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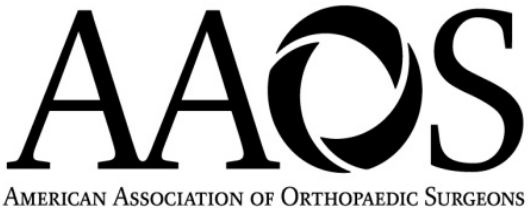

Statement

of

Peter J. Mandell, MD

On

Physician Organization Efforts to Promote High Quality Care and

Implications for Medicare Physician Payment Reform

Committee on Ways and Means

Subcommittee on Health

US House of Representatives

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Chairman Herger, Ranking Member Stark, and other distinguished members of the Ways and Means Health subcommittee, thank you for the opportunity to testify on behalf of the American Association of Orthopaedic Surgeons (AAOS). The AAOS represents over 18,000 board-certified orthopaedic surgeons nationwide. My name is Peter Mandell, MD, and I serve as Chair of the AAOS's Council on Advocacy. I have practiced orthopaedic surgery on the San Francisco Peninsula for the last 37 years. On behalf of the AAOS and my orthopaedic surgeon colleagues across the country, thank you for inviting our organization to testify today on Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform. AAOS recognizes the huge undertaking of developing a long-term sustainable solution to the Medicare physician payment system and we are happy to aid in this effort. We are committed to the development and encouragement of best practices that provide the highest quality of care for musculoskeletal patients while remaining cost effective. We are already involved in several quality initiatives that we believe can be used by Congress as a model for future payment reforms. These initiatives include the development of clinical practice guidelines (CPG), appropriate use criteria (AUC), our joint registry program, and patient safety measures. Policy reforms that provide incentives for the delivery of high quality health care should be coupled with payment reforms that include greater patient involvement in order to preserve the Medicare program.

Quality-Based Payment Reform Models

There is no "one-size-fits-all" when it comes to creating new payment models for the Medicare system. Each of the following types of payment systems has merit: capitation with warranties and floors, episode-of-care, tier-based payment systems and traditional fee-for

service. The AAOS created a Health Care Systems Committee to keep abreast of efforts to test alternative payment systems specific to orthopaedic care. The AAOS has held seminars at several recent meetings to provide education to our members about various payment models that incorporate quality-based payment.

The AAOS strongly supports efforts by Congress to incorporate quality, efficiency and patient outcomes into the Medicare physician payment system. Congress should provide financial incentives that reward higher quality care based on appropriately risk-adjusted, patient-centric measures of health outcomes. This approach must be risk adjusted to account for the medical, social, and personal patient co-morbidities that are beyond a provider's control. These would include factors such as obesity, diminished mobility, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use, and disparities in health care access.

A payment model that is based solely on the cost of procedures and their outcomes, without consideration of the above factors or the quality of life benefits derived by patients, would be ineffective. One payment model that could provide appropriate incentives for high quality care would establish different payment tiers based on appropriately adjusted outcomes so that the highest quality care is paid at a higher rate than lower quality care. This system would be built upon factors such as evidence-based guidelines, appropriate use criteria, risk-adjusted performance measures, and mandatory participation in national registries.

The majority of specialty societies, including AAOS, have created a foundation of quality measures and continuously evolving evidence in virtually every area of medical practice. The AAOS has a sufficient foundation of outcomes research to begin to determine what constitutes

a high quality orthopaedic outcome compared to a low quality outcome. Quality measures should be utilized to develop a new physician payment model, but only if the development process includes specialty-specific input from all physician specialties who are impacted by the payment system.

New payment models that provide positive financial incentives for higher quality care would lead to better patient outcomes with improved patient involvement in decision-making. Payment systems should reward physicians for developing medically innovative treatments that increase quality and reduce costs. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required open surgery and inpatient hospital stays. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars per year in reduced costs, principally through reductions in hospital stays. Tying payment to quality and to savings generated by medical innovation will reduce overall Medicare costs and drive innovation.

Coordinated care models offer another approach for payment and delivery system reform. The AAOS supports efforts to develop and evaluate payment methodologies that will incentivize coordination of care among providers (including physicians and hospitals) and help curb health care inflation. As the demand for musculoskeletal care increases with a more active society and an aging population, it is imperative for orthopaedic surgeons to be included in the discussions and to take a lead role in the development and deployment of such programs.

Currently, hospitals are paid under a Diagnosis Related Groups (DRG)-based prospective payment system which adjusts for severity and resource use in the discharge diagnosis. Physicians have traditionally been separately paid under a fee-for-service schedule without

incentives to control volume or cost. The Centers for Medicare and Medicaid Services (CMS), along with multiple other stakeholders, believe that there are savings to be realized if the hospital and the physicians are paid and incentivized by the same methodology. With a single payment issued for the entire episode of care, interested parties hope to align the incentives of the facility and all involved providers, resulting in more efficient delivery of care and better compliance with standards and reporting requirements.

As traditionally defined, an "episode of care" bundled payment is a single payment made to all providers – physicians, facilities, laboratories, and all other health care professionals – for the entire episode of care provided to the patient. Episode of care payment programs may include a physician incentive or gainsharing component. Gainsharing refers to an arrangement between a physician and a hospital to share in the cost savings that result from specific actions to improve the efficiency of care delivery. Gainsharing programs may also be established independent of bundled payment programs.

Episode of care, or bundled payment methodologies and gainsharing arrangements may carry unintended consequences. One possible consequence is deliberate rejecting of complex or risky patients. The patient must be the focal point of any initiative and therefore the system must not create incentives to treat healthier patients and limit access to sicker ones. Additionally, because a bundled payment would include a specific time period defining the episode of care, a workable and reasonable re-admission policy would be an essential piece to such initiatives. The system should not create incentives for patient diversion when a discharged patient in need of re-admission is sent to a different facility or provider. Developing

a coherent risk adjustment policy is the primary method for preventing the practice of deselecting patients and addressing the readmission issues with this method of payment.

Lastly, Congress should provide incentives for care that is innovative and high quality. Musculoskeletal disorders and diseases are the leading cause of disability in the United States. The economic impact of these conditions is staggering. In 2004, the sum of the direct expenditures in health care costs and the indirect expenditures in lost wages for persons with a musculoskeletal disease diagnosis has been estimated to be $849 billion dollars, or 7.7% of our gross domestic product. [1] In addition, musculoskeletal conditions are also the greatest cause of total lost work days and hospital bed days in the U.S. At least one study has indicated that 17% of workers employed in the previous 12 months in the U.S. reported lost work time totaling nearly 437.6 million days as a result of musculoskeletal conditions. [2] Congress must recognize this reality by rewarding this type of care as more valuable than care that contributes little to societal well-being and economic productivity.

Elevating the Quality of Orthopaedic Care

Beginning in 2006, with the creation of the AAOS Guideline and Technology Oversight Committee, the AAOS introduced the concept of evidence-based medicine into our clinical practice guideline development process. The implications of this commitment to evidence-based medicine on the part of the AAOS in the development of its Clinical Practice Guidelines (CPGs) are profound. No longer are CPGs subject to the potential self-serving bias of a panel of "experts"; but, rather they are constructed on the basis of a systematic review and ranking of the quality of the literature that is then objectively used to arrive at the conclusions and

[1] Surg, *Burden of Musculoskeletal Diseases in the United States*.
[2] Ibid.

recommendations in these CPGs. Furthermore, each step of this process is clearly articulated and documented, which increases transparency. Any outside agency can take the same literature base (often up to 6000 articles reviewed for a given guideline), follow the AAOS process and, in all likelihood, come up with the same conclusions and recommendations, free of bias to the greatest extent possible. It is important to note that although AAOS supports the use of AUCs and CPGs, no guideline ought to supersede the clinical judgment of a trained physician.

The AAOS believes that one important test of whether the AAOS or any other professional organization has succeeded in producing objective guidelines is to see whether those guidelines continually serve the financial interests of the physician groups that wrote them. The AAOS understands the importance of objectivity. For instance, the AAOS has come out against the use of arthroscopy in most patients with knee osteoarthritis and against the use of vertebroplasty in patients with osteoporosis-related spinal fractures. As a result, our CPGs have gained praise from both the lay press as well as the AMA for their process of development and the objectivity of their evidence-based recommendations. The AAOS CPGs provide guidance for clinicians in a way that will benefit patients and contribute greatly to the quality of health care being provided.

AAOS CPGs have already been incorporated into payment systems, and the AAOS has been supportive of the correct application of AAOS guidelines into coverage policies. However, we have also been diligent in responding to payers who have misinterpreted or misapplied our guidelines to not cover certain procedures when the AAOS CPG did not advise against the use of the treatment. It is important for specialty societies that have CPGs to engage with payers,

both public and private, to ensure coverage policies are evidence based and appropriate for the best patient care.

In the last 18 months the AAOS has also committed to the development of Appropriate Use Criteria (AUC) which have even more applicability for payment systems based on quality of care. Appropriate Use Criteria provide specific guidance on what is and what is not the appropriate use of a particular technology or service. AUC can easily be adapted into performance and quality measures and therefore be integrated into tiered quality payment models.

American Joint Replacement Registry

The American Joint Replacement Registry (AJRR) is a not-for-profit 501(c)(3) organization for data collection and quality improvement initiative for total hip and knee replacements. The AAOS is a founding supporter of the AJRR, which is working to become the national total joint replacement registry in the US. The registry is governed and funded by a multi-stakeholder model comprised of orthopaedic surgeons, hospitals, payers and implant manufacturers. The AJRR is focused on improving the quality, outcomes, and cost-effectiveness of total joint replacement (TJR) surgeries through the achievement of several objectives:

1) Establish an infrastructure and a uniform system for collecting device information and monitoring outcomes of TJR throughout the U.S.
2) Create real-time survivorship curves to serve as a trip-wire in order to detect poorly performing implants

3) Establish a uniform system that can be used to define the epidemiology of TJR for outcomes research to improve the quality and outcomes of patient care
4) Provide regular feedback to surgeons, hospitals and implant manufacturers concerning their relative performance compared to peers (national joint registries in other countries have proven that this iterative feedback to providers improves quality and reduces cost.)

The AJRR Board of Directors will establish the policies and procedures that governs data use, dissemination, and reporting, including the relationship with organizations external to the national registry, such as Health and Human Services (HHS), Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS). The AJRR believes that for the most comprehensive collection of core data, the reporting system must maximize existing data collection systems and rely upon participating hospitals for submission of data to the registry. They also believe that the analysis and interpretation of registry data must be objective and scientific.

The AJRR currently collects data on both Medicare and non-Medicare patients without distinguishing between the two types of patients. Data collected includes patient information, hospital name and NPI, surgeon name and NPI, laterality, and implant information. The goal of this data collection is to inform patients and surgeons about these procedures allowing them to optimize outcomes and reduce the rate of revisions. Even a small reduction in the rate of revisions will save Medicare dollars that can be used to increase research. We hope that the AJRR will become the national total joint registry dedicated to improving arthroplasty care in the US.

Improving the Delivery System

The AAOS has been engaged in the health care delivery reform discussions occurring across the country between physicians, payers, hospitals, and other health care stakeholders. The AAOS is actively analyzing the concept of the Accountable Care Organization (ACO) and responded to the proposed and final rules establishing the Medicare Shared Savings programs. The Medicare proposed rule was released in March of 2011, but well before that, the AAOS had held a day-long symposium on the topic, in August of 2010. This symposium brought together members of the AAOS Health Care Systems Committee and experts in payment reform like former CMS administrators Mark McClellan, MD and Robert Berenson, MD. Based on the symposium, the AAOS developed a short primer that was distributed to AAOS Fellows at the 2011 AAOS Annual Meeting and subsequently available online as a PDF. The primer was very well received and many other specialty societies used it as an introduction to the topic even before Medicare began to outline what an ACO might look like.

In 2011, the summer symposium focused on hospital-physician alignment strategies such as episode-of-care models, gainsharing arrangements, co-management relationships, and hospital employment. As in 2010, experts in the content area were invited to participate and helped develop a primer on the topic that was distributed to AAOS Fellows at the 2012 Annual Meeting. The 2012 summer symposium will focus on the concept of the Medical Neighborhood and the role of surgeons and specialists in this new approach to health care delivery. The emphasis in all three symposia has been on how to better align physician payments with initiatives that deliver the highest quality care to our patients.

Electronic Health Records

The AAOS consistently encourages all members to adopt innovative and new technologies such as Electronic Health Records (EHRs). However, there must be interoperability standards for all such systems. The AAOS also supports the development of appropriate standards for meaningful use of EHRs by Government agencies and private carriers which balance the needs of patients, physicians, and regulators. Finally, the AAOS believes these standards should be collaboratively developed by physicians through their professional organizations in cooperation with government agencies. The process should emphasize the requirements for the highest level of quality patient care while recognizing the limits and clinical specialty focus of physicians who use the systems. Since 2010, the AAOS has maintained an EHR project team which guides AAOS activity and education in the EHR arena. Among their accomplishments has been the submission of extensive written comments to the CMS Office of Technology on their Meaningful Use of EHR Stage I and Stage II standards.

The AAOS has also undertaken considerable efforts to educate AAOS members in implementation of EHRs in their practices and how to take advantage of government EHR incentives. We have published a series of articles in our journals and newsletters and have created a series of webinars on the topic. In addition, we have dedicated a section of our website to the provision of EHR related resources.

We believe the Medicare physician payment system should offer significant incentives to adopt these systems as we believe widespread utilization of EHRs will lead to improvements in patient care and in savings for payers.

Patient Safety

Patient safety is an integral part of the AAOS quality efforts. The AAOS was a leader in preventing wrong site surgery when it initiated its "sign your site" campaign in 1997 to prevent wrong site surgery. This campaign falls under the purview of the AAOS Patient Safety Committee, which is currently working on a number of other issues related to quality, including issues surrounding surgical site infections and surgical checklists. Many of their initiatives could be incorporated into payment systems that reward quality and efficiency as they provide guidance to practitioners on how to provide the highest quality care for our patients.

Additionally, as a "spin off" of Clinical Practice Guidelines (CPG) and as an implementation tool, the AAOS has recently developed clinical patient management checklists. Since the product often is not a literal checklist but rather a care process for the patient, no checklist can be applicable in every instance and each surgeon should act on a case by case basis. Checklists are particularly important because they have a direct influence on physician behavior.

All of the above quality improvement activities have been developed and/or supported by the AAOS and are changing the face of orthopaedic practice nationwide.

Patient Access and Involvement

The AAOS embraces change that improves quality and lowers cost, but the patient must be the primary focus of all initiatives. Orthopaedic surgeons need to be knowledgeable about what their medical decisions cost, while ensuring that they are able to make proper choices in the best interest of patients, consistent with the best available evidence. Orthopaedic surgeons should continuously work to improve the quality and cost-efficiency of patients' outcomes. A

facility's attempt to control costs and maintain clinical programs should not interfere with the surgeon's goal of providing the highest quality care and serving the patient's best interest. As part of a collaborative effort, orthopaedic surgeons within a facility should participate in the development of cost-containment strategies as long as patient care is never compromised and the proper safeguards are in place.

There are several ways the AAOS believes patients can become involved with seeking out appropriate, high value health care service. First, in the absence of true SGR reform, Congress should permit private contracting between patients and providers. This will help providers close the gap between inadequate Medicare payments and the cost of providing services to seniors.

Second, Congress should consider enabling Medicare beneficiaries to assume greater responsibility by cost-sharing for the Medicare program, with protections for low income beneficiaries, in order to preserve their access to quality care. There are a broad range of options that policymakers could consider for enhancing beneficiary cost-sharing.

The Medicare system needs to be transformed from its current emphasis on paying for services regardless of quality or costs to a system that provides meaningful and sustained incentives for high quality, innovative, and cost effective care for Medicare patients. Accomplishing this goal will require the cooperation of Congress, the Centers for Medicare and Medicaid Services (CMS), physicians, and patients. However, we believe it can be accomplished and that now, more than ever before, is the right time to concentrate our efforts in this direction.

Thank you for allowing me to participate in the hearing today, and we look forward to continued dialogue with your committee on this important topic.