AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Letter of Intent – American Association of Hip and Knee Surgeons

Dear Committee Members,

On behalf of the American Association of Hip and Knee Surgeons (AAHKS), I would like to express intent to submit a Physician-Focused Payment Model for review by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in 2017.

Payment Model Overview

AAHKS proposes a model to provide episode payments for total joint arthroplasty (TJA) and associated services under a physician-initiated bundle. The episode parameters will mirror the CJR and BPCI Model 2. Payment for the bundle will be similar to the CJR but will also test four additional risk stratification options. The model is intended to satisfy the requirements of an advanced alternative payment model (APM).

This would be a five-year demonstration project. This episode of care would mimic the Model 2 BPCI and CJR program. The episode would start with admission to the hospital and would continue for 90 days after admission. All accrued costs associated with the episode would be added to the bundled episode. CMS would take a 2% discount from a 2-year historical average to determine target price in the first 2 years, MSA geographic average pricing would be used in years 3, 4 and 5. For clinically integrated network programs, if a historical target cannot be fairly determined due to disparity, geographic pricing can be used for year 1 and 2 or an average of all the constituents of the virtual group minus the 2% discount.

Goals of the Model

The purpose of this model is to reduce health care spending for TJA without compromising clinical quality or patient outcomes. In such respects the model shares the goals of the CJR but is also designed to be available to assist underserved TJA surgeons with meeting the three aims of an advanced APM. This advanced APM would allow third party conveners and episode initiators to help under-capitalized hospitals and surgeons to participate in the model. Additionally, AAHKS hopes to expand the scope of value based care by bringing the opportunity to participate in advanced APMs to additional regions and settings not served by current CMS offerings. The risk stratification options should eliminate barriers to access of care for high risk patients (lemon dropping) and dissuade choosing only the best risk profile patients (cherry-picking), predictable, unintended consequences under the current APMs.

Expected Participants

Many of the areas not served by APMs convened by CMS are more rural, with lower population density and fewer providers per capita. The hospitals are usually smaller than their counterparts in current APM MSAs, and as a consequence usually lack the resources to develop techniques to manage the bundle. These regions also have higher costs for TJA. Providers who practice in these areas are currently not able to participate in an APM. Specialists, like adult reconstruction orthopaedic surgeons, are currently limited to participating in MIPS, and may have little incentive or training in techniques to increase quality and decrease cost while delivering TJA. We would aim to start with engaging physicians in West Virginia, Georgia, Nevada, Montana and Mississippi.

Implementation Strategy

AAHKS will form an independent entity, Arthroplasty Bundle Management (ABM) LLC, which will partner with conveners and episode initiators to assist orthopaedic surgeons. ABM will require quality and patient reported outcomes (PROMs) reporting through the American Joint Replacement Registry, Electronic Medical Record participation, patient satisfaction reporting specifically geared toward TJR (as opposed to the CJR program requirements of hospital-wide HCAPHS reporting), and limited physician financial risk with or without the hospital either through episode initiation or a quality/financial metric to be determined. In addition, ABM would collect data to allow appropriate risk adjustment measurement. ABM would develop 3 categories of patient cohorts (low risk pool, intermediate risk pool, and high risk pool) based on the severity of comorbidities. Under the model, CMS or commercial payers would provide additional payments for Intermediate and High Risk cohorts in order to protect access for these patients and avoid highly selective patient selection and patient class avoidance cherry picking or lemon dropping.

AAHKS will partner with ABM to develop techniques to educate its members on techniques of improving quality, decreasing cost, and managing risk. ABM would create divisions to convene the bundle, manage the bundle, and manage downside risk. ABM would help providers negotiate with participating hospitals to achieve goals of decreased cost and improved quality. ABM will serve as a convener for underserved physician and patient populations with insufficient volume under the current APMs. ABM will work with the physician and hospital groups to provide financial and quality analytic data to allow for successful implementation of the AAPM.

Timeline

AAHKS expects to submit the proposal in the late spring of 2017 for implementation by spring 2018.

Sincerely,

Mark I. Froimson, MD
President

CC: William A. Jiranek, MD, Immediate Past President
Richard Iorio, MD, Co-Chair, AAPM Task Force
Adolph P. Yates, MD, Co-Chair, AAPM Task Force
Michael J. Zarski, JD, Executive Director