

June 17, 2022

VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1771-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: 2023 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 2023 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 2023 IPPS Proposed Rule are as follows:

I. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights – IPPS Arthroplasty Rate Increases Highlight Disparity in Medicare Physician Reimbursement – (Sec. II)

CMS proposes increases in the relative weights of the four primary MS-DRGs associated with lower joint arthroplasty.¹ Combined with proposed increases in the national standardized

¹ Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC (469); Major joint replacement or reattachment of the lower extremity (470); Hip replacement with Principal Diagnosis of Hip Fracture with MCC (521); Hip replacement with Principal Diagnosis of Hip Fracture.

amount, on which DRGs are calculated to derive payment amount, this leads to increases in Medicare payment rates for these arthroplasty codes:²

MS-DRG	2022		2023 Proposed		% Change from 2022
	Weight	Rate	Weight	Rate	
469	3.0859	\$18,890.79	3.2463	\$20,502.88	+8.5%
470	1.9003	\$11,632.97	1.9249	\$12,157.22	+4.5%
521	3.0662	\$18,770.20	3.0245	\$19,102.04	+1.7%
522	2.1894	\$13,402.74	2.1812	\$13,775.95	+2.7%

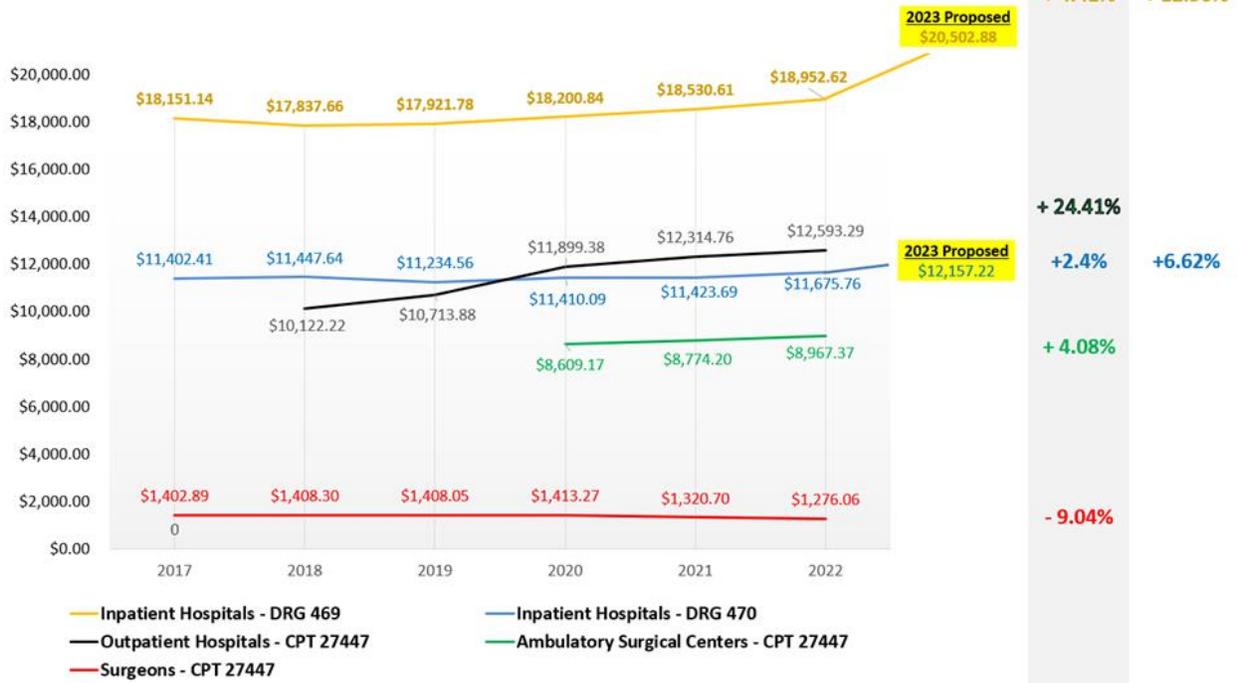
AAHKS generally supports increased payment rates to facilities for arthroplasty due to the extreme complexity of the procedure, innovations in the standard of care and outcomes, and to recognize increased costs through the COVID-19 public health emergency (PHE). Nevertheless, the ongoing annual increases in Medicare facility payments for arthroplasty present a stark contrast with severely decreasing Medicare physician payments for arthroplasty. Medicare payments for the professional component of arthroplasty has been cut by 9% since 2017 and we anticipate CMS will propose additional reductions for 2023 under the Physician Fee Schedule (PFS).

It seems unfair that Medicare payment formulas make physicians carry the burden of cost reductions while hospital payments continue to increase. Reduced reimbursement may prevent surgeons from sustaining independent practices, which may lead to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas. Reduced reimbursement for THA/TKA can also lead to surgeons shifting their focus to other procedures and conditions for which they have trained, despite the accelerating need for joint replacement in the Medicare age eligible population.

While payments under the IPPS and PFS may be calculated according to separate statutory formulas, CMS and Congress should be alarmed at the divergent trends in facility and surgeon reimbursement for arthroplasty. CMS should explicitly state whether it believes that Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for arthroplasty paired with severe cuts to the professional services for those procedures, and if so, why. If not, CMS should articulate to Congress any necessary adjustments to statutory reimbursement formulas so that there may be a unified coordinated CMS policy towards the value of arthroplasty. The disturbing and divergent trends are apparent when graphically tracked as follows:

² These calculations assume national standardized amount for a hospital with a 67.3% labor share, participating as an EHR Meaningful User and a wage index greater than 1.0.

Changes to Medicare Reimbursement for Total Knee Arthroplasty Between 2017 and 2023 Under the Proposed Rule
 COMPARING PAYMENTS FOR HOSPITALS, AMBULATORY SURGICAL CENTERS, OUTPATIENT DEPARTMENTS, AND FOR SURGEONS



II. New Measures Being Proposed for the Hospital Inpatient Quality Reporting (IQR) Program - Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF#3559) – (Sec. IX.E.5.g)

a. Prior AAHKS Comments on THA/TKA PRO-PM

Last year, CMS sought stakeholder feedback on the prospect of eventually adding THA/TKA PRO-PM as a new measure to the IQR Program. The IQR is a pay-for-reporting quality program that subjects hospitals that fail to meet program requirements to a ¼ reduction in their Annual Payment Update under the IPPS. The THA/TKA PRO-PM would report the hospital-level risk-standardized improvement rate (RSIR) in PROs following elective primary THA/TKA for Medicare FFS beneficiaries aged 65 years and older.

We commented at the time that AAHKS supports future addition of the THA/TKA PRO-PM to the IQR program. We support the addition because CMS incorporated suggestions from AAHKS in structuring PRO measures in the CJR program. Namely, (1) that any PRO measure should utilize HOOS Jr. and KOOS Jr. as the survey instruments, and (2) that outcome measures should be risk-adjusted.

Last year, we also asked that:

- CMS use a 2-year phased implementation of the PRO-PM into the IQR as it may take several years for all the arthroplasty related care components in a hospital and surgeon practice to coordinate on the collection and reporting of PROM;
 - CMS study eventual exemption criteria as it is not clear 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; and
 - CMS use this opportunity to encourage self-reporting of data through an arthroplasty-specific registry, such as the American Joint Replacement Registry (AJRR)
- b. AAKHS Support for Adding Measure to IQR Program Measure Set as a Mandatory Measure in 2025

CMS now proposes to formally add THA/TKA PRO-PM to the IQR on a mandatory basis for procedures occurring July 1, 2025, through June 30, 2026. CMS proposes to first allow two years of voluntary submission of data for this measure, beginning January 1, 2023, for which hospitals would receive confidential feedback reports that detail submission results from the reporting period. CMS proposes to calculate and provide each participating hospital with their risk-standardized improvement rate as part of the confidential feedback reports. CMS is formally allowing hospitals to choose to: (1) Send their data to CMS for measure calculation directly; or (2) utilize an external entity, such as through a vendor or registry, to submit data on behalf of the hospital to CMS for measure calculation.

Because CMS has incorporated AAKHS suggestions on voluntary reporting and submission methods, AAKHS supports the proposal to add the measure to the IQR program. Nevertheless, AAKHS offers the following comments and questions on the THA/TKA PRO-PM that request CMS to address before mandatory reporting commences in 2025.

c. Cohort – (Sec. IX.E.5.g.5)

We have concerns that the THA/TKA PRO-PM cohort appears to include some procedures that are so complex as to no longer be relatable to other arthroplasties. According to the measure methodology report, the cohort includes “Elective primary THA/TKA procedures only . . . patients with fractures and revisions, malignant neoplasms, or mechanical complications are not included.”³ Patients with a history of a prosthetic knee joint infection will have surgery to reimplant their knee arthroplasty coded as 27447, but these patients present significant added complexity that cannot be measured against other arthroplasty procedures and should be

³ Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation, *Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip and/or Total Knee Arthroplasty: Hospital-Level Performance Measure*, Version 1.0 Methodology Report, pg. 23 (Mar. 2021).

excluded from the cohort. Otherwise, referral hospitals that bear the burden of care for such patients could be adversely affected by poor measure results for factors outside of the control of the surgeon and care team as the patients do not truly represent primary surgical procedures as there is no other appropriate CPT code for such patients.

Similarly, arthroplasty procedures should be excluded from the measure cohort when the medical record includes diagnosis of nonunion. That is, when arthroplasty is being performed on a joint in which a previously fractured bone failed to heal after an extended period. This is another instance in which a procedure likely has CPT 27447 or 27130 as a primary code but the record also includes an ICD-10 code for nonunion, which presents a level of complexity and challenge that makes the procedure an outlier compared to other lower joint arthroplasty procedures.

We ask that CMS consider removing these procedures from the measure cohort in the future. AAHKS experts are ready to answer any questions for CMS and Yale CORE officials on this topic.

d. Measure Calculation – (Sec. IX.E.5.g.8)

It is not clear from our reading of the Yale CORE measure methodology report whether adjustments for non-response bias account for patients with limited English proficiency. Such patients would be especially challenged with completing a PRO and hospitals with a disproportionate population of patients with limited English proficiency would be expected to have a lower response rate. The methodology report states that the technical expert panel (TEP) “highlighted that the ideal combination of instruments should consider the needs of individuals with lower levels of education, English language skills, literacy, and numeracy.”⁴

The methodology report explains that the THA/TKA PRO-PM measure weights responses from patient demographic factors that are found to be associated with lower completion rates: age, sex, race, low SES, and postoperative complication following hip or knee procedure.⁵ The report emphasizes that the measure utilizes data that is available. It is not clear whether the non-response bias adjustments do not account for limited English proficiency because the data is not captured or because the hospital and CMS do not have access to such data.

e. Data Submission – Pre-Operative Assessment Variables – (Sec. IX.E.5.g.9)

Per the measure methodology report, the measure includes patient reported responses on "total painful joint count (Patient reported in no-operative lower extremity joint)" and "quantified spine pain (patient-reported back pain, Oswestry index question)."⁶ We ask if analysis has been conducted on whether the additional patient questions in addition to HOOS

⁴ *Id.* at pg. 26.

⁵ *See id.*

⁶ 87 Fed. Reg. 28527 (May 10, 2022).

Jr/KOOS Jr. and PROMIS-Global, and VR-12 begin to impact patient responsiveness and question completion? We appreciate that the measure methodology report refers to AAHKS' work with CMS on the topic of short, manageable survey instruments:

CMS received feedback from stakeholders that the 40 or more questions required to complete the HOOS or KOOS instruments were too burdensome for national adoption. Both an AAHKS-convened PRO Summit for Total Joint Arthroplasty and the public comment for CMMI's CJR model revealed broad stakeholder support for shifting to less burdensome instruments. The HOOS, JR and KOOS, JR instruments were proposed by a consensus group of stakeholders through public comment as alternatives.⁷

Patient survey instruments fall somewhere on a spectrum with helpful, illustrative information on one extreme and likelihood of patient completion and low burden to patients and providers on the other end of the extreme. HOOS JR/KOOS JR have been favored by AAHKS because they obtain key information from patients and yet are significantly shorter than other instruments, thus keeping provider and patient burden low and increasing the likelihood of completion. The addition of new patient-reported questions to this measure (total painful joint count, quantified spine pain) increases the administrative burden of the measure and likely have some impact on completion rates. We wonder if the impact on completion rate has been measured. We suggest CMS use the two years of voluntary reporting to assess if completion rates are different with these new questions from completion rates of similar PROMs under the CJR.

III. New Measure Being Proposed for the Hospital Inpatient Quality Reporting (IQR) Program - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF #1550) – (Sec. IX.E.5.i)

CMS removed the original THA/TKA Complication measure from the Hospital IQR Program in 2018. Its removal at the time was a part of a CMS effort to reduce provider burden since the measure was also being reported under the Hospital VBP Program. CMS believed that the costs associated with at the time outweighed the benefit of its continued use in the program.

In 2018, AAHKS commented to CMS that we supported the removal of THA/TKA Complication, and two other measures, from the IQR because of our key principles for federal health policy which include is that the burden of excessive physician reporting on metrics detracts from care. AAHKS believes that quality measures, and especially outcome measures, are essential to a modern value-based health care system. We also believe that the use of measures should be limited to those that meaningfully predict the quality of care. Further, that excessive and unnecessary reporting has a counter-productive effect on provider burden and measure response rates.

⁷ Yale CORE THA/TKA PRO-PM Methodology Report, pg. 26.

CMS proposes to adopt a newly refined version of THA/TKA Complication measure into the Hospital IQR Program that would expand the measure outcome to include 26 additional mechanical complication ICD–10 codes. CMS believes that the 26 additional complication codes that would be added would make the THA/TKA Complication measure more accurate in accurately capturing complications following arthroplasty. Presumably, more accurate to a degree to make it worth the cost to CMS of administering the measure.

AAHKS’s response to this proposal for 2023 is as follows. First, we endorse the inclusion of the 26 additional mechanical complication ICD–10 codes THA/TKA Complication measure. These complications codes are clinically appropriate to be paired with arthroplasty and will improve the measure’s accuracy. Second, we do not object to the addition of this measure to the IQR program as the data for the measure is derived by CMS from Medicare claims and therefore creates no additional reporting burden for patients or surgeons.

IV. Proposed Refinement of the Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF #3474) – (Sec. IX.E.6.a)

CMS proposes a refinement to the current IQR Program THA/TKA Payment measure, to expand the measure outcome to include 26 clinically vetted mechanism complication ICD–10 codes, for the FY 2024 payment determination and subsequent years. These are the same 26 complications codes that CMS has proposed adding to the THA/TKA Complication measure.

As discussed above, we believe that these 26 complication codes are appropriate to include in arthroplasty measures. Therefore, AAHKS supports this refinement to the THA/TKA Payment measure.

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

Sincerely,



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