AAOS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

June 14, 2024

The Honorable Ron Wyden
Senate Finance Committee Chair
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Senate Finance Committee Ranking Member
United States Senate
Washington, D.C. 20510

Dear Senator Wyden and Senator Crapo:

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are writing to share our feedback on the 'Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B' white paper published by the Senate Committee on Finance on May 17, 2024. AAOS is appreciative of the Committee's recognition that there are several significant barriers to optimal physician engagement in the Medicare program concerning patient access to care and quality reform.

Conversion Factor Fluctuations

AAOS has supported the process of adopting a conversion factor update such as the Medicare Economic Index (MEI) that would more appropriately adjust for the market conditions physicians are facing. The current conversion factor does not reflect the impact of inflation on practice expenses, and we urge the Committee to codify inflationary updates that will ensure stability for physicians and their practices. The Centers for Medicare & Medicaid Services (CMS) has relied on American Medical Association (AMA) physician cost data for 50 years in updating the MEI and 30 years in updating the resource-based relative value scale (RBRVS). The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. Therefore, we support updating the MEI weights while recognizing that any future updates should be based on the most recent data collection efforts, which are currently in process by the AMA.

AAOS supports the following actions Congress could take to mitigate the impact of inflation and consistently decreasing physician reimbursement under the Medicare Physician Fee Schedule:

- **Pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act of 2023, to provide an annual inflationary update to Medicare physician payments based on the Medicare Economic Index (MEI), as physicians are the only group in the Medicare payment system whose reimbursement is not adjusted for inflation.**

- **Eliminate certain budget neutrality requirements by, at a minimum, amending 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current $20 million budget neutrality adjustment trigger to $100 million and indexed to adjust for inflation moving forward.**

- **Invest savings generated by any new Medicare payment policy (e.g., site neutrality) to offset the cost of improving the Medicare physician payment system.**

Budget Neutrality Adjustments to the Conversion Factor

Updating the budget neutrality statutory threshold of $20 million per calendar year to an amount that provides for necessary policy changes without causing cuts to all aspects of the Medicare Physician Fee Schedule (MPFS) is essential to creating stability in the payment system. AAOS has consistently supported waiving budget neutrality requirements to prevent cuts to orthopaedic services. These fluctuations have had impacts ranging from 0 to -4% on orthopaedics over the last several years, before they were mitigated in part through passage of year-end spending bills.[1] Yet, as the Committee recognizes, the impact that the Evaluation and Management (E/M) visit inherent complexity code (Healthcare Common Procedure Coding System (HCPCS) G2211) has on the overall budget neutrality adjustment is disproportionate. In our comments on the Calendar Year (CY) 2024 MPFS we supported the indefinite delay in implementation of this E/M complexity add-on code; however, CMS finalized the code effective January 1, 2024.

AAOS continues to oppose implementation of code G2211 to be used with E/M visits providing an add-on payment for complex patients. We believe implementation of this code negatively impacts surgeons and patients and is unnecessary due to the new office or outpatient E/M coding structure. Physicians and other qualified health professionals have the flexibility to report a higher-level E/M code to account for increased medical decision-making or total time for the encounter. Existing codes are available for reporting the work and time across various complexity levels which make code G2211 duplicative of work that is already represented in the Current Procedural Terminology (CPT) code set. Implementing this unnecessary code may result in overpayments as well as penalize all physicians due to the reduction in the Medicare conversion factor which remains required due to budget neutrality statute.

Incentivizing Participation in Alternative Payment Models

We are pleased to see that the Committee acknowledges the importance of Accountable Care Organizations (ACOs) led by independent physician groups as a key enabler of savings and quality care for patients. AAOS encourages the passage of legislation that will incentivize the development of voluntary, longitudinal specialty care models on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, improved coordination, and lower costs to musculoskeletal care.

Ultimately, stakeholders want to create and participate in a model that helps patients achieve good health outcomes and enable physicians to sustainably care for the rapidly growing Medicare population. However, the current models are designed to place the risk and cost management aspects of value-based payments solely in the realm of primary care practitioners while keeping the specialists and their teams in the fee-for-service world.

[1] https://www.ama-assn.org/system/files/2021-01/2020-combined-impact-table.pdf

This is based on the premise that ACOs will be able to identify and refer patients to high value specialists while providing most of the care themselves. Given the proportion of Medicare dollars spent on specialty care and the prevalence of conditions that are treated by specialists, this is a recipe for failure. The AAOS strongly recommends an approach that allows risk sharing downstream with the specialists who provide care for these conditions. Providing efficient, evidence-based treatments for musculoskeletal conditions with an eye toward preventive care and improving overall health can only be accomplished with deep and expansive expertise in the most prevalent health conditions. To achieve the shared savings that CMS aims for, it mandates that the experts who work directly with patients on key decision making are incentivized toward value. The most promising model to facilitate ACO/Specialist collaboration is a condition-based payment mechanism.

The current total cost of care ACO model lacks an appropriate and functional mechanism to manage the incredible knowledge and improvements that have been realized in the delivery of specialty care over the past 30-40 years. In the musculoskeletal health arena, these changes have dramatically improved quality of life, maintenance of function, and freedom from pain for the large population of Americans who suffer from chronic musculoskeletal conditions such as arthritis and low back pain. At the same time, orthopaedic surgeons have worked closely with CMS to adopt and implement alternative payment models to continuously improve the quality and efficiency of care. Helping our aging population live independent and active lives is crucial to the sustainability of the Medicare program going forward. To imagine a world where patients have neglected hip and knee arthritis to the point that they can no longer care for themselves would require massive increases in long term care expenditure, which would place a substantial burden on the Medicare program.

AAOS responded to the August 2023 Request for Information on Episode-Based Payment Models (CMS-5540-NC) with detailed suggestions for how to accomplish this transition to patient-focused longitudinal care models.[2] We have also released a white paper, 'AAOS Recommendation: A Specialty Care Reimbursement Model to Operationalize Value-based Care for Musculoskeletal Conditions' that was developed in partnership with The Consortium for the Next Generation Alternative Payment Models, a multi-stakeholder coalition spear-headed by leaders from The University of Texas at Austin, Dell Medical School, the Duke Margolis Center for Health Policy, and the Duke University Health System.[3] The solutions for musculoskeletal care described in these documents are strongly aligned with the direction the Committee is proposing for value-based care.

Reducing Physician Burden Related to the Merit-Based Incentive Payment System (MIPS)

AAOS supports simplifying quality reporting programs to reduce physician burden. This may include, but is not limited to, removing, or updating the MIPS program reporting requirements or removing model overlap with other APMs. We also strongly support the use of Patient-Reported Outcome Measures (PROMs) to assess quality, as well as the use of Qualified Clinical Data Registries (QCDRs) to report quality measures. At the same

[2] https://www.aaos.org/globalassets/advocacy/issues/aaos-response-to-rfi-on-episode-based-models-november-2023.pdf
[3] https://www.aaos.org/globalassets/advocacy/issues/aaos-specialty-care-reimbursement-model.pdf

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time, it takes substantial time and resources for QCDRs to update their data capture capacity and IT resources to capture quality data. Implementation timelines for any new provisions must be considered vis-a-vis these factors impacting physician quality reporting.

Ensuring the Integrity of the Physician Fee Schedule
AAOS believes that CMS should continue to rely on the expertise of the AMA Resource-Based Relative Value Scale Update Committee (RUC), which is comprised of volunteers which include 32 physicians, over 300 medical advisors and other healthcare professionals representing each sector of medicine. The RUC has over thirty years of experience valuing services and is currently the best process for valuing physician work, practice expense and malpractice expense. AAOS discourages the use of outside data or processes without the RUC's involvement and believes it is essential to rely on their expertise which must be vigorously reviewed for accuracy for the purpose of evaluating physician work.

Ensuring Beneficiaries' Continued Access to Telehealth
AAOS appreciates the Committee's interest in preserving access to telehealth services that have a positive impact on access to care for Medicare beneficiaries. We believe that there should be permanent extensions to policies that pay in-person and telehealth services at the same rates, allow Medicare beneficiaries to access telehealth services from home, and ensure a robust list of covered services. Telehealth allows orthopaedic surgeons and surgical teams to improve quality of care by improving access, reducing patient travel burden, improving clinical workflows, and increasing practice efficiency and compliance with follow-up which ultimately enhances patient wellness. It would be beneficial for CMS to share frequent utilization trend updates that are specialty-specific and geographically coded, along with beneficiary dual-eligible status to better understand and target the use of telehealth to improve patient outcomes.

Thank you for your time and attention to the concerns and suggestions of the American Association of Orthopaedic Surgeons (AAOS). We look forward to working closely with the Senate Finance Committee to further improve the healthcare system and enhance the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

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AAOS President

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