AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Statement for the Record

House Budget Committee Hearing

Center for Medicare and Medicaid Innovation:
Scoring Assumptions and Real-World Implications

September 7, 2016

On behalf of 18,000 board-certified orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) would like to commend Chairman Tom Price, MD (R-GA), Ranking Member Chris Van Hollen (D-MD), and all other committee members for holding the House Budget Committee hearing titled, "Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications."

AAOS is particularly interested in the topic of this hearing because in November of 2015, the Centers for Medicare & Medicaid Services (CMS) finalized a new Medicare payment model for joint replacement surgery called the Comprehensive Care for Joint Replacement (CJR) model. The model, which began on April 1, 2016, targets the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements, both elective and non-elective, as well as other lower extremity joint replacement procedures. The stated goal of the model is to encourage hospitals, physicians, and post-acute care providers to work together from the initial hospitalization through 90 days post-discharge to reduce the cost of care and improve quality for lower extremity total joint replacements as well as hip fracture repairs.

The CJR model was the first ever mandatory bundled payment issued by the Center for Medicare & Medicaid Innovation (CMMI), which supports CMS on "development and testing of innovative health care payment and service delivery models." Recently, CMS has also announced a mandatory Part B drug payment model, a surgical hip/femur fracture treatment (SHFFT) model, and a mandatory cardiovascular bundled payment model. While AAOS supports the efforts of all stakeholders to develop and evaluate payment methodologies that will incentivize coordination of care among providers and help curb health care inflation, we have expressed to CMS our concern about serious unintended consequences for Medicare beneficiaries and physicians with these mandatory programs.[1]

In comments to CMS, AAOS objected to the mandatory nature of these models as we believe it will force into a bundled payment system many surgeons and facilities who lack the familiarity,

[1] See AAOS' CJR proposed rule comments at http://www.aaos.org/uploadedFiles/PreProduction/Advocacy/Federal/Issues/medicare/AAOS_CY2016_CMS_%20CCJR.pdf

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

experience, or proper infrastructure to support care redesign efforts, which may lead to care that is not as cost-effective as anticipated. The model will severely disadvantage those surgeons, non-physician providers, and facilities that either do not have the proper infrastructure to optimize patient care under episodes-of-care payment models and/or lack adequate patient volumes to create sufficient economies of scale. A voluntary program that allows surgeons, facilities, and non-surgical providers to tailor their episode-of-care models to their particular patient population would lead to far better patient care as well as more accurate and efficient payments. This also more effectively allows for best practices in bundled surgical care to be identified.

Still, a major reason CMMI has been increasing the push towards mandatory Medicare payment models despite widespread criticism[2] is the anticipated cost savings and quality improvement these programs offer[3] – in fact, the Congressional Budget Office (CBO) estimates that efforts by CMMI will reduce spending by about $27 billion. [4] However, CBO recently commented that "little information on [CMMI's] potential savings is available" and to date, "detailed findings are available for only one model, which did not yield net savings."[5] Additionally, while CMS recently announced that Accountable Care Organizations (ACOs) in 2015 had combined total program savings of $466 million, in fact, "Medicare spent $217 million more in bonuses to accountable care organizations than the ACO program saved."[6]

Because of the lack of reliable data, AAOS has argued specifically that the CJR and SHFFT models lack the evidenced-based approach necessary to truly leverage best practices in managing payments and delivery across the health care system. Further, in initiating the CJR and other mandatory payment models, CMS overlooks related costs such as those that may result from the programs' lack of risk-adjustment, lack of physician leadership, and short implementation timeline. Still, CMS continues to present – and CBO continues to score – all CMMI programs, including CJR, as cost-saving programs. As will likely be discussed in today's hearing, this may actually impede Congress from working with stakeholders and experts to develop legislative fixes that would improve these programs in ways that CMMI may not have considered.

For example, as we expressed in our CJR comment letter, CMS proposes to base adjustments for quality in the CJR model on measures that are neither risk-stratified nor risk-adjusted. Analyses of spending during joint replacement episodes have shown there is tremendous variation in post-acute care costs for patients receiving what is ostensibly the same basic procedure. It is clear that some of this variation reflects legitimate differences in patient needs and not "unnecessary" care. Patients with chronic illnesses or other comorbidities and/or greater functional or cognitive limitations will generally require rehabilitation for longer periods of time in more expensive

[2] http://thehill.com/policy/healthcare/291196-medicare-changes-fiercely-resisted
[3] http://www.hhs.gov/about/news/2015/07/09/cms-proposes-major-initiative-for-hip-and-knee-replacements.html
[4] https://www.cbo.gov/publication/50692
[5] https://www.cbo.gov/publication/50692
[6] http://insidehealthpolicy.com/daily-news/medicare-spent-683m-aco-bonuses-466m-program-savings

settings than "healthier" patients with fewer limitations. The program should be designed to enable teams of providers to redesign care in ways that reduce or eliminate avoidable spending while ensuring that patients with greater needs have access to increased levels of care. Moreover, the program should be designed so that it does not financially penalize providers who perform joint replacement surgeries on patients with greater needs and thereby either discourage providers from performing procedures on such patients or encourage providers to stint on needed care. This "cherry picking" or "lemon dropping" of patients with comorbidities could certainly lead to hidden costs for which CBO would not be able to account.

Additionally, the AAOS strongly believes that physicians – specifically for the CJR program, orthopaedic surgeons – should be the primary responsible party, or at least be equivalent in status to the acute care hospital. It is the orthopaedic surgeon who is involved in the patient's care throughout the episode of care, from the pre-operative workup, to the surgery itself, to inpatient post-operative care, to the post-operative care provided in rehabilitation facilities, at home, and in the physician's office. No other party in the total episode of care is as involved in all aspects of the patient's care, and no other party is as important to the final patient outcome and overall cost efficiency as the operating surgeon. Therefore, it is logical that all episodes treated under the program be overseen by orthopaedic surgeons and not an acute care hospital facility. In addition, we believe an orthopaedic surgeon bears the most risk throughout the episode of care and ultimately has the most insight into the best pathways to improving patient care quality and cost savings and should therefore lead the bundled payment initiative.

Finally, the speed with which CMS has been implementing these programs may result in significant startup and integration problems, which would make it more difficult to achieve improvements in patient quality of care as well as in costs. The AAOS has noted that quickly implementing these models may cause disruption in normal patient access to care patterns, potentially causing financial harm to physicians and facilities. A gradual transition from a voluntary to mandatory program would be more realistic and provide time for assessing the amount of coordination available and/or necessary, developing clinical pathways, and executing legal agreements between leaders of physician groups and managers of facilities, all "best practice" factors essential to a successful program.

To be sure, CMS has been responsive to many stakeholder concerns. AAOS was very encouraged to see that a new proposed rule makes significant changes to the CJR model and introduces a new voluntary model under the Bundled Payments for Care Improvement (BPCI) Initiative, creating pathways for physicians to qualify for payment incentives through Advanced Alternative Payment Models under the Quality Payment Program.[7] Still, we are committed to ensuring all physician payment reforms ultimately improve the care of musculoskeletal patients

[7] http://newsroom.aaos.org/media-resources/Press-releases/new-macra-proposed-rule-provisions-impact-orthopaedic-bundled-payments.htm

and will continue to work with CMS, members of Congress, and other stakeholders to accomplish this goal.

Without hard data from similar programs and with all of the unknowns in the CJR program (as explained above), the AAOS believes that it would be nearly impossible for CBO to correctly estimate the savings or costs associated with the Comprehensive Care for Joint Replacement bundled payment program. Furthermore, the fact that CBO continues to score all CMMI programs, including CJR, as cost-saving programs impedes Congress from being able to work with stakeholders and experts in the field to develop legislative fixes and solutions that would improve these programs in ways that CMMI may not have considered.

Again, the AAOS would like to thank Chairman Price and Ranking Member Van Hollen for holding this very important hearing. Please feel free to reach out if there are any questions, or if the AAOS can serve as a resource to you in the future.

Sincerely,

Gerald R Williams Jr, MD
President, American Association of Orthopaedic Surgeons