AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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July 10, 2020

**VIA REGULATIONS.GOV FILING**

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1735-P
P.O. Box 8013
Baltimore, MD 21244-1850

**RE: 2021 Medicare Inpatient Prospective Payment System 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 2021 (hereinafter referred to as "FY 2021 IPPS proposed rule" or "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 FY 2021 IPPS Proposed Rule are as follows:

## I. Hip and Knee Joint Replacements – New MS-DRGs (Sec. II.D.7.b)

### *a. Background*

CMS received a request from an external commenter in 2019 to restructure the DRGs for TJAs that utilize an oxidized zirconium bearing surface implants. Following analysis of TJA claims data, CMS instead proposed new DRGs for Total Hip Arthroplasty ("THAs") with a primary diagnosis of hip fracture. CMS performed analysis of those cases reporting THA with a principal diagnosis of hip fracture for both DRGs 469 and 470. CMS stated that, generally, when reviews

shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS often reassigns them to a different DRG with comparable resource use or creates a new DRG.

In this case, CMS proposes to create the following new MS-DRGs for FY 2021:

- MS-DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC);
- MS-DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC)

*b. <u>MS-DRG 521 and 522</u>*

***AAHKS Comment***: We agree that, generally, patients who undergo THA following hip fracture tend to require greater resources for effective treatment than those without hip fracture. Further, the increased complexity associated with hip fracture patients can be attributed to the post traumatic state and the stress of pain, possible peri-articular bleeding, and the fact that this subset of patients, most of whom have fallen as the cause for their fracture, are on average more frail than those who require THA because of degenerative joint disease. Most importantly, their urgent need precludes the correction of reversible risk factors and planning of perioperative care that has become the norm for elective THA.

We have concerns regarding the proposed impacts on reimbursement levels for DRGs 469 and 470, particularly or 469. New DRGs should not be a reason to lower reimbursement for DRG 469 and 470. CMS analyzed average cost and length of stay of hip fracture cases compared with non-hip fracture cases and presented the results in the following Chart 1:

**<u>CHART 1</u>**

| MS-DRGs for Total Hip and Knee Replacement Procedures with a Principal Diagnosis of Hip Fracture | | | |
|---|---|---|---|
| **MS-DRG** | **Number of Cases** | **Average Length of Stay** | **Average Costs** |
| MS-DRG 469-All cases | 25,701 | 5.9 | $22,126 |
| MS-DRG 469 – Cases reporting a total hip replacement procedure with a principal diagnosis of hip fracture | 14,163 | 7.2 | $21,951 |
| MS-DRG 470-All cases | 386,221 | 2.3 | $14,326 |
| MS-DRG 470- Cases reporting a total hip replacement procedure with a principal diagnosis of hip fracture | 47,632 | 4.5 | $16,092 |

CMS found that the average costs for hip fracture cases in DRG 470 were nearly $2,000 more than those of non-fracture cases. Further, the average length of stay nearly doubles. This

is not surprising given the expected complexity associated with hip fracture cases. We are grateful that reimbursement for DRG 470 is not reduced but we are disappointed to observe that the proposed 2021 reimbursement for DRG 470 remains nearly flat (see Chart 2 below) as CMS continues its trend of reducing the weights for this procedure.

What was more interesting was the average costs for hip fracture cases within DRG 469 (cases with major complicating conditions) which had marginally lower average costs per episode in spite of a longer average length of stay as illustrated in Chart 1. This, too, is reflected in proposed weights for a new DRG 521 below:

**CHART 2**

| Past and Proposed 2021 IPPS Reimbursement Levels | | | | | | |
|---|---|---|---|---|---|---|
| **Code (DRG/CPT)** | **2019** | | **2020** | | **2021** | |
| | **Weight** | **Rate** | **Weight** | **Rate** | **Weight** | **Rate[1]** |
| **469** | 3.1742 | $17,921.78 | 3.1399 | $18,200.84 | 3.0989 | $18,530.61 |
| **470** | 1.9898 | $11,234.56 | 1.9684 | $11,410.09 | 1.9104 | $11,423.69 |
| **521** | -- | -- | -- | -- | 3.0652 | $18,329.99 |
| **522** | -- | -- | -- | -- | 2.1943 | $13,121.34 |

c. *Impact on CJR Model*

***AAHKS Comment:*** If THAs with fracture were moved into new DRGs it would mean that such cases would no longer be included in CMS models and quality programs based on DRGs 469 and 470. This would impact programs such as the Comprehensive Care Joint Replacement ("CJR"), the Readmissions Reduction Program, Value-Based Purchasing, Hospital Compare, and any other program that does not distinguish between elective and non-elective TJA. It also affects the surgeon specific complication and episode of cost measures contributing to the MIPS quality score under MACRA.

An admission of DRGs 469 or 470 currently triggers CJR episodes. If CMS finalizes the new DRGs for hip fractures without adding the new fracture DRGs as 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 may be administratively simpler for some 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

[1] Projected by CMS of the baseline amount that will be paid *nationally* for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. These figures assume hospital reported quality data and is a meaningful EHR user.

to the value-based care incentives of the CJR. As noted in AAHKS' comment letter on the proposed CJR extension[2], the model has been significantly improved since its inception. Ongoing access to the CJR model continues to present an opportunity for gain sharing and more comprehensive care coordination that should be continued for hip fracture cases.

We assume adding DRGs 521 and 522 to the CJR program as new episode triggers 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.

## II. Market-Based MS–DRG Relative Weight Proposed Data Collection and Potential Change in Methodology for Calculating MS–DRG Relative Weights (Sec. IV.P)

CMS is proposing that hospitals report the following on their Medicare cost reports:

- median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage ("MA") payers, by MS-DRG; and
- median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG.

CMS further proposes that this collected data would be used in a potential change to the methodology for calculating the IPPS DRG relative weights to reflect relative market-based pricing. Beginning in 2024, CMS would implement a methodology for estimating the DRG relative weights using the median payer-specific negotiated charge for each MS-DRG for payers that are MA plans.

***AAHKS Comment***: We appreciate the work of CMS and this Administration to improve the transparency of health care prices for consumers. We agree that patients should have as much information as is possible about likely out of pocket costs for care. We further believe that it is in the interest of patients to provide them with data on providers' average costs and charges.

Nevertheless, as we stated in our comment letter to the 2020 Medicare Outpatient Prospective Payment System Proposed Rule, "AAHKS does not support any actions by the Medicare program to collect or disclose providers' payer-specific negotiated rates." Making public what has historically been proprietary, confidential negotiated rates would limit providers' leverage in negotiating private reimbursement rates with payers. Payers could identify the lowest rate disclosed between other payers and providers and set that low rate as a "ceiling" rate under a contract. While price transparency and surprise bills are an important issue, we support solutions that do not involve undermining the historic principles of achieving efficient prices through confidential negotiations with competing payers.

[2] See AAHKS Comment Letter to CMS regarding CJR Model Three-Year Extension and Changes to Episode Definition and Pricing Proposed Rule: CMS 5529-P (June 22, 2020).

We also understand that CMS is transparent in its interest to use this policy to reduce reimbursements to health care providers, citing the Secretary's report, "'Reforming America's Healthcare System Through Choice and Competition,' which recognized the importance of price transparency in *bringing down the cost of healthcare*."[3] In this case, bringing down the cost of health care consists of reimbursing health care providers less for treating beneficiaries enrolled in Medicare FFS. We believe that the nation's health care providers should not be expected to carry the weight of system-wide cost reduction solely through cuts in reimbursements for services delivered to beneficiaries. Nor does evidence suggest this is a driving force behind health care inflation.

If CMS is ultimately successful in litigation over this policy and proceeds in spite of provider objections, we urge that CMS take great caution, as it is difficult to predict all of the corresponding secondary impacts of this policy on plan and FFS reimbursements to health care providers.

CMS assumes that relative prices paid by either MA plans or other commercial insurers would be a better reflection of hospitals' true relative costs across DRGs than the current system of using cost report data to estimate relative costs. This is an unfounded assumption. Contracting and MA reimbursement model trends are an evolving phenomenon and illustrate that MA and commercially negotiated rates take into account any number of unique circumstances and factors that are unrelated to the cost of care. Privately negotiated rates between providers and MA plans have never been intended to be solely a proxy for the cost of care.

Areas in the country that have dominant MA programs relative to provider hospitals have greater leverage than those parts of the country with multiple MA providers and fewer hospital systems. It also does not account for those MA programs that are part of vertically integrated and local market dominant systems that negotiate charges on a system favorable basis rather than through pure market forces. In short, MA rates negotiated with hospitals are influenced by free market forces by design; this is far different than Medicare FFS rates and should not be used to influence those rates.

Concerns also arise in the many cases where MA-provider contracts reimburse for procedures based on a percentage of Medicare's FFS reimbursement rate. In some cases, MA-provider contracts reimburse at a lower percentage than Medicare FFS rates. In these cases, if CMS lowers a FFS DRG reimbursement based on MA commercial contracts, it would lead to a cascading reduction in reimbursements to providers under those MA provider contracts. Eventually a downward spiral would be created under such contracts wherein the Medicare FFS program and MA plans refer to each other's reimbursement rates to further and further reduce payments to providers.

[3] 85 Fed. Reg. 32790 (May 29, 2020) (emphasis added).

In the reverse cases where MA rates are higher than FFS, if MA plans see Medicare FFS rates increasing, the plans may renegotiate contracts rather than implement a corresponding increase in their reimbursements. Driving industry-wide contract negotiation would be time consuming for plans and providers. This process would need to be frequently repeated as Medicare FFS rates were constantly evolving based on commercial contracting trends. Or, as MedPAC has suggested, to the degree plan contracts reimburse the FFS rate, this effort would not reflect commercially-negotiated rates, but rather would be a circular confirmation of the Medicare FFS rate.

For these reasons, we urge CMS not to collect average MA and commercial rates through hospital cost reports and not to use such data as a factor in establishing DRG weights. Any such efforts require vastly more analysis of the secondary impacts of its proposal on MA contracting and the corresponding impacts on providers and access to care.

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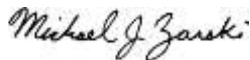
AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,

C. Lowry Barnes, MD
President



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