AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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June 28, 2021

**VIA REGULATIONS.GOV FILING**

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1752-P
P.O. Box 8013
Baltimore, MD 21244-1850

**RE: 2022 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 2022 (hereinafter referred to as "FY 2022 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 2022 IPPS Proposed Rule are as follows:

## I. Excluding COVID-19 Diagnosed Payments from Measure Denominators Starting in FY 2023 for the Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary THA/TKA (NQF #1551) Measure under the Hospital Readmissions Reduction Program (Sec.V.G.6.c)

CMS proposes modifying the Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary THA/TKA (NQF #1551) condition-specific readmission measure, and four other measures, to exclude COVID-19 diagnosed patients from the measure denominators beginning with the FY 2023 program year.

**AAHKS Comment:** We support this adjustment as a reasonable means to mitigate the impact of COVID on the Readmissions Reduction Program. We appreciate this as an ongoing policy as it is unclear how long hospitals will be treating patients with COVID-19, particularly as vaccine-resistant strains and variants may emerge. Although COVID impacted these condition/procedure-specific measures, the impacts were less severe overall compared to other measures and will be more completely mitigated by updating the measure specifications to exclude Medicare beneficiaries with a secondary diagnosis of COVID-19. We agree this measure would not need to be updated for the FY 2022 program year because the only data that would have been affected by the COVID-19 public health emergency was from the first and second quarters of CY 2020, which was excluded under the Extraordinary Circumstances Exceptions granted in response to the public health emergency.

## II. Hospital Inpatient Quality Reporting (IQR) Program - Potential Future Inclusion of a Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (Sec. IX.C.9.b)

Under the Hospital IQR Program, CMS collects quality data from hospitals paid under the IPPS, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care. The IQR is also intended to encourage hospitals and clinicians to improve the quality and cost of inpatient care provided to all patients. The data collected through the program are available to consumers and providers on the Medicare "Care Compare" website. Hospitals that fail to report designated quality measures are subject to a one-fourth reduction of the applicable percentage increase in their Medicare annual payment update for the applicable fiscal year. Hospitals that are subject to payment reductions under the Hospital IQR Program are also excluded from the Hospital Value Based Payment Program.

CMS seeks stakeholder feedback on the prospect of later adding the Patient-Reported Outcome-Based Performance Measure *Hospital-Level, Risk-Standardized Improvement Rate in Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty* (NQF ID# 3559) (hereafter "THA/TKA PRO-PM") as a new measures to the IQR Program.

***AAHKS Comment***: We support addition the THA/TKA PRO-PM to the IQR program. Development, dissemination, and adoption of provider-developed arthroplasty outcome measures has long been a priority of AAHKS in order to truly measure the value of joint replacement to patients. For arthroplasty, PROs are the best available means for a patient-centered measurement of functional status improvement, the ultimate objective of arthroplasty. AAHKS members were involved in the Technical Advisory Group and the Technical Expert Panel that contributed to the development of this measure.

The THA/TKA PRO–PM reports the hospital-level risk-standardized improvement rate in PROs following elective primary THA/TKA for Medicare FFS beneficiaries aged 65 years and older. The THA/TKA PRO–PM uses four sources of data for the calculation of the measure:

- PRO data to measure substantial clinical improvement;
- Medicare claims data to identify eligible elective primary THA/TKA procedures for the measure cohort and additional variables for risk adjustment and accounting for response bias, including patient demographics and clinical comorbidities;
- Medicare enrollment and beneficiary data to identify race dual eligibility status;
- U.S. Census Bureau survey data to allow for derivation of a socioeconomic status (SES) index score

*a. Feedback on THA/TKA PRO-PM*

We appreciate that the measure includes two joint-specific PRO instruments, the Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR) for completion by THA recipients and the Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR) for completion by TKA recipients, as well as either the Patient-Reported Outcomes Measurement Information System (PROMIS)-Global or the Veterans RAND 12-Item Health Survey (VR–12). This aligns with recommendations of the *Patient Reported Outcomes Summit for Total Joint Arthroplasty* convened by AAHKS in Baltimore, Maryland on August 31, 2015 to obtain a consensus regarding the PROs and risk variables best suited for THA and TKA performance measures. Representatives from AAHKS, the American Association of Orthopaedic Surgeons, The Hip Society, The Knee Society, and American Joint Replacement Registry (AJRR), CMS, and the Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation (Yale/CORE) participated to develop consensus and inform the use of PROs in the then-new Comprehensive Care for Joint Replacement Model (CJR). Clinical experts at the Summit:

- Recommended either the PROMIS Global or the VR-12 instruments to be used to collect general health information due to the redundancy that would result if CMS required both general health PRO instruments which each evaluate physical and emotional health, the significant investment the National Institutes of Health (NIH) in the PROMIS instruments, and the adoption of PROMIS Global instruments by many facilities
- Recommended KOOS, JR instruments to be used as an efficient and reliable short-form alternative to the full KOOS instrument as the appropriate disease-specific patient survey instruments for lower extremity joint replacement due to data validations demonstrating high internal consistency for KOOS, JR. and that the short-form instrument was highly responsive to joint replacement with a near-perfect correlation with both the pain and activities of daily living/function domains of the full KOOS and the WOMAC
- Declined to endorse the full KOOS instrument due to the substantial burden the instrument's overall length and number of questions would impose on patients, orthopaedic surgeons, and their staff

We particularly welcome the risk model developed for this measure. Since 2015, AAHKS has consistently stressed the need for a vigorous risk adjustment methodology under

arthroplasty quality and performance measures. Without such risk adjustment, measures could be used to penalize the hospitals and surgeons that treat the sickest patients.

Furthermore, as the CJR and other models shift to regional benchmarking, hospitals and arthroplasty practices that disproportionately care for medically complex patients will be in direct competition with those that treat a healthier patient base. Without incorporating risk adjustment, performance measures could incentivize cherry-picking and lemon-dropping. We have long favored the inclusion in risk adjustment of sociodemographic factors of patients and their use in this measure mirrors the recent addition of socioeconomic adjustment in the CJR. We also support the extension of the postoperative assessment period to 300 to 425 days to better assess the long-term impacts of the procedure.

*b. Comments on IQR Implementation*

When CMS ultimately proposes formally to add this PROM-PM to the IQR, a phased implementation path will be necessary. Our members' experience with PROMs reporting in CJR participating hospitals finds that it takes several years for all the arthroplasty related care components in a hospital and surgeon practice to coordinate on the collection and reporting of PROMs. Some larger, CJR-participating facilities may be ready now for mandatory reporting but smaller facilities will require several years. The PROM collection and reporting is valuable and appropriate in this case, but it is nevertheless an administrative burden on multiple parties that make a PROM capture rate of 60-70% a challenge. We recommend a two-year voluntary reporting period before reporting becomes mandatory. Further study is necessary on eventual exemption criteria for hospitals. Specifically, notwithstanding the fact that CareCompare reports the number of facility patients that are assess for each measure, the question remains of how small must a facility or its arthroplasty volume be before there is insufficient data to meaningfully project that quality of arthroplasty procedures using this PROM-PM.

Regarding data collection and submission, self-reporting through an arthroplasty-specific registry has several benefits. The self-reporting gives participating facilities better real-time appreciation of their current PROM performance. Further, this is an opportunity to encourage provider utilization of QCDRs, such as the American Joint Replacement Registry (AJRR), which is the registry primarily used for physician-level reporting for CJR, BPCI-A, and MIPS. AJRR supports a PROM platform for facilities to easily collect and upload PROM submissions. Additionally, AJRR has formed multiple partnerships to include more approved PROM technological vendors. These efforts have led to substantial growth in PROMs capture. By the end of 2019, 209 sites have submitted PROMs to the AJRR, which is an increase of over 13% compared to 2018. The AJRR has the additional advantage of compliance processes that audits data quality to ensure completeness of data submission.

We believe the THA/TKA PRO–PM measure is appropriate to apply soon to hospital outpatient departments, ambulatory surgical centers, or hospital inpatient procedures followed by observation stays. As CMS is rushing a policy to eliminate the Medicare Inpatient Only List and aggressively incentivize the performance of arthroplasty in non-inpatient settings, it is

important that performance measure data is developed to compare the impact on patients across different arthroplasty sites of care. As we have noted to CMS before, little data exists on outpatient arthroplasty performance in the Medicare population. Some additional time may be necessary for ASCs and outpatient departments to develop the policies and procedures to collect and report this data, but it must be required eventually. Ideally, all Medicare arthroplasty facilities will be measured on the same mandatory performance data.

*c. Considerations for Future Use of the THA/TKA PRO-PM*

*Hospital-Level, Risk-Standardized Improvement Rate in Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty* (NQF ID# 3559) is a new measure but we anticipate its future value in other Medicare value-based care programs. If and when CMS is evaluating how to incorporate this THA/TKA PRO-PM into some other program to impact provider payment, CMS should establish a benchmark percentage rate of success for reaching a significant clinical improvement (the outcome of the measure) rather than requiring providers to compete for percentile rankings of success rates across tightly bunched score rates. This would help, especially in early implementation, to avoid marginalization of patients based on perceived risk factors and their possible loss of access to care.

Further, if scores are used to impact payment, CMS should consider replicating the stratified methodology of the Readmissions Reduction Program, wherein hospital performance is assessed relative to the performance of hospitals within the same peer group. We favor the method used by the Readmissions Reduction Program to stratify hospitals into five peer groups, or quintiles, based on proportion of the patient population dually eligible for Medicare and Medicaid.

## III. MARKET-BASED MS–DRG RELATIVE WEIGHT – PROPOSED POLICY CHANGES (SECTION V.L)

In the 2021 IPPS Final Rule, CMS finalized a policy that hospitals report the following on their Medicare cost reports: (1) The median payer-specific negotiated charge that the hospital has negotiated with all of its MA payers, by MS-DRG; and (2) The 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 stated at the time 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.

CMS is now proposing to repeal these policies and plans.

***AAHKS Comment***: We thank CMS for proposing this repeal in response to stakeholder comments. We do not support ongoing 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 all parties' leverage in negotiating private reimbursement rates between providers and payers. Providers could identify the highest rate disclosed between other payers and providers and set that high rate as a "floor" rate under a

contract. While price transparency is an important issue, we believe solutions should be pursued that do not involve undermining the historic principles of achieving efficient prices through confidential negotiations with competing payers.

At the time this policy was proposed, CMS was transparent in its interest to use this policy to reduce reimbursements to 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*."[1] 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.

The proposed policy had assumed 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. The proposal did 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 very different than Medicare FFS rates and should not be used to influence FFS 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.

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

[1] 85 Fed. Reg. 32790 (May 29, 2020) (emphasis added).

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 thank CMS for deciding 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,

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