AAOS
American Academy of Orthopaedic Surgeons
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Statement for the Record

U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors"

June 22, 2023

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the June 22, 2023 hearing, "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors" before the U.S. House of Representatives Committee on Energy and Commerce's Subcommittee On Oversight & Investigations. 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 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.

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 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

[1] https://www.cbo.gov/publication/51919
[2] https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf

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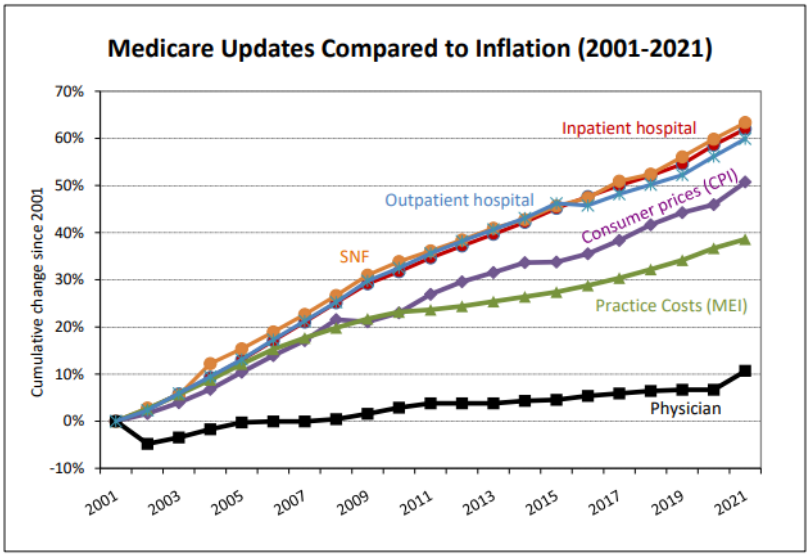
the past two decades. Alternatively, Medicare hospital updates totaled roughly 60% between 2001 and 2021, with average annual increases of 2.4% for both inpatient and outpatient services.

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 6 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 faced another round of significant payment cuts on January 1, 2023. The Calendar Year (CY) 2023 MPFS Proposed Rule cut the Medicare conversion factor by 4.42%. The 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. AAOS was pleased to see Congress take action late last year with the passage of an omnibus spending package that increased the conversion factor to $33.88, a reduction of only 2%, for 2023, with a 3.5% cut slated for 2024.

This cut, combined with the pending threat of the 4% PAYGO reduction and a lack of inflationary update, is simply not sustainable. Medicare's budget neutrality requirement — unique to the physician payment program — has also been a key driver of the broken payment system. It requires CMS to implement across-the-board cuts if changes to the Medicare physician fee schedule cause expenditures to exceed $20 million annually. This trigger amount has remained the same since its implementation in 1992. Such systemic issues 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.

HHS Secretary Xavier Becerra outlined the threats posed by this instability in his recent testimony before the Energy and Commerce committee, saying it is, "not just a headache, it's a real threat to how physicians can plan their life forward."[3] Secretary Becerra has also previously said of his support for Medicare Payment reform, "you'd never want professionals ... thinking that there's another profession for them down the line because they're just not making ends meet where they are, so we'd like to be supportive."[4]

The threats to the healthcare workforce are not theoretical. According to the Medicare Payment Advisory Commission (MedPAC), among Medicare beneficiaries looking for a new primary care physician, half had issues finding one. And among Medicare beneficiaries looking for a new specialist, one-third struggled to find one.[5] Recognizing the challenges brought on by rising costs that are "difficult for clinicians to absorb," MedPAC recommended that Congress begin connecting physician base payment to the MEI beginning in calendar year 2024.[6]

Without a permanent fix to Medicare's broken payment system, the patchwork of yearly updates and temporary fixes will further destabilize healthcare system financing and pose a particular threat to many orthopaedic private practices. A permanent fix is also vital to slowing the rapidly accelerating consolidation in healthcare. The ever-growing financial pressures and administrative burdens associated with practicing medicine are driving physician burnout and creating an environment where smaller independent practices and independent physicians are eager to be bought-out by larger hospitals, health care systems and insurance companies. Accelerating vertical and horizontal consolidation in health care is reducing competition and threatening patients' access to high-quality care, particularly in rural areas and low-income and marginalized communities. Bringing physician payment into alignment with the actual costs of practicing medicine is the best way to fight back against this consolidation.

Therefore, Congress should:

- **Stop all Medicare physician payment cuts scheduled for calendar year 2024.**

- **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.**

[3] House Committee on Energy and Commerce Health Subcommittee Hearing: "Fiscal Year 2024 Department of Health and Human Services Budget" March 29, 2023. Retrieved April 6, 2023 from https://www.youtube.com/watch?v=OPMG5OU0I6c&t=5416s

[4] https://www.medpagetoday.com/publichealthpolicy/medicare/97730

[5] https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf

[6] MedPAC March 2023 Report to the Congress, "Medicare Payment Policy" p. 130 Retrieved April 6, 2023 from https://www.medpac.gov/wpcontent/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

- **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.**

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 Medicare claims data for quality improvement and studies of patient safety. It is our understanding that CMS chose instead to use an existing process to comply with Section 105(b) due to a lack of new funds for this requirement. 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 requirement of MACRA.

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. AAOS originally planned to refresh Medicare claims data quarterly. Currently, due to the lengthy nature of the process and the high direct costs for data acquisition, we can only obtain claims data annually. 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. Data management plan self-attestation questionnaire
    5. Data specification and request detail spreadsheet
    6. Invoice and updated data specification spreadsheet
    7. ResDAC administrative review process
    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. Seven years since the law was supposed to take effect, QCDRs are still subject to this time-consuming and costly process for accessing claims data. The monetary cost of obtaining Medicare claims data through the ResDAC process is nearly prohibitive. As it currently stands, the process costs approximately $80,000-$100,000 per year depending on the data set request.

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.

Starting in 2023, CMS started establishing MIPS Value Pathways (MVP) as an alternative reporting mechanism for physicians. However, the finalized MVPs are not appropriate for every specialty and this pathway has neither reduced reporting burden nor has it been a meaningful

improvement over MIPS so far**. Instead, Congress must urge CMS to develop value-based care models that allow better participation options and more accountability to specialty care physicians.**

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."[7] 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 *The Meaningful Access to Federal Health Plan Claims Data*, 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.

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

[7] 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

assess the clinical and social factors that make 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.[8]

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. As the BPCI-A and CJR models come to an end and CMMI considers the design and requirements for the next generation of APMs, it is essential that they remain voluntary in nature and limited in administrative burden. AAOS believes that creating specialty care pathways for the treatment of musculoskeletal conditions within Accountable Care Organizations will be one way to accomplish this.

Therefore, Congress should:

- **Urge CMS to consider a voluntary specialty condition model benchmark with negotiated sharing of gains/losses for physician-led ACOs and mandatory sharing for hospital ACOs.**
- **Urge CMS to perform an analysis of methods that enable ACO providers to identify and refer to high value specialists instead of relying on existing claims data and inadequate risk adjustment algorithms.**

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.

[8] https://innovation.cms.gov/data-and-reports/2022/cjr-fg-thirdannrpt