September 27, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201  
Attn: CMS-1717-P

Re: Medicare Program: Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgery Center (ASC) Payment Systems and Quality Reporting Programs for Calendar Year 2020

Dear Administrator Verma:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, would like to thank you for the opportunity to submit comments regarding the proposed rule relating to the calendar year (CY) 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and other matters. Our comments focus on the consumer and beneficiary impact of various payment and coverage policies. Specifically, our comments will be limited to: hip replacements; knee replacements; and price transparency.

Removing Total Hip Replacement from the Inpatient Only List

CMS proposes to remove CPT code 27130 (total hip arthroplasty) from the inpatient only list. Under current policy, hospitals can only be paid for performing a beneficiary’s total hip replacement in an inpatient setting. If adopted, this policy would allow hospitals to be paid for performing a beneficiary’s total hip replacement in an outpatient setting. Partial hip replacement would remain on the inpatient only list. AARP agrees with CMS’ proposal but is concerned about the impact of medical review on beneficiary access to this treatment in the setting most appropriate for the individual.

AARP notes CMS’ discussion that “appropriately selected patients could have this procedure performed on an outpatient basis.” (84 FR 39524). Such patients would include those with relatively low anesthesia risk and without significant comorbidities who have family members at
home who can assist them following the procedure. These patients would also be able to tolerate outpatient rehabilitation in either an outpatient facility or at home post-surgery. AARP believes the decision as to whether to perform a total hip replacement as an inpatient or outpatient should be one that the beneficiary makes with his or her physician. In a later section of the proposed rule, CMS indicates once procedures are removed from the inpatient only list, they are subject to the 2-midnight rule (e.g., patients would only be appropriate for inpatient admission if the admitting physician believes the patient is expected to need hospital care that crosses 2 successive midnights or documentation in the medical record supports the physician’s determination that the patient requires inpatient hospital care). Once removed from the inpatient only list, procedures are subject to initial medical review for compliance with the 2-midnight rule by Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIO). The BFCC-QIO may refer hospitals for lack of compliance with the 2-midnight rule to Recovery Audit Contractors (RAC). However, the rule proposes that procedures would not be subject to a RAC referral within the first calendar year of being removed from the inpatient only list.

If CMS finalizes this proposed policy, AARP is concerned about application of medical review for compliance with the 2-midnight rule to total hip replacement—a procedure that is likely to require inpatient care in the vast majority of circumstances for aged Medicare beneficiaries. The 2-midnight rule was intended to improve guidance for hospitals and physicians as to when a patient is appropriately admitted as an inpatient for procedures that are often performed as inpatient or outpatient depending on the patient’s circumstances. While AARP continues to be concerned about substituting a medical reviewer’s judgment for the patient’s physician when making a determination as to the setting where a procedure is performed, we are especially concerned about subjecting an invasive procedure like total hip replacement to the medical review for compliance with the 2-midnight rule and particularly referral to the RAC only one year after the procedure’s removal from the inpatient only list. In our view, strong deference should be made to the judgment of the physician in consultation with the patient when procedures that have historically been appropriate only for inpatient admission are made eligible for Medicare payment on an outpatient basis. AARP urges CMS to reconsider application of medical review to total hip arthroplasty for compliance with the 2-midnight rule immediately following its removal from the inpatient only list and potential referral to RACs for lack of compliance after one year. Such policies are premature at this time. The threat of potential RAC audits could place undue pressure on providers to avoid otherwise appropriate inpatient admission of older, sicker individuals who need hip replacements. Before requiring that hip replacements comply with the 2-midnight rule, CMS should publicly report the proportion of hip replacements that are performed in an outpatient setting and the subsequent rates of inpatient admission and emergency room visits.

**Adding Total Knee Replacement to the Ambulatory Surgical Center List**

Covered surgical procedures in an ambulatory surgical center (ASC) are surgical procedures that are separately paid under the outpatient prospective payment system (OPPS) that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure (e.g., the patient would not require overnight care). CMS annually evaluates whether there are surgical procedures
that meet these criteria that could be added to the ASC list. Among the surgical procedures that CMS proposes to add to the ASC list as a result of this evaluation is CPT code 27447 for total knee replacement. CMS recounts past comments that orthopedic surgeons are increasingly performing these procedures safely and effectively in ASCs on non-Medicare patients and Medicare patients enrolled in Medicare Advantage (MA) plans. CMS states that it is “convinced that there is a small subset of Medicare beneficiaries who may be suitable candidates to receive total knee replacement in an ASC setting based on their clinical characteristics.” (84 FR 39543).

AARP has several concerns with CMS’ proposal to add total knee replacement to the ASC list. To start, traditional Medicare beneficiaries who receive total knee replacements are likely to be older and sicker than non-Medicare or MA patients.

In addition, in the hospital outpatient department, the minimum 20 percent coinsurance would equal at least $2,392.05 for total knee replacement according to Addendum B of the OPPS proposed rule (Medicare’s total OPPS payment would be $11,960.25). However, section 1833(t)(8)(C) limits the copayment amount to the inpatient hospital deductible ($1,364 for 2019). In the ASC setting, there is no such limitation. Medicare’s payment according to Addendum AA of the OPPS proposed rule would be $8,639.97. The 20 percent coinsurance would be $1,727.99, or $363.99 more than the amount of the beneficiary’s copayment based on the 2019 inpatient deductible. While we recognize that the inpatient deductible for 2020 may rise, it seems highly likely that Medicare beneficiaries would pay several hundred dollars more out-of-pocket for a total knee replacement in an ASC setting than in a hospital outpatient department setting, despite a lower total payment from Medicare in the ASC compared to the hospital outpatient department.

Also, Medicare’s payment in the outpatient setting is determined under the comprehensive-APC methodology, meaning that Medicare packages payment of all ancillary services to the hospital resulting in no beneficiary coinsurance beyond the inpatient deductible cap. However, in the ASC, Medicare would pay separately for ancillary services that are integrally related to the surgical procedure, potentially further raising beneficiary out-of-pocket costs.

Moreover, physicians often own ASCs and ASC list procedures are not subject to the Stark self-referral rules that limit the circumstances under which physicians can refer patients for receiving services where the physician has an ownership interest. As a result, beneficiaries could be referred to an ASC for total knee replacement unaware that the procedure will cost them more.

We urge CMS to add a requirement that a beneficiary who is a candidate for a total knee replacement be informed that referral to an ASC will be more costly than if the same procedure is performed in the hospital outpatient department. The physician should also be required to inform the beneficiary they are being referred to an ASC where the physician has an ownership interest. Only after the beneficiary has consented to the higher coinsurance, after being informed of these requirements and documented in the medical record, should Medicare pay for the procedure in the ASC setting. We urge CMS to adopt such a requirement before it finalizes its policy adding a total knee replacement to the ASC list.
Price Transparency

CMS proposes to expand hospital charge display requirements to include charges and information based on negotiated rates and for common shoppable items and services, in a manner that is consumer friendly. We applaud CMS’s effort to bring more useful data to consumers by mandating disclosure of negotiated rates, not merely chargemasters or menu prices. AARP believes individuals should know the financial costs of the health care they receive, and that price information can be a useful tool for consumers to make informed decisions about their care. As we have previously noted, a hospital’s chargemaster or listed price menu is not a particularly useful source of information, because it does not reflect the person’s actual out-of-pocket costs. While the negotiated rate is a more accurate reflection of consumer costs, it is still incomplete. We recommend that CMS require hospitals to also post corresponding expected beneficiary out-of-pocket coinsurance amounts. This would offer more meaningful price transparency and allow consumers to know their true financial costs.

Thank you for the opportunity to comment on the proposed rule. If you have any questions about our comments or need more information, please feel free to contact Andrew Scholnick of our Government Affairs staff at 202-434-3770 or ascholnick@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs