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

August 31, 2022

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013, Baltimore, MD 21244-8013

RE: CMS-4203-NC - Medicare Program; Request for Information on Medicare Advantage

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 Request for Information (RFI) on the Medicare Advantage (MA) program.

AAHKS is the foremost national specialty organization of more than 4,600 physicians with expertise in total joint arthroplasty (TJA) procedures, aka lower extremity joint replacement (LEJR). 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.

Much of our comments are informed by a poll of AAHKS members in Mach 2022 (the 2022 AAHKS Survey) in response to growing concerns on prior authorization practices. While AAHKS did not limit the 2022 AAHKS Survey to MA plans, the survey results highlight the significant burdens the current prior authorization framework imposes on providers and underscores the barriers and delays that impact patients in need of treatment.

Our comments on the RFI are as follows:

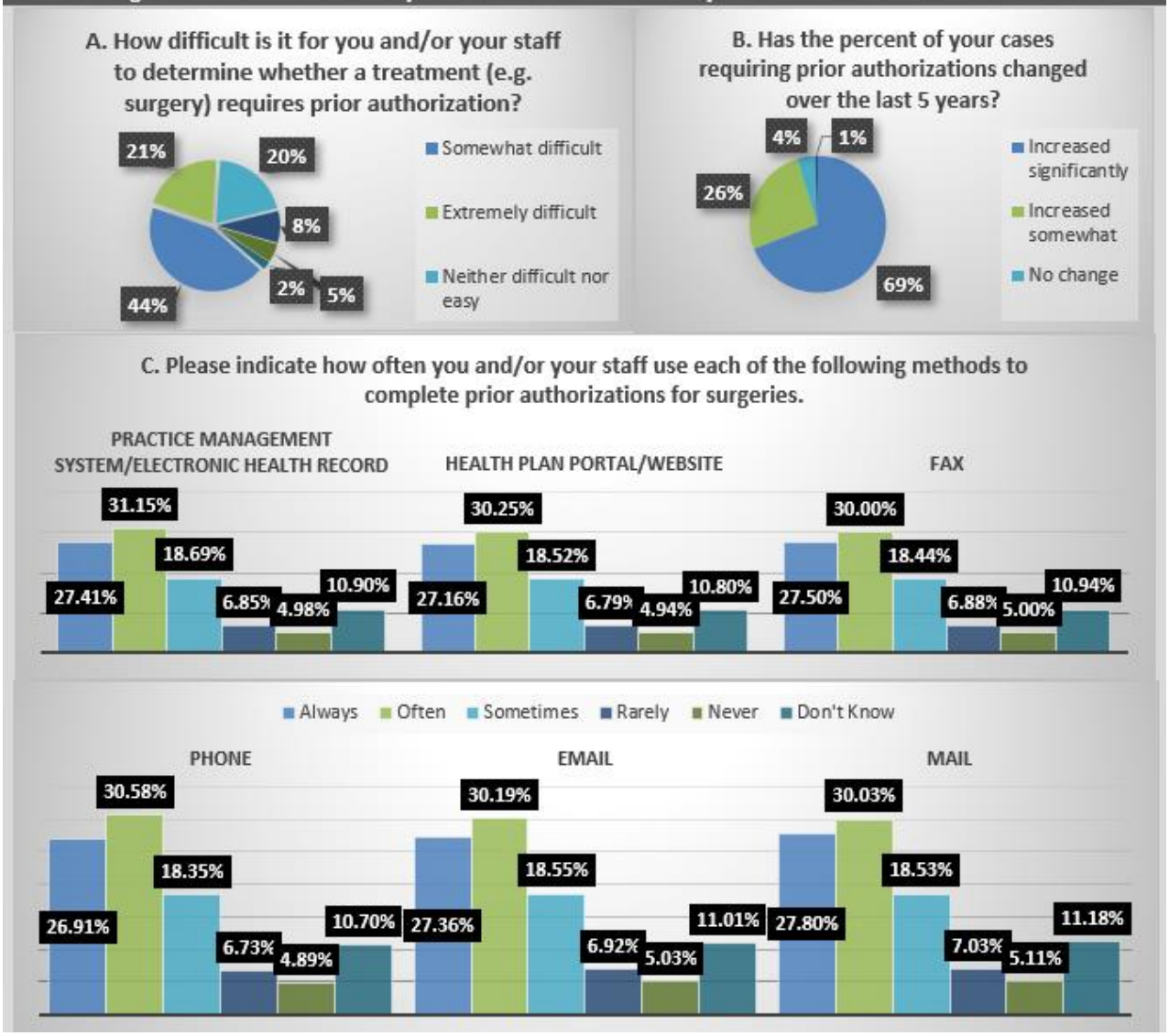
I. Prior Authorization - Expand Access: Coverage and Care (Sec.II.B.10)

CMS asks: How do MA plans use utilization management techniques, such as prior authorization?

As applied to LEJR, MA plans are increasing the use of prior authorization, and doing so through a variety of methods. Most significantly, there is a lack of transparency as to the circumstances in which prior authorization is required. Approximately 65% of respondents to the "2022 AAHKS Survey reported determining whether certain treatments require prior authorization to be either "somewhat difficult" or "extremely difficult." *See Figure 1(A).* Further

concerning, approximately 95% of AAHKS' respondents reported that the proportion of cases requiring prior authorization "increased significantly" or "increased somewhat" over the past 5 years. *See Figure 1(B).*

Figure 1: 2022 AAHKS Survey Results – Concerns with Payor Prior Authorization Standards



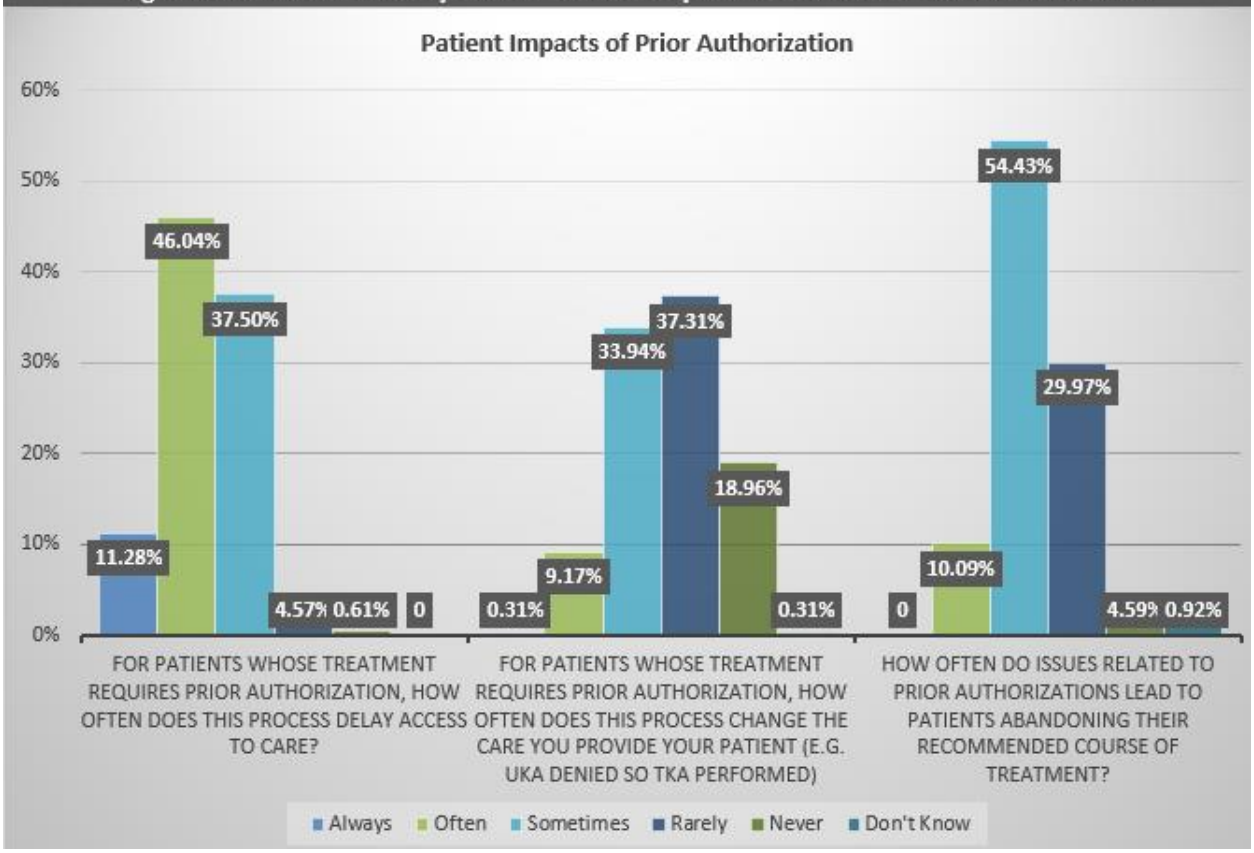
The information in Figure 1(C) highlights the inefficiency underlying the current prior authorization system with respect to the varying methods providers use to complete prior authorizations for surgeries. Approximately one-third of AAHKS' respondents "always" use each mode of communication noted on the 2022 AAHKS Survey—including practice management systems, electronic health records (EHRs), health payor portals/websites, fax, phone, email, and mail—to complete prior authorizations for surgeries. Approximately one-third of respondents stated they "always" use practice management systems/EHRs or health payor portals/websites, which may indicate that a significant portion of providers may face issues transitioning to electronic prior authorization.

There is a need for MA program standards requiring plan clarity on their respective standards so providers and patients understand when prior authorization may be required ahead of time. This would better enable providers and their patients to improve their planning and coordination to focus on the patient-provider relationship without an unexpected need for prior authorization interrupting providers' workflow and impeding patients' care.

CMS asks: What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

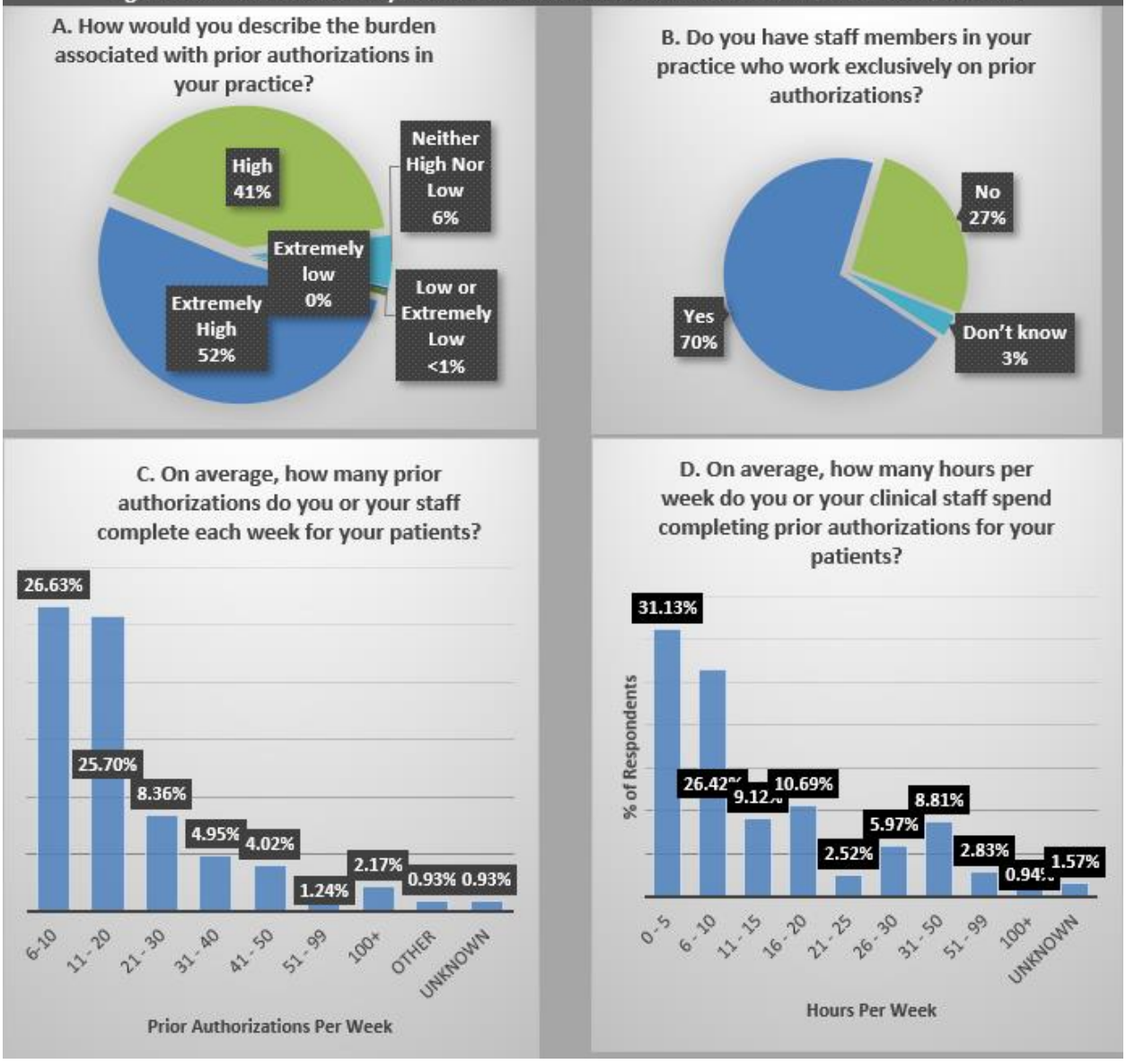
The current prior authorization framework imposes barriers and delays for patients that may jeopardize patients' health. Approximately 57% of respondents to the 2022 AAHKS Survey indicated patients whose treatment requires prior authorization always or often experience delays in access to care. While 37% of respondents indicated prior authorization would rarely change the care the provider would provide to their patient, almost one-third answered "sometimes." Additionally concerning, 54% of respondents stated issues related to prior authorizations sometimes led to patients abandoning their recommended course of treatment. *See Figure 3*.

Figure 3: 2022 AAHKS Survey Results – Patient Impacts Associated with Prior Authorization



The burden of excessive prior authorization practices falls on providers as well. Providers already face high administrative burdens when complying with current prior authorization requirements. Approximately 52% of respondents to the 2022 AAHKS Survey describe burdens associated with the prior authorization as being "extremely high," while 42% of respondents described the burdens to be "high." *See Figure 4*. Approximately 70% of respondents reported employing full-time staff dedicated exclusively to prior authorization.

Figure 4. 2022 AAHKS Survey Results - Provider Burdens Associated with Prior Authorization



As such, AAHKS supports further testing and implementation of attachment standards in the context of prior authorization. Adoption of any one standard should coincide with other policy solutions that address underlying payor policies and the burdens providers may face implementing health IT systems that incorporate such attachment standards. AAHKS urges HHS

to consider the already high burdens providers face under current payor prior authorization requirements so that additional standards do not lead to imposing additional burdens.

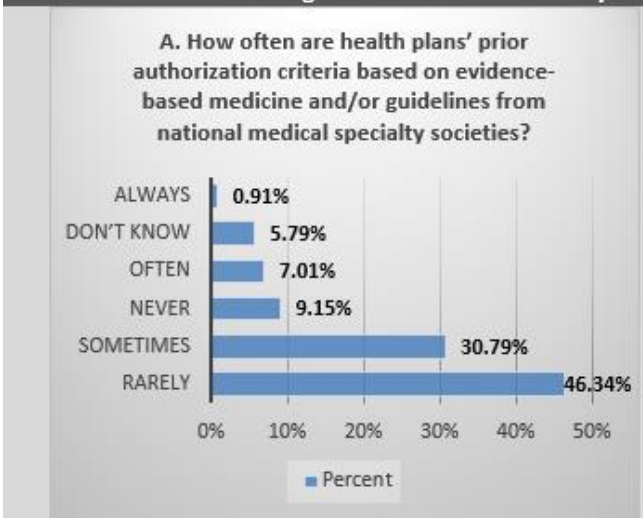
II. Data Standards for Prior Authorization (Sec.II.B.11)

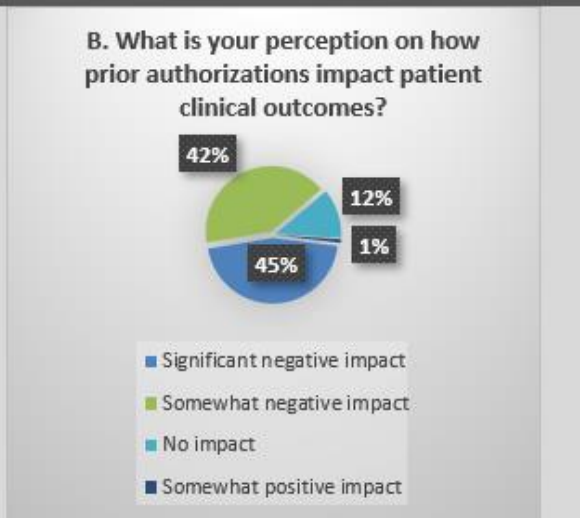
CMS asks: What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques?

Prior authorization standards should be evidence-based. Less than 1% of respondents to the 2022 AAHKS Survey stated health payors always base prior authorization criteria on evidence-based medicine and/or guidelines from national medical specialty societies, while a significant 46% of respondents stated payors rarely used such data in prior authorization criteria. Approximately 87% of 2022 AAHKS Survey respondents perceive prior authorization of having a "significant negative impact" or a "somewhat negative impact" on clinical outcomes. *See Figure 2*. AAHKS believes these findings and the overall inconsistency and lack of transparency regarding the criteria and expertise upon which payors develop their prior authorization standards indicate a significant need to streamline prior authorization according to the best evidence-based practices.

MA plans should base prior authorization criteria on peer-reviewed, evidence-based medicine and guidelines from national medical specialty societies reviewed by qualified experts to ensure better alignment with the clinical process and enable providers and their patients to better understand the criteria payors use to make prior authorization determinations. Further, MA plan staff and contractors who review and make determinations in response to prior authorization requests must have the adequate, appropriate, and specific qualifications required for such determinations using payors' evidenced-based clinical criteria.

Figure 2: 2022 AAHKS Survey Results – Clinical Considerations





CMS asks: How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

AAHKS urges CMS to issue guidance to ensure MA plan beneficiaries do not face more restrictive prior authorization criteria than required under the Original Medicare (FFS) program. The Medicare Managed Care Manual specifies that "MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services."[1] However, a 2022 report issued by the HHS Office of the Inspector General entitled "*Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*" found that 13% of MA organizations' prior authorization denials analyzed met Medicare coverage rules and "likely would have been approved […] under original Medicare." Further, OIG found that in many cases, MAOs denied such requests after applying specific clinical criteria not required by Medicare.[2] As detailed in the 2022 OIG Report and highlighted in the 2022 AAHKS Survey, denials and delays related to prior authorization can adversely impact patients. As such, AAHKS requests that CMS adopt more specific guidance for MA plans to ensure MA enrollees have equal opportunity to access medically necessary care without delay or additional burden. Particularly for procedures like LEJR for which LCDs exist in the Medicare program.

AAHKS believes that systematic reform of payors' prior authorization frameworks across the healthcare system can begin with changes to MA plans and encourages CMS to implement such changes in a manner scalable to other payors that seek to follow CMS' lead. As noted by the HHS Office of the National Coordinator in its *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs,* payors' and health IT developers' attempts to address prior authorization in an ad hoc manner ultimately resulted in the current prior authorization framework comprised of diverse and varying requirements that reflect individual payor's technology considerations, lines of business, and customer-specific constraints. As CMS works to continue improving MA plans through adoption of new prior authorization policies, AAHKS encourages adoption of similar prior authorization policies by other payors.

III. Impact of High MA Enrollment on Medicare Writ Large (Sec. II.D.3)

CMS asks: "As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?"

a. CMS Must Guard the Integrity of Original Medicare Against Interference by MA Plans for Their Own Ends

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf; 10.2
[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

As MA enrollment grows, MA plans have a greater incentive to interfere in Original Medicare to reduce payments under the Physician Fee Schedule (PFS), upon which many of their contracted provider payment rates are based. For example, following a process established by CMS for the public to nominate potentially misvalued CPT codes, one anonymous party in 2018 nominated seven high volume codes for review, including LEJR codes 27447 and 27130.[3] 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., argued that overestimates are 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 whose commercial, Medicare Advantage, or Medicaid managed care rates were based on the PFS.

It was disappointing that CMS was persuaded to refer to the CPT codes to the RUC in spite of several points against the referral. First, Anthem's allegations that intra-service times from the 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, actually from only one report by the Urban Institute regarding intra-service time,[4] had substantive shortcomings compared to the robust data from the RUC survey methodology. Data from only two facilities formed the basis of the analysis, which was significantly small in comparison to RUC survey data on the same procedures. Important characteristics of the facilities and surgeons were not provided. Together, these factors resulted in a clear selection bias and, as stated by the study's author, "these sites were very much a sample of convenience and should not necessarily be viewed as representative of other health systems."[5] Additionally, the Urban Institute report was designed as a feasibility study to obtain empirical time data and an author of the report explicitly stated not to rely on its' results for procedure valuation.

Medicare statute and regulation already provide for periodic review of CPT code valuation. Therefore, CMS should be skeptical of misvalued code nominations from insurance companies that purport an interest in the long-term funding of the Original Medicare program

[3] 83 Fed. Reg. 35733 (July 27, 2018).
[4] Urban Institute, *Collecting Empirical Physician Time Data - Piloting an Approach for Validating Work Relative Value Units* (Dec. 2016).
[5] *Id*. at pg. 5 (emphasis added).

or appropriate reimbursements to providers for services to Medicare beneficiaries. If CMS fails to protect the CPT code valuation process from this kind of abuse, the integrity of CMS' RVU valuation system will be undermined. Congress gave the Secretary a mandate to appropriately reimburse providers who serve Medicare beneficiaries, and this mission should not be conflated or confused with payers' commercial objectives to improve their negotiating leverage with physicians and increase profits. The time, attention, and resources of the Original Medicare program should be prioritized towards coverage and reimbursement policy of the Original Medicare program and not diverted to serve the ends of private insurers.

b. The Emergence of Value-Based Care Arrangements and Alternative Payment Models Depresses Physician Fee Schedule Rates Overtime

The growth of MA enrollment combined with the expansion of value-based arrangements under Original Medicare calls into question the long-term appropriateness of time-based provider payment methodologies under the Medicare program. Many episodic procedures, such as LEJR, are more likely to be performed under Advanced Payment Models (APMs) under within Original Medicare or other value-based arrangements with MA plans. CMS should preserve incentives for the transition to value-based care by not reducing fee-for-service rates based on new value-based care driven efficiencies.

LEJR procedures are increasing provided to beneficiaries covered under MA, for which the provider has contracted with the plan for a value-based reimbursement. This means that fewer and fewer LEJR procedures nationally are reimbursed on a fee-for-service basis under Original Medicare wherein physician reimbursement is based on physician time. Instead, Medicare APMs and MA plans incentivize surgeons to improve efficiency and outcomes for patients. Surgeons have succeeded in safely returning LEJR patients to their homes sooner, reducing readmissions, and saving money for the Medicare program. This has been accomplished through shifting more surgeon time from post-operative visits to preservice optimization time to improve the likelihood of successful outcomes for the patient. This means that some surgeon time has shifted outside of the episode window upon which Original Medicare bases its reimbursement. This, in turn, has led CMS to reduce its payments to orthopaedic surgeons for LEJR under Original Medicare.

Such a reduction broadcasts a strong, chilling message to all physicians participating in—or considering participating in—APMs: when providers in the vanguard of value-based care and bundled payments begin to achieve some efficiencies in the delivery of care, CMS will use those positive developments as a justification to cut fee-for-service reimbursement. The potential to improve care for our patients and reduce overall Medicare expenditures through Advanced APMs and other value-based care arrangements should not be threatened by simultaneous reductions in work RVUs under the PFS.

The combination of the Medicare program putting LEJR procedures at the forefront of value-based care and simultaneously reducing PFS reimbursement reduction for these procedures cannot help but create an impression among orthopaedic surgeons that their

profession is under assault. In effect, the Medicare program is encouraging orthopaedic surgeons to take on more risk under APMs, but simultaneously reducing fee-for-service reimbursement, leaving our members bearing more risk combined with lower reimbursement.

Instead, CMS should take proactive efforts to ensure providers are appropriately, fairly, and adequately reimbursed to continue incentivizing provider participation in Medicare's value-based innovation models. The impacts of a procedure transitioning to value-based care may change practice patterns and the demands of surgeon attention, focus, and time. AAHKS urges CMS to take these differences into account when valuing codes.

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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