AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1786-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: 20243 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2024 (hereinafter referred to as "2023 OPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,900 physicians with expertise in total joint arthroplasty 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:

- Patient access, especially for high-risk patients, and physician incentives must remain a focus;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- Payment reform is most effective when physician-led; and
- The burden of excessive physician reporting on metrics detracts from care.

Our comments on the 2024 OPPS Proposed Rule are as follows:

I. Proposed Updates Affecting OPPS & ASC Payments - OPPS Arthroplasty Rate Increases Highlight Disparity in Medicare Physician Reimbursement (Sec. II & XIII)

CMS proposes increases to the weights of the primary CPT codes associated with lower joint arthroplasty: 27447 & 27130. Combined with increases based on the proposed hospital inpatient market basket percentage of 3.0 percent, this leads to increases in Medicare OPPS payment rates for these arthroplasty codes.

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 beginning with the COVID-19 public health emergency and continuing today. Nevertheless, the ongoing annual increases in Medicare facility payments for lower extremity joint replacement (LEJR) present a stark contrast with severely decreasing Medicare physician payments for LEJR. Medicare payment rates for the professional component of arthroplasty have been cut by nearly 11 percent since 2020. It is unfair that Medicare payment formulas make physicians carry the burden of LEJR cost reductions while facility payments continue to increase.

While payments under the OPPS 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. CMS should explicitly state whether it believes that Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for LEJR paired with severe cuts to the professional services for those procedures, and if so, why. If not, CMS should articulate to Congress any necessary adjustments to statutory reimbursement formulas so that there may be a unified coordinated CMS policy towards the value of arthroplasty. The disturbing and divergent trends are apparent per below:

Code	2023	2024 (Proposed)	% Change from 2023	% Change Since 2020
OPPS – CPT 27447	$13,048.08	$13,269.40	**+1.7%**	**+11%**
ASC – CPT 27447	$9,5068.60	$9,6646.38	**+1.5%**	**+9%**
IPPS - DRG-469	$20,602.57	$21,636.40	**+5.0%**	**+16%**
IPPS - DRG-470	$12,189.78	$12,226.85	**+0.6%**	**+7%**
PFS - CPT 27447	$1,300.92	$1,264.71	**-2.8%**	**-10.5%**

This disparity highlights the need for Congress to add an inflationary adjustment factor for Medicare physician payments. H.R. 2474, the *Strengthening Medicare Patients and Providers Act*, which would adjust physician payments to the Medicare Economic Index, is one such way to ensure that Medicare payment rates keep up with the actual costs physicians encounter in real medical practice today.

Further, considering President Biden's *Executive Order on Promoting Competition in the American Economy*[1], CMS should evaluate whether its proposed reductions in Medicare physician rates, paired with increases in facility rates, promote competition in health care or facilitate consolidation. AAHKS is optimistic for the future passage of H.R. 3284, the *Providers and Payers COMPETE Act of 2023*, which recently was reported out of the House Committee on Energy & Commerce by a vote of 49-0. HR 3284 would require the Secretary of the Department 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

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

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 reductions.

II. Proposed Adoption of New Measures for Hospital OQR Program Measure Set (Sec. XIV.B.3.b)

CMS proposes to adopt the *Risk-Standardized Patient Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM)* measure to the Hospital Outpatient Quality Reporting System beginning with voluntary CYs 2025 and 2026 reporting periods in 2025 and 2026, to be followed by mandatory reporting beginning in 2027 reporting tied to a 2030 payment determination.

We support the proposed adoption of the THA/TKA PRO-PM to the OQR program. Development, dissemination, and adoption of provider-developed arthroplasty outcome measures has long been a priority of AAHKS in order to truly measure the value of joint replacement to patients. For arthroplasty, PROs are the best available means for a patient-centered measurement of functional status improvement, the ultimate objective of arthroplasty. AAHKS members were involved in the Technical Advisory Group and the Technical Expert Panel that contributed to the development of this measure.

AAHKS provided extensive detailed comments on this proposed measure set in our comment letter on the 2022 OPPS Proposed Rule. We appreciate that CMS made improvements based our comments on phased implementation, appropriate joint-specific PRO instruments, and alignment across settings.

We remind CMS that, if and when CMS evaluates how to incorporate this THA/TKA PRO-PM into some other program to impact provider payment, CMS should establish a benchmark percentage rate of success for reaching a significant clinical improvement (the outcome of the measure) rather than requiring providers to compete for percentile rankings of success rates across tightly bunched score rates. This would help, especially in early implementation, to avoid marginalization of patients based on perceived risk factors and their possible loss of access to care.

Additionally, if scores are used to impact payment, CMS should consider replicating the stratified methodology of the Readmissions Reduction Program, wherein hospital performance is assessed relative to the performance of hospitals within the same peer group. We favor the method used by the Readmissions Reduction Program to stratify hospitals into five peer groups, or quintiles, based on proportion of the patient population dually eligible for Medicare and Medicaid.

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

Sincerely,

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