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–9912–IFC
P.O. Box 8016
Baltimore, MD 21244-1816

RE: CMS–9912–IFC - Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency - Comprehensive Care for Joint Replacement (CJR) Model

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 provisions relating to the Comprehensive Care Joint Replacement ("CJR") Model as contained in the Interim Final Rule with Comment ("IFC"), *Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency*.

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 IFC are summarized as follows:

- PY5 should extend to December 31, 2021 to contain the impact of COVID-19 within PY5
- Beginning in PY6, CJR should shift to voluntary participation
- 2 reconciliation periods will reduce the burden of the long PY5 for participants
- We support the addition of DRGs 521 and 522 to the CJR but new DRG reimbursement levels may distort incentives

- Given the current nation-wide spike in COVID-19 cases and the resulting cancellation of elective procedures, CMS must revert to its earlier policy of ending the Extreme and Uncontrollable Circumstances policy only upon conclusion of the public health emergency ("PHE")
- CJR and value-based care has been seriously undermined by CMS' reduction in Medicare TJA reimbursement

I. Extension of Performance Year 5 Only Through to September 30, 2021 is Not Supported by COVID projections (Sec. II.G.2)

CMS seeks comments on its extension of PY5, as well as the suggested duration of PY 6, if finalized.

AAHKS Comment: We support the extension of CJR PY 5 to December 31, 2021. In recognition of the burden faced by providers in responding to the COVID-19 pandemic, and its impact on procedure volume within the CJR, it would make no sense to spread CJR operations under the pandemic over several different PYs. CMS should extend PY5 at least through the duration of the PHE to allow time to resume normal volume to elective procedures following the pandemic. Given the spike in COVID rates, the slow pace of vaccination, and the recent closures of elective procedures in many facilities, we are unaware of what factors CMS views that suggest that the disruptions of the pandemic and the PHE and their impact on elective procedures will be over in September 2021. Unless April 2021 sees an exponential upward trend in elective procedures following mass vaccinations, and a significant drop in the national COVID case rate, further extending PY5 through the end of 2021 is the only rational step.

PYs 7 and 8 should remain 12 month PYs, each beginning with episodes ending on or after January 1, 2023 or January 1, 2024, respectively. As CJR performance years have mainly coincided with calendar years, we suggest maintaining that alignment for consistency and for administrative simplicity for participant hospitals for whom calendar year arrangements are more common.

Given our recommended extension of PY5, we recommend that PY6 run for 12 months, comprising all CJR episodes between December 31, 2021 and December 31, 2022. This keeps the end of PY6 aligned to the calendar year like PYs 7 and 8 and allows CMS to shorten PY6 further if it becomes appropriate to extend PY5 through 2021 due to the pandemic.

We remind CMS that AAHKS has long stated 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. The eventual transition to PY6 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.

II. Additional Reconciliations for Performance Year 5 (Sec. II.G.3)

AAHKS Comment: We support conducting two reconciliations for PY5 in order to break up what would otherwise be a 21-month gap between reconciliation payments during the COVID-19 pandemic.

III. DRG 521 and DRG 522 Assist CJR but New DRG Reimbursement Levels May Distort Incentives (Sec. II.G.4)

CMS made technical changes retroactive to October 1, 2020, to add the new DRG 521 and DRG 522 codes to the CJR.

AAHKS Comment: We thank CMS for adding these new DRG codes as episode triggers to the CJR. It is 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. Also, maintaining hip fractures in the CJR means those procedures remain subject to the value-based care incentives of the CJR.

Nevertheless, we use this opportunity to reiterate concerns over the impacts on reimbursement levels for DRGs 469 and 470, stemming from the creation of the new DRGs.[1] As Medicare FFS reimbursement rates fall or remain steady, while outpatient reimbursement rates increase, we fear incentives may be created to conduct outpatient TJAs when not clinically appropriate.

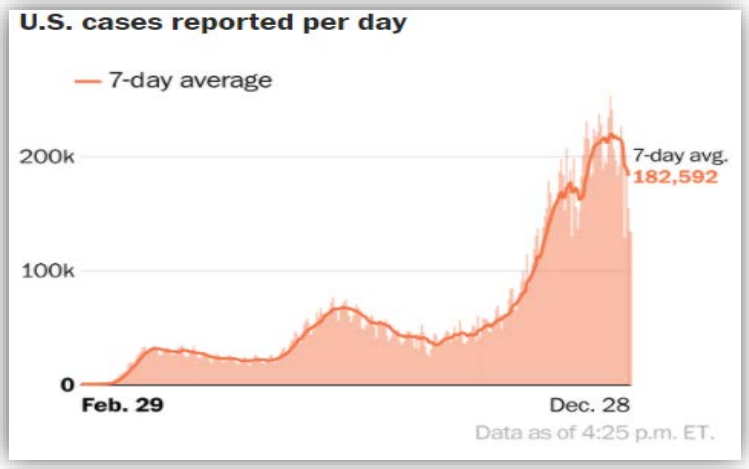
IV. Changes to Extreme and Uncontrollable Circumstances Policy for the PHE for COVID–19 (Sec. II.G.5)

CMS has modified the Extreme and Uncontrollable Circumstances policy to expire on the earlier of either March 31, 2021, or the last day of the emergency period. CMS states that its intension is to maintain the ability of the CJR model to generate savings after Medicare claims data indicated an increase in new CJR episodes after April 2020 when elective surgeries resumed.

AAHKS Comment: We strongly disagree with CMS' proposal to cut off providers from relief under the Extreme and Uncontrollable Circumstances policy. This proposal is carelessly based on outdated projections of the impact of the pandemic and would create even more burdens for providers during a national emergency and PHE. CMS may have drafted this policy when it seemed that the pandemic was in retreat nationwide. Today, that perception could not be further from the truth. Nationwide, and in every state, the COVID case rate has skyrocketed

[1] See AAHKS comment letter on the 2021 Medicare IPPS proposed rule (July 10, 2020).

to levels higher than those of March and April 2020. In truth, even though vaccinations have commenced, there is no reason to believe that the impacts of this pandemic will end in March 2021. This recent trend is also reflected in new cancellations of elective procedures in a growing number of facilities. More than 100 hospitals have suspended some or all elective surgeries, and the number is increasing.[2]



Source: The Washington Post (Dec. 28, 2020)

CMS' new policy instead to protect only COVID-diagnosed CJR episodes from downward risk misses the point of how providers are impacted by the pandemic. It is not the case that only COVID patients are difficult to manage during the pandemic. Rather, all hospital operations, incentives, and procedures have been adjusted during the public health emergency to prioritize (1) preventing transmission, and (2) expanding capacity to treat COVID patients. Our CJR participating members will continue to perform TJAs, when allowed, as efficiently as possible in a manner to protect the safety of the patient and other providers, but it is simply not the case that overall CJR performance of non-COVID patients should be evaluated and assessed under the same standards that would apply in the absence of a pandemic.

Orthopaedic surgeons and their practices have been significantly impacted by the pandemic. Consistent with CMS guidelines on elective procedures, many AAHKS practices closed for several months in 2020. That suspension has created a backlog in joint replacement surgeries to be scheduled, but also equates to lost volume for surgeons as they had already been operating at full capacity before the pandemic. Additionally, the ability for these surgical practices to work at full capacity is now diminished due to the extra precautions of reducing COVID-19 transmission risks in the surgical setting. Closed practices and delayed surgeries impact not only surgeons but also the staff they employ.

[2] Becker's Hospital Review, "*116+ hospitals postponing elective surgeries broken down by state*" , Alia Paavola (Dec. 21, 2020), available at: https://www.beckershospitalreview.com/patient-flow/110-hospitals-postponing-elective-surgeries-by-state.html

Moreover, of AAHKS members surveyed:

- 12% report that their hospitals are still unable to recommence elective inpatient surgery
- 60% report that their clinic volume is reduced
- 27% report that restrictions on elective procedures have remained in place with no change
- 49% report that they remain unable to rehire furloughed staff
- 52% report they are concerned that their work poses a risk to their families.

CMS' policy strikes us as yet another confounding example of CMS proactively burdening providers who are trying to safely provide medical services during a pandemic. It is ironic that in the midst of a global pandemic and economic recession, when CMS and HHS are stretching their legal authority to ease regulatory burdens and deliver billions of dollars in health provider relief, that CMS feels now is the best time to increase financial risk for providers who are facing losses based on factors outside of their control.

We are already disappointed that CMS could not identify legal authority to waive budget neutrality for the 2021 Physician Fee Schedule conversion factor cuts, and that CMS could not stand up to the AMA RUC and its clearly misinformed recommended cuts in 2021 to physician reimbursement for TJA. By also proposing to prematurely end the Extreme and Uncontrollable Circumstances policy, especially when many specialists are struggling to maintain staff salaries amidst a public health driven reduction in patient volume, CMS seems to be intentionally penalizing orthopaedic surgeons.

CMS should revert to its earlier policy of ending the Extreme and Uncontrollable Circumstances policy only upon conclusion of the PHE.

V. CJR and Value Based Care Has Been Seriously Undermined by CMS' Reduction in Medicare TJA Reimbursement

CMS must address its internal contradiction that the Medicare program is reducing FFS reimbursement for TJA in a manner that undermines its value based care objectives.

As a reminder of the developments around TJA RVUs over the last two years, a for-profit commercial insurance company manipulated CMS' public nomination process in 2018 for potentially misvalued codes to be reviewed by the AMA RUC. The insurer's intention was to ultimately drive down reimbursement to their contracted physicians who are paid a percentage of Medicare rates. The AMA RUC evaluation of the TJA codes noted a reduction in physicians' post-operative time due to emerging efficiencies under value-based care arrangements, but did not recognize corresponding increases in physicians' pre-operative time which is necessary to secure improved clinical outcomes for hip and knee replacement patients. Nevertheless, CMS chose to accept the RUC recommendations, proving once again that CMS diverges from the RUC only when the RUC recommends increases in physician reimbursement.

We project that our members face a 10% PFS reduction in TJA codes in 2021 due to the conversion factor and RUC reduction in the Medicare PFS 2021 Final Rule.[3] Such a reduction broadcasts a strong, chilling message to all physicians participating in—or considering participating in—APMs: when providers in the vanguard of value-based care and bundled payments begin to achieve some efficiencies in the delivery of care, CMS will use those positive developments as a justification to cut fee-for-service reimbursement.

The potential to improve care for our patients and reduce overall Medicare expenditures through Advanced APMs and other value-based care arrangements is threatened by simultaneous reductions in FFS reimbursement. In effect, the Medicare program is encouraging orthopaedic surgeons to take on more risk under alternative payment models, but simultaneously threatening to reduce overall reimbursement, leaving our members at *greater risk* for a *chance* to share savings from *lower* reimbursement. Rate reduction is risky in light of extensive CMS-driven transition in regulation and reimbursement of joint replacement surgery now, including the transition or procedures to outpatient and Ambulatory Surgery Centers (ASCs); learning the 2-midnight rule for physicians who were never previously subject to it; CJR extension and interaction with BPCI-A; upcoming MIPS MVP episodes; and partnering with CMS to develop new models and new measures.

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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

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cc: **Brad Smith,** Deputy Administrator for Innovation and Quality and Director, CMMI
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[3] This 10% reductions accounts for the 3.75% increase provided for 2021 in the 2021 Omnibus Appropriations Law. (PL 116-260).