

September 11, 2023

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare 2024 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 2024 (hereinafter referred to as “CY 2024 PFS proposed rule” or “proposed rule”).

AAHKS is the foremost national specialty organization of more than 4,900 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 four principles:

- Payment reform is most effective when physician-led;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- 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 2024 PFS proposed rule are summarized as follows:

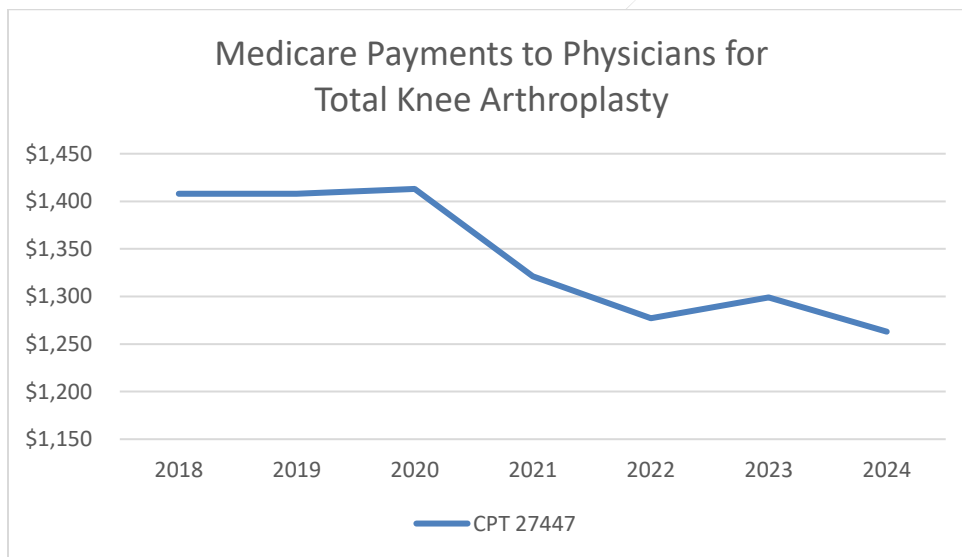
I. Executive Summary

- CMS should provide technical assistance to Congress to waive budget neutrality adjustments for the Physician Fee Schedule Conversion Factor, or otherwise prevent the 3.34% cut in physician payments for hip and knee replacement proposed for 2024.
- AAHKS strongly supports adjusting the timeframe and the fracture exclusions to improve the accuracy of Total Hip Arthroplasty (THA) quality measure.
- CMS’ proposal to not cover Remote Physiologic Monitoring (RPM) or Remote Therapeutic Monitoring (RTM) in the global period stands in contrast to AAHKS members’ recommendations based on their experience.

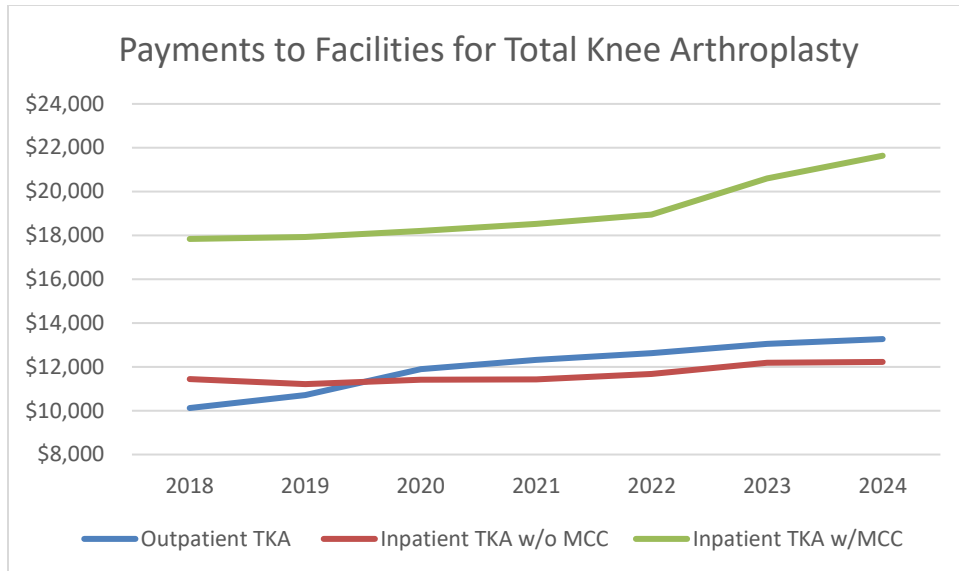
II. Calculation of the CY 2024 PFS Conversion Factor (Sec. VII.C.1.Table 102)

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 2024, CMS proposes a PFS conversion factor of \$32.75, \$1.14 decrease from the 2023 conversion factor of \$33.89, 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. Congress acted in the Consolidated Appropriations Act of 2023 to reduce these cuts by 2.5% in 2023 and 1.25% in 2024, however the proposal nevertheless represents a significant cut and continues the trend of reimbursement reductions for arthroplasty services. This will result in a 2.8% reduction in reimbursement for TJA procedures (CPT codes 27447 & 27130) in 2024. 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 10.5% in three years.



The sustained, severe reductions should be contrasted with Medicare payments to facilities for the same procedure over a similar timeframe, in which payments have increased 7-16% for inpatient procedures and have increased nearly 12% for outpatient procedures. It seems difficult to justify that Medicare payment formulas make physicians carry the burden of cost reductions while hospital payments continue to increase. Reimbursements to physicians account for less than 6% of total Medicare payments to providers for TJA procedures.



Such reduced reimbursement makes it more difficult for surgeons to sustain independent practices or have a realistic range of options for practice models. This leads 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 Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (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 PFS conversion factor, or otherwise prevent the 2.8% cut in physician payments for TJA proposed for 2024.

This issue 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, in light of President Biden’s *Executive Order on Promoting Competition in the American Economy*¹, CMS should evaluate whether its proposed reductions in Medicare physician 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 payers. Such reporting is an

¹ EO 14036 (July 9, 2021).

important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates reductions.

III. Changes to Timeframes for the Functional Status for THA Measure

CMS proposes changes to improve the accuracy of quality measure #376, *Functional Status Assessment for Total Hip Replacement*, “measuring the percentage of patients 19 years of age and older who received an elective THA and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after surgery”. First, CMS proposes to revise timeframe for the follow-up assessment *from 270-365 days after surgery to 300-425 days after surgery*. Second, CMS proposes to revise the measure denominator exclusions which are intended to remove non-elective procedures. The current exclusion of patients with “*two fractures present at the time of the procedure*” would be revised to “*one or more specific lower body fractures indicating trauma in the 24 hours before the start of the THA*”

We are providing below, the comments regarding these proposed changes that AAHKS provided to Mathematica and the National Committee for Quality Assurance (NCQA) in June of 2022:

AAHKS strongly supports adjusting the timeframe. Many of our members are actively collecting PRO-PM measures and are challenged by the inconsistency of collection time frames set by CMS and other entities. We fully support and request that CMS use consistent time frames for the PRO-PM. We strongly supported the 300-425 timeframe for collection of post-operative PRO-PM, which is the same time frame applied to the Hospital PRO-PM reporting and remains the timeframe recommended for ambulatory as well as clinician/clinician groups PRO-PM reporting for QPP. Post-operative appointments often occur after 1 year due to patient preferences, scheduling, and other issues and therefore we recommend extending the timeframe to include more patients in this measure. We do not believe that there are significant long-term consequences to patient care or practice management in extending the time frame. We believe that not making the change would have significant consequences to compliance because the time frame is not the same as for other quality reporting programs within CMS.

On fracture exclusions, because the measure is seeking to capture elective primary total joint replacement patients, we support exclusion of all patients who have a fracture diagnosis at the time of the procedure. There is an increasing number of geriatric patients and resultant complex geriatric fractures about the knee treated with TKA and the increasing number of total hip arthroplasty being performed for proximal femoral and acetabular fractures; however, it is unreasonable to ask such patients to complete a functional assessment prior to surgery at the time of the fracture and these patients do not represent elective TJA patients.

Further, the exclusion should be broader to exclude patients who have a lower extremity fracture diagnosed during the admission for THA and prior to the start of the surgery. Many patients will have a delay of over 24 hours before getting surgery for a hip fracture and the

standard is to operate before 48 hours. By setting the measure to exclude only those diagnosed within 24 hours of the start of the THA, CMS is effectively excluding the healthiest fracture patients who get a THA and including the sickest. More importantly, neither group is representative of the elective THA population.

IV. Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) – Clarifications for Appropriate Billing (Sec. II.D.1.f.2.b.(5))

CMS is proposing a new policy whereby for an individual beneficiary who is currently receiving services during a global period, such as for TJA, a physician may furnish RPM or RTM services, and receive separate payment, *only* if the remote monitoring services are unrelated to the TJA procedure for which the global procedure is performed.

We believe this proposal is misguided and argue that remote monitoring services are critical for optimal outcome of surgical procedures and therefore must be covered beyond the global payment in order to incentivize utilization.

AAHKS members report that the best use case for RTM is post-operatively, that RTM decreases time to catch complications, decreases number of therapy sessions, allows more consistent Patient-Reported Outcome Measures (PROMs) collection, avoids certain in person visits for people with transportation issues, and will help drive reporting to American Joint Replacement Registry (AJRR). While there are other uses for this technology, post-op monitoring is the best and would effectuate the goals of decreasing complications and readmissions.

We are concerned with the unintended outcomes. If the proposed rule becomes policy, it is unlikely, according to our members, that anyone outside of the groups in fully at-risk arrangements will undertake the financial loss to enroll and manage patients in remote monitoring without compensation and thereby forego the benefits listed above.

**

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,



Javad Parvizi, MD, FRCS
President



Michael J. Zarski, JD
Executive Director

cc: Chiquita Brooks-LaSure, Administrator
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Meena Seshamani, Director, Center for Medicare

Liz Richter, Deputy Director, Center for Medicare

Ryan Howe, Director, Hospital and Ambulatory Policy Group, Center for Medicare