AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Statement for the Record

House Ways and Means, Health Subcommittee Hearing

Current Status of the Medicare Program, Payment Systems, and Extenders

May 18, 2017

On behalf of over 18,000 board-certified orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) would like to commend Chairman Pat Tiberi (R-OH) and Ranking Member Sander Levin (D-MI) for holding the Ways and Means Subcommittee on Health hearing, "Current Status of the Medicare Program, Payment Systems, and Extenders." The AAOS appreciates your willingness to consider necessary changes for Medicare programs and payment systems.

Medicare provides federal health insurance for 57 million people and is a major portion of the country's budget. It is projected that between 2010 and 2050, the population ages 65 and older will double, from about 40 million to 84 million people. Musculoskeletal conditions are extremely prevalent in this elderly population and orthopaedic surgical interventions offer elderly patients the ability to maintain an active lifestyle and improve their overall health and quality of life. Medicare continues to face both short-term and long-term fiscal challenges that impact both patients and providers.

The AAOS respectfully requests that the subcommittee consider our comments below, which will help to improve quality and access to musculoskeletal care for our Medicare patients.

2016 PQRS & MU Reporting Relief. The AAOS embraces change that improves quality and lowers cost, but the patient must be the primary focus of all initiatives. There have been challenges for providers in meeting the requirements of Physician Quality Reporting System (PQRS) and Meaningful Use (MU) and these burdensome reporting requirements take valuable time away from the patient. We appreciate the Administration's recent aim to reduce the administrative burden on clinicians and to introduce greater flexibility in reporting requirements and eligibility rules. Congress should join us in urging the Centers for Medicare & Medicaid Services (CMS) to change 2016 PQRS requirements by reducing the number of measures for success to six measures. This would be consistent with the Merit-based Incentive Payment System (MIPS) and would enable more physicians to succeed. Additionally, Congress should urge CMS to substantially expand the hardship exemption criteria for 2016 MU to include older physicians, low-volume physicians (similar to MIPS), hospital-based physicians, rural practices and small practices.

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2015 Edition CEHRT. We strongly urge Congress to remove the requirement for providers to upgrade to 2015 Edition Certified EHR Technology (CEHRT). The most recent requirements for CEHRT were approved in 2015, but most EHR developers have not yet met them. Only 54 of the over 3,700 EHR products are currently certified and posted on the Certified Health IT Product List (CHPL). Physicians should not be subject to financial penalties under the Quality Payment Program (QPP) and MU because vendors have not certified their 2015 Edition products in a timely manner. CMS should continue to allow the use of both 2014 and 2015 Editions and permit participants to meet modified Stage 2 MU and Advancing Care Information (ACI) measures.

MACRA: Merit-Based Incentive Payment System (MIPS). The AAOS is pleased that 2017 will be treated as a "transition year," with a gradual buildup starting in 2018, although we believe the transition should be complete with no penalties for failing to report, as opposed to the minimum reporting requirements in the final rule.

AAOS encourages removal of the requirement to report on all patients going forward. It is widely known that orthopaedic medicine lacks validated patient reported outcome based performance measures (PRO-PM) and has few process measures. AAOS suggests that in areas where there are no validated clinician level quality measures, and until the time these are developed, those physicians be allowed to participate in MIPS voluntarily.

MACRA: Advanced Alternative Payment Models. AAOS supports innovative voluntary bundled and episode-of-care payment models in the Medicare program. However, we strongly believe that mandated participation in these models will force many surgeons and facilities into a bundled payment system who lack familiarity, experience, or proper infrastructure to support care redesign efforts. This will not only hamper provider participation in these models, but will bias model performance evaluation, lead to inaccurate reimbursements, and may negatively affect patient care.

The Comprehensive Care for Joint Replacement (CJR) and the Surgical Hip and Femur Fracture Treatment (SHFFT) models' mandatory participation requirement is flawed and should be replaced by a voluntary payment model for providers and facilities. The proposal to include all episodes and all providers and facilities 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 (such as in the Bundled Payment for Care Initiative (BPCI) models) 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. Voluntary programs can be geographically scaled once we have peer-reviewed evaluation results from limited demonstrations.

We urge Congress to work with CMS to revise the mandatory nature of the proposals and instead create incentives for interested participants that would reward innovation and high quality patient care. We believe the programs should be voluntary for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, coordinated, and lower costs for musculoskeletal care and who have the infrastructure necessary to carry out an episode of care approach to payment and delivery. Specifically, we recommend that CMS require that any participating entity have verifiable interoperability, infrastructure, and agreements between all necessary entities.

Physician-Led Care Management. The CJR and SHFFT models are hospital-led initiatives. This is problematic on various levels and the AAOS strongly believes this aspect of the Medicare model requires change to enable physicians to use their clinical judgement to decide on the setting and other parameters of an episode of care. For example, an orthopaedic surgeon is involved in the patient's care throughout the episode of care, from the pre-operative workup, followed by the surgery, 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 as the operating surgeon. 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 efficiency and should therefore lead the bundled payment initiative.

We recommend the operating surgeons and physician groups have the ability to be in charge of the bundle, or explicitly create a mechanism allowing the surgeon or group to participate with a facility or third party to manage the episode, collect payments, recoup overpayments, and return "shared savings" across the spectrum of care. Having the hospital in charge of the bundle provides the hospital inappropriate leverage over surgeons and other participants and could allow some hospitals to exclude surgeons and other care providers if those parties don't wish to meet the hospital's terms.

Additionally, AAOS recommends that Congress work with CMS to eliminate all limits on gainsharing among providers to give providers flexibility to allocate the CMS payment among the members of program teams in ways that maximize incentives for each specific team, as opposed to a one-size-fits-all model. Prohibiting compensation to any provider designed to reward them for increases in the number of procedures they perform must continue, but there would be no ban on payments that help control costs within a CMS episode.

Adequate Risk Adjustment. A recent analysis[1] of Medicare claims for patients in Michigan who underwent lower extremity joint replacements in the 2011-13 period concluded that hospitals treating medically complex patients may be unintentionally penalized without proper risk adjustment. Reconciliation payments were found to be reduced by $827 per episode for each standard-deviation increase in a hospital's patient complexity. This study also estimated that risk adjustment could increase reconciliation payments to some hospitals up to $114,184 annually. Thus, the CJR and SHFFT models need financial, clinical and socio-economic risk adjustment. This study also highlights that these models are unique because the target price is calculated as a blend of a particular hospital's historical episode spending and the average spending of other hospitals in the same region with the weight of the regional benchmark increasing over time. This is going to increase the financial disparity for hospitals treating more medically complex patients. The AAOS recommends risk adjustment in all Medicare programs based on important patient characteristics such as age, socio-economic status (SES), marital status, clinical co-morbidities, functional status, etc. in addition to the target price stratification in both the CJR and SHFFT models.

Further, the existing literature shows racial disparity in utilization of elective joint replacement (41.5 per 10,000 for black patients vs. 68.8 per 10,000 for white patients; P<.001)[2] and that minorities are more likely to receive joint replacement at low-volume/low-quality hospitals compared with nonminority patients and may have worse outcomes including higher rates of hospital readmission[3]. Thus, one unintended consequence of the CJR model may be to accentuate racial disparity in joint replacement surgery.[4] An interesting finding of the BPCI Year 2 evaluation[5] is that the shift from more expensive institutional post-acute care (PAC) to home and community based PAC contributed to major reduction in the cost of orthopaedic surgeries. While this finding implies that CJR and SHFFT episodes may encourage hospitals to provide better quality PAC, it must be considered that BPCI participants operate in more affluent areas. On the other hand, lower SES and minority patients may not have adequate support at home or transportation to receive home and community based rehabilitation services.**Error! Bookmark not**

[1] Ellimoottil, C., Ryan, A. M., Hou, H., Dupree, J., Hallstrom, B., & Miller, D. C. (2016). Medicare's New Bundled Payment For Joint Replacement May Penalize Hospitals That Treat Medically Complex Patients. *Health Affairs*,*35*(9), 1651-1657.

[2] Singh, J. A., Lu, X., Rosenthal, G. E., Ibrahim, S., & Cram, P. (2014). Racial disparities in knee and hip total joint arthroplasty: an 18-year analysis of national Medicare data. *Annals of the Rheumatic Diseases*,*73*(12),2107-2115. .

[3] Jorgenson, E. S., Richardson, D. M., Thomasson, A. M., Nelson, C. L., & Ibrahim, S. A. (2015). Race, Rehabilitation, and 30-Day Readmission After Elective Total Knee Arthroplasty. *Geriatric Orthopaedic Surgery & Rehabilitation*, *6*(4),303-310.

[4] Ibrahim, S.A., Kim, H., McConnell, K. (2016). The CMS Comprehensive Care Model and Racial Disparity in Joint Replacement. *JAMA.* Published online September 19, 2016. doi:10.1001/jama.2016.12330.

[5] Dummit, L. A., Kahvecioglu, D., Marrufo, G., Rajkumar, R., Marshall, J., Tan, E., ... & Hassol, A. (2016). Association between hospital participation in a Medicare bundled payment initiative and payments and quality outcomes for lower extremity joint replacement episodes. *Jama*, *316*(12), 1267-1278.

defined. Thus, CJR and SHFFT episodes may not have the same potential for improving the quality of care while reducing costs of care without adequate risk adjustments.

The BPCI, CJR, and SHFFT models are all triggered by an inpatient stay and are paid on the basis of a triggering Medicare Severity Diagnosis-Related Group (MS-DRG). The problem with this design is that there is considerable variation among cases within a MS-DRG and therefore uniform target pricing is unreasonable. For example, the patient population and related risks for elective knee or hip replacements are very different from emergent hip fracture that may include replacement. Similarly, total ankle replacement costs much more and has far less volume than total hip or knee replacement. All of these procedures are covered under MS-DRGs 469 and 470. Thus, such elements of model design are likely to lead to cherry-picking of patients and limit access to care for Medicare beneficiaries.

Develop Appropriate Quality Measures. It is important to have validated and reliable quality measures to have successful value-based care models. Currently, the medical specialty of orthopaedics has no validated outcome measure and consequently, the Medicare payment models rely on weak quality connectors. The NQF # 1550 calculates hospital-level complication rates following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) with the goal to reduce complication rates. It addresses a priority condition (osteoarthritis) and is expected to lead to reduced morbidity and mortality post THA and TKA. This measure has not been vetted for use in hip fractures and if used as a surrogate from the hospital's Total Joint Arthroplasty (TJA) experience will unfairly measure those hospitals with a smaller arthroplasty experience. Likewise, the collection of the patient reported outcome measures (PROMs) will be skewed. The Hip Disability and Osteoarthritis Outcome Score (HOOS), JR. is a patient-relevant short-form survey based on the HOOS, focusing specifically on outcomes after THA. The instrument does not have validity for application to hip fractures.

Global Codes Reporting and Data Collection. The AAOS is concerned that the steps proposed by CMS, particularly the requirement that all providers use G-codes for all post-operative patient encounters, are unnecessarily burdensome for physician and physician practices. This will most likely result in inaccurate data, and represents an overreach according to the language in MACRA calling for CMS to collect data on resources used in the post-operative global period. While AAOS acknowledges CMS' response to our comments in this regard, even requiring mandatory reporting from all providers furnishing global surgery services in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island will be unduly burdensome for providers. AAOS urges Congress to prioritize efforts to not use the G-codes as proposed by CMS, to not make the claims reporting universal to all Medicare providers using global period codes, and to utilize representative samples of services and other approaches that are likely to yield more reliable and accurate data without imposing major burdens on hundreds of thousands of providers.

Translation & Interpreting Services. The AAOS urges Congress to remove the burdensome requirements in the Affordable Care Act (ACA) for insurers and the health care industry to provide translation and interpreting services for limited English proficiency (LEP) individuals. In certain settings, such as rural areas, it is difficult to procure translation and interpreting services.

IPAB Repeal. The AAOS opposes the Independent Payment Advisory Board (IPAB) and supports repeal of this entity. IPAB's mandate to contain Medicare costs will likely subject physicians to unfair cuts in reimbursement. IPAB is severely constrained in what it can recommend to slow the pace of Medicare spending growth. IPAB recommendations cannot increase beneficiary premiums or cost-sharing and cannot reduce benefits in any way. IPAB cannot recommend tax increases. The only options available are adjustments to what Medicare pays for various medical services. Because hospitals are exempt from cuts until 2020, the burden of payment reductions will fall heavily on physicians.

The AAOS recognizes the importance of lowering health care costs and we are committed to improving the value of health care. Medicare payment policy requires a broad and thorough analysis of the effects on all providers and beneficiaries. Unfortunately, the IPAB threatens unnecessary and harmful cuts to physicians causing undue burden on physicians and their practices. We urge Congress to repeal this provision.

Lift the Ban on Physician-owned Hospitals. AAOS urges Congress to lift the ACA's ban on new Physician-owned Hospitals (POHs) participating in the Medicare and Medicaid programs. The POHs have been shown to provide higher quality care at lower cost compared with those run by non-physicians or appointed boards. Compared to general hospitals, POHs have received higher quality ratings by CMS. These hospitals contribute to local economies and meet a growing demand for health care services, especially in rural areas. A recent peer-reviewed article[6] dispelled concerns of cherry-picking by POHs as compared to non-POHs. Patients at POHs are equally likely to be minorities or to use Medicaid and had similar numbers of chronic diseases and predicted mortality scores.

Thank you again for holding this important hearing on Medicare's payment systems and programs. The AAOS is committed to continue working with Congress and the Administration to ensure that patients have access to the highest quality musculoskeletal care. Please contact Catherine Boudreaux, Senior Manager of Government Relation (boudreaux@aaos.org) if you have any questions or if the AAOS can serve as a resource to you.

[6] Blumenthal, D. M., Orav, E. J., Jena, A. B., Dudzinski, D. M., Le, S. T., & Jha, A. K. (2015). Access, quality, and costs of care at physician owned hospitals in the United States: observational study. *BMJ*, *351*, h4466.