AAHKS
AMERICAN ASSOCIATION OF
HIP AND KNEE SURGEONS

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June 10, 2024

VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1808-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: 2025 Medicare Inpatient Prospective Payment System Proposed Rule & Proposed Transforming Episode Accountability Model (TEAM)

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 2025 (hereinafter referred to as "FY 2025 IPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 5,200 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 four principles:

- Payment reform is most effective when physician-led;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- 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.

I. Summary of Comments

- Proposed arthroplasty payment rate increases for facilities highlights the disparity in Medicare physician reimbursement
- Proposed IPPS market basket update is inadequate to meet the actual costs faced by facilities
- We support the removal of duplicative measures from the Hospital Value-Based Payment Program

- Excluding physicians from the definition of TEAM model participant diminishes the expertise and clinical input of the one provider most responsible for the patient's care before, during and after the procedure
- Excluding physicians from acting as participant conveners under the TEAM model will further exacerbate provider consolidation trends
- Participating hospitals should be required to enter into shared savings agreements with the applicable surgeons under the model
- Excluding ASCs from items and services included in the TEAM model episode will skew incentives for determining the best site of service/admission status for procedures under the TEAM model
- We do not object to a 30-day episode window under the TEAM model
- CMS should expedite the development of procedure specific measures so that provider care teams can be evaluated for their performance related to the episode, as opposed the hospital's overall performance on unrelated measures under TEAM
- We support Including the Hospital-Level THA/TKA PRO-PM Measure in TEAM for LEJR
- We support collecting TEAM quality data through the Hospital Inpatient Quality Reporting and Hospital-Acquired Condition Reduction Programs
- Publicly reporting PRO-PMs for hospitals and surgeons under the TEAM model may disadvantage those physicians and hospitals who accept higher risk and socially disadvantaged patients
- The proposed 3-year rolling benchmarking methodology with annual updates under TEAM is too aggressive for many rural and small providers with little experience in value-based care
- We recommend that CMS set the TEAM model high episode spending cap at the 90th percentile, not the 99th
- The proposed TEAM discount factor is too aggressive for many rural and small providers with little experience in value-based care
- Limiting applicable TEAM HCC counts to a 90-day look-back period from the anchor procedure, instead of the prior year a used under current CMMI models, undermines the purposes of value-base care

Our detailed comments on the FY 2025 IPPS Proposed Rule are as follows:

II. 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 to increase the relative weight of three of the four primary MS-DRGs associated with lower joint arthroplasty.[1] CMS proposes minor reductions in the relative weight of the other procedure. Combined with proposed increases in the national standardized amount,

[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 (522).

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

MS-DRG	FY 2023		FY 2024		% Change from 2023	FY 2025 (Proposed)		% Change from 2024
	Weight	Rate	Weight	Rate		Weight	Rate	
469	3.2314	$20,602.57	3.3298	$21,636.27	**+5.02%**	3.3019	$22,010.80	**+1.73%**
470	1.9119	$12,189.78	1.8817	$12,226.85	**+0.30%**	1.9051	$12,699.59	**+3.87%**
521	3.0192	$19,249.63	2.9942	$19,455.62	**+1.07%**	2.9240	$19,491.68	**+0.19%**
522	2.1729	$13,853.85	2.1122	$13,724.59	**-0.93%**	2.1206	$14,136.13	**+3%**

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 for labor and supplies remaining from the COVID-19 pandemic. Nevertheless, the ongoing *annual increases in Medicare facility payments* for arthroplasty present a stark contrast with severely *decreasing payments for arthroplasty under the Medicare Physician Fee Schedule* (PFS). Medicare payments for the professional component of arthroplasty have been cut by 5.5% since 2017 and overall physician payment arthroplasty has been cut 11% in that period.

It is a challenging proposition for policy makers to ask that physicians carry the burden of Medicare expenditure reductions while hospital payments continue to increase, especially given the fact that the physician fee accounts for less than 6% of the overall episode of care cost. Reduced reimbursement prevents surgeons from sustaining independent practices, which is directly contributing to an increase in mergers and consolidation in healthcare. 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 also leads 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. We have commented previously that CMS should explicitly state whether it believes 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. In light of President Biden's *Executive Order on Promoting Competition in the American Economy*,[3] CMS should clearly understand that its very own proposed reductions in Medicare physician rates decreases

[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.
[3] EO 14036 (July 9, 2021).

competition in health care or facilitate consolidation and goes directly against President Biden's executive order.

Because of these concerns, AAHKS is optimistic for the future passage of H.R. 3284, the *Providers and Payers COMPETE Act of 2023*, which has been reported out of the House Committees on Energy & Commerce and Ways & Means, to require the Secretary of Health and Human Services (HHS) to assess and report to Congress on the impact of any Medicare reimbursement or regulatory changes on consolidation of healthcare providers and payers. Such reporting is an important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates.

III. Inflation Adjustment: Proposed Changes in the Inpatient Hospital Update for FY 2025 – (Sec. V.B.1)

CMS proposes a net 2.6% payment rate increase for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users—reflecting the projected hospital market basket update of 3.0% reduced by a 0.4% productivity adjustment.

Given measurably high inflation and increased costs for labor, equipment, drugs and supplies, the proposed market basket update is inadequate to meet the actual costs faced by facilities. Since FY 2022, CMS has finalized market basket payment updates based on data that did not anticipate or incorporate the record high inflation and significant increases in the costs of labor, drugs and supplies.

The proposed FY 2025 market basket payment update would severely exacerbate this problem and does not properly recognize the high financial pressures that hospitals currently face. As a matter of principle, AAHKS believes all Medicare payment systems for providers and facilities, and especially physicians, should be annually updated to account for real increases in cost inputs experienced in the real world.

Currently, Medicare payment systems vary significantly in the degree to which annual payment increases correspond with inflation if they do at all. Focused reform, including for physician payment, is needed on this topic. For the purposes of this proposed rule, AAHKS supports a higher market basket payment update under the IPPS to reflect the actual effects of inflation on hospital operating costs. AAHKS endorses an annual inflation-based payment update based on the full Medicare Economic Index (MEI), as has been recommended by MedPAC.

IV. Hospital Inpatient Quality Reporting (IQR) Program

a. Proposal to Remove Four Clinical Episode-Based Payment Measures Beginning with the FY 2026 Payment Determination (Sec. IX.C.6.b)

CMS is proposing to remove four condition-specific episode-based measures that are duplicative of a more broadly applicable measure in the Hospital Value-Based Payment (BVP) Program. Specifically, the VBP's *Medicare Spending Per Beneficiary Hospital measure (CBE #2158*) ("MSPB Hospital measure") captures the same data as the four clinical episode-based payment measures being proposed for removal in addition to a much larger set of conditions and procedures. The measures CMS is proposing for removal are as follows:

- *Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CBE #3474) (THA/TKA Payment)*
- *Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI) (CBE #2431)*
- *Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure (HF) (CBE# 2436)*
- *Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia (PN) (CBE #2579)*

AAHKS supports the removal of these payment measures as proposed because duplicative measures should be avoided to prevent hospitals from being rewarded/penalized more than once for any given quality measure.

b. Ongoing Implementation of Mandatory Reporting of Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF#3559) (Sec. IX.C.)

As finalized in the 2023 IPPS Final Rule, mandatory reporting under the IQR of new Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618) commences on July 1, 2024 for the FY 2027 payment year. Hospitals and surgeons have been partnering since 2023 to prepare for this new mandatory reporting.

We wish to raise reports from our members that some small and rural providers are struggling to meet the July 1, 2024 deadline for mandatory reporting. CMS should anticipate the additional technical assistance and/or case-by-case extensions may be necessary.

Comments and Feedback on the New TEAM Model

V. Model Participation – (Sec. X.A.3.a)

a. Proposed TEAM Participant Definition - (Sec. X.A.3.a.(2).(b))

i. Inclusion of Acute Care Hospitals and Exclusion of the Physicians Who Actually Manage an Episode

CMS proposes to limit TEAM participants to acute care hospitals as the only entity able to initiate a model episode. We understand CMS' multiple reasons for limiting participation in this way: having an adequate volume of episodes, access to resources, readiness for mandatory participation, hospital experience in discharge planning, administrative efficiency, and others.

Based on our members' extensive experience in the CJR and BPCI-A, the long-standing position of AAHKS is that physicians with requisite qualifications should be permitted to participate in any CMMI model as episode initiators and conveners. This includes allowing non-physician organizations to serve as "conveners." Notwithstanding the reasons cited by CMS for limiting participants to acute care hospitals, it is the physicians who actually are responsible for managing a procedure within a facility and who are in the best position to broadly manage included items and services in the episode in the context of the underlying condition and procedure.

For example, orthopaedic surgeons are deeply involved in the discharge planning process following LEJR, beginning planning well before the procedure itself to anticipate where the patient can find care, support, and a safe stair-free environment during the immediate recovery period. Also, orthopaedic surgeons are not solely procedure specialists but also serve as a patient's primary care provider for the purposes of managing long-term chronic orthopaedic conditions like osteoarthritis.

We understand that many physician surgical practices may be unprepared for mandatory participation as participant/bundle-holder in an episode payment model, but more must be done to recognize and favor the physician's role in the model as the individual responsible for clinical care. When the patient has a question about the procedure, they call the physician, not the hospital.

As a compromise measure, we recommend that participating acute care hospitals be required to enter into shared savings agreements with the applicable surgeon. Under the CJR, CMS anticipated that hospitals "might" choose to share savings with physicians, but the experience of our members is that such agreements are few and far between. While CJR has shown a level of success in reducing Medicare expenditures for LEJR, we believe the savings under TEAM could be even greater if physicians share in financial incentives by uniformly being included in the shared savings of a hospital. Details such as minimum gainsharing percentages

and the handing of downside risk will have to be addressed in subsequent rulemaking to implement the policy.

Further, we recommend CMS allow physician groups to voluntarily participate in the TEAM model in geographic regions NOT selected for mandatory participation. This would allow CMS to accomplish its objective of evaluating the model results of all hospitals in the mandatory regions head-to-head, but also maintain a model that is physician centered. CMS could evaluate performance differences between mandatory participant hospitals and voluntary physician participant/conveners.

ii. Unintentional Impacts of Excluding Physicians: More Health Care Provider Consolidation

Another concern with limiting model participation to acute care hospitals and excluding the physicians who actually manage care and hold the doctor-patient relationship is that it amounts to yet another federal action that gives more power to facilities and health plans relative to physicians. Such federal policies are the primary driver behind the consolidation in health care providers that this administration has stated is a concern.

There is a misconception that consolidation happens because retiring physicians want to sell their practices to “cash out.” Instead, for many physicians, selling to private equity (PE), a large health system or to a private payer is the only means to continue to practice medicine in the face of reimbursement cuts and cost increases. Our members are clear: private practice surgeons by definition would like to remain independent and the ONLY reason consolidation occurs is because running a practice with the current level of Medicare reimbursement coupled with inflation is financially unfeasible. Unfortunately, according to the American Medical Association (AMA), the number of doctors owning their practices has declined drastically in recent years.

Continued Medicare cuts to physician reimbursement for LEJR, which has drastically outpaced overall cuts to the physician fee schedule over the past 30 years, is the primary factor driving health care consolidation in orthopedic surgery and the growing inability of physicians to maintain an independent practice. These declining reimbursement rates, particularly a 65% cut in real dollar Medicare rates over 30 years, make maintaining an independent practice financially unfeasible.

For example, current Medicare reimbursement to physicians for total hip arthroplasty is only 35% of the amount it would have been if adjusted for inflation each year since 1992. Illustrated another way, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 22% since 1995. When adjusted for inflation, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 65% since 1995. Such sustained cuts inarguably make it financially unfeasible for our members to afford to practice independently.

If physicians are excluded from a leadership role in new CMMI episode payment models, the number of independent physician practices will decline even faster. Payers and facilities will be encouraged in their attitude that physicians and the doctor-patient relationship are simply cost-inputs to be reduced and managed.

b. Items and Services Included in Episodes - (Sec. X.A.2.b.(5))

CMS proposes that the episode will include all items and services paid under Medicare Part A and Part B, including:

Physicians' services	Inpatient hospital services	Inpatient psychiatric facility services
Long-Term Care Hospital services	Inpatient Rehabilitation Facility services	Skilled Nursing Facility services
Home Health Agency services	Hospital outpatient services	Outpatient therapy services
Clinical laboratory services	Durable medical equipment	Part B drugs and biologicals
Hospice services	Part B professional claims within 3 days of the hospitalization	

CMS proposes to exclude from episodes, for both the baseline period and performance years, those items and services clinically unrelated to the anchor hospitalization, such as oncology, trauma medical admissions, organ transplant, ventricular shunts, diseases of the eye, pregnancy and childbirth, newborns, and HIV. AAHKS does not object to the included and excluded services for the episode. We appreciate the model will include inpatient and outpatient LEJR, as outpatient LEJR was added to the CJR model in 2021 following the removal of THA and TKA from the Medicare Inpatient Only (IPO) List.

We note the exclusion from the model of LEJR performed in Ambulatory Surgical Centers (ASCs). We hope that Medicare will eventually expand TEAMs to ASCs performing LEJR, at least on a voluntary basis. When Medicare covers surgical procedures at multiple sites of service but proposes an episode payment model covering only some of those sites of service, risks arise for distortions in referral patterns and in the model patient population.

As we shared with CMS in 2020 regarding the addition of outpatient procedures to the CJR, it is possible that lower resource utilizing, healthier patients who are able to receive TJA procedures in ASCs will not be included in TEAMs denominators for cost and quality performance metrics. Therefore, model evaluations and results will not present a comprehensive assessment of the model's impact on Medicare covered LEJR. Conversely, some hospitals could feel incentivized to direct high-cost, complex LEJR patients (or perceived poorly performing surgeons) to ASCs to improve their own facility's quality scores. Either way, when a covered site of service is not included in a model, it increases the likelihood that additional financial considerations will influence decisions on the site of service for a patient.

Potentially even more problematic with not including ASCs in the TEAMs model is the fact that currently in the US there is a huge shift of LEJR out of the hospitals into ASCs, leaving only the higher risk patients remaining in the hospital. These high-risk patients are the ones unlikely to perform well compared to historical metrics and costs. Over the time-period outlines for the TEAMs program, this will only accelerate and will distort the ability for CMS to evaluate the programs efficacy. Finally, LEJR is the only procedure in the TEAMs model that is undergoing this transformative exodus from the hospital setting.

We request that CMS respond to the following questions in the TEAMs Final Rule:

- What was CMS' rationale for excluding ASCs from the model?
- What conditions would need to be present for CMS to expand the model to ASCs?
- What percentage of Medicare covered THA and TKA are performed annually in the following settings: inpatient, outpatient, ASC?
    - Stakeholders would likely value this data for the other TEAMs covered procedures as well.

c. *Episode Length – 30 Days (Sec. X.A.2.b.(5).(d))*

CMS proposes that episodes would end 30 days after discharge from the anchor hospitalization or anchor procedure and that day 1 of the 30-day post-acute portion of the episode is the date of the anchor procedure or the date of discharge from an anchor hospitalization. CMS' rationale for switching to a 30-day episode from the 90-day episode used in CJR is that (1) durations longer than 30 days pose a greater risk for the hospital due to medical events outside the intended scope of the model and (2) the need for care for chronic conditions and other non-anchor conditions becomes much more prevalent in days 31 to 90 following hospital discharge. A 30-day episode would position the physician specialist as the principal provider near the anchor event with a hand off back to the primary care provider for longitudinal care management.

AAHKS does not object to this episode length and appreciates CMS' attempt to develop an episode that is less likely to include medical events unrelated to the anchor condition.

VI. Quality Measures and Reporting (Sec. X.A.3.c.)

a. *Overview of Proposed TEAM Measures - (Sec. X.A.3.c.2)*

CMS is proposing to require reporting of three measures under the model:

- For all TEAM Episodes: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356);
- For all TEAM episodes: CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135); and

- For Lower Extremity Joint Replacement (LEJR) episodes: Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618).

b. *Inclusion of Additional Measures in the 2023 Measures Under Consideration List - (Sec. X.A.3.c.2)*

CMS solicited feedback on any measures on the 2023 Measures Under Consideration (MUC) list that may be more clinically meaningful/appropriate for TEAM than the three measures proposed. CMS specifically requested stakeholder input on replacing the CMS PSI 90 measure with the following measures beginning with the TEAM second performance year (2027):

- Hospital Harm—Falls with Injury (MUC2023-048);
- Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (MUC2023-049); and
- Hospital Harm—Postoperative Respiratory Failure (MUC2023-050).

AAHKS generally supports the continued use of PSI 90 as a global measure of quality rather than replacing PSI 90 with the suggested measures which do not cover the breadth of post-operative care and complications that are covered in PSI 90. Additionally, AAHKS' perspective on replacing the CMS PSI 90 measure with the specific MUC measures is as follows:

i. <u>Hospital Harm—Falls with Injury (MUC2023–048)</u>

AAHKS supports the use of a measure of fall/fall prevention, but we are concerned that the stated measure lacks specificity and may lead to unequal assignment. While PSI 08-In Hospital Fall with Hip Fracture Rate is clear on which patients qualify, MUC2023-048 lacks specificity as to what constitutes a "moderate or major" injury. Without a clear and distinct definition of everything that is included within this broad category, we are not supportive of this measure as written.

ii. <u>Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (MUC2023–049)</u>

AAHKS believes that this measure has merit. However, we are concerned that the measure fails to account for circumstances outside of the control of the hospital reporting the measure. The hospital should not be held accountable for Failure-to-Rescue if the patient's complication occurred outside of the hospital as the hospital is not in control of the patients care at the time of the complication, transport to the hospital (if required) and further care if provided at a different facility. We would favor use of this measure if there were specification that the complication occurred during the patient's hospital admission for the specified procedure.

iii. <u>Hospital-wide Quality Measures Under an Episode Payment Model</u>

A notable downside to using hospital-wide measures under an episode payment model is that quality scores for the procedure care team will be influenced by facility quality performance on measures for which the procedure team had no connection. The hospital may be the model participant, but the eventual scores under the model, and the potential for physician partners with a gainsharing agreement with the facility to share in savings, will be adversely at risk for care outside of their control.

CMS acknowledges that it proposes these facility-wide measures in the absence of procedure specific measures for the model covered procedures, apart from LEJR. CMS should work with measure collaborators to expedite the development of procedure specific measures for surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure.

c. AAHKS Supports Including the Hospital-Level THA/TKA PRO-PM Measure in TEAM for LEJR - (Sec. X.A.3.c.3.c.)

CMS is proposing to require submission of THA/TKA PRO-PM for LEJR episodes. AAHKS is supportive of the ongoing use of the Risk-Standardized PRO-PM following THA/TKA without any change. This measure underwent an extensive development process by YALE-CORE with significant stakeholder input. Due to the nature of procedures included in the TEAMS model, AAHKS believes that requiring the hospital to obtain any type of PROM from a patient with an emergent surgical condition (i.e., hip fracture) would be inappropriate for the patient.

d. AAHKS Supports Collection of TEAM Quality Data Through Hospital Inpatient Quality Reporting (IQR) and Hospital-Acquired Condition (HAC) Reduction Programs - (Sec. X.A.3.c.4.)

CMS solicited feedback on whether the collection of quality measure data should be administered through the existing mechanisms of the Hospital IQR and HAC Reduction Programs, given that all three measures are or will soon be required to be reported under both programs. The result of this proposal would be that hospitals would not need to submit additional data for TEAM.

AAHKS is supportive of minimizing the reporting burden placed upon hospitals and therefore, supports administration of quality measure data through the existing mechanisms of Hospital IQR and HAC Reduction Programs. However, we note that a number of our members report that some small and rural providers are struggling to meet the July 1, 2024 deadline under the IQR of Hospital-Level THA/TKA PRO-PM. CMS should anticipate the additional technical assistance and/or case-by-case extensions may be necessary.

e. Display of Quality Measures and Availability of Information for Public - (Sec. X.A.3.c.5.)

CMS is proposing to display quality measures on the publicly available CMS website in a form and manner consistent with other publicly reported measures. CMS would share each TEAM participants' quality metrics with the hospital prior to display on the CMS website. The timeframe for when TEAM participants would receive data on our proposed measures align with the Care Compare schedule. Scores would be reported every performance year, with a one-year lag.

AAHKS is supportive of the publicly reporting outcomes data in general. However, we are not supportive of publicly reporting TEAMS quality scores because not all hospitals in a market/region will have TEAMS scores which may unfairly advantage/disadvantage participating hospitals when patients seek services in a region and not all hospitals have reporting data. Having only some hospitals in a region participate creates inequality in patients' ability to evaluate the competing hospitals because there is this additional data provided only for some of the hospitals. We favor publicly reporting of data when all hospitals have an equal opportunity to have their data risk stratified and presented in the same manner. For example, the THA/TKA PRO-PM which will be reported by all hospitals through the IQR.

There is significant concern that publicly reporting PRO-PM's for hospitals and surgeons may disadvantage those physicians and hospitals who accept higher risk and socially disadvantaged patients. The difficulty of obtaining PRO-PM metrics in underserved and socially disadvantaged populations is further exacerbated by a greater incidence of medical and social risk factors for readmissions, ER visits and adverse outcomes in certain vulnerable populations and geographic regions. The disincentive of treating such patients by hospitals and surgeons to avoid poor relative public reported PRO-PM's and outcomes, as well as protect against downside financial risk in TEAMs, will further hinder access to appropriate surgical LEJR care for certain patients and decrease health equity efforts.

VII. Pricing and Payment Methodology - (Sec. X.A.3.d.)

a. Baseline Period for Benchmarking - (Sec. X.A.3.d.(3).(a).)

CMS proposes to use 3 years of baseline episode spending, rolled forward for each performance year, with more recent baseline years weighted more heavily, to calculate TEAM target prices. We understand the precedent for such calculation of target prices as CMS uses a 3-year baseline under the CJR and since 2021 has updated the CJR baseline annually instead of every two years. However, as this model is intended to capture many regions and facilities that are rural, small, and/or with little experience with value-based care, we believe this benchmarking methodology is too aggressive for many of those providers. The "ratchet-effect" of this methodology will prove too aggressive for some participants that are new to episode payment models. More so than under the CJR, some providers that are mandated to be a part of this model will be severely challenged to achieve episode spending within the target price.

b. High-Cost Outlier Cap - (Sec. X.A.3.d.(3).(e).)

For the purposes of a high-cost outlier policy for TEAM, CMS proposes to cap both baseline episode spending and performance year episode spending at the 99th percentile of spending at the MS–DRG/HCPCS episode type and region level, referred to as the high-cost outlier cap. Although we recognize CMS's efforts to identify outlier spending in the model, we believe that providers should not be punished for taking the risk of treating the most vulnerable and complex patients. Capping episode costs only above the 99th percentile imposes extraordinary risk on providers. As this model is intended to capture many regions and facilities that are rural, small, and/or with little experience with value-based care, we believe the proposed outlier cap is too aggressive for many of those providers. As we commented in 2020 on the similar CJR policy, CMS has not shared why it proposes such an onerous, high level. As an alternative, AAHKS recommends that CMS set the high episode spending cap at the 90th percentile.

c. Discount Factors - (Sec. X.A.3.d.(3).(g).)

CMS proposes to apply a 3% discount factor to preliminary episode target prices for episodes. CMS considered, but decided against, applying lower discount factors of 2%, 1%, or 0.5% for some episodes based on type of procedure or type of facility. We believe this is a missed opportunity to structure TEAM to gradually ramp up the model for providers who are newer to value-based care or who serve a more chronic, high-acuity disadvantaged population. As this model will capture many regions and facilities that are rural, small, and/or with little experience with value-based care, we believe a 3% discount factor is too aggressive for many of those providers.

d. Risk Adjustment and Normalization - (Sec. X.A.3.d.(4).)

CMS proposes to risk adjust episode-level target prices at reconciliation by the following beneficiary-level variables: age group, Hierarchical Condition Category count (a measure of clinical complexity), and social risk.

AAHKS endorses the application of a robust risk adjustment methodology under the model. AAHKS advocated for the importance of risk adjustment under episode payment models since CJR was first proposed. As we shared at that time, the lack of a risk adjustment methodology would penalize the providers that treat the sickest patients. Hospitals and TJA practices that disproportionately care for medically complex patients would be in direct competition with those that treat a healthier patient base. Subsequent CMMI reports confirmed our concerns by finding that CMMI models without risk adjustment were more likely to see a reduction in patients that were perceived to be sicker and higher cost, as providers were incentivized to shift such patients elsewhere.

However, we strongly object to CMS' proposal to limit applicable HCC counts to a 90-day look-back period from the anchor procedure. CMS should instead continue the endorsed policy of the JR of using HCCs from prior years' annual file. For smaller, rural providers and those treating

an underserved population, it is not necessarily the case that all chronic conditions that can add costs and complexity will be captured in patient medical records from the 90 days prior to the procedure. Many fee-for-service providers have not been incentivized up-to-now to record all diagnosis codes in all encounters. If CMS moves to limit HCCs to only a 90-day look-back period, participants will be disadvantaged relative to CJR participants and others due to the coding practices of other providers over whom they have no control.

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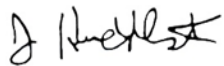
AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,



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