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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: July 28, 2021

Re: Summary of the Proposed 2022 Medicare Payment Rules: Physician Fee Schedule; Outpatient Prospective Payment System; and Ambulatory Surgical Centers

The Centers for Medicare & Medicaid Services (CMS) recently released both the CY 2022 Medicare Physician Fee Schedule (PFS) proposed rule and the CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS & ASC) proposed rule. Comments on the proposed rules are due September 13, 2021. The following is a summary of policies in the proposed rules that may affect AAHKS members.

See the last page for a table summarizing proposed changes in Medicare rates in 2022.

PHYSICIAN FEE SCHEDULE

Conversion Factor

- CMS proposes a PFS conversion factor of **$33.58**—a $1.31 decrease from the 2021 conversion factor of $34.89—to reflect the proposed budget neutrality adjustment that accounts for changes in relative value units (RVUs) and the expiration of the one-time 3.75% payment increase Congress provided through the Consolidated Appropriations Act, 2021.

Discussion Regarding CMS' Consideration of RUC RVU Recommendations

CMS discusses the methodology used to establish work RVUs and its approach to reviewing recommendations by the AMA-RUC and developing proposed values for specific codes.

- CMS adjusts work RVUs and/or times to account for overlapping activities in the recommended work RVUs and/or times in cases in which CMS believes the RUC has not adequately accounted for the overlap. One minute of preservice evaluation or postservice time equates to 0.0224 of a work RVU.

- CMS "observed that for many codes reviewed by the RUC, recommended work RVUs appeared to be incongruous with recommended assumptions regarding the resource

costs in time [particularly] for a significant portion of codes for which [CMS] recently established or proposed work RVUs that are based on refinements to the RUC-recommended values."

- CMS states that when RUC-recommended work RVUs do not appear to account for significant changes in time, rather than ignoring the RUC-recommended value, CMS uses the recommended values as a starting reference then applies other methodologies, such as survey data, building block, crosswalks to key reference or similar codes, and magnitude estimation method, to account for the reductions in time CMS believes were not otherwise reflected in the RUC-recommended value.

- Regarding decreasing work RVUs, CMS highlights: "[w]e do not imply that the decrease in time as reflected in survey values should always equate to a **one-to-one or linear decrease in newly valued work RVUs**. Instead, we believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs. If the RUC's recommendation has appeared to disregard or dismiss the changes in time, without a persuasive explanation of why such a change should not be accounted for in the overall work of the service, then we have generally used one of the aforementioned methodologies to identify potential work RVUs, including the methodologies intended to account for the changes in the resources involved in furnishing the procedure."

- CMS notes several stakeholders, including the RUC, have expressed general objections to CMS' methodologies and deemed CMS' actions in adjusting the recommended work RVUs as inappropriate. Other stakeholders have also expressed general concerns with CMS refinements to RUC-recommended values in general.

- CMS notes it did not receive any specific suggested alternatives for making adjustments to recognize overall estimates of work in the context of changes in the resource of time for particular services when it sought commentary in the 2017 PFS final rule (81 FR 80272 through 80277). CMS "looks forward to continuing to engage with stakeholders and commenters, including the RUC, and will continue to welcome feedback from all interested parties regarding valuation of services for consideration through the rulemaking process."

2023 Implementation of MIPS Value Pathways (MVPs)

- CMS proposes to begin implementing the Medicare Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) beginning in 2023. MVPs are intended to "simplify the MIPS clinician experience, improve value, reduce burden, and better inform patient choice in selecting clinicians". This 2023 timeframe is intended to provide practices the

time to review requirements, update workflows, and prepare their systems as needed to report MVPs.

- For the 2023 and 2024 performance years, required "MVP Participants" will mean:
  - individual clinicians,
  - single specialty groups,
  - multispecialty groups,
  - subgroups, and
  - APM entities that are assessed on an MVP for all MIPS performance categories.

- Beginning in the 2025 performance year, multispecialty groups willd be required to form subgroups in order to report MVPs.

- CMS proposes to begin with 7 MVPs of complementary measures and activities intended to supports patient-centered care, interoperability, and reduce the reporting burden for clinicians.
  - ***Lower Extremity Joint Repair***
  - Rheumatology
  - Stroke Care and Prevention
  - Heart Disease
  - Chronic Disease Management
  - Emergency Medicine
  - Anesthesia

Proposed Improving Care for Lower Extremity Joint Repair MVP

- Quality Measures
  - 0350: Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy
  - 0351: Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation
  - 0376: Functional Status Assessment for Total Hip Replacement
  - 0470: Functional Status After Primacy Total Knee Replacement
  - 0480: Risk-standardized complication rate (RSCR} following elective primary THA and/or TKA
  - 0128: Preventive Care and Screening: BMI Screening and Follow-Up Plan
    - CCOME6: Patient-Reported Pain and/or Function Improvement after APM Surgery and CCOME7: Patient-Reported Pain and/or Function Improvement after THA were considered but not included

- Improvement Activities
  - IA CC 15: PSH Care Coordination: Contributes to the coordinated care of the patient required after a procedure such as a hip/knee replacement. The

Perioperative Surgical Home (PSH) strives to provide the patient with the "right care, in the right place, at the right time" to ensure patient satisfaction while reducing complications and costs.

- IA PSP A 27: Invasive Procedure or Surgery Anticoagulation Medication Management: To address blood-clotting issues commonly associated with hip/knee replacement. Statistical data indicates that hip and knee replacements are a commonly performed inpatient procedure with long recovery times that often incur sizable expenses in terms of hospitalization and rehabilitation.
- IA_AHE_3: Promote use of Patient-Reported Outcome Tools
- IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- IA_BE_12: Use evidence-based decision aids to support shared decision-making
- IA_ CC_ 7: Regular training in care coordination
- IA_ CC _9: Implementation of practices/processes for developing regular individual care plans
- IA_ CC_ 13: Practice improvements for bilateral exchange of patient information
- IA _PSP A_ 6: Consultation of the Prescription Drug Monitoring Program
- IA_PSPA_7: Use ofQCDR data for ongoing practice assessment and improvements
- IA_PSPA_l8: Measurement and improvement at the practice and panel level

- Cost Measures - Elective Primary Hip Arthroplasty and Knee Arthroplasty episode-based measures

Quality Payment Program Changes in 2022

- For HHS' Public Reporting on Compare Tools, CMS proposes to publicly report clinician affiliations to certain types of facilities (for example, LTCHs, IRFs, etc.). CMS seeks comment through a RFI to inform the ways in which utilization data may be useful to patients and caregivers for their health care decisions. In order to give MIPS eligible clinicians time to familiarize themselves with MVPs and subgroup reporting, CMS proposes to delay public reporting of new improvement activities and Promoting Interoperability measures and attestations reported via MVPs by 1 year, and begin publicly reporting subgroup-level performance information in PY 2024, on the compare tool hosted by the U.S. Department of Health and Human Services. CMS is also proposing to create a separate subgroup workflow that would allow subgroup performance information to be publicly reported in an online location that can be navigated to and from an individual clinician or group profile page. This also aligns with the historical approach to report performance information at the level that it is submitted.

Updates to the Physician Self-Referral Regulations

- CMS proposes revising the "Stark" regulations that identify when aggregate compensation to a physician results in an indirect compensation arrangement to include

as a potential indirect compensation arrangement any unbroken chain of financial relationships in which the compensation arrangement closest to the physician (or immediate family member of the physician) involves compensation for anything other than services that he or she personally performs.

- As such, arrangements for the rental of office space or equipment that meet the other conditions of the Stark regulations would be subject to the prohibition on percentage-based and unit-based (often referred to as "per-click") compensation formulas in the exception for indirect compensation arrangements.

Proposed Changes to the Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

- CMS proposes certain exceptions to the electronic prescribing of controlled substances (EPCS) requirement for schedule II, III, IV, and V controlled substances set forth in the SUPPORT Act. These exceptions would apply (1) when the prescriber and dispensing pharmacy are the same entity; (2) to prescribers who issue 100 or fewer controlled substance prescriptions for Part D drugs per calendar year; and (3) to prescribers who are in the geographic area of a natural disaster, or who are granted a waiver based on extraordinary circumstances

- CMS proposes extending the start date for compliance actions to January 1, 2023, in response to stakeholder feedback, but solicits comment on whether the original date of January 1, 2022, should remain, in light of the proposed exceptions. CMS also seeks comment on different types of compliance actions.

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

Preservation of the Medicare Inpatient Only (IPO) List

- Last year, CMS stated that it no longer considered the IPO list necessary to identify services that require inpatient care and began a process to phase-out the IPO list between 2021-2023. Beginning in 2021, 298 musculoskeletal-related services were removed.

- CMS now says that maintaining the IPO list gives the agency more ability to ensure patient safety by carefully reviewing procedures one-by-one for potential removal form the IPO list. Accordingly, CMS proposes that it will preserve the IPO and that in 2022, the previously removed musculoskeletal-related CPT codes will be returned to the IPO list, including

    - 27702 (Arthroplasty, ankle; with implant [total ankle]); 27703 (Arthroplasty, ankle; revision, total ankle); 27445 (Arthroplasty, knee, hinge prosthesis [for example, walldius type]); 27487 (Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component); 27488 (Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee); 27125 (Hemiarthroplasty, hip, partial [for example, femoral stem prosthesis, bipolar arthroplasty]); 27132 (Conversion of previous hip surgery to total hip with or without autograft or allograft); 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft); 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft); 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft); and 27140 (Osteotomy and transfer of greater trochanter of femur [separate procedure]).

- TKA and THA will remain available for outpatient reimbursement because these procedures were earlier removed from the IPO list on an individualized review.

- CMS seeks public comment on whether any of the approximately 298 musculoskeletal-related CPT codes should remain *off* the IPO list.

- Informal reports are that CMS staff and the Biden administration were uncomfortable with the aggressive IPO list phase-out timeframe as implemented by the Trump administration. Nevertheless, CMS maintains an institutional orientation towards greater site neutrality in coverage and payment.

Interaction between Inpatient Hospital Admissions and the 2-Midnight Rule

- CMS proposes to reinstate the policy whereby procedures that are removed from the IPO list on or after January 1, 2021 are exempt from the following reviews for 2 years:
    - Site-of-service claim denials
    - Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and
    - RAC reviews for "patient status" (that is, site-of-service)

Contraction of the List of ASC Covered Surgical Procedures

- Last year, CMS adopted a new method to add procedures to the ASC covered procedures list (CPL). What had earlier been 5 factors under which CMS would exclude procedures from the CPL were converted to 5 factors that individual physicians should consider when determining whether a procedure should be performed on a particular patient in an ASC. This had the effect of essentially adding 267 surgery/surgery-like codes to the ASC CPL.

- CMS now proposes that it will reverse this policy and return to its earlier policy of evaluating individual procedures for possible exclusion from the CPL based on 5 factors. This means that 267 surgery or surgery-like codes added to the CPL in 2021 will be removed in 2022.

- TKA and THA will remain on the ASC CPL because these procedures were earlier added to the CPL based on individualized review.

Adding a Patient-Reported Outcomes Measure (PROM) Following Elective THA or TKA

- CMS seeks public comment on priorities for quality measurement in outpatient settings due to changes to the IPO list.

- CMS also requests comment on the potential future development and inclusion of a PROM following elective outpatient THA/TKA as a hospital quality measure. CMS previously established the voluntary PRO data collection opportunity under the Comprehensive Care for Joint Replacement (CJR) model and developed the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary THA/TKA performance measure (THA/TKA PRO-PM)[1] to be submitted by participating hospitals. CMS subsequently updated the measure based on stakeholder feedback. Earlier this year, AAHKS responded to CMS' request for input on the potential to add such a PROM to the Hospital Inpatient Quality Reporting System.

[1] NQF ID # 3559; CMIT ID # 3198.

Increased Penalties for Failure to Make Hospital Standard Charges Transparent

- CMS earlier implemented a policy requiring hospitals to make public their standard charges (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format.
- CMS now proposes to increase monetary penalties for hospitals in violation of the new price-transparency requirements. The proposal would increase the maximum fines from $300 per day to as much as $5,500 per day for hospitals with more than 30 beds. CMS is responding to reports that most hospitals are not taking adequate measures to comply with requirements to publish cash prices and payor-negotiated rates.

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Medicare Payment Trends for Hip and Knee Surgeries in the United States

Code (DRG/CPT)	2018		2019		2020		2021		2022 (proposed)		% Change from 2021
	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	
IPPS[1],[2]											
469	3.201	$17,837.66	3.1742	$17,921.78	3.1399	$18,200.84	3.0989	$18,530.61	3.0866	$18,952.62	+2.3%
470	2.0543	$11,447.64	1.9898	$11,234.56	1.9684	$11,410.09	1.9104	$11,423.69	1.9015	$11,675.76	+2.2%
521	--	--	--	--	--	--	3.0652	$18,329.99	3.0663	$18,827.97	+2.7%
522	--	--	--	--	--	--	2.1943	$13,121.34	2.1903	$13,449.08	+2.5%
OPPS											
27130	--	--	--	--	147.2988	$11,899.38	148.7344	$12,314.76	149.5497	$12,630.52	+2.5%
27447	128.7225	$10,122.22	134.7827	$10,713.88	147.2988	$11,899.38	148.7344	$12,314.76	149.5497	$12,630.52	+2.5%
27429*	128.7225	$10,122.22	134.7827	$10,713.88	147.2988	$11,899.38	148.7344	$12,314.76	149.5497	$12,630.52	+2.5%
ASC											
27130	--	--	--	--	--	--	180.4429	$8,833.04	181.6368	$9,096.01	+2.9%
27447	--	--	--	--	180.3081	$8,609.17	179.2409	$8,774.20	180.4523	$9,036.69	+2.9%
27429*	111.2415	$5,069.83	151.2694	$7,041.74	224.0958	$10,717.80	211.7260	$10,364.41	213.4983	$10,691.57	+3.1%
PFS											
27130[3]	35.9996	$1,409.74	36.039	$1,408.77	36.0896	$1,415.07	34.8931[4]	$1,322.45	33.5848	$1,278.24	-3.4%
27447[5]	35.9996	$1,408.30	36.039	$1,408.05	36.0896	$1,413.27	34.8931[6]	$1,320.70	33.5848	$1,276.89	-3.4%

[1] **National Payment Amount** – Projected by CMS of the baseline amount that will be paid nationally for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. *See footnote 2.*

[2] Assumes hospital reported quality data and is a meaningful EHR user.

[3] **Total RVUs** – 2020 (39.21); 2021 (37.88); 2022 (38.06)

[4] **2021 Final PFS Conversion Factor** – Conversion factor (CF) reduction required by statutory budget neutrality adjustment law. Partially offset by CF increase based on (1) one-time 3.75% increase for 2021, and (2) delayed implementation of the inherent complexity add-on code for e/m services (G2211).

[5] **Total RVUs**: 2020 (39.16); 2021 (37.83); 2022 (38.02)

[6] **2021 Final PFS Conversion Factor** – CF reduction required by statutory budget neutrality adjustment law. Partially offset by CF increase based Increase based on (1) one-time 3.75% increase for 2021, and (2) delayed implementation of the inherent complexity add-on code for e/m services (G2211).

** For comparison purposes with newly covered outpatient procedures, the CPT code for Reconstruction Knee is included*