AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

OFFICE: 847.698.1200 • FAX: 847.698.0704 • WEB: aahks.org
9400 W Higgins Road, Suite 230 • Rosemont, IL 60018-4976

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VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1772-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: 2023 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 2023 (hereinafter referred to as "2023 OPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,600 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 three principles:

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

Our comments on the 2023 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 3.1 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 through the COVID-19 public health emergency. 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 hospital 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 when graphically tracked as follows:

- **2023 Physician Payment for CPT 27447 (TKA) - $1,277.88 (down 10.7% since 2020)**
- **2023 OPPS Payment for CPT 27447 (TKA) - $13,274.06 (up 30% since 2018)**
- **2023 ASC Payment for CPT 2447 (TKA) - $9,351.90 (up 8.6% since 2020)**
- **2023 IPPS Payment for DRG 469 (Knee replacement with MCC - $20,502 (up 15% since 2018)**

II. Request for Information on Use of CMS Data To Drive Competition in Healthcare Marketplaces (Sec. XIX)

a. Background

CMS seeks stakeholder input regarding the President's July 9, 2021, Executive Order on Promoting Competition in the American Economy (EO 14036) to address excessive concentration, abuses of market power, unfair competition, and the effects of monopoly and monopsony. Upon release of the EO, the White House noted that hospital consolidation is a major concern, and that ''[h]ospital consolidation has left many areas, especially rural communities, without good options for convenient and affordable healthcare service.''

Specifically, CMS seeks information from the public on how data that CMS collects could be used to promote competition across the health care system or protect the public from the harmful effects of consolidation within healthcare. CMS also wishes to know what additional information collected by CMS would be useful for the public or researchers who are studying the impacts of mergers, acquisitions, consolidations, or changes in ownership?

b. Health Systems Consolidate and Gain Leverage When Physicians are Weakened

AAHKS believes that if the Biden Administration and CMS are truly concerned about competition and consolidation in the health care industry, it is necessary to (1) address causal factors within the control of the federal government, instead of focusing solely on effects on consumers, and (2) take a broad perspective on industry-wide trends, beyond facility consolidation. In our experience, facilities consolidate and exercise more market power when federal and state policies weaken physicians.

Facilities have greater power to consolidate and abuse market power when physicians are placed in a much weaker financial position relative to the facilities. We noted above that Medicare payments to facilities for lower joint arthroplasty have increased significantly in recent years. The OPPS rate for LEJR has increased 30% since 2018. In contrast, Medicare payments to physicians for LEJR have dropped by nearly 11% since 2020.

Federal payment disparities such as this are a material factor in leverage and market strategy between physicians, facilities, and payers. Reduced reimbursement makes it much harder for surgeons to sustain independent practices, which may lead to the merger or consolidation of practices with facilities and regional health systems. Such 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 LEJR 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 growing Medicare population.

Facilities in such consolidated markets may charge far higher prices than hospitals in markets with several competitors. They can also exercise leverage to pay employed physicians at much lower rates than hospitals in markets with several competitors. Facilities' leverage over other providers is also strengthened when the CMS Innovation Center offers multiple value-based care models for which facilities alone are permitted to act as conveners.

c. The Anticompetitive Results of Reducing Medicare Payments to Physicians Should Not be a Surprise

CMS discusses literature synthesized by MedPAC suggesting that, even when Medicare or Medicaid revenues increase, hospitals still aimed to negotiate larger, rather than smaller, rate increases from commercial insurers. Further, that these high prices primarily reflected hospitals negotiating higher prices with insurers, rather than cost shifting as a result of lower Medicare or Medicaid rates. CMS and the Biden Administration should ask themselves, if this is the result of higher Medicare revenues for hospitals, what is the likely effect on competition and consolidation of lower Medicare revenues for physicians?

d. State Laws as a Factor

CMS notes the findings of the ASPE report analyzing PECOS data, observing that there is wide variation in facility ownership changes by state. CMS should review state specific data for any correlation between change of ownership rates and state laws impacting the leverage of facilities. State laws permitting aggressive noncompete provisions in employment contracts give facilities extensive leverage over physicians which makes it easier for hospitals to hold on to more physician practices and increase leverage with payers. State certificate of need laws may also show some correlation with mergers and consolidation as such laws limit tools available to hospitals to compete in delivering services to local patients.

e. Payer Consolidation and Leverage Also Drives Provider Consolidation

CMS' review of factors reducing competition in the health care system must not overlook the role of payer consolidation and pressure upon providers. Payers' single-minded focus on reducing provider payments is rooted in controlling enrollee premiums but can also be taken to an extreme that is disconnected from the economic realities of delivering patient-centered care and quality outcomes at the physician level.

For example, due to payer consolidation, large health insurers have ever more motivation to interfere in Original Medicare to reduce payments to providers under the OPPS and the Physician Fee Schedule (PFS), upon which many of their contracted provider payment rates are based. In 2018, following a process established by CMS for the public nomination of potentially misvalued CPT codes, one anonymous party nominated seven high volume codes for review, including LEJR codes 27447 and 27130.[1] The anonymous submitter stated that a number of reports by media and federal advisory agencies found "a systemic overvaluation of work RVUs." The submitter, which was later revealed as private insurance company Anthem Inc.[2], argued that overestimates were due to preservice and postservice time (including follow-up inpatient and outpatient visits that do not take place) and intraservice time, and that previous RUC reviews did not capture these overestimates.

In other words, the submitter alleged that surgeons were spending less time in preoperative visits, intraoperative services, and postoperative visits, and that these reductions in time were not accounted for in the wRVUs for 27130 and 27447. Revising wRVUs to account for less time would lead to a reduction in Medicare reimbursement amounts paid to orthopaedic surgeons for LEJR. This in turn would lead to a reduction in Anthem reimbursement to contracted orthopaedic surgeons who's commercial, Medicare Advantage, or Medicaid managed care rates were based on the PFS.

It was disappointing that CMS was persuaded to refer the CPT codes to the RUC despite several points against the referral. First, Anthem's allegations that intra-service times from the

[1] 83 Fed. Reg. 35733 (July 27, 2018).
[2] Now Elevance Health, Inc.

2013 RUC survey were not accurate was contradicted by direct evidence and that the 2013 intra-service times were an accurate assessment of the typical time required to perform the surgeries and still appropriate for valuation. Second, the data cited by Anthem, from a single report by the Urban Institute regarding intra-service time,[3] had substantive shortcomings compared to the robust data from the RUC survey methodology. The Urban Institute report was designed as a feasibility study to obtain empirical time data and an author of the report explicitly warned readers not to rely on its' results for procedure valuation.

To protect against payer consolidation and abuses, CMS should focus its time, attention, and resources towards coverage and reimbursement policy for the purposes of the Original Medicare program and not divert to serve the ends of private insurers.

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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,

Bryan D. Springer, MD
President

Michael J. Zarski, JD
Executive Director

cc: Meena Seshamani, MD, PhD, Director, Center for Medicare
Liz Richter, Deputy Director, Center for Medicare
Ryan Howe, PhD, Deputy Director, Hospital and Ambulatory Policy Group, CM

[3] Urban Institute, *Collecting Empirical Physician Time Data - Piloting an Approach for Validating Work Relative Value Units* (Dec. 2016).