AAOS
American Association of Orthopaedic Surgeons

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Ms. Chiquita Brooks-LaSure, Team Lead
Mr. Robert Gordon, Team Lead
Biden-Harris Transition Team: Department of Health and Human Services

Submitted electronically

Ms. Brooks-LaSure and Mr. Gordon,

On behalf of the 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to share our positions on the most pressing health policy issues. The AAOS works closely with legislators on Capitol Hill and regulators at the Department of Health and Human Services (HHS), including at the Centers for Medicare and Medicaid Services (CMS), and the Food and Drug Administration (FDA). AAOS also regularly meets with the White House Office of Management and Budget and the Executive Office of the President of the United States. In addition to commenting on annual payment rules and collaborating across coalitions to introduce physician and patient-benefiting legislation, AAOS partners with government leaders in health policy to improve value-based musculoskeletal care. We look forward to continuing this partnership with the Biden-Harris Administration and focusing on the following priorities:

AAOS Priorities

Recovering from the detrimental impacts of the COVID-19 pandemic on our nation's health and economy is our foremost shared priority. Physicians are not just prioritizing the health of their patients over their own health; they are jeopardizing the financial well-being of themselves and their staff as the number of outpatient visits and elective surgeries has been abruptly and continuously truncated. In the interest of public health, the livelihoods of those caring for our most vulnerable Americans is at stake. While other industries impacted by the economic crisis precipitated by COVID-19 can generate business through raising prices or offering additional services, physicians are hemmed into a system of fixed prices controlled by Medicare and commercial payers who use Medicare pricing as their baseline. This distinct financial arrangement, which is burdened by complex contracts and regulations, places physicians facing financial turbulence in a uniquely dire situation. Musculoskeletal care delivery and orthopaedic surgery were severely impacted by the much necessary guidelines to scale down or entirely stop elective surgeries during the pandemic.

AAOS supported CMS and HHS in following these guidelines.[1] Several of our practices had to furlough staff and take pay cuts during the first wave of the pandemic and are bracing for the current surge without recovering from the earlier one.[2] Orthopaedic surgeons continued to serve on COVID-19 wards side by side with their colleagues as their regular practices shut down. Earlier in the year, we

[1] https://www.aaos.org/about/covid-19-information-for-our-members/aaos-guidelines-for-elective-surgery/
[2] https://www.aaos.org/globalassets/about/covid-19/ama-physician-practice-survey-results.pdf

appreciated the distribution of grants from the HHS Provider Relief Fund (as mandated by the CARES Act) and hope that the Biden-Harris administration can work on additional financial relief packages to support struggling physician practices.

Contrary to the early support of physicians at the onset of the pandemic, CMS has just finalized payment cuts which are detrimental to the thousands of physicians, non-physician provider staff, and patients already suffering during the pandemic. We are profoundly concerned by CMS' failure to incorporate the American Medical Association (AMA) Relative Value Scale Update Committee (RUC)-recommended work and time incremental increases for the revised office/outpatient visit evaluation and management (E/M) codes into the global surgical codes. Finalizing this change, in addition to the 10.2% decrease in the conversion factor for 2021, will result in drastic cuts that will reduce payment and imperil access to high quality musculoskeletal care. For orthopaedic surgeons, these cuts are further compounded by CMS' decision to decrease the value of hip and knee arthroplasty (CPT codes 27130 and 27447) despite compelling evidence that these physicians invest significant time in value-based patient care to create substantive savings for the Medicare Trust Fund.[3]

In light of the partnership physicians maintain with the government in the provision of care through Medicare and Medicaid, not only during emergencies, but all-year through adoption of innovative care models, we request that the Biden-Harris Administration refrain from implementing any cuts to physician payment thereby hampering access to care during the pandemic.

Health Disparities in Musculoskeletal Care: The impact of social determinants of health on musculoskeletal care is pervasive. AAOS routinely requests that CMS consider a patient's social factors, mental health, and health literacy when implementing changes which impact access to care. We believe that integrating measures aimed at tracking and eliminating disparities in care into new and existing value-based payment models is one of the most promising ways to achieve health equity. Particularly as it relates to risk-adjustment in value-based payment models, AAOS supports the consideration of functional status, disability status, and socioeconomic status. As noted in our June 2020 Comprehensive Care for Joint Replacement (CJR) 3-Year Extension Proposed Rule comment letter, individuals with disabilities and those belonging to minority groups are likely to need better quality and institutional post-acute care because of their health status and socio-economic conditions. Addressing these variables is necessary to promote greater physician adoption of value-based payment models. Financial penalties as a result of caring for more complex patients further reinforces a system that provides fewer resources to safety-net hospitals and capitulates healthcare outcome disparities. Given that racial equity is a priority for this Administration, we hope that you will consider these issues in designing and updating models of care.

Prior Authorization: AAOS is particularly concerned with the proliferation of new prior authorization requirements by commercial payers, and increasingly, in federal payment regulations. Clinicians go through years of carefully tailored training to ensure they can provide high-quality,

[3] https://www.aaos.org/globalassets/advocacy/issues/aaos-2021-mpfs-comments.pdf

optimal patient care. The decision to perform a procedure, prescribe a medication, and determine the course of care for their patient is not only based on this experience, but also with the intimate conversations, unique circumstances, and personal preferences of their patients in mind. We are fully supportive of all efforts to improve patient outcomes and the value of evidence-based care. However, the prior authorization processes currently in place, do not account for these realities or aim to improve quality of care. Patients suffer because payer intermediaries are determining the appropriateness of their care and delaying necessary and timely care. Patients may also be subject to higher health care premiums to offset the costs of prior authorization programs. Similarly, providers and practitioners have significant administrative burdens and additional costs to comply with these new requirements. The prescriptive nature of non-evidence based prior authorization requirements stifles innovation and the variable application across commercial payers leads to scattershot approaches. It is neither efficient nor sustainable to have the internal day-to-day operations of provider practices dictated by external entities with conflicting interests.

Physician-Owned Hospitals: AAOS encourages HHS to explore all regulatory avenues for lifting the ban on new and expanding Physician-Owned Hospitals (POH). Considering the ongoing issues brought to the forefront because of the COVID-19 pandemic, the value of POHs has never been as evident. They contribute to local economies, meet a growing demand for health care services, and can shift focus and address frontline issues without the administrative red tape that cripples larger hospital systems. Concerns that POHs could have an incentive to serve only the most profitable patients have been dispelled by peer-reviewed research highlighting equitable, quality outcomes in POHs.[4] AAOS supports allowing expansion of POHs that see primarily patients with Medicaid. While this will improve access to care for many vulnerable patients, we urge the Administration to consider lifting the ban on expansion of all POHs.

Telehealth: Prior to the onset of the COVID-19 pandemic, AAOS released a position statement supporting the implementation of robust and comprehensive telehealth services based on clinical decision making. We believe that, like most issues impacting musculoskeletal care, physicians and patients should be the final arbiter of the need and appropriateness of telehealth services. As has been demonstrated during the pandemic, telehealth is a powerful tool and should be reimbursed at the same allowable rates as face-to-face visits. AAOS believes the current Public Health Emergency (PHE) telehealth flexibilities should be allowed beyond the pandemic, on a permanent basis.

Value-based Payment Models: Orthopaedic surgeons continue to be active participants in alternative payment models (APMs) and are engaged in efforts to improve quality care and patient outcomes. This includes models like the Comprehensive Care for Joint Replacement (CJR) model and Bundled Payment for Care Improvement Advanced (BPCI-Advanced) programs. AAOS strongly opposes mandatory models and believes that physician-led voluntary models offer the best opportunity to accelerate value-based care while enabling practices to effectively adapt to those changes. In fact, the

[4] Blumenthal Daniel M, Orav E John, Jena Anupam B, Dudzinski David M, Le Sidney T, Jha Ashish K et al. Access, quality, and costs of care at physician owned hospitals in the United States: observational study *BMJ* 2015; 351:h4466

AAOS is interested in continuing the work that started in 2019 with CMS and the Center for Medicare and Medicaid Innovation (CMMI) to explore more advanced models, such as condition-based bundle payments, so long as they are voluntary. This would allow our surgeons to be responsible for managing the condition and deciding on the treatment pathway, thereby improving population health outcomes. Many AAOS members are working in good faith to adopt these models, but there are not enough models for participation and the thresholds for participation are too high. We would ask for additional voluntary models that can allow more inclusion for a broader swath of specialty physicians.

Thank you for your time and attention to the health policy priorities of the American Association of Orthopaedic Surgeons (AAOS). The AAOS looks forward to working closely with the Biden-Harris Administration on further improving the health care system and enhancing the care of musculoskeletal patients in the United States. We look forward to attending a meeting with your team as separately requested by us. Should you have any questions or would like to work together in pursuit of our shared goals, please do not hesitate to contact Shreyasi Deb, PhD, MBA, AAOS Office of Government Relations at deb@aaos.org.

Sincerely,

Joseph A. Bosco, III, MD, FAAOS
President, AAOS

cc: Daniel K. Guy, MD, FAAOS, First Vice-President, AAOS
Felix H. Savoie, III, MD, FAAOS, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
William O. Shaffer, MD, FAAOS, Medical Director, AAOS
Graham Newson, Director, Office of Government Relations, AAOS