September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

***RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage (CMS-1784-P)***

The American Alliance of Orthopaedic Executives (AAOE) submits these comments and recommendations on behalf of our over 1,300 members and 660 medical practices across the country whose mission is to promote quality healthcare practice management in the orthopedic and musculoskeletal industry. We appreciate the opportunity to provide comment on the 2024 Physician Fee Schedule Proposed Rule.

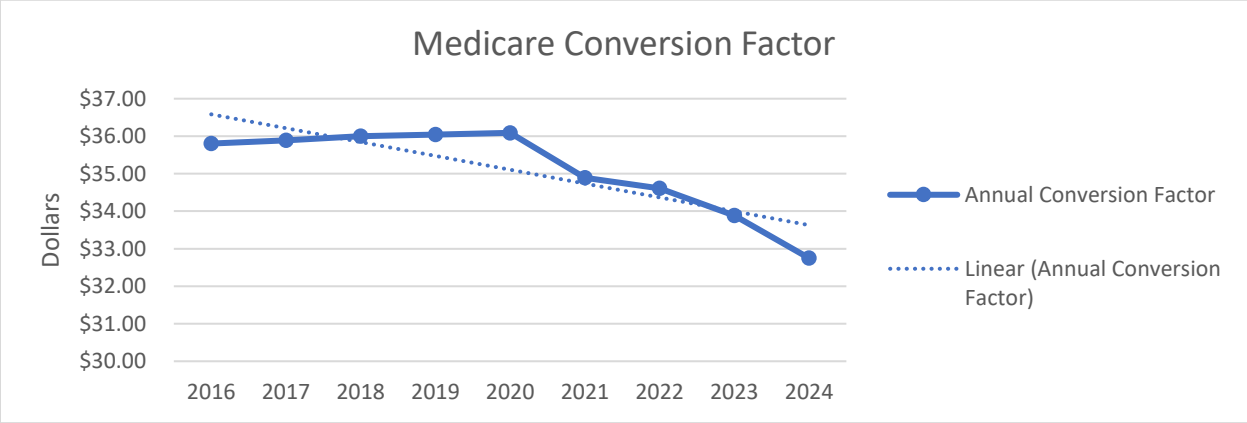
<u>The Problem</u>

Year-over-year cuts to Medicare physician reimbursement jeopardize our ability to keep our doors open and care for patients in our communities. While costs of running medical practices have gone up by 47%, physicians' payments, when adjusted for inflation, have declined 26% from 2001 to 2023, making it harder for small, rural, and low-income serving practices to stay open. In fact, the number of doctors not accepting Medicare has more than doubled since 2009. Additionally, a June 2022 MedPAC report recommended that CMS increase Medicare payments to physicians as well as to other health care sectors. MedPAC identified 57 conditions that can be evaluated, treated, and billed at the same rate regardless of the setting in which the care takes place.

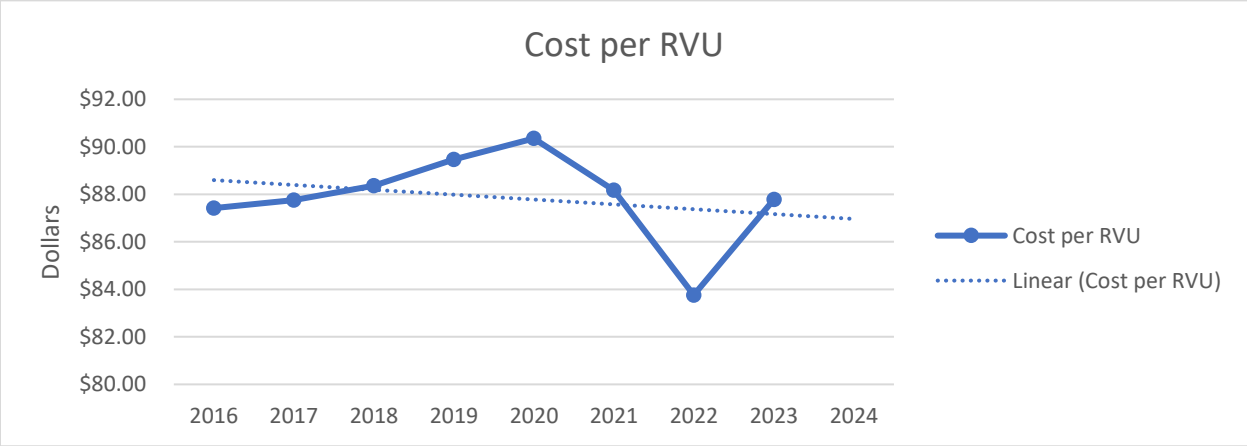
CMS's recently released proposed changes to the Physician Fee Schedule (PFS) include yet another reduction in the Medicare Conversion Factor (MCF). This reduction continues a downward trend in provider reimbursement at a time when costs to provide care continue to climb. Medical Group Management Association (MGMA) conducted a survey of 517 medical group practices, ranging from small single provider practices to large 2,400 physician health systems across 45 states, assessing the potential impact of such payment cuts to Medicare rates in 2023, and

evaluating how their practices would respond to such payment cuts. 58% of the surveyed medical practices are considering limiting the number of new Medicare patients. Over the past nine years the MCF has either remained stagnant or as noted below (Graph 1) taken a steep downward trend.

Graph 1




At the same time as reimbursement levels have dropped, costs associated with providing care continue to rise. The data below is for a large health care provider in the San Francisco Bay Area and demonstrates the cost per RVU generated over the same time (Graph 2).




There is a drop in cost from 2020 to 2022, during the pandemic which can be associated to a variety of causes. The financial analysis is that between public health emergency funds, reduced patient volumes, flexing of staff during the pandemic, and related to the patient volumes and

demands cost per RVU dropped. However, it should be noted that it has quickly returned and is again trending upward well above the reimbursed rate of the MCF.

For many practices Medicare, as a payer, is in an unsustainable position. Growing numbers of Medicare eligible individuals and a smaller workforce have substantially reduced the maintained viability of the program. This continued reduction in MCF and the growing cost of providing care decreases the pool of providers who wish to remain in the Medicare system. Unfortunately, as more providers stop accepting Medicare patients, demand on those that do accept Medicare will grow. Wait times to get into providers will become longer, fewer choices of providers will be available, and these changes will have a deleterious influence on patient outcomes.

Regarding site-neutral payments, higher payments for hospital outpatient departments (HOPDs) create an unfair playing field and incentivizes the sale of physician practices to hospitals which only exacerbates the health care consolidation issue facing this country. Physician offices, if acquired by a hospital, regardless of distance from that hospital, will start receiving higher payments with no significant change in operations or quality of care if they are converted to an HOPD. While hospital costs are typically higher than a free standing or private practice, there are frequently situations where a hospital can charge more for a test or procedure that utilizes the same technology and professionals that a private practice does, but they are allowed to charge more simply because they are a hospital. When you couple that with the increase in hospital acquisitions of more primary care providers, who are responsible for most of the referrals for these types of services, costs will continue to increase.

While Medicare is struggling, providers are taking financial losses, health systems are decreasing staffing, wait times to access care are increasing and meanwhile insurance companies are taking in exorbitant profits. These profits have grown over the pandemic as premiums continue to rise, and fewer patients were accessing the health care system. As providers struggled to maintain viability, cost of supplies, inflation, and wages continue to increase and premiums for their own insurance increases as well.

Recommendations

AAOE is very supportive of recent legislative efforts to have at a minimum an inflationary adjustment to the Medicare Reimbursement Rate. While this will not entirely solve the cost

difference between providing care and the reimbursement for Medicare patients, any positive change will help maintain the providers within the Medicare system.

On the Physician Fee Schedule, one possible change could be that Medicare Advantage Plans pay into the Medicare system a portion of savings and be expected to meet outcomes and provider satisfaction to offer these plans to individuals. This payment to Medicare can help to reduce the burden for the larger population of standard Medicare beneficiaries while also requiring outcomes measures that grade and guarantee improvement in patient health instead of creating administrative work for providers, prior authorizations, and causing delays or reducing access to care. Health care practices are being placed in a situation that they can no longer provide the levels of care desired. As a result, patient outcomes will continue to be negatively influenced as wait times become longer and more practices decline Medicare and Medicare Advantage patients. The program is in need of change.

On Site-Neutral Payments, brief progress was made on higher payment levels for HOPDs in 2015 when the Bipartisan Budget Act implemented site-neutral payments and required HOPDs acquired after Nov. 2, 2015, to be paid under the PFS rather than OPPS. These gains were mostly reversed in 2017 when the 21st Century Cures Act added site-neutral payment exemption rules that would allow some developing off-campus provider-based hospital departments to continue billing under OPPS. In the June 2023 Report to Congress, MedPAC recommended aligning payment rates across ambulatory settings (HOPDs, physician offices, ASCs) for selected services especially in the wake of Medicare insolvency and increasing consolidation. AAOE supports a full or partial return to site-neutral payments.

AAOE is ready to provide thoughts and conversation on the current situation and future direction of the provision of orthopedic care for stakeholders. We thank you for the opportunity to comment and look forward to working with CMS and HHS to provide the best care available.

Sincerely,

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2023 – 2024 President, American Alliance of Orthopaedic Executives