AAHKS
AMERICAN ASSOCIATION OF
HIP AND KNEE SURGEONS

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September 9, 2024

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare 2025 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 calendar year 2025 (hereinafter referred to as "CY 2025 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 5,200 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.

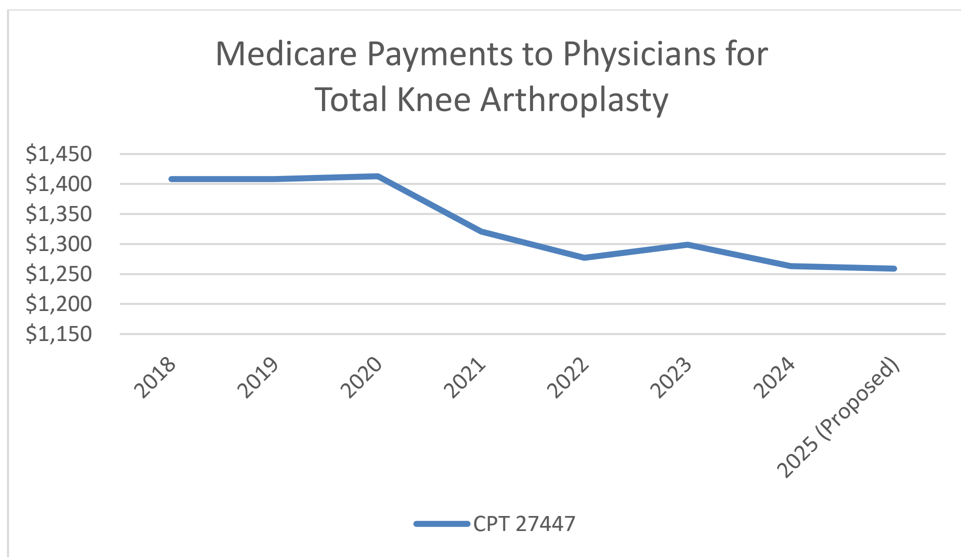
Our comments focus on the 2025 PFS proposed rule follow:

I. Calculation of the CY 2025 PFS Conversion Factor (Sec. VII.C.1.Table 126)

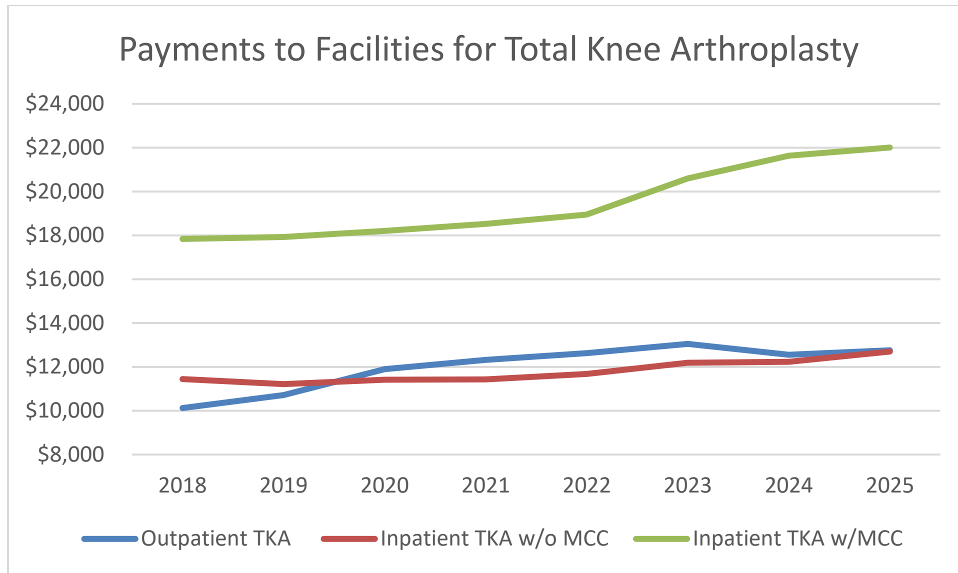
The Medicare statute requires that any increases or decreases in RVUs may not cause the amount of Medicare PFS expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. When this threshold is exceeded, CMS makes other increases 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 2025, CMS proposes a PFS conversion factor of $32.36, a $0.93 decrease from the 2024 conversion factor of $33.29, to reflect the proposed budget neutrality adjustment that accounts for changes in RVUs. This reduction also takes into account the expiration of the 2.93% temporary increase Congress provided through the Consolidated Appropriations Act (CAA), 2024. Congress has acted in previous years to reduce these cuts (ex. a 2.5% fix in the Consolidated Appropriations Act of 2023 and a 1.25% fix in 2024), however this back and forth between CMS and Congress and the uncertainty it creates is unsustainable.

No provider should have to expect a significant cut year over year while being expected to improve care and outcomes. AAHKS is incredibly disappointed that this year's proposed PFS conversion factor continues the trend of reimbursement reductions for arthroplasty services. To be clear, the proposed cut will result in an approximately 0.28% reduction in reimbursement for TJA procedures (CPT codes 27447 & 27130) in 2025. With payment reductions in 2021 due to the conversion factor and CMS' decision to reduce TJA wRVUs, Medicare reimbursements to physicians for TJA will have fallen by 10.5% in three years.



Additionally, the sustained, severe reductions to physicians outlined above is in stark contrast to the payment increases of 7-16% for inpatient procedures and 12% for outpatient procedures for facilities in the same time period. We request clarity on the CMS decision making process that places an outsized burden on physicians that are required to do the procedure "provided" by these facilities.



This administration has been clear that a key goal is to address mergers and consolidation in health care, yet the administration misses an opportunity here to acknowledge and the financial stability needed to sustain an independent practice without turning to mergers and consolidation to stay in business. Our members do not want to sell their practices. They know that consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas.

Further, our members wish to remain in their field of choice. Reduced reimbursement for Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) has sadly led 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.

We implore the administration not to miss the connection between ever falling Medicare reimbursements and health care industry consolidation. Waiving budget neutrality in the Physician Fee Schedule could turn around the consolidation momentum in health care. We ask that the administration provide CMS leadership to work with 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 2025.

Our members also firmly believe – and have asked 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], we ask CMS to evaluate whether its proposed reductions in Medicare physician rates promote competition in health care or facilitate consolidation.

AAHKS is also working with Congress to pass the *Providers and Payers COMPETE Act (H.R. 3284)*, that 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 important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates reductions.

Instead of the back and forth between Congress and CMS on proposed cuts to doctors, our members ask that CMS work closely with Congress to improve what has become a broken process of cuts and end of year band aids. It will take Congress, CMS and impacted providers like our members to work together to find a better solution going forward and we are ready and willing to work with CMS and Congress to address this crucial issue.

II. Potentially Misvalued Services (Sec. II.C.3.a.(2))

CMS is required by law to evaluate CPT codes as potentially misvalued at least once every five years. CMS considers "nominations" from the public on potentially misvalued codes and reviews each flagged code on an individual basis. For the second year in a row, the 090-day global code CPT 27279[2] has been nominated as potentially misvalued due to the absence of separate direct PE inputs for this service in the non-facility office settings, The nominators are seeking separate direct PE inputs for this service to better account for valuation when performed in the nonfacility/office setting.

We agree with CMS that the submitted studies in support of the nomination collectively report heterogeneous safety outcomes. The large variabilities in safety outcomes reported in the studies, coupled with several unreported outcomes, may indicate that we have little knowledge about the effect of the service on safety outcomes, prompting the need for further investigation. Therefore, we do not support at this time CMS referring this code to the AMA RUC as potentially misvalued.

[1] Executive Order 14036 (July 9, 2021).
[2] (ARTHRODESIS, SACROILIAC JOINT, PERCUTANEOUS OR MINIMALLY INVASIVE (INDIRECT VISUALIZATION), WITH IMAGE GUIDANCE, INCLUDES OBTAINING BONE GRAFT WHEN PERFORMED, AND PLACEMENT OF TRANSFIXING DEVICE).

III. Strategies for Improving Global Surgery Payment Accuracy (Sec. 5.b)

a. Proposed Modifiers

CMS proposes to "broaden the applicability of transfer of care modifiers" (-54, -55, and -56) for 90-day global services to require their use when a physician expects to furnish only preoperative management, surgical care only, or postoperative management only. Also, CMS proposes to create a new code, GPOC1, for postoperative care services to more appropriately compensate time and resources rendered by a physician who was not involved in the surgical procedure.

AAHKS supports the introduction of GPOC1 as a global post-operative add-on code as a path to payment for surgeons to furnish evidence-based care (e.g., fracture care management) after the surgical window. However, in order to safeguard against consolidation, AAHKS strongly opposes a reduction in physician compensation due to the introduction of GPOC1 (see comments provided in Section I of this letter regarding the urgent need for CMS and Congress to collaborate on PFS reform). While the introduction of GPOC1 may be a step in the right direction to support care coordination following surgery, AAHKS also encourages CMS to explore a new longitudinal care model to unite orthopedic surgeons with other provider types who care for beneficiaries with orthopedic needs, such as fracture care management.

b. CMS Cannot Improve Payment Accuracy by Focusing Only on Reductions of Global Surgery While it Also Wishes to Incentivize Care Coordination

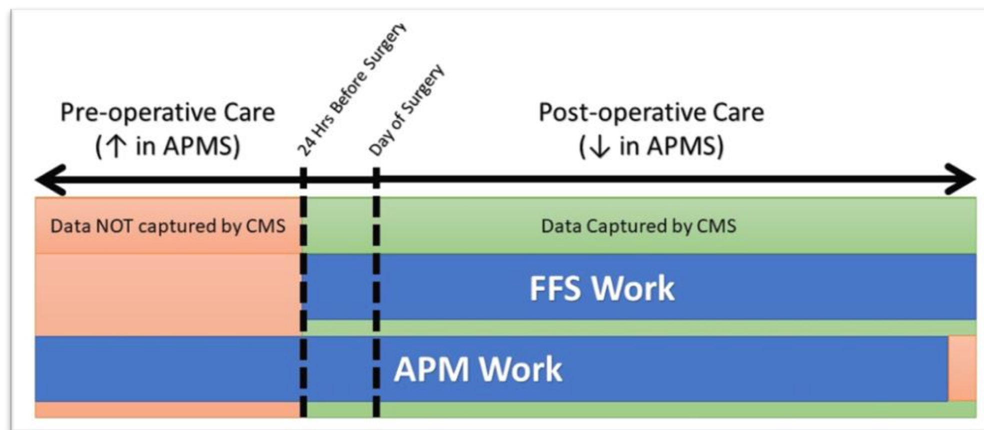
If CMS wishes to "improve the accuracy of payment for the global surgical packages" it can require the RUC to recommend wRVUs based upon a consistent percentile level from physician surveys. As discussed below regarding the valuation for CPT 27447, when the RUC and CMS have actual physician work survey data, they use wildly varying percentiles to set value. The arbitrary nature of the valuation (median amount for some procedures, 25th percentile for some procedures, below 20th percentile for others), suggests that CMS is motivated, not by standards for payment accuracy, but by reducing program expenditures.

Another necessary element to "improve the accuracy of payment for the global surgical packages" is for CMS to look at the entire global surgical package and not post-operative visits alone. The shift to value-based care in the last decade has led to evolutions in how many surgical procedures are managed which requires a new comprehensive consideration on assessing value.

Orthopaedic surgeons, and THA and TKA procedures specifically, have been at the forefront of the transition to value-based care as high-volume, high-value procedures present significant opportunities for improvements in quality and efficiency. Hip and knee surgeon participation in alternative payment models (APMs) is approaching 50%, the highest rate of any subspecialty. Our members' work within CJR and BPCI-A models has improved outcomes, reduced patient time spent in the hospital, and subsequently saved Medicare hundreds of millions of dollars.

Much of the effectiveness of these programs, however, has come from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work. Our members and associated qualified health professionals, and clinical staff have experienced significant increases in preservice work to optimize patients through screening, education, and 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 fall outside of the global surgical bundle because they are not included in the traditional RUC survey definition of "pre-service activities," nor the time clinical staff spent providing certain pre-service activities for the patient and family.

Increase in Arthroplasty Preservice Optimization Time Due to Value-Based Care



Evidence has made clear that the additional time spent on these preoperative activities has resulted in improved clinical quality for patients and significant savings by reducing patients' post-operative lengths of stay, readmissions, and other complications. An April 2019 New England Journal of Medicine article estimated that 42% of TKA and THA procedures over a two-year period were performed under the CJR and resulted in a 3.1% reduction in Medicare spending for Total Knee Replacement and Total Hip Replacement.[3] It is important to note that it is the increased work by surgeons, managing the patient experience and optimization, that leads to arthroplasty savings realized in reduced spending by the facility and post-acute care.

Penalizing surgeons for this successful collaboration, by reducing valuation for post-operative visits while not reimbursing preservice optimization time, does not lead to more accurate payments. We encourage CMS to evaluate whether current global surgical bundles are capturing all pre- and post-operative work and consider whether CPT codes exist for work performed outside the bundles.

[3] Michael L Barnett, et al., Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, 380 NEW ENGLAND J. OF MED., 252-262, (Jan. 17, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsa1809010.

We wish to echo the comments of our colleagues at the Bone Health and Osteoporosis Foundation and the American Society for Bone and Mineral Research who have argued that Medicare's global payment structures contribute to the osteoporosis care gap as orthopedic surgeons treating an acute conditions like fracture are not compensated for the time and services required to address the underlying chronic condition of osteoporosis.

IV. <u>Quality Measures - Proposed Changes to the 2025 MIPS MVP Pathway: Improving Care for Lower Extremity Joint Repair</u>

CMS proposes to make several modifications to the Improving Care for Lower Extremity Joint Repair Merit-based Incentive Payment System Value Pathway (MIPS-MVP), including to revise Q376: Functional Status Assessment for Total Hip Replacement such that the timing of the encounter aligns with the post-surgical assessment timeframe of 300-425 days following the original THA surgery. AAHKS supports finalizing this revision as proposed to align the Q376 timeframe with that of other quality reporting programs (e.g., the Hospital-Level THA/TKA Patient Reported Outcome-Based Performance Measure).

Additionally, with regards to Q470: Functional Status After Primary Total Knee Replacement, AAHKS supports CMS' proposal to clarify that if a tool other than the Oxford Knee Score (OKS) or Knee injury/Osteoarthritis Outcome Score Joint Replacement (KOOS, JR.) is used to assess a patient's functional status, this should result in a performance not met. This revised clarification is consistent with current report practices for outcomes and, therefore, AAHKS supports finalizing as proposed.

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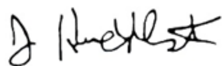
AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,



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