

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201

Submitted electronically via Regulations.gov

SUBJECT: Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)

Dear Ms. Verma,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on CMS' proposal to cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model, as well as revise certain aspects of the active bundled payment model, Comprehensive Care for Joint Replacement (CJR).

Background

The CJR model, which is currently in its second performance year, is a mandatory bundled payment program designed to pay providers a single payment for an episode of care for a hip or knee replacement. The CJR regulations require that hospitals in 67 randomly selected metropolitan statistical areas (MSAs). In general, participation in the CJR model runs until January 1, 2021.

The EPMs were designed around three clinical conditions for which CMS believes hospitals have a significant opportunity to redesign care, improve quality and control costs:

- 1) Acute Myocardial Infarction (AMI) Model;
- 2) Coronary Artery Bypass Graft (CABG) Model; and
- 3) Surgical Hip and Femur Fracture Treatment (SHFFT) Model.

Unlike predominately elective lower extremity joint replacement procedures covered by the CJR Model, most AMI, CABG and SHFFT hospitalizations are non-elective and tend to include patients with multiple chronic conditions that contribute to illness. Additionally, these episodes historically have significant variation in spending. The EPMs were scheduled to launch on January 1, 2018, and end on December 31, 2021. Participation in EPMs was mandatory for hospitals located in select MSAs. The AMI and CABG models were originally mandated in 98 MSAs, comprising approximately 1,120 hospitals. The

SHFFT model would be implemented in the 67 CJR MSAs, including approximately 860 hospitals.

The CR Incentive Payment Model was also scheduled to begin on January 1, 2018, and end on December 31, 2021. As designed, the CR Incentive Payment Model was initially mandated in 90 MSAs, 45 of which would also be AMI and CABG EPM MSAs. Providers in these 90 MSAs would have received \$25 per CR service for the first 11 services and \$175 per service thereafter.

Over the last year, CMS has delayed implementation of the EPMs and made amendments to the existing mandatory model. Now, CMS is proposing to cancel the EPMs and CR Incentive Payment Model completely. While CMS considered alterations to the design of these models, CMS ultimately did not believe providers would be afforded enough time to prepare for such changes, given the planned January 1, 2018, start date. CMS further proposes changes to CJR by prospectively making participation voluntary for hospitals in approximately half of the geographic areas selected for participation, reducing the number of mandatory regions from 67 to 34 nationally. Also, CMS is proposing several technical refinements and clarifications for certain CJR model payment, reconciliation, and quality provisions, and a change to the criteria for the Affiliated Practitioner List to broaden the CJR Advanced Alternative Payment Model (APM) track to include additional eligible clinicians.

Mandatory Participation

The AANS and CNS very much appreciate and support CMS' proposal to cancel the EPM initiative and to scale back the CJR initiative. However, we request that CMS make participation in the CJR completely voluntary for all providers. Echoing concerns raised in the past, the AANS and CNS strongly oppose compulsory participation in alternative payment models. It is critical that CMS maintain voluntary participation models that allow hospitals and surgeons to tailor bundled and other innovative payment reforms to their specific patient populations, practice settings, administrative capabilities and resources. This is especially important as physicians transition to a new Medicare payment system in which substantial annual Medicare updates may be tied to participation in these models.

As we have noted in the past, mandatory models unfairly target providers who might not have participated in the Bundled Payments for Care Improvement (BPCI) initiative or tested other bundled payments to date for legitimate reasons. These providers, many of whom are smaller hospitals or systems, face real challenges, such as a lack of resources to better coordinate care (including a lack of access to interoperable EHRs), insufficient patient volumes, and/or a lack of negotiating power in their community. These challenges will not be resolved, and will only be exacerbated, by forcing providers in different settings and with varying resources into the same box. What these providers need most is more flexibility, better support and guidance, and stronger incentives — not a restrictive mandate.

The AANS and CNS agree with CMS that these proposed cancellations and changes will give the agency more flexibility to design and test other episode-based payment models, while still being allowed to test and evaluate the impact of the CJR model on enhancing the quality of care while reducing costs.

We also appreciate efforts by CMS to ensure that more clinicians participating in the CJR model will be considered eligible for the Advanced APM Qualifying Participant track of the Quality Payment Program (QPP), and thus exempt from MIPS. This is important because very few specialists are currently eligible for the APM track of the CJR due to a lack of relevant models. Furthermore, by making more participants of this model eligible for the QPP's APM track, CMS will be creating an incentive for voluntary participation in this model that can help neutralize the impact of it no longer being mandatory.

The Role of the Physician

As we have also mentioned in the past, no bundled payment model can achieve success without hospital/physician alignment. While the hospital might be in the best position to manage certain aspects

of a bundled payment model, physicians play an integral role in efforts to redesign care delivery in a way that can yield efficiencies, while protecting the needs of the patient. For acute care models, in particular, physicians make the critical decisions that can result in the success (or failure) of a bundle.

Under the CJR, hospitals would continue to be exclusively responsible for the bundled-payment program and would control any financial surpluses. Although CMS anticipates that hospitals will seek to enter into financial arrangements with providers and suppliers caring for patients in the episode, there is no explicit language that addresses the role of the physician in this model. This is problematic for multiple reasons. For one, it gives hospitals unfettered authority to restrict services and other care decisions made by physicians to mitigate risk under the CJR model. We question what protections CMS would offer to maintain a physician's freedom to determine the best course of treatment or medical services for each patient. Also, what is the incentive for a physician to demonstrate superior efficiencies if all of the incentives go directly to the hospital? In acute care episodes, in particular, physicians bear a significant portion of the risk and typically have the most insight into the best pathways for improving patient care quality and efficiency.

Once again, the AANS and CNS urge CMS to adopt a mechanism to ensure that clinically relevant physicians play a leading role in these models. This could be accomplished by ensuring that they are integrated into the leadership and/or governance that oversees efforts to redesign care such that the most clinically appropriate care is not sacrificed to achieve cost savings. These models also should preserve the opportunity for physicians to control the bundle in terms of directing the care and receiving and/or distributing payments if they so choose. It is critical that physicians and other relevant clinical experts have a leading role in defining episodes, appropriate risk adjustment and attribution methodologies, and fair mechanisms for distributing payments under bundled models. Physicians must not be divorced from opportunities to contribute thoughtfully to decisions that could contribute to better care under these models.

The CJR model also incentivizes hospitals to acquire post-acute care facilities and surgery practices, while precluding independent practices from performing surgeries at the hospital. **We question how CMS plans to guard against hospital-driven vertical integration or other forms of market consolidation that could lead to higher costs and limit physician autonomy and patient access to care. Similarly, we urge CMS to adopt a policy that prohibits hospitals from coercing physician participation in the CJR or any other hospital-directed model.** For example, hospitals should not be allowed to use provider restrictions or provider credentialing to limit the ability of physicians to perform services covered by this model if they are not willing to sign a participation agreement with the hospital. These protections are needed to preserve physician autonomy, but more importantly, to ensure that Medicare beneficiaries maintain a choice of provider.

Regarding gainsharing, CMS finalized its decision to cap gainsharing payments for a calendar year paid to a physician who is a CJR Collaborator at 50 percent of the total Medicare-approved amounts for services furnished by that physician. In its latest rule, CMS seeks comment on these gainsharing caps and other limitations put in place to ensure program integrity, including any alternative gainsharing caps that CMS should apply to physicians and other practitioners and groups. **The AANS and CNS continue to believe that the gainsharing cap is arbitrary and may not reflect the efforts that the physician undertook to meet required quality metrics and reduce total payments.** Rather than setting this arbitrary limit, CMS should allow the providers to determine the distribution — provided, however, that the physicians have equal input into this distribution methodology.

The AANS and CNS also continue to have concerns about what we have interpreted as CMS' decision to restrict gainsharing payments made to a CJR Collaborator that is a physician group to only practitioners who furnish a service to a CJR beneficiary during an episode of care. If we are interpreting this policy correctly, **we reiterate our opposition to this restriction on the distribution of gainsharing**

payments, which we do not believe is necessary to prevent program abuse. We instead urge CMS to grant physician group practices the ability to determine the most appropriate method of distributing gainsharing payments. If our interpretation of this policy is inaccurate, then we request that CMS provide clarification.

Again, the AANS and CNS much appreciate that the agency is proposing to scale back these mandatory payment models, for its decision to instead pursue additional voluntary bundled payment opportunities over the short term, and for its effort to expand opportunities for specialists to participate in Advanced APMs and qualify as qualified providers under the QPP.

As the CJR and other bundled payment models evolve, it is critically important that CMS continue to engage clinical experts and that the models themselves preserve a role for physician leadership in regards to the model design and distribution of payments. It is also critically important that these models enable teams of providers to redesign care in ways that reduce avoidable spending while ensuring that patients who need individualized care are still able to receive it. The AANS and CNS look forward to working with CMS to refine and test alternative payment models going forward.

Sincerely,



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