AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 5529-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Comprehensive Care for Joint Replacement (CJR) Model Three-Year Extension and Changes to Episode Definition and Pricing

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 proposed rule to extend the Comprehensive Care Joint Replacement ("CJR") Model Three Year Extension and Changes to Episode Definition and Pricing ("Proposed Rule").

AAHKS is the foremost national specialty organization of more than 4,000 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 is guided by 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 on the CJR Extension Proposed Rule are summarized as follows:

- AAHKS welcomes the addition of outpatient TJA to the CJR but this highlights the need for better guidance from CMS on the application of the 2-midnight rule to TJA
- The proposed blended rate for MS–DRG 470 (without hip fracture and outpatient TKA & THA without hip fracture) may encourage more use of the outpatient setting than is clinically appropriate
- The high episode spending cap should be set at 90%
- AAHKS welcomes the expanded risk adjustment methodology with some questions and suggestions

- The three-year extension is welcome but CJR participation should be voluntary
- AAHKS welcomes the removal of the gainsharing cap
- AAHKS is developing proposals for a site-neutral TJA bundled payment model encompassing ASCs *and* hospitals
- Adding new DRGs 521 and 522 to the CJR would preserve the volume of TJA procedures that are subject to value-based care incentives

I. Changes to Episode Definition to Include OP THA/TKA (Sec. II.A.2)

CMS proposes to expand the CJR episode of care to include outpatient Total Hip Arthroplasty ("THA") and Total Knee Arthroplasty ("TKA") beginning in 2021. This change is intended to coordinate the CJR with CMS' removal of TKA and THA from the Medicare inpatient only ("IPO") list in 2018 and 2020, respectively. Further, CMS desires consistency between the CJR and BPCI-A which commenced inclusion of outpatient TJA in 2020.

AAHKS Comment: We welcome the addition of outpatient TJA procedures to the CJR episode of care. This has long been a top priority of AAHKS since CMS began removing TJA procedures from the IPO list. Our concern, articulated in comment letters to CMS since 2017, has been that with the two-midnight rule, there is a strong incentive on hospitals to drive performance of TJA to the outpatient setting. It then follows that the absence to-date of outpatient TJA from the CJR means that lower resource utilizing, healthier patients who are able to receive TJA procedures on an outpatient basis are more likely to be removed from the denominators for cost and quality performance metrics.

We appreciate that CMS itself conceded a concern that, given ongoing differences in reimbursement, continuing to exclude outpatient TJA from the CJR would create a financial incentive to perform more TJAs in the more expensive inpatient setting. The experience of our members since removing TJA procedures from the IPO list suggests the opposite. Due to fear of noncompliance with the two-midnight rule, hospitals are driving TJA procedures to the outpatient setting in instances where it might be clinically inappropriate. We refer you to our membership survey results included in our comment letter on the 2019 Medicare Outpatient Prospective Payment System Proposed Rule.

This leads us to re-emphasize multiple earlier requests to CMS to issue detailed guidance on the application of the 2-midnight rule to TJA procedures. Our members report that a majority of their facilities are making outpatient the default admission status for all TJA procedures.[1] We can suspect whether this is done for administratively simplicity, to minimize risk of violating the 2-midnight rule, or some other reason. CMS has an essential role to play in better educating hospitals and physicians. Our experience around the TKA tells us that not all hospitals review essential Medicare regulatory preamble language. CMS statements included in the Proposed Rule preamble need to be made directly available to hospitals through guidance and educational

[1] "The Unintended Impact of the Removal of Total Knee Arthroplasty from the Center for Medicare and Medicaid Services Inpatient Only List," *Journal of Arthroplasty,* December 2018.

material to ensure hospitals do not improperly pressure THA to be performed on outpatient status. Therefore, we strongly encourage CMS/CCSQ to update MLN guidance, issued specific to TKA,[2] to include THA, and to include illustrative clinical examples that AAHKS provided to CCSQ at their request in early 2019. Such guidance will increase the likelihood of hospital awareness of CMS' important preamble statements on patient selection.

II. Target Price Calculation (Sec. II.2.B)

CMS proposes to set target prices for four types of CJR episodes for nine different regions based on one year of regional spending data.

- MS–DRG 470 with hip fracture (which would include outpatient THA episodes with hip fracture)
- MS–DRG 470 without hip fracture (which would include outpatient TKA episodes and outpatient THA episodes without hip fracture)
- MS–DRG 469 with hip fracture
- MS–DRG 469 without hip fracture

CMS further proposes to change the basis for the target price from three years of claims data to the most recent one year of claims data. CMS believes the change eliminates the need for continued use of the national trend update factor as well as the twice yearly update to the target prices to account for changes in Medicare payment rates.

AAHKS Comment: We are concerned that the blended rate for MS–DRG 470 without hip fracture (outpatient TKA & THA without hip fracture) encompasses too great a range in costs between inpatient and outpatient cases, regardless of risk adjustment. This could lead to hospitals directing even more cases to an outpatient setting in order to fall under the blended target price, regardless of clinical appropriateness.

We note that in the Proposed Rule, CMS states that "Our analysis of this 2018 claim data shows that approximately *25 percent* of TKAs are being performed in the outpatient setting, annually."[3] This is in contrast to CMS's statement in the 2020 Medicare Outpatient Prospective Payment System Proposed Rule that "We note that TKA procedures were still predominantly performed in the inpatient hospital setting in CY 2018 (*82 percent of the time*) based on professional claims data."[4] We request that CMS clarify the difference between these 25 and 18 percent outpatient setting figures. Further, we request that CMS track what portion of CJR TKA procedures are performed on an outpatient basis and that this be compared against the same metric for Medicare non-CJR TKA procedures. Tracking this data is essential to understanding the incentives potentially created by the blended target price.

[2] See MLN Matters, *Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and Application of the 2-Midnight Rule*, (Jan. 24, 2019).
[3] 85 FR 10518 (Feb. 24, 2020) (emphasis added).
[4] 84 FR 39543 (Aug. 9, 2019) (emphasis added).

We thank CMS for the move to regional data only in setting target prices. AAHKS has previously asked that CMS permit hospitals to opt-in to regional-only data prior to PY 6. Nevertheless, we urge CMS to evaluate the impact of the transition on safety-net hospitals that do not compete on a regional basis and that might otherwise value the predictability of target prices based on hospital-specific data.

Finally, we note that in the 2021 Medicare Inpatient Prospective Payment System ("IPPS") Proposed Rule, CMS proposes to create new MS–DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC) and new MS–DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC).[5] CMS would move all hip fracture cases from DRGs 469 and 470 and into DRGs 521 and 522. CJR episodes are triggered by an admission of DRGs 469 or 470, therefore if CMS finalizes the new DRGs for hip fractures there would be no remaining hip fracture cases in DRGs 469 and 470. Thereby, the separate target prices proposed above for 469 (with hip fracture) and 470 (with hip fracture) would, we assume, become moot and unused. Alternatively, if CMS adds DRGs 521 and 522 to CJR as new episode triggers, we assume that target prices for these codes would supplant those for hip fracture discussed above. Further, we assume that CMS would import one year of DRGs 469 and 470 hip fracture claims history to serve as the basis for setting target prices for the new 521 and 522.

III. High Episode Spending Cap (Sec. II.B.2)

CMS proposes to set a high outlier limit above the regional average episode cost whereby the episode costs above the 99th percentile would be capped at the 99th percentile amount.

AAHKS Comment: Although we recognize CMS's efforts to identify outlier spending in the model, we believe that hospitals and surgeons should not be punished for taking the risk of treating the most vulnerable and complex patients. Capping episode costs only above the 99th percentile imposes extraordinary risk on providers and we do not understand what leads CMS to propose such a high level. As an alternative, AAHKS recommends that CMS set the high episode spending cap at the 90th percentile.

IV. Additional Episode-Level Risk Adjustment (Sec. II.C.4)

CMS proposes to risk-adjust each patient-level target price using two patient-level risk factors: the CMS-Hierarchal Condition Category ("HCC") condition count risk adjustment factor and the age bracket risk adjustment factor. Therefore, for each patient, the regional target price for a particular MS-DRG and fracture status would be increased or lowered by a risk factor multiplier that captures that patient's number of HCCs and age.

AAHKS Comment: We thank CMS for adding this level of risk adjustment to CJR. Since 2015, AAHKS has consistently noted the need for a vigorous risk adjustment methodology under CJR.

[5] *See* 85 Fed. Reg. 32505-32510 (May 29, 2020).

Without it, the CJR penalizes the hospitals and surgeons that treat the sickest patients. Furthermore, with the shift to regional benchmarking, hospitals and TJA practices that disproportionately care for medically complex patients will be in direct competition with those that treat a healthier patient base. Without incorporating risk adjustment, the CJR, or any other APMs created by CMS, will create a reimbursement environment that increasingly incentives cherry-picking and lemon-dropping.

We have shared with CMMI our recommendation that risk adjustment encompass the sociodemographic factors or patients as well as their orthopaedic complexity. Nevertheless, we understand that CMS is proposing the HCC condition count as it is a methodology with which CMS has experience in through the Medicare Advantage (MA) program. The HCC methodology to date projects the risk of a broader MA enrollee patient population, rather than single-facility TJA patients. HCC is an improvement over the very limited risk adjustments currently used in CJR, but we have the following questions:

- Will the HCCs be sufficiently captured through outpatient ICD-10 codes (as in MA) as well as inpatient? From what preceding period will outpatient codes be drawn?
- Has CMS considered the relative impact on the perioperative period of some of the cardiovascular/pulmonary codes that might be impactful than chronic disease codes longitudinally, but do not have as much impact in an acute intervention setting? Not all HCC codes carry similar risk.

We look forward to collaborating with CMS on the evolution and refinement of CJR risk adjustment methodology, which will be relevant to subsequent TJA models. We ask that CMS provide additional risk adjustment for those factors which our members report as predictive of cost variation: functional status, dual eligibility, social determinants of health, and post-discharge destination.

V. Three Year-Extension (Sec. II.D)

CMS proposes to extend the CJR model's operation beyond its current scheduled end date of December 31, 2020 to December 31, 2023. The next three years would be known as CJR Performance Year 6 (2021) through Performance Year 8 (2023).

AAHKS Comment: We support extending the CJR by three years through 2023. Our views on the possible extension of Performance Year 5 into March 2021 will follow in our comment letter on the Interim Final Rule on COVID-19 Response (CMS-1744). As explained above, we believe that a number of changes CMS is proposing will improve the performance of the CJR and we believe three years will allow sufficient time to evaluate the impact of those improvements to episode definition, risk scores, etc. Three years also providers CMS with sufficient time to collaborate with specialty societies and other stakeholders on the development of a model to follow CJR. See comments in **Section VII**.

Nevertheless, AAHKS has long stated our position that participation in Medicare episode payment models should be voluntary. As shared in our October 16, 2017 comment letter on the Advancing Care Coordination Proposed Rule (CMS-5524-P), mandatory models are imposed unequally on facilities with different levels of experience and preparedness for them. After five years of mandatory participation in the CJR, this extension provides CMS the opportunity to transition CJR to voluntary participation. We remain concerned that introducing CJR first through a mandatory requirement for certain geographic areas seemingly violates the limitations on CMMI's authority to expand models. Under section 1115A(c) of the Social Security Act, the Secretary's authority to impose mandatory participation models "through rulemaking," exists only after a new models has been tested and formally evaluated.

VI. Gainsharing Cap Eliminated (Sec. II.G)

CMS proposes to eliminate the 50% cap on gainsharing payments, distribution payments, and downstream distribution payments when the recipient of these payments is a physician, non-physician practitioner, physician group practice, or non-physician practitioner group practice.

AAHKS Comment: Since CJR's inception, we have disagreed with the limits on gainsharing imposed on the primary physician surgeons. These physicians have expanded responsibility and data collection duties and play a critical role in redesigning care. These physicians should be adequately compensated for the additional time and work involved in CJR without an arbitrary cap being imposed by CMS.

AAHKS supports the removal of all limits on gainsharing between participant hospitals and collaborators. Hospitals and collaborators should be free to freely negotiate the terms of their partnership with physicians so they can be rewarded for cost savings they help produce. AAHKS welcomes CMS' elimination of the 50% cap on gainsharing payments.

VII. Bundled Payments in ASCs (Sec. II.J)

CMS soliciting comments on the design of a potential future bundled payment model for TJA procedures in ASCs.

AAHKS Comment: We recommend against a separate bundled payment model for ASCs. If there were separate models for ASCs and hospitals it would exacerbate the existing problem of drawing low-cost, low-complexity outpatient TJA episodes out of hospitals, thereby skewing target prices and performance. Rather, we believe CMMI should consider a single site-neutral TJA model that encompasses ASCs and inpatient and outpatient hospitals procedures. AAHKS is developing recommendations related to such a model, which we will soon share with CMS.

A fundamental element of any model encompassing ASCs must be adequate target price setting. For example, as we have commented before, CMS' 2020 reimbursement level for TKA in the ASC setting is approximately $8,639.97. If CMS' goal is to make TKA available at ASCs, that low proposed reimbursement rate will lead many ASCs will decline to perform the procedure for FFS

patients. CMS should closely evaluate whether that rate will succeed in accomplishing CMS's goal of making TKA procedures in ASCs available to Medicare beneficiaries.

VIII. Impact of Proposed New Hip Fracture DRGs on CJR Model (2021 IPPS Proposed Rule Sec. I.C.7.b)

In the 2021, Medicare IPPS Proposed Rule, CMS proposes to create new MS–DRG 521 (*Hip Replacement with Principal Diagnosis of Hip Fracture with MCC*) and new MS–DRG 522 (*Hip Replacement with Principal Diagnosis of Hip Fracture without MCC*).[6] We appreciate CMS extending the public comment period on this CJR Extension Proposed Rule to allow us to comment on the impact of the new DRGs on the CJR in general.

AAHKS Comment – CJR episodes are currently triggered by an admission of DRGs 469 or 470. If CMS finalizes the new DRGs for hip fractures without adding the new codes are episode triggers to the CJR, it would have the effect of removing all hip fracture cases from the CJR. We believe there is value in maintaining hip fracture cases in the CJR. First, notwithstanding the new codes, it would still be administratively simpler for CJR participants and associated surgeons to continue performing hip fracture THAs under CJR arrangements than to begin removing cases from the CJR. Second, maintaining hip fractures in the CJR would mean those procedures remain subject to the value-based care incentives of the CJR. Notwithstanding the issues noted in this comment letters wherein AAHKS believes the CJR model can be significantly improved, the model itself presents an opportunity for gain sharing and more comprehensive care coordination that should be continued for hip fracture cases.

Therefore, we support adding DRGs 521 and 522 to the CJR program and new episode triggers. We assume this would have a neutral economic impact on the model and participants as CMS already offers a separate target price for hip fracture cases in DRGs 469 and 470.

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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,

C. Lowry Barnes, MD
President

[6] *See* 85 Fed. Reg. 32505-32510 (May 29, 2020).

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Executive Director

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