AAOS
American Association of Orthopaedic Surgeons

June 10, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1785-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov

Subject: CMS-1808-P
Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Brooks-LaSure:

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS) and the orthopaedic specialty societies and state societies that agreed to sign on, we are pleased to provide comments in response to the Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes (CMS-1808-P) published in the Federal Register on April 10, 2024.

Transforming Episode Accountability Model

AAOS appreciates that the Center for Medicare and Medicaid Innovation (CMMI) recognizes the value that orthopaedic surgeons have brought to the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A) models over the last several years. Our members have been strong partners in improving care, leading the transition to value-based care, and generating substantial savings for the Medicare program. In anticipation of the sunsetting of the CJR and BPCI-A models, AAOS leadership has been in close contact with CMS leadership to share our thoughts on future orthopedic value-based care models. In our numerous letters and conversations with the agency, we expressed our concern with the prospect for mandatory participation in any future models. Therefore, we

are now dismayed to understand that the proposed Transforming Episode Accountability Model (TEAM) will be mandatory for all the hospitals selected by CMS to participate.

The fact that this program will exclude patients having surgery outside the hospital setting and those who have a Medicare Advantage plan is going to make it very difficult to create any change based on the program. This exclusion is so significant that we believe it will severely limit the validity of the model test, for which CMS claims making the model mandatory is required. For the broader community of orthopaedic surgeons, it will be hard to justify value-based care changes based on such a narrow patient population. Hospitals that have already adjusted for BPCI-A or CJR will likely continue "business as usual". Those who have not made any changes won't have enough incentive to change based on this. We acknowledge that there could be benefits if CMS better defines the types of partnerships that will be allowed to create savings in working with other entities. Unfortunately, those are all at the discretion of the hospital.

Mandatory Nature of Model

While AAOS strongly supports the development and implementation of voluntary models, we believe that the proposal to mandate participation by acute care hospitals in CMS selected geographic regions is flawed and should be replaced by a voluntary approach that includes physicians. A voluntary approach allows surgeons to tailor their episode-of-care models to their patient population and would lead to improved patient care and more accurate and efficient payments. We are additionally concerned that CMS states in the proposed rule that a voluntary approach was considered for this model but later dismissed because they believed it would not lead to meaningful evaluation findings. AAOS finds this to be a poor rationale for such a drastic proposal given that research on the impact of the CJR model found limited cost-savings to the Medicare program.[1] Moreover, a 2023 report from the Congressional Budget Office (CBO) analyzing CMMI activities in the first ten years of its operation determined that they increased direct spending by $5.4 billion. Furthermore, CMMI spent $7.9 billion on model operation, yet those models (including CJR and BPCI-A) only reduced spending on health care benefits by $2.6 billion.[2]

What is also curious is that the same CBO report, when looking at the effects of the voluntary Accountable Care Organizations' Medicare Shared Savings Program (MSSP), found that the physician-led ACO's MSSP generated $256 million in net savings while the hospital-led ACO's created $112 million in net costs to Medicare.[3] While there may be overlap here with participants in some of the other alternative payment models, it is clear that what yielded results was not mandatory, hospital-controlled APMs. It is with this in mind that we urge CMS to reverse their proposal and make participation in TEAM voluntary.

[1] https://www.nejm.org/doi/full/10.1056/NEJMsa1809010
[2] https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf
[3] https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf

We **strongly urge** CMS to revise the mandatory nature of the proposal and instead create incentives for interested participants that would reward innovation and high-quality patient care. We believe that the program should be voluntary and on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to deliver high quality and well-coordinated care to their patients.

Payment Sharing

AAOS is concerned that CMS is placing all the financial upside and downside risks in the care of the acute care hospital episode initiator. Although our surgeon leaders will be responsible for the treatment of patients presenting in the hospital setting with the three categories of orthopaedic episodes included in the model proposal, they will be subject to the hospitals' discretion to distribute any of the savings that they generate through their care delivery. We find this to be a reversal of the recent calls for collaborative, physician-led team-based care that are the hallmark of successful value-based care initiatives.[4] While we can appreciate the complexity required to determine the financial arrangements between the initiating hospital, the surgeon providing acute care, and the subsequent handoff to the primary care physician and other post-acute care providers, AAOS requests that CMS require hospitals to pass the savings generated by this model to those physicians leading the care for the participating patients.

Moreover, we are concerned that the requirement for hospitals to coordinate post-acute care may lead to further consolidation. Specifically, we believe that this may create a perverse incentive for hospital systems to purchase skilled nursing facilities, physical therapy groups, and outpatient surgery centers to better control costs, increase savings, and ensure that hospitals are meeting the care coordination requirements of this model. As we have noted in recent comments, patients often pay the price for a consolidated health care market.[5] With fewer choices available to obtain routine diagnostic tests, they are less likely to follow through with the preventative and non-operative care that can lead to improved quality of life and lower overall healthcare costs. Despite promises of increased productivity and reducing redundancies, consolidation has not resulted in the lower costs and better care promised by the massive U.S. health care systems. Rather, research shows that increased consolidation has led to higher health care prices across the board. The consolidation of practices and integration with hospital systems can lead to increased prices for common orthopaedic procedures and decrease competition and opportunities among independent practices in the same market. A New York Times analysis in 2018 found that average hospital prices increase

[4] https://www.aaos.org/globalassets/advocacy/issues/aaos-specialty-care-reimbursement-model.pdf, https://www.acpjournals.org/doi/full/10.7326/M23-2260

[5] https://www.aaos.org/globalassets/advocacy/issues/aaos-comments-on-ftc-competition-rfi-5.6.24.pdf

dramatically following mergers.[6] For example, the costs for knee replacement and lumbar spine fusion were approximately 30 percent higher in concentrated markets versus competitive markets.[7]

Episode Length

AAOS believes that the 30-day episode length is too short to account for the true timeline of when patients are seen for post-acute care visits from the treating surgical team. The typical follow up care for total joint replacement patients is at least eight weeks, if not twelve. Patients are often seen for a post-operative visit at two weeks to check the incision and ensure that they are improving their range of motion and have appropriate pain control. They are then typically seen again at a six or eight-week visit for post-operative x-rays and to continue monitoring their healing and range of motion. Most patients having hip or knee replacement surgery will be doing some version of supervised physical therapy for at least six to eight weeks after the surgery as well. Given this timeline, a 30-day episode is far too short to provide appropriate post-operative care for these patients. It is also very difficult to assess their actual post-operative costs, complications, and other issues in such a short window. This also has significant impacts on how surgeons are paid for the work they do within the hospital setting and the typical Medicare payment window for the clinical episodes proposed in this model. While this proposed model episode is 30-days, most MS-DRGs for orthopaedic procedures are 60- or 90-day global periods. Any meaningful measure of joint replacement patient care should be extended to at least 60- or 90-days.

As we explained in 2017 on our comments on the Surgical Hip and Femur Fracture Treatment (SHFFT) proposed mandatory model, AAOS strongly believes this aspect of the model requires change to designate those physicians – specifically orthopaedic surgeons – be the primary responsible party, or at least be equivalent in status to the acute care hospital leading an episode payment model. 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.

Setting of Care

Given that Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) were removed from the Medicare Inpatient Only List and have since been performed in the Hospital Outpatient (HOPD) setting and the Ambulatory Surgical Center (ASC) settings, we believe that it is a missed opportunity for this model to

[6] When Hospitals Merge to Save Money, Patients Often Pay More - The New York Times (nytimes.com)
[7] JC Robinson. Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology. Am J Managed Care 2011; 17(6): e241-e248

exclude those Lower Extremity Joint Replacement (LEJR) episodes occurring beyond the hospital setting. This may have the unintended effect of pushing cases that are inappropriate for the outpatient setting to outpatient care, as hospitals try to avoid the risks associated with the TEAM model. Likewise, cases where the patient may be better suited to care provided in the outpatient setting may be pushed to the inpatient setting for hospitals who believe they can benefit from the upside risk associated with taking on the case.

Advancing Patient Safety and Outcomes Across the Hospital Quality Programs- Request for Comment

The AAOS appreciates the opportunity to provide feedback on the proposed Quality Data Reporting Requirements for Specific Providers, particularly regarding the Patient Safety Structural measure and measures related to unplanned patient returns post-discharge.

First, we echo concerns raised about the impact of penalties for conditions unrelated to the initial condition, such as penalizing orthopaedic surgeons for non-orthopaedic-related return to the Emergency Department (ED) or admission. Data from Michigan joint registries show a significant portion of such returns are non-orthopaedic in nature, such as new cardiac events or gastrointestinal issues. While orthopaedic surgeons take full responsibility for surgery-related conditions, such as infection, insufficient pain control, or thrombosis, surgeons have limited control over non-orthopaedic issues postoperatively. Overly prescriptive criteria or broad penalties may lead to unintended consequences, such as physicians being hesitant to advise patients to seek emergency care, outpatient surgery criteria forcing a higher volume of minor procedures into inpatient settings, or surgeons limiting access to outpatient surgery for patients with comorbidities that may impart any degree of risk; these measures will limit access to care and increase healthcare costs needlessly.

Second, we agree that efforts should be made to improve discharge processes and reduce unplanned returns. While the existing Excess Days in Acute Care (EDAC) measures capture some post-discharge events, they do not comprehensively represent all outcomes of interest to patients, such as ED visits or receipt of observation services within 30 days post discharge. We support exploring measures that better represent these outcomes and incentivize hospitals to improve discharge processes. However, any new measures should not lead to physicians deferring timely evaluation of post-op concerns or cherry-picking patients.

In conclusion, AAOS supports the goal of enhancing patient safety and outcomes through quality reporting programs. We recommend a balanced approach that considers the complexities of postoperative care and avoids unintended consequences.

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Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant proposals made in the FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Tern Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

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AAOS President

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This letter has received sign-on from the following orthopaedic societies:

American Orthopaedic Society for Sports Medicine (AOSSM)
American Orthopaedic Foot & Ankle Society (AOFAS)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand Professional Organization (ASSH)
Cervical Spine Research Society (CSRS)
Limb Lengthening and Reconstruction Society (LLRS)
Musculoskeletal Tumor Society (MSTS)
Orthopaedic Trauma Association (OTA)
Scoliosis Research Society (SRS)