AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

September 6, 2016

Andrew M. Slavitt
Acting Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-5517-P, P.O. Box 8016,
Baltimore, MD 21244-8016.

Submitted electronically via http://www.regulations.gov.

Subject: (CMS-1656-P)
Proposed Rule: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Acting Administrator Slavitt:

On behalf of the 18,000 board-certified orthopaedic surgeons who comprise the membership of the American Association of Orthopaedic Surgeons (AAOS) and that of the orthopaedic sub-specialty groups who agreed to sign-on, we are pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule on the Medicare Program's **Proposed Rule on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1656-P)** published in the Federal Register [42 CFR Parts 416, 419, 482, 486, 488, and 495] on July 14, 2016.

Site of service differentials

A key proposal in this year's rule is to implement Section 603 of the Bipartisan Budget Act (BBA) of 2015, which will affect how Medicare pays for certain items and services furnished by certain off-campus outpatient departments. Currently, services received by Medicare beneficiaries in an off-campus Hospital Outpatient Department (HOPD) or off-campus Provider-based Department (PBD) have a higher total payment amount than when the same services are received in a physician's office. The higher amount is because Medicare pays two separate claims in the former settings—one under the Outpatient Prospective Payment System (OPPS) for the institutional services and one under the Medicare Physician Fee Schedule (MPFS) for the physician's services. It is widely known that in their recommendation to the Congress, the Medicare Payment Advisory Commission (MedPAC) has regularly noted that Medicare should not provide higher reimbursements for a given service when it is provided in a costlier setting but instead should make resource-based payments needed to provide high quality care in the most

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efficient setting. Thus, MedPAC previously recommended site-neutral payments for certain services provided in both HOPDs and in physician offices. In our response to past OPPS payment rules, the AAOS had consistently expressed concern that the difference between ambulatory surgical centers (ASCs) and hospital HOPD rates continued to diverge creating financial incentives to use the HOPD rather that the ASC setting. The AAOS is supportive of the CY 2017 proposal for site-neutral payments and to have physicians at non-excepted PBDs bill and be paid under the MPFS at the non-facility rate.

Meaningful Use

Per the Medicare Access and CHIP Reauthorization Act (MACRA) Proposed Rule, 2017 is the first Merit-Based Incentive Payment System (MIPS) performance period in the Quality Payment Program (QPP). However, 2017 is also the last year that a first time Meaningful Use (MU) program participant may apply for an exception to avoid penalty in 2018. Thus, in 2017, a new MU participant would need to participate in both the MU program and the Advancing Care Information program of the QPP to avoid any payment adjustments. Given that many physicians and their infrastructure are not ready for participation in these programs, AAOS supports CMS' CY 2017 proposal to allow physicians who have not been able to participate in the MU program so far to apply for hardship exemptions.

In terms of the reporting period, the AAOS had previously commented asking for a 90-day reporting period in the MU program. Thus, the CMS proposal to reduce reporting period requirements from a full calendar year to a 90-day reporting period is encouraging. However, since there are no changes to the Physician Quality Reporting System (PQRS), physicians utilizing clinical quality measures to fulfill PQRS reporting requirements will continue to face the heavy burden of a full year reporting.

Hospital Value-Based Purchasing (VBP) Program Update

In the proposed rule, CMS called for comments on the concerns with overlapping prescription of opioids. As orthopedic surgeons are the third highest prescribers of opioids, the AAOS Board of Directors (http://newsroom.aaos.org/media-resources/Press-releases/aaos-board-of-directors-approves-information-statement-to-combat-growing-opioid-epidemic.htm) have been supportive of standardized protocols to control prescriptions and use. They called for protocols to set ranges for acceptable amounts and durations of opioids for various surgical and non-surgical conditions and procedures and discouraged prescription of opioids for pre-operative and non-surgical patients. The AAOS Information Statement on Opioid Use, Misuse and Abuse in Orthopaedic Practice called for active physician participation in curbing the opioid epidemic, continued medical education for physicians on this issue, better communication and physicians and patients and multi-specialty opioid use tracking. For more information on this statement, please

visit: http://www.aaos.org/uploadedFiles/PreProduction/About/Opinion_Statements/advistmt/1045%20Opioid%20Use,%20Misuse,%20and%20Abuse%20in%20Practice.pdf.
Thus, AAOS is supportive of the removal of the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) from the VBP reporting requirements beginning in 2018. We urge CMS to include inputs from orthopaedic surgeons and other high prescribing physician groups in developing alternative pain management items.

Solicitation of Public Comments on the Possible Removal of Total Knee Arthroplasty (TKA) Procedure from the IPO List

Total knee arthroplasty (TKA) or total knee replacement, CPT code 27447(Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)), has traditionally been considered an inpatient surgical procedure. However, this Proposed Rule is seeking comments on the removal of TKA from the IPO list. CMS has previously considered the removal of TKA from the IPO list in the 2013 OPPS/ASC proposed rule. In the 2017 Proposed Rule, CMS is not specifically proposing a policy change, however, they will consider it for future rulemaking.

In terms of the removal of TKA from the IPO list, the AAOS does not support moving TKA from the IPO list at this time. As part of the proposed rule summary, CMS posted specific questions related to the appropriateness of a potential change and we are providing responses to the specific questions raised by CMS below.

CMS Question 1: *Are most outpatient departments equipped to provide TKA to some Medicare beneficiaries?*

Orthopaedic surgeons, especially hip and knee surgery specialists, have identified seven different scenarios in which total knee arthroplasty may be considered outpatient:

- TKA, done in hospital, not admitted, discharged to home on day of surgery (DOS).
- TKA, done in hospital, admitted, meets “criteria”, discharged to home on DOS.
- TKA, done in hospital, not admitted but observed, discharged to home on post-op day #1 (POD1).
- TKA, done in hospital, admitted, meets “criteria”, discharged to home on POD1.
- 27447, done in ASC, discharged to home on DOS.
- 27447, done in ASC, discharged to home POD1 (nurse stays overnight too).
- 27447, done in ASC, requiring hospital admission on DOS or POD1 (i.e., failed outpatient procedure)

Most outpatient departments are not currently equipped to provide TKA to some Medicare beneficiaries. This requires exceptional patient selection, exceptional surgical technique, and a carefully constructed post-op care plan. Very few hospitals have all of these currently in place to date.

CMS Question 2: *Can the simplest procedure described by CPT code 27447 be performed in most outpatient departments?*

There is no simple CPT code 27447 procedure, all are total knee arthroplasties. For the same reason as above, most outpatient departments are not prepared to successfully complete an outpatient total knee for a Medicare beneficiary.

CMS Question 3: *Is the procedure described by CPT code 27447 sufficiently related to or similar to the procedure described by CPT code 27446 such that the third criterion listed at the beginning of this section for identifying procedures that may be removed from the IPO list, that is, the procedure under consideration for removal from the IPO list is related to codes that we have already removed from the IPO, is satisfied?*

The AAOS wishes to note that the procedure described by CPT code 27446 can be performed through a much smaller and limited incision than required by CPT code 27447. This is especially true when patellar resurfacing is performed as a part of CPT code 27447, which requires a large exposure.

CMS Question 4: *How often is the procedure described by CPT code 27447 being performed on an outpatient basis (either in an HOPD or ASC) on non-Medicare patients?*

We are not aware of specific data on frequencies of TKA performed in the outpatient setting for non-Medicare patients. We urge CMS to survey commercial payers, who certainly have such data, on this question.

CMS Question 5: *Would it be clinically appropriate for some Medicare beneficiaries in consultation with his or her surgeon and other members of the medical team to have the option of a TKA procedure as a hospital outpatient, which may or may not include a 24-hour period of recovery in the hospital after the operation?*

An outpatient TKA procedure would be appropriate only for carefully selected patients who are in excellent health with no or minor medical comorbidities. Currently, most surgeons engage in shared decision making with patients on the post-procedure length of stay to best avoid complications.

CMS Question 6: *CMS is currently testing two episode-based payment models that include TKA: The Comprehensive Care for Joint Replacement (CJR) Model and the Bundled Payment for Care Improvements (BPCI) Model. CMS is seeking comment on how they could modify the CJR and BPCI models if the TKA procedure were to be moved off the IPO list.*

As noted earlier, we do not support removing TKA from the IPO list at this time. However, we agree that changes in CJR and BPCI models could be considered if and when such a decision is made by CMS, but only with careful review of procedure volumes and the impact on costs. With increase in procedure volumes and a better understanding of the total costs of these procedures (such as the post-acute care costs, home health costs, the difference between hospital and ACS fees and the increased intensity of treatment by the surgeon), CJR and BPCI models can be modified appropriately to include outpatient joint replacement procedures. Thus, it is premature at this stage to modify these models in the absence of appropriate data.

We believe that it is premature to set reimbursements (or even have an inpatient-outpatient payment differential) for TKA procedures without appropriate data. Even if there is a policy proposal to introduce a setting-based payment differential, the savings generated should be used for gain-sharing payments and incentives for patients and physicians to choose the most efficient procedure and setting.

An important source of saving for CMS on TKA procedures could be through an incentive system for obese patients (and their surgeons) with specific body mass index-loss goals in the same year that a TKA or total hip arthroplasty (THA) procedure is done.

In addition, per this proposed rule CMS is proposing to remove four spine procedures from the IPO list: namely, CPT code 22840 (Posterior non-segmental instrumentation; CPT code 22842 (Posterior segmental instrumentation; CPT code 22845 (Anterior instrumentation; 2 to 3 vertebral segments; CPT code 22858 (Total disc arthroplasty (artificial disc); second level, cervical. The AAOS would like to comment that beyond the listed criteria used to determine procedures that will be removed from the IPO list, CMS should consider our responses on risk assessment and patient selection as well as specifically ask for stakeholder input before finalizing this proposal.

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Thank you for considering our comments on these important matters. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director

by email at shaffer@aaos.org.

Sincerely,

Gerald Williams, Jr., MD
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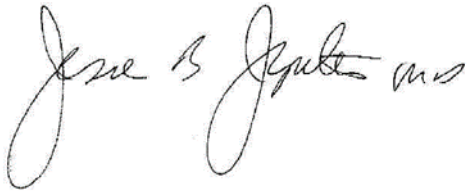

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