AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

OFFICE: 847.698.1200 • FAX: 847.698.0704 • WEB: aahks.org
9400 W Higgins Road, Suite 230 • Rosemont, IL 60018-4976

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VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: FY 2017 Hospital Inpatient Prospective Payment Systems Proposed Rule

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 2017 (hereinafter referred to as "FY 2017 IPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of 2,710 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 offers these comments in anticipation of continued close collaboration with CMS to ensure Medicare hospital payment reforms benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of the FY 2017 IPPS proposed rule:

I. Combination Codes for Removal and Replacement of Knee Joints - Section II.F.8.b.(2)

CMS proposes to add 58 new code combinations to version 34 ICD-10 in order to fully account for the removal and replacement of knee joints within MS-DRGs 466, 467, and 468. AAHKS members have previously raised with CMS that these code pairs should group to the hip and knee arthroplasty MS-DRGs as they did under ICD-9. Otherwise, the ICD-10 MS-DRG logic model prevents revision total knee replacements from being appropriately grouped in situations where a knee spacer is removed and the prosthesis is re-implanted. To qualify for a

revision MS-DRG, there are two procedure codes that must be present: (1) removal of the spacer; and (2) replacement of the prosthesis.

In the list of ICD-10 code combinations for revision surgeries, CMS omitted the codes for removal of knee spacers. This results in the grouping software only recognizing the procedure codes for the placement of prosthesis, causing the encounter to be grouped into an incorrect MS-DRG. CMS acknowledged this error in the 2016 IPPS final rule, but only fixed the spacer combinations for hip surgeries.

AAHKS Comment: We strongly support CMS' proposal to assign 58 additional joint revision combination codes to MS-DRGs 466, 467, and 468 to allow for proper grouping of use of knee spacers, effective October 1, 2016. While we are grateful for CMS' proposed resolution, AAHKS remains concerned with the impact of the error on hospitals participating in the Comprehensive Care for Joint Replacement ("CJR"), in which the error has been in effect since April 1, 2016. The lack of appropriate combination codes for knee joints means that more complex and more expensive revision surgeries will be coded incorrectly as primary encounters until October 1, 2016, thus driving up expenditures attributed to primary encounters for CJR participants.

We will be working with Center for Medicare and Medicaid Innovation ("CMMI") to discuss how expenditures for knee revisions by CJR participants may be appropriately attributed for the April 1 to October 1, 2016 time period.

II. Risk-Adjusting for Sociodemographic Factors Under the Hospital Readmissions Reduction Program – Section IV.G.4 and the Hospital Inpatient Quality Reporting (IQR) Program – Section VIII.A.6.a

CMS references in several areas of the proposed rule its policies regarding the use of sociodemographic factors in quality measures, noting that it continues to have concerns about holding hospitals to different standards for the outcomes of their patients of diverse sociodemographic status. CMS states this is because it does not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. In addition, CMS references current efforts by the National Quality Forum ("NQF") and the Office of the Assistant Secretary for Planning and Evaluation ("ASPE") to pilot measures that risk-adjust for sociodemographic factors and conduct research on the impact of sociodemographic status on quality measures.

AAHKS Comment: AAHKS believes that adequate risk adjustment is vital to appropriately incentivize providers and educate the public based on the quality or provider performance as opposed to the wide-variation in health status of different patient populations. The Readmissions program and Quality Reporting program will not achieve their objectives to improve clinical care if providers are held accountable for factors not within their direct control.

Historically, AAHKS members have primarily been assessed on readmission, re-operations, cost, and length-of-stay. Most importantly, whatever quality assessments are used, they must be risk-adjusted or else the measures lose their comparative value. Factors such as health status, stage of disease, genetic factors, local demographic and socioeconomic factors significantly impact the quality and outcomes of surgeries performed by AAHKS members. These factors must be reflected in quality assessments to accommodate real variations in patient need and the costs of care.

We look forward to the results of the work by NQF and ASPE and their contribution to better risk adjustment under the IPPS, CJR, Merit-Based Incentive Payment System ("MIPS"), and Alternative Payment Models ("APMs").

III. Value-Based Purchasing ("VBP") Program Proposed Scoring Methodology for the Proposed AMI Payment and HF Payment Measures – Section IV.H.4.a.(3)

CMS is considering adopting a scoring methodology for a future VBP program year that would assess quality measures and efficiency measures in tandem to produce a composite score reflective of value. Currently, the Hospital VBP Program assesses quality and efficiency separately through distinct performance measures and domains. CMS is concerned that a hospital could earn a higher payment adjustment relative to other hospitals by performing well on the quality-related domains but without performing well in the Efficiency and Cost Reduction domain.

CMS seeks comments on two general approaches. Under the first approach, CMS would use specific measures of value which could be developed by measure developers, incorporated into the Hospital IQR Program, and then added to VBP. Secondly, CMS could use the existing scoring methodology to incorporate value based on performance on quality and cost measures or domain scores. CMS expresses interest in applying this new value score to "high-cost, high clinical-impact conditions."

AAHKS Comment: There is a limit to how existing VBP quality and efficiency measures are able to realistically reflect hospital "value," particularly as some of those surgical procedure measures were never meant to reflect "value." Therefore, AAHKS strongly urges that any new assessment of "value" under the VBP be based on new measures. The TJA procedures performed by AAHKS members perfectly illustrate this issue.

The VBP Clinical Care Domain includes NQF # 1550 (Hospital-level Risk Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty), assessing complications following admission for TJA. Complications may include: acute myocardial infarction, pneumonia, or sepsis/septicemia within 7 days of admission; surgical site bleeding; pulmonary embolism or death within 30 days of admission; mechanical complications; periprosthetic joint infection; or wound infection within 90 days of admission. These factors are important measures of quality, but are far too narrow in scope to

capture value of the underlying procedure. Value to the patient undergoing the procedure is measured by the patient with consideration of many more factors, including quality of life, duration of implant, and other issues beyond the 90-day timeframe of NQF # 1550.

Work is needed to develop meaningful measures that capture patient value of TJA procedures. We know that beyond cost-efficiency and short-term quality issues, our patients judge value on long-term quality of life issues such as ease of movement/discomfort, mobility, and the existence of any emerging deficiencies in the joint implant itself. AAHKS therefore recommends that CMS pursue the first approach described: develop new specific measures of value through the measure development process that will eventually be incorporated into the Inpatient Quality Reporting ("IQR") program and then the VBP program. We understand that it will be a "lengthy process" to develop new measures that appropriately reflect the value to the patient of a TJA procedure over the long-term. It would be expected to be a lengthy process if pursued correctly with input and guidance from specialty societies. We believe there is interest among measure developers to address this next level of TJA measures, drawing from patient-reported outcome measures, the American Joint Replacement Registry, and other sources to capture the value to the patient of the full life of a joint implant. AAHKS already has demonstrated experience in partnering with CMS, other payers, and measure developers on the adoption of other consensus outcome measures.

AAHKS opposes CMS' second proposed approach: using VBP's existing scoring methodology to account for value based upon some combination of quality and efficiency scores. Existing VBP measures and scoring methodologies are of a limited scope and were not designed to create a quality/efficiency judgment of the value of a hospital's performance on TJA procedures for patients and payers. An approach that is based only on cost-efficiency and short-term outcomes could incentivize the provision of care that unintentionally leads to longer-term negative outcomes: use of lower-cost/lower-quality implants; decreased length of stay; insufficient use of physical therapy or home health care. This is an issue for all TJA measures and many other measures of specific surgical procedures. Furthermore, it would be a disservice to beneficiaries if publicly available VBP measures of value only reflect the short-term risks to CMS, as a payer, of complications. Again, such measures are appropriate for quality, but are only a portion of the calculations of value to the beneficiary. VBP measures should not inappropriately steer beneficiaries between providers based on a misconception of value to CMS as the payer.

Furthermore, CMS states that, "Without a measure or score for value that reflects both quality and costs, our ability to assess value is limited." Notwithstanding its name, the VBP program has a focus on achieving value though clinical quality measures. Section 1886(o) of the Social Security Act directs the Secretary to incorporate "efficiency measures" into the VBP in 2014, but this mandate does not extend to adopting value measures. AAHKS does not object to the eventual use of such measures, but the programmatic interest in "value" should not outpace technical capacity to measure a concept that is defined differently by various patients and providers.

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AAHKS appreciates your consideration of our comments. You can reach me at mzarski@aahks.org, or you may contact Joshua Kerr at jkerr@aahks.org.

Sincerely,

Michael J. Zarski, JD
Executive Director
AAHKS