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September 8, 2015, electronic submission via http://www.regulations.gov [Docket ID: CMS-2015-0082]

Mr. Andrew M. Slavitt, MBA
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule [File Code CMS-5516-P]

Dear Acting Administrator Slavitt:

On behalf of the membership of the American Orthopaedic Foot & Ankle Society (AOFAS), we appreciate the opportunity to offer comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed rule on the payment model for comprehensive care for joint replacement (CCJR). The AOFAS represents 2,200 orthopaedic surgeons specializing in the surgical and non-surgical treatment of diseases and deformities of the foot and ankle.

The AOFAS supports the agency's efforts to develop appropriately structured alternative payment models available to physicians and other providers. We are concerned, however, about unintended consequences that implementation of the CCJR payment model as currently proposed could have on Medicare patients and physicians. We ask CME to strongly consider significant changes to the proposed model.

- **Exclude Inappropriate Conditions from the Program: Total Ankle Arthroplasty and Reattachment Procedures of the Lower Leg, Ankle, and Foot** – CMS proposes to include all lower extremity joint arthroplasty procedures within DRGs 469 and 470. Two of the three quality measures for reconciliation payment are specific to total hip arthroplasty (THA) and total knee arthroplasty (TKA), and it would not be appropriate to apply them to total ankle arthroplasty (TAA).

  TAA has a very different cost structure than THA and TKA. TAA has a more fragile soft tissue envelope than THA and TKA and more often requires additional concurrent procedures to balance the ankle ligaments and properly align the foot under the ankle. TAA implants cost on average more than THA and TKA implants. Patients who undergo ankle procedures have a much longer non-weight bearing period, which impacts their post-operative mobility and the post-acute care they need. Further, while bundled payments for THA and TKA have been explored through CMS programs, including the Acute Care Episode and Bundled Payments for Care Improvements as well as commercial bundled demonstrations, there has been no similar experience with TAA.

  The AOFAS recommends that CMS revise the conditions included in the program and specifically exclude all ankle arthroplasty procedures. The AOFAS also believes that reattachment procedures of the lower leg, ankle, and foot have significantly different cost structures than THA and TKA and should also be excluded from the program.

- **Incorporate Risk Adjustment Factors into the Payment Plan** – While CMS proposes to base adjustments for quality on current Inpatient Prospective Payment System (IPPS) quality measures and future outcome measures for DRGs 469 and 470, these measures are not risk adjusted. Post-acute care can vary tremendously for patients with chronic illnesses and those with other functional or cognitive limitations who undergo TAA. The AOFAS believes that risk adjustment needs to be included in any payment plan.

- **Align Incentives and Risk for Physician Care Providers** – Unlike the currently voluntary Bundle Payment Care Initiative (BCPI) in which a number of physician practices participate and in which physicians receive incentives and bear risk, in the CCJR-proposed model hospitals will receive most of the incentives and bear most of the risk. The AOFAS requests that risk and incentives be aligned so that physicians, who order the care patients undergoing TAA receive, have an appropriate share in the risks and incentives.

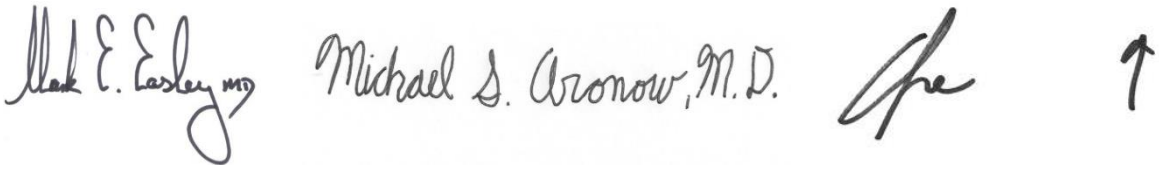
- **Use a Voluntary Participation Model to Better Reward Innovation and Encourage High Quality Patient Care** – The proposed payment model mandates participation by all surgeons, providers, facilities and other parties within the 75 designated Metropolitan Statistical Areas (MSAs). This will disadvantage surgeons, providers and facilities that lack the infrastructure to optimize patient care for TAA under the payment models. The AOFAS requests that CMS revise the mandate for participation and instead implement a voluntary participation program that would reward innovation and high quality patient care.

- **Payment Models that Reflect New Technology Costs Will Encourage Patient Care Advances and Procedure-Specific Best Practices in Post-Acute Care** – As detailed above, TAA is a new and evolving technology with higher costs than hip and knee replacement devices and very different post-acute. Including TAA in the proposed payment model with THA and TKA could disadvantage patients by leading to unintended consequences such as hospital pressure on physicians to avoid advances that keep patients mobile and improve their quality of life or operate on higher risk patients.

- **Delay Proposed Payment Implementation to Enable Provider Readiness** – The proposed model calls for immediate and full implementation of the proposed payment model as of January 1, 2016. We believe the 60-day transition time between the deadline for comments and the implementation date is insufficient to appropriately implement and transition to this model and recommend that implementation be delayed to allow for infrastructure readiness.

Thank you for the opportunity to provide comments to the CMS on the bundled payment model. We look forward to working with the agency on refinements to the program and on improving care for patients with musculoskeletal diseases and deformities of the foot and ankle. If you have questions or comments, please contact Lousanne Lofgren, CAE, Executive Director, at zlofgren@aofas.org, 847-430-5077.

Sincerely,



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cc: Lousanne Lofgren, CAE
Executive Director