

September 30, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 1753-P
Baltimore, Maryland -21244-1850

Submitted electronically to CMSOrthopedicsMeasures@yale.edu

Re: Project Title: Development of a Hospital-Level 90-Day Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for a Combined Inpatient (IP) and Outpatient (OP) Setting Measure

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on Development of a Hospital-Level 90-Day Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for a Combined Inpatient (IP) and Outpatient (OP) Setting Measure.

AAHKS continues to support measures promoting quality of care in order to improve patient outcomes and AAHKS has supported the Hospital-Level 90-Day Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure and the recently proposed expansion to include 26 additional complication codes. We are generally supportive of the expansion of the Hospital-Level 90-Day Risk- RSCR Following Elective Primary THA and/or TKA for a Combined Inpatient (IP) and Outpatient (OP) Setting Measure, but we have several areas of concern regarding the combining of IP and OP into a single measure. AAHKS believes that applying quality measures to all THA/TKA patients irrespective of site of service is an important goal.

We continue to believe that CMS should provide more specific guidance for the determination of IP versus OP status. We are unaware of what unintended consequences the removal of TKA/THA from the Inpatient Only (IPO) list has had on RSCR and believe that further clarification and guidance will ensure consistency in the claims data which are used as the basis for the measure. Additionally, because of the absence of “present on admission” (POA) diagnoses in OP patients, we believe that this difference in data may impact the risk standardization as we do not know the impact of the absence of POA diagnoses on the measure.

As expressed in the Technical Expert Panel report, we also support the inclusion of race, socioeconomic, and additional social determinants of health (SDOH) factors in the measure. The data presented in the appendix of the Draft Measure Methodology Report demonstrate differences in RSCR for hospitals based on low/high percentage of Black patients, low/high

percentage of other non-White patients, and patients with dual-eligibility. While there was near perfect correlation of RSCR with/without race, with/without adjusting for dual eligibility, and with/without adjusting for the Agency for Healthcare Quality and Research Socioeconomic Status Index (ASI), we remain concerned that this aggregation of the data does not best reflect differences that may exist in individual hospitals/communities/regions and CMS should continue to examine the contribution of these and other SDOH factors in the measure. Exclusion of such factors may have unintended consequences on patient access and care that must be prevented.

Thank you again for the opportunity to provide comments on this measure. If you have any questions, please contact Michael Zarski at mzarski@ahhs.org or Joshua Kerr at jkerr@ahhs.org.

Sincerely,

A handwritten signature in black ink, appearing to read "B.D.S.", enclosed within a thin black rectangular border.

Bryan D. Springer, MD
President

A handwritten signature in black ink, appearing to read "Michael J. Zarski", written in a cursive style.

Michael J. Zarski, JD
Executive Director