AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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September 13, 2021

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare 2022 Physician Fee Schedule Proposed Rule

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on its Medicare physician fee schedule (PFS) proposed rule for fiscal year 2022 (hereinafter referred to as "FY 2022 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,000 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by its three principles:

- Payment reform is most effective when physician-led;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus.

Our comments focus on the FY 2022 PFS proposed rule are summarized as follows:

I. Executive Summary

- CMS should explain how or why it uses different standards to derive work RVU values from the RUC survey process.
- A new process is needed for the RUC and CMS to account for new non-face-to-face preservice patient optimization time (more than a day before admission and unrelated to initial E/M visits) driven by value-based care arrangements for joint arthroplasty.
- CMS should provide technical assistance to Congress to waive budget neutrality adjustments for the Physician Fee Schedule Conversion Factor, or otherwise prevent the 3.4% cut in physician payments for hip and knee replacement proposed for 2022.

- AAHKS supports revoking Medicare enrollment for providers who surrender their DEA certificate in order to avoid a DEA investigative demand, so long as appropriate appeals mechanisms are available.
- AAHKS supports extending to 2023 the start of compliance with new requirements for electronic prescribing of controlled substances under a Medicare Prescription Drug Plan.
- CMS should expand methods to include stratification of condition/procedure specific readmission measures by race and ethnicity, which may be a social and cultural disparity.
- AAHKS supports the inclusion of Lower Extremity Joint Repair as one of the initial MVPs for 2023.

II. Valuation of Specific Codes – Methodology for Establishing Work RVUs (Sec. II.E.2)

In the proposed rule preamble, CMS engages in a discussion to respond to specialist society comments in prior years regarding the methodology used by CMS to establish work RVUs as well as CMS' approach to reviewing recommendations by the American Medical Association-RVS Update Committee (AMA-RUC) and developing proposed values for specific codes.

a. RVU Adjustments Derived from Physician Surveys

CMS states that it is surprised at specialty society objections to CMS assigned RVU values since "much of the information [CMS uses] to make adjustments *is derived from* their survey process." Regarding decreasing work RVUs, CMS further states, "[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*."

We do not doubt that CMS RVU values are "derived from" surveys. Nor does AAHKS believe that decreases in time should always equate to one-to-one or linear decreases in work RVUs. Rather, it is not clear to AAHKS how or why CMS uses different standards to derive RVU values from the RUC survey process. For instance, as we explained in the AAHKS comment letter on the 2021 PFS proposed rule, CMS valued TJA (CPTs 27447 & 27130) wRVUs *below* the *20th percentile* of the RUC survey values. This type of anomalous, punitive, low valuation is contrasted against the wRVUs assigned to the revised evaluation and management (E/M) codes which become effective in 2021. For those E/M codes, the values are based on the *median* of the RUC's survey results. Provider confidence in the integrity of the work RVU valuation process depends upon an explanation of what factors lead CMS to accept different percentile valuations based on RUC surveys for codes, even when physician intensity values are unchanged.

CMS also says it is suspicious when the RUC does not recommend time reductions commensurate with surveys if the RUC has not also defined how intensity has increased for the procedure. We believe that collaboration between the RUC and CMS is necessary to establish how to evaluate and account for increases in intensity of global episodes associated with value-based care arrangements due to additional physician work to coordinate extra patient preparation and post-acute services.

b. Accounting for Physician Preservice Time

CMS describes how it relies on the RUC's current methodology to account for preservice time. AAHKS reiterates the arguments from our 2021 PFS proposed rule comment letter, that a new process is needed for the RUC and CMS to account for new non-face-to-face preservice patient optimization time (more than a day before admission and unrelated to initial E/M visits) driven by value-based care arrangements for joint arthroplasty.

Such preservice, patient optimization time is indicative of more participation in alternative payment models (APMs), both voluntary (BPCI and BPCI)) and involuntary (CJR), in which orthopaedic surgeons, and THA and TKA specifically, are at the forefront of the transition to value-based care. In addition, THA and TKA are uniquely targeted through CMS competition driven measures with financial consequences. TJA is the only procedure set being held accountable for 90 day costs, 90 day complications, 30 day readmissions, and soon, patient reported outcomes. Many of the new efficiencies in APMs arise from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work.

AAHKS members, associated qualified health professionals, and clinical staff have responded with significant increases in preservice work to optimize patients through screening, education, coordination of care with other health care providers (patients' primary care physicians, medical specialist consultants, physical therapists, post-acute care, and others), and from other activities required to ensure the best outcome for a patient's surgery. However, these activities on behalf of the patient and family are not included in the traditional RUC survey definition of "pre-service activities," as well as the time clinical staff spent providing certain pre-service activities for the patient and family.

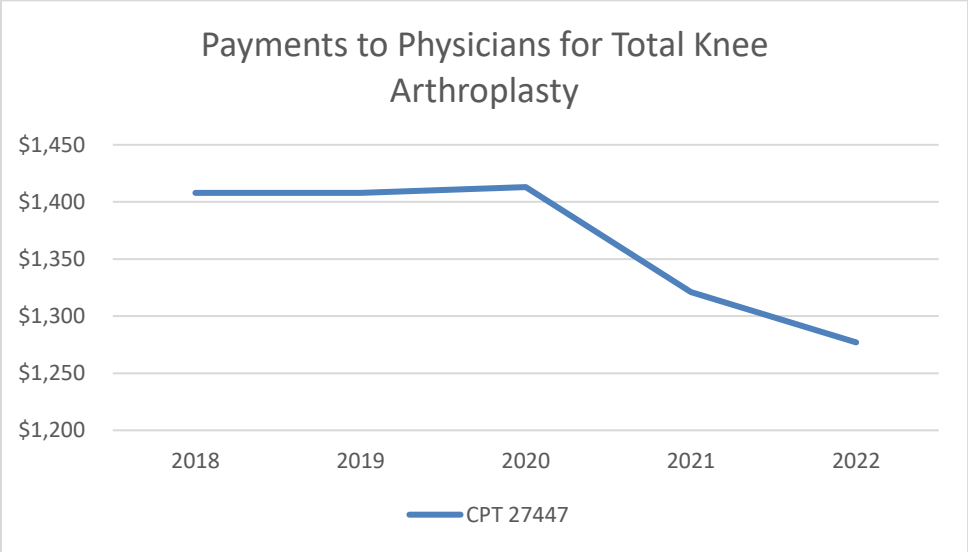
CMS has recently recognized that such physician work time lies outside of the timeframe of CPT and APM episode windows and outside of window of RUC surveys of preservice time. This is evidenced by CMS adopting the cost measure *COST_KA_1; 2020 COST Measure #019* in which CMS considers the TJA procedure time to commence in a 30-day pre-operative period. We believe the recognition of such preservice time will become even more apparent in light of the CMMI Director's recent statements suggesting there will be more mandatory APMs in the future.

III. Calculation of the CY 2022 PFS Conversion Factor (Sec. VII.C.1.Table 121)

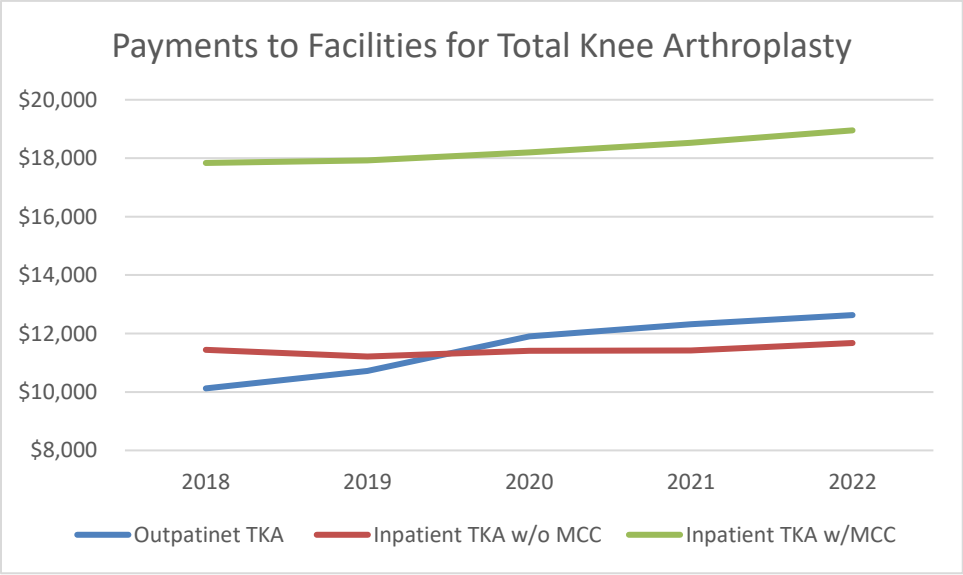
The Medicare statute requires that any increases or decreases in RVUs may not cause the amount of Medicare PFS expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. When this threshold is exceeded, CMS makes other increases or cuts in the PFS to maintain "budget neutrality." In general, this means that increases in RVUs, if not offset by other decreases in RVUs, will be offset by a reduction in all procedures rates through an adjustment to the PFS conversion factor.

For 2022, CMS proposes a PFS conversion factor of $33.58, $1.31 decrease from the 2021 conversion factor of $34.89, to reflect the proposed budget neutrality adjustment that accounts

for changes in RVUs and the expiration of the one-time 3.75% payment increase Congress provided through the Consolidated Appropriations Act, 2021. This will result in a 3.4% reduction in reimbursement for TJA procedures (CPT codes 27447 & 27130) in 2022. With payment reductions in 2021 due to the conversion factor and CMS' decision to reduce wRVUs, Medicare reimbursements to physicians for TJA will have fallen by 9% in two years.



This should be contrasted with Medicare payments to facilities for the same procedure over a similar timeframe, in which payments have increased 2-6% for inpatient procedures and have increased 20% for outpatient procedures. It seems unfair that Medicare payment formulas are making physicians carry the burden of cost reductions while hospital payments continue to increase. Reimbursements to physicians account for less than 10% of total Medicare payments to providers for TJA procedures.



Such reduced reimbursement may prevent surgeons from being able to sustain independent practices, which may lead to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas. Reduced reimbursement for THA/TKA can also lead to surgeons shifting their focus to other procedures and conditions for which they have trained, despite the accelerating need for joint replacement in the Medicare age eligible population. CMS should provide technical assistance to Congress to waive budget neutrality adjustments for the Physician Fee Schedule Conversion Factor, or otherwise prevent the 3.4% cut in physician payments for TJA proposed for 2022.

IV. Deny or Revoke Enrollment for Surrender of Drug Enforcement Administration (DEA) Certificate of Registration in Response to Show Cause Order (Sec. III.N.2.b)

CMS currently will deny or revoke Medicare enrollment of any provider whose DEA certificate of registration is suspended or revoked. CMS proposes to also revoke Medicare enrollment for providers who surrender their DEA certificate in order to avoid a DEA investigative demand related to alleged improper prescribing. Such revocation procedures seem to be a necessary tool in strategies to limit the risk of opioid abuse and addiction. AAHKS supports this change so long as appropriate appeals mechanisms are in place for providers to justify their actions if necessary.

V. Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (Sec. III.Q)

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. In light of ongoing disruptions in orthopaedic surgery practices due to the public health emergency, AAHKS believes that extending the compliance start date to 2023 balances a reduction in provider burden with reasonable time to educate and prepare practices for complaisance.

VI. Future Potential Stratification of Quality Measure Results by Race and Ethnicity (Sec. IV.A.1.d.(1))

CMS is considering expanding disparity methods to include stratification of condition/procedure specific readmission measures by race and ethnicity, which may be a social and cultural disparity. CMS refers to studies that have shown that, among Medicare

beneficiaries, racial and ethnic minority persons often experience worse health outcomes, including more frequent hospital readmissions and procedural complications. AAHKS supports this expansion, which would help address the real variation in patient costs our members routinely observe in race, ethnicity, and/or poverty. In terms of stratifications of measures, we continue to emphasize the additional use of less race-driven stratification by dual eligibility and/or zip code, or income, the first of which would be in harmony with the Medicare hospital readmission reduction program.

VII. Establishing a Portfolio of MVPs (Sec. IV.A.3.b.(4)(c))

CMS is creating "a more streamlined MIPS program" to reduce reported complexities with data submission, confusion surrounding measure selection, and lower barriers to APM participation through a new framework called MIPS Value Pathways (MVPs). The most significant change under MVPs is that eventually all MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Rather, measures and activities in an MVP would be connected around a clinician specialty or condition and encompass a set of related measures and activities.

CMS proposes to begin the program in the 2023 performance year with seven MVPs of complementary measures and activities intended to support 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; and Anesthesia.

AAHKS supports the inclusion of Lower Extremity Joint Repair as one of the initial MVPs to be implemented for 2023. The rationale for this inclusion mirrors many of the factors we have highlighted previously, identifying AAHKS members as at the forefront of the shift to value-based care. We have a higher portion of the members of our specialty already participating in the MIPS program or APMs.

VIII. Proposed Improving Care for Lower Extremity Joint Repair MVP Beginning with the CY 2023 MIPS Performance Period/2025 MIPS Payment Year (Appendix 3; Table F)

MVPs consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.

As CMS continues to refine the measures included within the Lower Extremity Joint Repair MVP, we request that CMS avoid measurements of performance based on administrative data sets. We have endorsed such measures in the past in the context of use in MIPS through elective selection. Moving forward, MVPs should seek new ways to utilize existing registry data to the maximum extent possible to drive data collection with elements outside of the administrative sets; this would allow better capture of value with better specialty specific risk adjustment. Ideally, patient reported outcome measures should carry the greatest weight. Quality measures

should continue to be included if they are adjusted to accept and align with the improved exclusion criteria. Procedure-specific cost measures are also valuable to include if they are appropriately risk adjusted.

Also, CMS should recognize that physicians may be willing to undertake the burden of collecting and reporting quality data, if they have a role in developing the quality measures. This has been the case in the adoption of patient reported outcome measures (PROMs) specific to joint arthroplasty, the collection of which has been mandated through the CJR with a generally successful surgeon response. We are encouraged by CMS' recently stated interest in adding PROMs for arthroplasty to the Inpatient Prospective Payment System and Outpatient Prospective Payment System (*Hospital-Level, Risk-Standardized Improvement Rate in Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty* (NQF ID# 3559)). We ask that there be consideration of the cost and time burdens involved, and that some form of quality score/payment incentive be tied to tiers of PROM reporting.

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

Sincerely,

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