



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

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November 15, 2018

Brenda Destro, PhD

Deputy Assistant Secretary for Planning and Evaluation, Room 415F

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

Submitted electronically via email

REQUEST FOR INFORMATION: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Dr. Destro,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to share comments on the recent 'Request for Information' (RFI) on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

The AAOS is committed to improving musculoskeletal care for patients, especially those who are vulnerable with socio-economic risk factors. In response to an RFI on the new direction for the Innovation Center at the Centers for Medicare and Medicaid Services (CMS) dated November 20, 2017¹, AAOS urged CMS to include important patient characteristics such as age, socio-economic status (SES), marital status, clinical co-morbidities, functional status, social and familial support in their evaluation of Medicare and Medicaid payment models. Medicare beneficiaries with such risk factors should be factored into the target price used in many Innovation Center models. AAOS also asked CMS to incorporate the risk stratification

¹ AAOS comments on Centers for Medicare & Medicaid Services: Innovation Center New Direction. Available: https://www.aaos.org/uploadedFiles/PreProduction/Advocacy/Federal/Issues/medicare/AAOS%20comments_RFI%20on%20CMMI%20new%20direction_final.pdf

recommendations that the Assistant Secretary for Planning and Evaluation (ASPE) made to Congress in your 2016 report.²

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

It is heartening to note that CMS launched the Accountable Health Communities (AHC) Model in 2016 that addresses a critical gap among clinical care, community services and family support in the health care delivery system “by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries’ through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.” Such effort is essential to address the social and economic risk factors experienced by certain racial and ethnic groups and within certain geographical areas. We hope that the AHC participants include support specialists (such as orthopaedic surgeons) in their patients’ care plans as they assess unmet needs in their communities.

There is increased awareness among payers that chronic illnesses (such as diabetes, obesity, stroke, heart disease, and cancer) disproportionately impact low-income individuals and minorities.³ Hence both CMS and commercial insurance companies have launched episodic payment models, accountable care organizations and other innovations to treat co-morbid chronic conditions so that the patients’ emergent and predictable acute care needs are optimized.

Today, most Medicare beneficiaries are covered by CMMI payment models. Hence, it is important that the new value-based payment models in Medicare identify and address social economic risk factors. Lower extremity joint replacement (LEJR) procedures is one of the most common procedures in this population. The ASPE’s finding that safety-net providers were more likely to receive penalties have been corroborated in studies focusing on musculoskeletal care.

² REPORT TO CONGRESS: SOCIAL RISK FACTORS AND PERFORMANCE UNDER MEDICARE'S VALUE-BASED PURCHASING PROGRAMS. Available: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>

³ “The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases, ” Health Affairs Blog, August 17, 2017. DOI: 10.1377/hblog20170817.061561.

For example, a recent analysis⁴ of Medicare claims for patients in Michigan who underwent lower extremity joint replacement LEJR during the period 2011–13 concluded that hospitals treating medically complex patients experienced unintentional penalties when proper risk adjustment is not accounted. Reconciliation payments were found to be reduced by \$827 per episode for each standard-deviation increase in a hospital’s patient complexity. These unintentional penalties for safety net hospitals must be addressed. This study also estimated that risk adjustment could increase reconciliation payments to some hospitals up to \$114,184 annually. Thus, the Comprehensive Care for Joint Replacement (CJR) model in the study, referenced above, requires financial, clinical, and socio-economic risk adjustment to address treatment of these more complex patients. Another important point raised by this study is that the CJR model uses a novel calculation of the target price (a blend of a hospital’s historical episode spending and the average spending of other hospitals in the same region). Predictably, the regional benchmark, increasing over time, will drive increasing financial pressures on hospitals treating more medically complex patients.

Which social risks are most important to capture?

The mechanism for disparities in musculoskeletal care is not well understood. Racial and ethnic minorities have a greater incidence of arthritis and chronic disability than the population in general.⁵ For example, African-Americans have a lower utilization of total joint arthroplasty for a variety of reasons, including patient trust, perceived limited satisfaction with results by peers, varying knowledge about total joint arthroplasty, and concerns about pain associated with these procedures. However, not enough emphasis is laid on these concerns across the profession. Hence, national professional organizations (such as AAOS) are championing new research and designing collective physician education on these topics.

For an orthopaedic surgeon, language barriers with patients is a key issue. It is a major difficulty to find medically trained translators leading to delays in care, additional cost, miscommunication and in proper informed consent. It is accurate to state that such translation services may cost the system as much as the patient visit reimbursements. Active

⁴ 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.

⁵ Morgan, R. C., & Slover, J. (2011). Breakout session: ethnic and racial disparities in joint arthroplasty. *Clinical Orthopaedics and Related Research*, 469(7), 1886.

communication at hospital discharge is necessary for an optimal transition and to avoid post-acute adverse events. Understanding of medications and the type of follow-up care needed is low among patients with limited English proficiency and medical literacy.⁶ Given that language concordance improves outcomes, there must be systematic identification of patients with limited English proficiency and reimbursement mechanisms that are reliable.

As for issues related to poverty, our surgeons find that unmet medical transportation needs and environmental hurdles in neighborhoods and homes present challenges for post-acute recovery. There is a rich body of literature that argues that provision and payment of social services under Medicare is a major necessity in our communities. Certainly, paying for transportation to and from appointments or care facilities would significantly enhance access to care as public transportation can be challenging for orthopaedic patients with limited mobility. In addition, greater access to home safety assessments and the ability to pay for a ramp to enter the home or make other mobility enhancements are frequently necessary to avoid lengthy institutional post-acute care. Unfortunately, there are not enough resources and incentives for screening for these issues routinely. The AAOS believes that physicians and other health care providers would be more likely to do such screenings if they knew where to direct vulnerable patients locally. Social workers are not so common in orthopaedic practices, and this is a specialized skill and service that is required if our surgeons are to effectively help their patients with issues beyond their clinical expertise that affect care outcomes. It usually only happens when the patient sees the social worker prior to discharge after a procedure and would be more effective and more widely utilized if there was better connectivity to local government and nonprofit human service organizations.

Lastly, the most difficult social risk factor to identify is the existence of ‘implicit bias’ among clinicians.⁷ Racial/ethnic concordance among physicians and their patients lead to improved communication and thus improved outcomes. There is a rich body of literature that has found that implicit or unconscious bias is alive and thriving among all of us. Medical training should

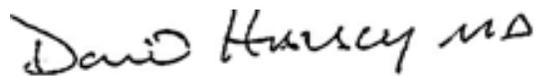
⁶ Karliner, L. S., Kim, S. E., Meltzer, D. O., & Auerbach, A. D. (2010). Influence of language barriers on outcomes of hospital care for general medicine inpatients. *Journal of Hospital Medicine*, 5(5), 276-282.

⁷ “Examining Provider Bias in Health Care Through Implicit Bias Rounds, ” Health Affairs Blog, July 17, 2017. DOI: 10.1377/hblog20170717.060993

actively involve awareness of socio-cultural factors that impact care and practical steps to mitigate implicit bias. Recognition of our own implicit bias is the first stepping stone.

The AAOS appreciates your request for information on this important issue and hope that HHS and the Congress will be able to develop practical policies that address some of the social risk factors that impact our patients. Our comments are simply indicative of deep-rooted issues in this area, and we look forward to working with you in improving the quality of musculoskeletal care for all of our patients. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

A handwritten signature in black ink that reads "David Halsey MD". The signature is written in a cursive, slightly slanted style.

David A. Halsey, MD
President, American Association of Orthopaedic Surgeons

cc: Kristy L. Weber, MD, AAOS First Vice-President
Joseph A. Bosco, III, MD, AAOS Second Vice-President
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