AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
United States House of Representatives
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
United States House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Bradley Schneider
United States House of Representatives
300 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael C. Burgess, M.D.
United States House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad R. Wenstrup, D.P.M.
United States House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, M.D
United States House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to provide comments for the Request for Information regarding the implementation of Pub.L. 114–10, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and associated payment mechanisms. AAOS appreciates the opportunity to share our feedback on the implementation of MACRA since it was signed into law in 2016.

The original intent of MACRA—to incentivize the shift of U.S. healthcare spending and delivery from a fee-for-service model to a value-based care model—has been successfully implemented in some respects, but overall has failed to address the (1) financial sustainability of the Medicare

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Physician Fee Schedule (MPFS), (2) the need to develop and improve qualified clinical data registries, and (3) the necessity of developing more advanced alternative payment models.

Improvements to these three areas will greatly improve delivery of care and the sustainability of Medicare.

Executive Summary

MACRA was intended to shift from fee-for-service to value-based payments. *Current implementation has NOT addressed:*

1. Sustainability of the Medicare Physician Fee Schedule;
    a. Widening gap between physician payments and rate of inflation.
    b. Conversely, hospital and facility payments have increased to outpace inflation.
    c. Physician practices will soon become unsustainable. Current conversion factor is trending towards $31.00- the rate from 1992.

    Congress Must:

    - **Pass H.R. 8800 the *Supporting Medicare Providers Act of 2022*, which prevents the 4.42% cut to the MPFS CF for CY 2023.**
    - **Suspend PAYGO payment cuts before January 1, 2023 to prevent an additional 4% cut to Medicare physician reimbursement**
    - **Provide a permanent inflationary update to Medicare physician payments, as physicians are the only group in the Medicare payment system whose reimbursement is not adjusted for inflation.**
    - **Extend the $500 million exceptional performance bonus and the SURS program.**

2. Section 105(b) requirements for Qualified Clinical Data Registries (QCDRs).
    a. These are required to provide transparent, real-time, continuous, and comprehensive access to Medicare claims data.
    b. The current system contains a minimum 7-month delay in data delivery. The process is both cumbersome and costly.
    c. The process for authorization of services through Medicare Advantage is not transparent, is not evidence-based, and interferes with access to care.
    d. The current process *does not comply* with Congressional directives.

    THEREFORE:

    - **Congress must work with CMS together to fulfill the original directive of the law and create an efficient, affordable, and concise process for continuous access to this data.**

- **Congress must urge CMS to make cost measure benchmarks available on a rolling, close to real-time basis during the actual measurement year, considering sample sizes, billing delays, and using ranges, instead of specific numeric targets, for performance and payment.**
- **Congress should pass H.R. 5394 *the Meaningful Access to Federal Health Plan Claims Data Act of 2021*, which would create greater interoperability between clinician-led clinical outcomes data and Medicare claims data to define new value of new medical technologies and therapies, creating greater value in Medicare spending.**

3. Obligation to develop novel alternative payment models which are physician-led and maintain access to care.
    a. AAOS physicians work has resulted in an estimated $61.6 million estimated net savings in the first three performance years of the CJR program;
    b. Physicians are overloaded with administrative burden to comply with the numerous value-based payment models and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs.
    c. AAOS is pleased that the BPCI-A model is being extended through 2025. Given the model's success, a key lesson from BPCI-A should remain at the forefront when designing future models.

THEREFORE:

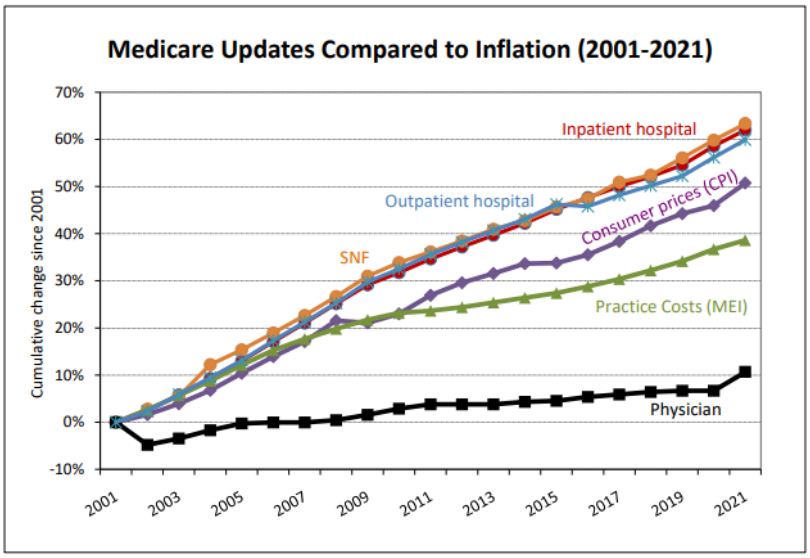
- **Any legislation passed by Congress must support surgeon-led models, which are highly effective at achieving participation from physicians, savings to the Medicare program, and patient engagement in their care.**
- **Urge CMS to reinstate the financial methodology used in BPCI Classic for BPCI Advanced and allow excess NPRA funds to flow to any PGP participating in BPCI Advanced to offset overhead and related costs for participating in the new model.**
- **Urge CMS to remove limits to gainsharing agreements, in addition to the payment cap, and encourage gainsharing arrangements that help to control the costs of care while not impairing care quality.**

I. Medicare Physician Fee Schedule

Costs associated with practicing medicine since the COVID-19 pandemic are higher than that of running a practice in pre-pandemic times. The Congressional Budget Office estimates that up to 50% of healthcare facilities could be running with negative margins by 2025.[1] Physician payment

[1] https://www.cbo.gov/publication/51919

in Medicare lacks an automatic annual update to keep pace with inflation, causing physician reimbursement by Medicare to increase far below the rate of inflation. Since 2001, the cost of running a medical practice has increased 39%, but the Centers for Medicare & Medicaid Services (CMS) has only increased reimbursement for physicians by 11%.[2] As a result, when adjusting for inflation in practice costs, Medicare physician reimbursement has actually dropped by 20% over the past two decades. Alternatively, Medicare hospital updates totaled roughly 60% between 2001 and 2021, with average annual increases of 2.4% for both inpatient and outpatient services. Physicians are the only group in the Medicare payment system whose reimbursement is not adjusted for inflation.



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

In 2021, Congress acted to mitigate most impending cuts to Medicare reimbursement set to take place in 2022. The *Protecting Medicare and American Farmers from Sequester Cuts Act* (S. 610) provided a 3% positive adjustment to the MPFS conversion factor (CF) for 2022, averted a 4% Medicare payment reduction due to statutory pay-as-you-go (PAYGO) requirements and phased in a 2% cut due to sequestration policy over six months. These critical payment reduction relief policies effectively turned a potential 9.75% cumulative cut to Medicare reimbursement in 2022 into a 2.5% cut. Although short-term in nature, this relief provided some necessary financial stability for Medicare clinicians, including orthopaedic surgeons, and helped to ensure our nation's seniors maintained access to high-quality care.

Unfortunately, physicians face another round of significant payment cuts on January 1, 2023. If finalized, the recently released Calendar Year (CY) 2023 MPFS Proposed Rule will cut the Medicare conversion factor by 4.42%. The proposed CY 2023 conversion factor of $33.08 is significantly lower than the rate of $36.6873 paid in 1998 and trending toward the $31.0010 CF in place in 1992 when CMS first implemented the MPFS.

[2] https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf

This cut, combined with the pending threat of the 4% PAYGO reduction and a lack of inflationary update, is simply not sustainable. Systemic issues such as the negative impact of the MPFS's budget neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for physicians moving forward, threatening beneficiaries' timely access to essential health care services.

Without Congressional intervention, current payment policies will further destabilize healthcare system financing and pose a particular threat to many orthopaedic private practices.

Therefore, Congress should:

- **Pass H.R. 8800 the *Supporting Medicare Providers Act of 2022*, which prevents the 4.42% cut to the MPFS CF for CY 2023.**
- **Suspend PAYGO payment cuts before January 1, 2023 to prevent an additional 4% cut to Medicare physician reimbursement**
- **Provide a permanent inflationary update to Medicare physician payments, as physicians are the only group in the Medicare payment system whose reimbursement is not adjusted for inflation.**
- **Extend the $500 million exceptional performance bonus and the SURS program.**

II. Qualified Clinical Data Registries

One area that has been a particular pain point for AAOS is the accessibility of Medicare claims data for our Qualified Clinical Data Registries (QCDRs). MACRA included a provision, Section 105(b) "Expanding the Availability of Medicare Data", which was supposed to have taken effect on July 1, 2016, and would have granted QCDRs access to real-time Medicare claims data for quality improvement and studies of patient safety. However, CMS chose to direct registries to the CMS Research Data Assistance Center (ResDAC) to obtain Medicare claims data instead of coming into compliance with Section 105(b).

The ResDAC program was established to respond to requests from researchers and is inappropriate to meet the continuous and comprehensive access to Medicare claims data required by QCDRs. CMS later announced that they would not adopt the directive from Congress to grant QCDRs access to Medicare claims data and asked that registries apply to become "Quasi Qualified Entities" to obtain Medicare claims data, a lengthy process which does not satisfy the "real-time" requirement of MACRA. Below represents the current steps QCDRs must take in order to obtain Medicare claims data:

Mechanics of the Current Process for Accessing Claims Data through the ResDAC Program

- *AAOS Registries must submit the following documents and approvals prior to dataset creation (4-5 months)*
    1. Annual research protocol extension request
    2. RIF request letter (summary)

3. Data use agreement update form
4. Full request details document
5. Data destruction methodology document
6. Data specification and request detail spreadsheet
7. Invoice and updated data specification spreadsheet
8. CMS approval of final request

- *Data processing and delivery (1-2 months)*

The process detailed above highlights just how significantly CMS' lack of compliance with Congress's directive has impacted the work that QCDRs are doing to surveil and analyze healthcare outcomes. This inefficiency comes at the detriment of Medicare beneficiaries' access to the most advanced, safe, and valuable treatments. In addition, the monetary cost of obtaining Medicare claims data through the ResDAC process can be considerably prohibitive. AAOS is anticipating that the cost of this data will escalate as the AAOS Family of Registries grows and the volume of requests increases exponentially. Six years since the law was supposed to take effect, QCDRs are still subject to this time-consuming and costly process for accessing claims data. It is important to incentivize the creation and ease of managing of QCDRs as the US population ages and the health care sector moves to more value-based investments. QCDRs help with improving population health outcomes, effectiveness of care pathways and surveillance of drugs and devices. To create a sustainable future for the Medicare program, policy makers must focus on ease of access and interoperability of Medicare data to aid in decision making and quality improvement.

Therefore, Congress must work with CMS together to fulfill the original directive of the law and create an efficient, affordable, and concise process for continuous access to this data.

III. Merit-based Incentive Payment System

Physicians are disincentivized to report through a QCDR or devote resources to measure development or QCDR development when there is no stability in quality reporting policies. Policies of the current Merit-based Incentive Payment System (MIPS) fail to acknowledge the time needed to adopt new guidelines and standards of care into practice. In addition, it takes time for sufficient data to be collected for benchmarking and tracking progress over time and physicians incur additional implementation costs. These challenges, as well as CMS' MIPS scoring policies, contribute to physician hesitation to adopt new quality measures. AAOS believes that the field of performance measurement and the shared goal to improve the quality of care for patients are negatively impacted by these policy decisions.

While AAOS understands the cost measure benchmarks are based on performance year Medicare claims data and thus are not published in advance of the performance period, AAOS believes CMS must take steps to inform physicians about their target spending and patient population throughout the measurement period.

Congress must urge CMS to make cost measure benchmarks available on a rolling, close to real-time basis during the actual measurement year, considering sample sizes, billing delays, and using ranges, instead of specific numeric targets, for performance and payment.

If providing rolling benchmark information is not yet feasible, CMS must run the measures based on three prior years' Medicare claims data and publish the benchmarks for informational purposes. This is especially critical when CMS introduces new cost measures to MIPS as physicians have no reference point for the benchmarks.

Since the implementation of MIPS, CMS has stated that its desire is to reduce burden, encourage the use of reporting through electronic means, and promote the use of QCDRs to increase reporting on patient-reported outcome measures (PROMs). There is a long history of using PROMs in orthopaedic research and clinical care, from which invaluable insight into the barriers to successful measurement and quality improvement can be gained. AAOS strongly supports the use of registries for collection, standardization, and submission of PROMs and could also be a mechanism for collecting data on social determinants of health to better understand the prevention and treatment of musculoskeletal disease and injuries. Orthopaedic surgeons have found that "efforts to incorporate PRO measurement into routine clinical practice have been more challenging, though significant progress has been made in developing and validating PROMs for specific musculoskeletal disorders or treatments and those that give a broader picture of general health status."[3] Specifically, routine clinical care and implementation, as well as low patient response rates, are consistently seen as challenges to uniform application of PRO measurement.

Therefore, Congress should pass H.R. 5394 *the Meaningful Access to Federal Health Plan Claims Data Act of 2021*, which would create greater interoperability between clinician-led clinical outcomes data and Medicare claims data to define new value of new medical technologies and therapies, creating greater value in Medicare spending.

Finally, improved patient outcomes are most likely to be achieved when all parties of the U.S. healthcare system shift to more efficient and innovative practices, including Medicare, Medicare Advantage (MA), and commercial health plans.

In April 2022, the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services released a report which found that MA plans inappropriately denied up to 85,000 prior authorization requests in 2019, and nearly 20% of reimbursement payments were denied despite meeting Medicare coverage rules.[4] The report included dozens of individual examples of improper denials for orthopaedic patients, including wrongful denials of MRIs, shoulder and knee x-rays, inpatient admission, rehab admission, durable medical equipment, and follow-up visits. One patient detailed in the report requested a reverse total shoulder replacement but was denied for not meeting "internal criteria." The OIG determined the surgery was warranted, and yet the initial denial was not reversed on appeal.

While the prior authorization process is ostensibly intended to control costs, it can delay necessary medical care and negatively influence patient outcomes. A recent American Medical Association

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[3] American Academy of Orthopaedic Surgeons. (2018, March). Principles for Musculoskeletal Based Patient Reported Outcome-Performance Measurement Development. AAOS Position Statement 1188. https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1188-principles-for-musculoskeletal-based-patient-reported-outcome-performance-measurement-development.pdf

[4] Some Medicare Advantage Organization Denials of Prior Authorization ... https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

(AMA) survey found that 34% of physicians reported a serious adverse event for a patient—death, hospitalization, disability/permanent bodily damage, or other life-threatening event—due to prior authorization delays.[5] The same report found medical practices spend an average of two business days every week completing prior authorization requests, taking away valuable time that could be used to treat patients.

Congress should pass S. 3018/H.R. 3173 *the Improving Seniors' Timely Access to Care Act*, while also continuing its important oversight over MA plans.

IV. Alternative Payment Models

As it relates to orthopaedic surgery, a shift to value-based models has proven to be complicated and costly with limited return on the investment. Physicians are overloaded with administrative burden to comply with the numerous value-based payment models and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs.

When considering the goals of MACRA, it is important to return to the *intent* of the law and explore options for providing care in a way that is of high value while remaining accessible in implementation. This may look like a single system for designing and operating all value-based payment models, with one platform for measure testing, approval, and use, as well as the same single platform for submission. Such a platform would be compatible with both government-operated and privately-operated value-based care programs.

AAOS is supportive of advancing value-based care and developed a value-based care continuum (VBCC) to help orthopaedic practices better understand and navigate various alternative payment models created to achieve value-based care. AAOS also supports the creation of voluntary, physician-led alternative payment models that expand access to quality specialty care through wraparound approaches to musculoskeletal disorders. This includes care teams that assess the clinical and social factors that makes surgical and nonsurgical interventions safe, effective, and long-lasting. Orthopaedic surgeons should remain the foremost leaders of these care teams which may include mid-level practitioners, nurse navigators, and physical therapists. Essential to improved access is reduced administrative burden which detracts from time spent with the patient and slows the treatment process.

AAOS members are eager and willing participants in the transition to value-based care and were early adopters of value-based payment models, participating in the now partially-mandatory Comprehensive Care for Joint Replacement (CJR) and voluntary Bundled Payments for Care Improvement-Advanced (BPCI-A) programs. Our members' work to optimize patient care, increase value, and decrease costs resulted in an estimated $61.6 million estimated net savings in the first three performance years of the CJR program.[6]

In response to the Center for Medicare and Medicaid Services Innovation (CMMI) initiatives in the space of value-based payment reform, the American Association of Orthopaedic Surgeons

[5] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[6] https://innovation.cms.gov/data-and-reports/2022/cjr-fg-thirdannrpt

(AAOS) and physician leaders have worked closely to develop recommendations toward advancing high value orthopaedic payment and practice models.

With the end goal of moving away from dominant traditional fee-for-service models, the most promising step to date is the sharing of risk on the total cost of care with health systems through accountable care organizations (ACOs). Momentum is building among stakeholders in health care to shift the status quo toward a whole person approach that considers the patient's condition alongside their preferences, values, and needs (characterized as "Comprehensive Condition-Based Care"). Most health systems currently perform "nonoperative care" on the backdrop of primary care providers with insufficient support systems and/or training in managing musculoskeletal conditions. This often leads to a myriad of unnecessary imaging studies, non-value-added interventions, and delays to patient care. Once the primary care providers (PCP) has exhausted their capabilities in caring for a particular condition, they are expected to navigate a broad portfolio of specialists and subspecialists who are all working under different sets of incentives and payment infrastructures. This can be solved through condition-based payments with the aim of driving reorganization and model redesign on the specialty front. The end goal for ACOs would be early referral of these patients into the sphere of efficient, high quality specialty care teams without a concern that such patients will immediately become "high cost," but instead confident that they will receive high value care, including prevention and a focus on improving health overall.

In a comprehensive condition-based payment, a provider or team of providers is paid a contracted rate to provide all care for a specified medical condition (or set of conditions) while holding themselves accountable to outcome measures relevant to that condition. The team is, therefore, incentivized to deliver high-value care throughout the entire cycle of the condition, including appropriate decision-making around when to proceed with surgical or non-surgical interventions. Such a system offers multiple positive effects on the delivery of care for musculoskeletal conditions.

AAOS is pleased that the BPCI-A model is being extended through 2025. Given the model's success, a key lesson from BPCI-A should remain at the forefront when designing future models:

Any legislation passed by Congress must support surgeon-led models, which are highly effective at achieving participation from physicians, savings to the Medicare program, and patient engagement in their care.

The incentives for shifting to value-based care models should be strong enough to encourage participation without imposing mandatory changes on practices, which are often resource intensive to adopt. Although BPCI-A allows opportunities for our surgeons and their patients to participate in musculoskeletal care redesign, there are serious concerns with the methodology of the APM: In BPCI Classic, CMMI instituted an Incentive Payment Cap for physician and non-physician practitioners at 50% of the Part B payments for these episodes. However, this cap did not extend to the physician group practice (PGP) that employed the practitioner. The PGP itself could receive Net Payment Reconciliation Amount (NPRA) savings above the aggregate cap and utilize these savings to offset direct and indirect costs related to participation in BPCI Classic as well as general

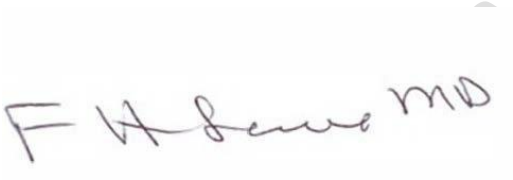
overhead for the group. In BPCI Advanced, CMMI elected to prohibit NPRA savings from flowing to a PGP working under a convening entity, so its physicians could only be reimbursed up to the 50% cap.

Therefore, Congress should:

- **Urge CMS to reinstate the financial methodology used in BPCI Classic for BPCI Advanced and allow excess NPRA funds to flow to any PGP participating in BPCI Advanced to offset overhead and related costs for participating in the new model.**
- **Urge CMS to remove limits to gainsharing agreements, in addition to the payment cap, and encourage gainsharing arrangements that help to control the costs of care while not impairing care quality.**

We look forward to working with you and your colleagues on the ideas outlined above. Please feel free to contact Catherine Hayes (hayes@aaos.org) if you have any questions or if the AAOS can further serve as a resource to you.

Sincerely,



Felix H. Savoie, III, MD, FAAOS
AAOS President

American Association of Hip and Knee Surgeons
American Orthopaedic Foot and Ankle Society
American Orthopaedic Society for Sports Medicine
American Shoulder and Elbow Society
Arthroscopy Association of North America
Orthopaedic Trauma Association

cc: Kevin J. Bozic, MD, MBA, FAAOS, AAOS First Vice-President
Paul Tornetta, III, MD, FAAOS, AAOS Second Vice President
Thomas E. Arend, Jr., Esq., CAE, AAOS CEO
Graham Newson, AAOS Vice President, Office of Government Relations