American Hospital Association

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November 30, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Comprehensive Care for Joint Replacement ICD-9-CM Code List for Hip Fractures.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Comprehensive Care for Joint Replacement (CJR) ICD-9-CM hip fracture code list.

Our members support the health care system moving toward the provision of more accountable, coordinated care. As such, they are in the process of redesigning delivery systems to increase value and better serve patients. The CJR payment model could help further these efforts to transform care delivery through improved care coordination and financial accountability. **However, in order to do so, it is critical that CMS provide all hospitals with a level playing field; we are concerned that its proposed hip fracture policy would not accomplish this goal.**

Under the CJR final rule, CMS will set separate target prices for patients with and without hip fractures, recognizing that the clinical and resource use differences between these patient populations differ substantially. Specifically, hip fracture patients follow a very different clinical pathway than non-hip fracture patients. Their surgeries are obviously unplanned, and they are more medically complex and functionally impaired – they have serious renal, cardiovascular and liver disease, as well as multiple comorbidities. These patients typically require care in an inpatient rehabilitation facility (IRF) – in fact, hip fractures are one of the 13 clinical conditions on which Congress and CMS has directed IRFs to concentrate their services.

Yet, in operationalizing this policy, CMS proposes to categorize a CJR episode as a hip fracture only if the *principal diagnosis* of the anchoring admission is on the CMS code list for hip

fractures. We are concerned that this methodology would not adequately identify the entire CJR hip fracture patient population. For example, if a Medicare beneficiary in a motor vehicle collision fractures both a lower and upper extremity, the principal diagnosis of the inpatient stay could be either condition[i] – even if the patient will ultimately be classified into one of the CJR *lower* extremity joint replacement diagnosis-related groups (DRGs). However, if the fractured *upper* extremity is selected as the principal diagnosis, this patient would not be considered a hip fracture patient under the CJR. Instead, he or she would be grouped into the non-hip fracture, elective joint replacement patient population target price – an inappropriate categorization given the significant differences between these patients.

Once CMS has identified CJR episodes using its previously finalized methodology, we recommend that it classify an episode as a hip fracture if the hip fracture diagnosis code appears in *any* diagnosis position, not just the principal diagnosis position. We believe that this methodology will more adequately identify the hip fracture patients that were included in the CJR. While we are disappointed that the agency did not incorporate a comprehensive risk-adjustment methodology into the program or exclude non-elective patients, appropriate implementation of its hip fracture policy will help ensure that hospitals treating the most complicated patients are not inappropriately penalized.

Thank you very much for the opportunity to comment. If you have any questions, please feel free to contact me or Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

cc: Patrick Conway, M.D.

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[i] The HIPAA-required *ICD-10-CM Official Guidelines for Coding and Reporting* developed by CMS and the National Center for Health Statistics provide coding guidance for when two or more diagnoses equally meet the definition for principal diagnosis: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf. Specifically, in such a scenario, "any one of the diagnosis may be sequenced first."