKS is the foremost national specialty organization of more than 4,000 members 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:

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

AAHKS endorses these measures. Our specific comments are as follows:

I.   The physician-specific recognition of complications measures for elective primary THA/TKA

In conjunction with CMS, CORE conducted a re-specification of the hospital THA/TKA complication and readmission measures for use in MIPS. CORE seeks to develop an Eligible Clinician ("EC") or EC group level outcome measure that reflects quality of care for patients undergoing elective primary THA/TKA. The measures' outcomes are any unplanned readmission

or one of the specified medical or surgical complications occurring during the index admission or during a readmission except death, which can occur anywhere as long as it is within 30 days of the state of the index admission. The measure is risk-adjusted and patient outcomes are attributed to the clinician who billed for the procedure. EC groups and EC are defined as unique combinations of National Provider Identifier ("NPI") or Tax Identification Numbers or ("TIN").

We support CMS' efforts to develop an eligible clinician-level and/or eligible clinician group-level outcome measure that reflects the quality of care for patients undergoing elective THA/TKA procedures. CMS partnership with CORE is a positive step towards accurately evaluate the quality of care provided by MIPS eligible clinicians or clinician groups.

AAHKS has long advocated for the development of risk-adjusted physician and group-specific measures for elective THA/TKA procedures. Such THA/TKA readmission and complication measures are a significant improvement over the prior hospital-specific THA/TKA outcome measures and will do much to advance clinician engagement in value-based care. AAHKS has also long advocated for all quality measures to be risk-adjusted, including risk adjustment for socioeconomic status ("SES"). We appreciate that CORE tested SES factors for inclusion and left such factors out of the measure adjustment only after determining that, in this case, the SES factors did not add any new value and were likely otherwise represented by clinical factors. Further, we also appreciate that the analysis showed that the performance of providers is not significantly influenced by the performance of their hospital.

II.   Response to specific questions

1. *"Does the measure identify the appropriate EC or EC group responsible for complications following elective primary THA/TKA procedures?"*

The measure attributes the outcome for each patient to the single clinician who files the Medicare physician claim for the THA/TKA procedure during the initial admission. When patients have multiple claims for a single THA/TKA procedure, an algorithm is used to identify the appropriate EC for attribution. For instance, if there are multiple physician submitting the Medicare claim for the THA/TKA, the algorithm will exclude, for purposes of quality measure attribution, any physicians who were assistants-at-surgery or who are not orthopaedic surgeons. In the absence of an identifiable billing surgeon, the measure will default to the Operator as listed on the hospital claim. We believe this is a reasonable and thorough algorithm to identify the surgeon most likely to be mainly responsible for the THA/TKA.

We believe the measure as designed will accurately identify the appropriate EC or EC group responsible for complications following elective THA/TKAs. Under the measure as developed by CORE, ECs are identified as unique combinations of NPI and TIN. Patients are attributed to a unique NPI/TIN combination and a single clinician may receive more than one measurement if they submit claims under two or more TINs for different groups.

CORE refers to groups of clinicians with the same TIN as MIPS EC groups. While the use of TIN as a group identifier means that MIPS EC groups will only approximately align with actual practice groups, we believe this is the most accurate means technically available to identify and measure physician groups.

2. ***"What, if any, additional validity testing would be meaningful for this measure?"***

We do not believe additional validity testing is necessary at this point. CORE seems to have taken appropriate steps to test and evaluate various aspects of the measure, as informed by practicing clinical experts.

Take, for example, the c-statistic (aka concordance statistic, the indicator of the measure's ability to correctly classify those patients who have had a complication). CORE found the measures performed with a c-statistic of 0.65. Potential c-statistic values range from 0.50, meaning no better than random chance, to 1.0, an indication of perfect prediction.

While 0.65 is not ideal and can be improved upon, we believe that 0.65 represents the likely highest level of accuracy possible to achieve with available administrative claims data. The 0.65 is certainly an improvement over the 0.60 score when the measure was initially developed. So we thank CORE for its work to improve the c-statistic.

Further, regarding the accuracy of measurement of clinicians for outcomes within their control, there have been some initial concerns over the possibility that high-performing surgeons could be dragged down by poorly-performing hospitals, and vice versa. However, we understand that this was evaluated and only affected a few surgeons either way, so we deem the risk not significant.

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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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