AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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June 27, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS–1607–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare Hospital Inpatient Prospective Payment System Proposed Rule for FY 2015 (CMS–1607–P)

Dear Ms. Tavenner:

The American Association of Hip and Knee Surgeons (AAHKS) is a national association of orthopaedic surgeons formed to provide leadership in advocacy, education and research to achieve excellence in hip and knee patient care. AAHKS is committed to promoting high-quality care for all of our patients, including Medicare beneficiaries. We therefore appreciate this opportunity to provide comments to CMS on its proposed rule that would make changes to the Medicare hospital inpatient prospective payment system (IPPS) and fiscal year (FY) 2015 rates ("Proposed Rule").

Our comments focus on the following provisions of the Proposed Rule:

- AAHKS commends CMS for adopting refinements to its readmissions measures to better identify planned readmissions and exclude hip fracture patients. We also suggest additional refinements to exclude or appropriately risk adjust for conversion of previous hip surgery to total hip arthroplasty.

- AAHKS suggests refinements to the total hip arthroplasty (THA) and total knee arthroplasty (TKA) complication measure (NQF #1550) under the Hospital Value-Based Purchasing (VBP) Program and the Hospital Inpatient Quality Reporting (IQR) Program to improve risk adjustment.

- AAHKS recommends that CMS present additional details about its proposed THA/TKA "surgical episode" under the Hospital VBP Program, particularly with regard to how this measure would account for quality/outcomes in addition to costs and the risk-adjustment parameters. We recommend that the public have an additional opportunity to review and comment on this proposal before CMS moves ahead on a hip/knee surgical episode under the VBP program.

Our detailed comments follow.

I. Hospital Readmissions Measures

In the final FY 2014 IPPS rule, CMS adopted its proposal to add the following measure to the Hospital Readmissions Reduction Program in 2015: Hospital-level 30-day all-cause risk-standardized readmission rate following elective THA and TKA. At the time, CMS incorporated the Planned Readmission Version 2.1 algorithm to better identify planned readmissions that do not generally signal poor quality of care. In the proposed FY 2015 rule, CMS is proposing to use Planned Readmission Algorithm Version 3.0, which reflects small changes to the tables of procedures and conditions used to classify readmission as planned or unplanned. CMS expects that this update will slightly reduce the number of unplanned TKA/THA readmissions. CMS also is proposing to refine the measure cohort for the THA/TKA readmission measure to exclude patients with hip fracture coded as either principal or secondary diagnosis during the index admission in response to observed hospital coding practices during a national dry run. CMS also proposes making corresponding changes to the same THA/TKA readmission measure that will be used beginning with the FY 2016 payment determination under the Hospital IQR Program.

We share CMS's commitment to high-quality care for patients undergoing THA and TKA procedures, and we agree that efforts should be made to minimize unplanned readmissions. We likewise agree that CMS should ensure that its measure specifications appropriately exclude planned readmissions that do not relate to the quality of care in the initial encounter. We therefore support CMS's proposed adoption of Planned Readmission Algorithm Version 3.0 for the hospital-level 30-day all-cause risk-standardized readmission rate following elective THA and TKA measure under both the Hospital Readmissions Reduction Program and the Hospital IQR program. We likewise endorse CMS's proposal to refine the THA/TKA readmission measure cohort to exclude patients with hip fracture coded as either principal or secondary diagnosis during the index admission, since this would better align with current hospital coding practices and prevent hospitals from being unfairly penalized.

In the proposed rule, CMS also discusses the steps it will take to identify admissions specifically for THA/TKA for the purposes of calculating aggregate payments for excess readmissions, including a list of excluded admissions. We recommend that CMS expand its exclusion list to specifically exclude conversion of previous hip surgery to total hip arthroplasty (represented by CPT code 27132). We recognize that the current granularity of the ICD coding framework may complicate isolating these cases. Nevertheless, previous surgery of the hip is a specific risk factor for complications (e.g., infection, fracture), and these cases should be identified for purposes of the readmission measure. We encourage CMS to work with the Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation to determine the most appropriate method for excluding or risk-adjusting for such cases.

II. Hospital Value-Based Purchasing Program: THA/TKA Complications

CMS is proposing to adopt the following measure for the FY 2019 Hospital VBP Program: Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (NQF #1550). This

measure also is slated to be used in the Hospital IQR Program beginning with the FY 2015 payment determination.

AAHKS is concerned about the accuracy of administrative data sets that are the basis of NQF #1550. In particular, the coding data used for this measure has been known to underreport significant comorbidities, particularly obesity. Given the potential for such cases to skew Medicare VBP metrics, the current composition of this measure could result in problems with access to total joint surgery for certain classes of patients, including but not limited to the obese, lupus patients, and transplant patients. Likewise, NQF #1550 should be adjusted for socio-demographic factors, which are known to have significant correlation with the variability of outcomes. Such risk adjustment refinements are critically necessary to prevent the creation of disincentives that could compromise patient access to key orthopedic procedures based on clinical and socioeconomic factors.

III. Hospital Value-Based Purchasing Program: Surgical Episodes

For future years, CMS is considering expanding VBP Program Efficiency Domain measures to include risk-adjusted surgical episodes such as hip or knee replacement/revision to differentiate between hospitals that provide care "efficiently." The start of the episode would be triggered with the hospitalization for the specific condition, and standardized payments for clinically-relevant services provided during the 30-day episode window would be included in the measure.

AAHKS suggests that CMS describe in greater detail about how this measure would account for quality/outcomes in addition to costs. A critical component of any such measure would be the details of risk adjustment, and whether all relevant clinical and socioeconomic factors are weighed in the methodology. CMS also should provide additional details on how post-acute care spending, including beneficiary-driven site of care decisions that may be beyond the control of the physician or the hospital might impact calculation of the measure. We recommend that the public have an additional opportunity to review and comment on this proposal before CMS moves ahead on a hip/knee surgical episode under the VBP program.

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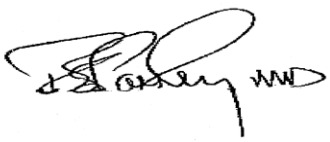
AAHKS appreciates your consideration of our comments. You can reach me at BParsley@bcm.edu, or you may contact Krista Stewart at krista@aahks.org.

Sincerely,



Brian S. Parsley, MD
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