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March 3, 2025

Stephanie Carlton
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

RE: CMMI Mandatory Transforming Episode Accountability Model (TEAM) Initiative

Dear Administrator Carlton,

We are writing to ask that CMS immediately stop implementation of the mandatory Transforming Episode Accountability Model (TEAM) initiative finalized by the Biden Administration as part of the Fiscal Year 2025 Medicare Inpatient Prospective Payment Systems Regulation (CMS-1808-P) because of the negative impact it would have on the nearly 2 million Medicare beneficiaries who suffer osteoporotic fractures each year. We have previously joined with other national patient advocacy and physician organizations in submitting comments to CMS asking the agency to address the significant care gap in secondary prevention of osteoporotic fractures by improving access to a widely adopted post-fracture care coordination model known as Fracture Liaison Services (FLS).

In finalizing its TEAM initiative, the Biden Administration CMS asserted that it was seeking to address high costs associated with hip and vertebral fractures. We have previously expressed our disappointment to CMS that the agency was focused on these presumptive osteoporotic fractures through the narrow lens of an acute episode rather than as sentinel events indicative of a treatable chronic condition (osteoporosis) that dramatically increases the risk of subsequent, preventable fractures. We fear that any episode-based savings within the TEAM initiative will be outpaced by the **lost** opportunity to avoid the cost of subsequent, preventable fractures suffered by beneficiaries.

Given the significant deficiencies U.S. patients experience in both primary and secondary osteoporotic fracture prevention services, it is not surprising that hip fracture and vertebral fractures were identified as drivers of high costs to the Medicare program and selected for inclusion in the TEAM initiative. Unfortunately, CMS was focusing on the wrong “problem” and devised a solution that could all but halt the efforts patient advocacy stakeholders have

prioritized to reduce **both** the costs and suffering associated with fractures through effective delivery of secondary fracture prevention services.

Despite availability of screening, diagnostic, and treatment tools, most Medicare beneficiaries with osteoporosis fail to receive care that might prevent osteoporotic fractures. Medicare beneficiaries suffered approximately 2.1 million osteoporotic fractures in 2016. Yet just 9% of female Medicare FFS beneficiaries were evaluated for osteoporosis with a bone mineral density (BMD) test within six months following a new osteoporotic fracture despite CMS' reinforcement of this standard of care through quality measures.

The statistics confirming the care gap in both primary and secondary osteoporotic fracture prevention reflect real world experience for Medicare beneficiaries when CMS directs post-fracture follow-up through "referral to primary care." It is the status quo that the TEAM initiative would likely cement despite its failure to curb the staggering cost of fragility fractures. Under this care delivery model, Medicare fee-for-service beneficiaries with an osteoporotic fracture disproportionately suffered poor health outcomes, including significantly increased mortality, subsequent fractures, hospitalization, and loss of the ability to live independently. These outcomes are neither anticipated by nor accounted for within the framework of TEAM and most will occur well after the 30-day TEAM episode has concluded.

Medicare costs are high for both initial and subsequent osteoporotic fractures. A report by the actuarial firm, Milliman, found that the per patient, per month (PPPM) medical costs were over $2,000 per month between months 3 and 11 ($2,097 per month), nearly 20% greater than the average monthly allowed cost in the year prior to the new osteoporotic fracture event ($1,775 per month).[9] Beneficiaries with a subsequent fracture within the three- year "episode" incurred annual costs over $30,000 higher in the year following a new osteoporotic fracture compared to the year before the fracture. The total annual cost for osteoporotic fractures among Medicare beneficiaries was $57 billion in 2018. Absent health system changes to detect, diagnose and treat the chronic, progressive disease of osteoporosis, annual costs of fragility fractures are expected to grow to over $95 billion in 2040.

Fracture Liaison Services (FLS) are an effective, evidence-based intervention for preventing secondary osteoporotic fractures. The TEAM initiative will threaten existing FLS programs and deter initiation of new ones. It has become clear that encouraging communication from acute to primary care has not closed the care gap in secondary prevention of fragility fractures. Efforts to date have relied on primary care yet failed to ensure that bone fragility follow-up is performed and/or that osteoporosis treatment is prescribed. The TEAM initiative would penalize facilities for the added cost of performing even a cursory inquiry into osteoporosis or other underlying causes of bone fragility, despite acknowledgment among bone health experts that a hip fracture in an individual over age 50 is clearly indicative of osteoporosis warranting timely, aggressive treatment and ongoing disease management.

Unfortunately, existing Medicare payment mechanisms and policies impede adoption of FLS. The TEAM initiative will not only disrupt the referral pathway upon which FLS programs rely, but act as an implicit, if not explicit, CMS endorsement of post-fracture care that ignores the

underlying cause of the fracture and diverts referrals away from bone health professionals and FLS programs.

Leading patient advocacy and bone health organizations have urged CMS to adopt a consensus-based proposal to improve health outcomes and reduce costs associated with osteoporotic fractures. We have urged CMS to recognize the FLS coordinated care intervention by identifying appropriate coding and payment mechanisms so that FLS programs could identify individuals who have suffered an initial osteoporotic fracture and provide the set of medically necessary services to give them the best chance possible of avoiding a subsequent and potentially catastrophic osteoporotic fracture.

<u>CMS should stop implementation of the TEAM initiative, at least until it can be redesigned in a way that facilitates, rather than impedes, access to evidence based FLS secondary fracture prevention services.</u>

If the TEAM model is continued, it should be modified as applied to episodes involving hip fractures and spinal fusion procedures in patients with known or suspected osteoporosis. These changes include:

- Enabling referral to an FLS practice as an alternative to primary care. FLS programs coordinate with primary care practitioners as well as other specialties in delivering secondary fracture prevention care.

- Exempting episodes for which an FLS referral is made and FLS services are initiated from the model.

    - Since benchmark costs will reflect the existing deficiencies in secondary fracture prevention, including cases with referral to FLS would ultimately deter access.
    - In addition, FLS care goals focus beyond the acute episode and “quality” cannot be determined within a 30-day episode.
    - We believe this approach is more workable than benchmarking FLS costs and assigning differential episode payment amounts, and more likely to benefit CMS than simply excluding all hip fractures, and spinal fusions in individuals with known or suspected osteoporosis from the model.

- Assigning a specialty code to identify FLS practices. This would be a secondary specialty since FLS programs are operated within orthopedic, endocrinology, rheumatology, women’s health, primary care, and other practice types. The specialty code would be reported by FLS practices, including those that:

    - Participate in AOS’ Own the Bone initiative, OR
    - Deliver FLS care through participation in AGS CoCare-Ortho, OR
    - Have received a certificate of completion for training administered through BHOF or the International Osteoporosis Foundation and deliver FLS care.

- Work with bone health and patient advocacy experts and the CMS Physician Fee Schedule team to identify or create a reimbursement mechanism that captures the services delivered within evidence based FLS programs. BHOF and its advocacy partners have interviewed FLS programs, ascertained the set of services provided by these programs, and developed crosswalk scenarios reflecting the time and resources required in a typical FLS care episode.

We appreciate the opportunity to share our recommendations of important steps that need to be taken to improve the care of millions of Medicare beneficiaries who suffer costly osteoporotic fractures every year.

If you have any questions, please contact Claire Gill, CEO of the Bone Health and Osteoporosis Foundation at cgill@bonehealthandosteoporosis.org if you or your staff have questions or would like to discuss these issues in greater detail.

Sincerely,

Bone Health and Osteoporosis Foundation
The Alliance for Aging Research
The Alliance for Women's Health and Prevention
Black Women's Health Imperative
Caregiver Action Network
Celiac Disease Foundation
Global Healthy Living Foundation
HealthyWomen
National Council on Aging
The National Spine Health Foundation