AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates

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 hospital inpatient proposed payment systems ("IPPS") proposed rule for fiscal year 2019 (hereinafter referred to as "FY 2019 IPPS proposed rule" or "proposed rule").

The American Association of Hip and Knee Surgeons ("AAHKS") is the foremost national specialty organization of more than 3,500 physicians with expertise in total joint arthroplasty ("TJA") procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by its 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 focus on the following provisions of the FY 2019 IPPS proposed rule:

I. **Removal and Reinsertion of Spacer; Knee Joint and Hip Joint – Section II.F.20.e**

AAHKS supports the proposed new MS-DRG assignments for procedures involving open removal and insertion of spacers into hip and knee joints. These procedures are invasive and typically require the resources of an operating room and general anesthesia. Our understanding is that CMS will assign the new procedure codes as follows:

ICD-10-PCS Procedure Code	Code Description	New MS-DRG Assignment
0SPC08Z	Removal of spacer from right knee joint, open approach	485, 486, 487. 488, 489
0SHC08Z	Insertion of spacer into right knee joint, open approach	485, 486, 487. 488, 489
0SPD08Z	Removal of spacer from left knee joint, open approach	485, 486, 487. 488, 489
0SHD08Z	Insertion of spacer into left knee joint, open approach	485, 486, 487. 488, 489
0SP908Z	Removal of spacer from right hip joint, open approach	480, 481, 482
0SH908Z	Insertion of spacer into right hip joint, open approach	480, 481, 482
0SPB08Z	Removal of spacer from left hip joint, open approach	480, 481, 482
0SHB08Z	Insertion of spacer into left hip joint, open approach	480, 481, 482

These additions correspond with provider-initiated proposals for similar CPT codes which are being made presently. The specificity and granularity of helpful administrative data for surgeons and hospitals will be improved by these additions.

II. Proposed New Measure Removal Factor – Hospital Inpatient Quality Reporting Program – Section VIII.A.4.b

CMS proposes to adopt a new factor to be used in consideration of whether a particular measure should be removed from the Hospital Inpatient Quality Reporting Program ("IQR"), namely, "the costs associated with a measure outweigh the benefit of its continued use in the program."

We appreciate that CMS is closely considering a wider range of factors to be used in considering measure removal. We have endorsed CMS's "Meaningful Measure Initiative" and look forward to continued progress by the agency in ensuring that Medicare quality programs truly improve health outcomes for patients while minimizing overall costs of operating under the Medicare program.

One of AAHKS's key principles for federal policy is that the burden of excessive physician reporting on metrics detracts from care. Therefore we support adding the new IQR measure removal factor 8, "the costs associated with a measure outweigh the benefit of its continued use in the program."

III. Proposed Removal of Program Measures – Hospital Inpatient Quality Reporting Program – Section VIII.A.5

Consistent with our endorsement of the Meaningful Measures Initiative discussed above, AAHKS supports CMS's proposal to remove 18 previously adopted measures that are no longer

relevant or where the burden of data collection outweighs the measure ability to contribute to improved quality of care, and to remove 21 other measures that are duplicative of those in other Medicare quality programs. In particular, we support the removal of the following from the IQR:

- Hospital-Level 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551) (READM–30–THA/TKA)

- Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) (Hip/Knee Complications)

- Hospital Survey on Patient Safety Culture

IV. Potential Future Inclusion of the Hospital Harm—Opioid-Related Adverse Events Electronic Clinical Quality Measure (eCQM) – Hospital Inpatient Quality Reporting Program – Section VIII.A.9.b

CMS is evaluating the potential use of a new measure under the IQR to indicate harm to a patient from an opioid-related adverse respiratory event. In this case, the measure uses the administration of naloxone, an opioid reversal agent, as an indicator of an adverse event. CMS states that the intent of this measure is for hospitals to track and improve their monitoring and response to patients administered opioids during hospitalization, and to avoid harm, such as respiratory depression, which can lead to brain damage and death. Further, CMS believes that reduction of adverse events in surgical and non-surgical patients receiving opioids, may be enhanced by measuring the rates of these events at each hospital in a systematic, comparable way.

CMS states that the numerator for this electronic outcome measure is the number of patients who received naloxone outside of the operating room either: (1) After 24 hours from hospital arrival; or (2) during the first 24 hours after hospital arrival with evidence of hospital opioid administration prior to the naloxone administration. CMS excludes cases of naloxone use in the operating room where it could be part of the sedation plan as administered by an anesthesiologist.

We are grateful for the recent attention by the Administration to this addiction crisis. As prescribers of pain medications, AAHKS members are aware of the risks and difficult issues faced by treating prescribers. We note that more transparent and thorough coverage of TJA procedures, when medically necessary, by both Medicare and commercial insurers, would reduce the initial need to prescribe pain medication.

We appreciate that this measure design attempts to focus specifically on in-hospital opioid-related adverse events, rather than opioid overdose events that happen in the community and may bring a patient into the emergency department. First and foremost, we strongly support

the CMS proposal to initially introduce this measure as *voluntary* for hospitals. We would like to see clinical performance under this measure tracked to ensure further evidence that it does not disincentivize naloxone use before the measure is incorporated more widely or made mandatory. We believe that standard clinical procedures to reduce opioid-related adverse events are rapidly emerging and will place clinicians and hospitals in a better position to manage clinical behavior under this measure soon.

We additionally wish to share that AAHKS members are working to reduce opioid use through effective care management. We believe there could be value in developing a MIPS quality measure for opioid-sparing approaches to managing pain. With the opioid crisis in mind, AAHKS intends to develop an opioid-sparing pain management quality measure applicable to total joint arthroplasty. Our overall goal is to develop or identify three processes, three structural and three outcomes measures for the physician to use at their discretion to satisfy various reporting requirements. We request that these measures be reviewed and validated by appropriate entities within HHS after they are developed.

V. The Role of Outpatient Procedures in Calculating Facility Measures - Retention and Proposed Removal of Quality Measures – Hospital Value-Based Purchasing Program – Section IV.I.2.a

We understand that CMS sees continued value in retaining certain hip replacement and knee replacement measures under the Medicare's Hospital Value-Based Purchasing Program ("VBP"). However, recent changes in other Medicare payment systems raise questions as to how measures related to total joint arthroplasty are calculated under the measures used in the VBP.

Following public notice and comment on the 2018 Medicare Outpatient Prospective Payment System ("OPPS") Proposed Rule, CMS finalized its proposal to remove TKA from the Medicare inpatient only procedure list ("IPO List"), effective January 1, 2018, allowing the procedure to be reimbursed as an outpatient or inpatient procedure. By removing TKA from the IPO List, the procedure becomes subject to the Medicare "2-midnight rule," wherein, if an admission for a procedure spans less than 2 midnights, the admission is generally assumed to be, and reimbursed as an outpatient procedure under the OPPS, rather than an inpatient procedure. After 6 months under this policy, we find that a significant number of TKA procedures span less than 2 midnights and are considered by many hospitals to be outpatient procedures.

In light of these changes and developments, we ask CMS to clarify whether a facility's outpatient TKA procedures are counted when CMS calculates Hospital-Level 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551) or Hospital-level Risk-Standardized Complication Rate(RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) (Hip/Knee Complications). Our review of the original measure specifications does not seem to indicate an answer to this question, as these measures were developed when TKA and THA were on the IPO List. Our interest applies to CMS's use of

these measures under the VBP and any other program in which CMS uses these or other measures of TKA.

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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,

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