Formerly the National Osteoporosis Foundation

Solving For a Care Gap That Largely Affects Women *While* Achieving Savings for the Medicare Program -- *With* Evidence-Based Low Cost, High Value, Underutilized Services

OMB Briefing

October 10, 2024

There is very broad and strong support for CMS to address the osteoporosis care gap.

- White House Women's Initiative Directs HHS to: "identify ways to improve … the clinical care that women receive" for diseases and conditions " ….**such as osteoporosis**."
- 2 years of Appropriations language calling for CMS to incentivize FLS in Medicare
- Bipartisan SFC letter to OMB calling for Medicare payment changes to support FLS
- 31 leading physician and patient organizations signed onto White Paper endorsing specific coding to support FLS
- 35 leading national women's health, physician, aging and bone health organizations sent 2025 PFS comments calling for FLS G code

Proposed Rule Question #1: How often do fracture patients fail to receive evidence-based follow-up?

	Patient pop.	Events/Year	1-year post-event risk	1-year post-event mortality	Diagnostics performed?	Treatment plan and follow-up
Osteo-porotic Fractures	70.5% of patients are female	2.1 M osteoporotic fractures 300K hip fractures (Milliman, 2021 update)	14 % of patients have a risk of a subsequent fracture within 1 year of hip fracture	19% die within 12 months after any osteoporotic fracture 30% of hip fracture patients die within 12 months	9% of patients receive a bone mineral density test w/in 6 months	Approximately 20% of ***hip fracture*** patients (two studies with slightly different numbers) receive medication. Significant proportion of patients stop taking prescribed meds.

Proposed Rule Question #1: How often do fracture patients fail to receive evidence-based follow-up?

In 2016

1.8 Million

Medicare Beneficiaries

Suffered approximately

2.1 Million

Osteoporotic Fractures

1 Fracture Every 16 Seconds

Milliman Report – 2021 Update (2016 claims data):

- $21,564 incremental cost for all types of osteoporotic fracture in Medicare FFS
- 14 % of hip fracture patients have subsequent fracture within 1 year
- Incremental cost of subsequent/secondary fracture exceeds ***$30,000***
- **Secondary** osteoporotic fractures cost ***$5.7 billion*** in 2016 among 290,000 Medicare FFS beneficiaries
- Does not include cost of non-skilled home and nursing home care or prescription drugs.

Significant Disparities and Inequities Exist in Post-Fracture Care and Outcomes

While suffering fewer osteoporotic fractures, Black Medicare FFS beneficiaries have higher hospitalization rates, higher death rates following fractures, and lower bone mineral density (BMD) screening rates.

- ***22% died within 12 months*** of an initial osteoporotic fracture, exceeding the national average rate of 19%.
- ***35.4% died within 2-3 years*** post-fracture, which is ~10% higher than national average
- ***Just 5% were tested*** within six months of a new osteoporotic fracture – when the need for treatment and action is highest.
- ***30% less likely*** to receive post-fracture physical therapy
- ***2.3 times higher risk of destitutio***n in the year following vertebral fracture. *

*J Am Geriatr Soc. 2020 Apr 26. doi: 10.1111/jgs.16455.

Fracture Liaison Service (FLS) is an internationally-recognized coordinated care secondary fracture prevention intervention grounded in ***decades of strong evidentiary support.***

2018 meta-analysis of FLS impact identified a total of 159 publications, including 74 controlled studies (16 RCTs; 58 observational studies). Compared with patients receiving usual care (or those in the control arm), patients receiving care from an FLS program had:

- ***Less than half the rates of Subsequent Fracture***
- ***Lower Mortality***
- ***Doubled rates of Risk Assessment & Diagnosis***
- ***Doubled rates of Treatment Initiation***
- ***Significantly Greater Treatment Adherence***

(Wu C-H, Tu S-T, Chang Y-F, et al.)

Fracture Liaison Services are a proven intervention to close care gap, a well-established model internationally, and supported by decades of evidence

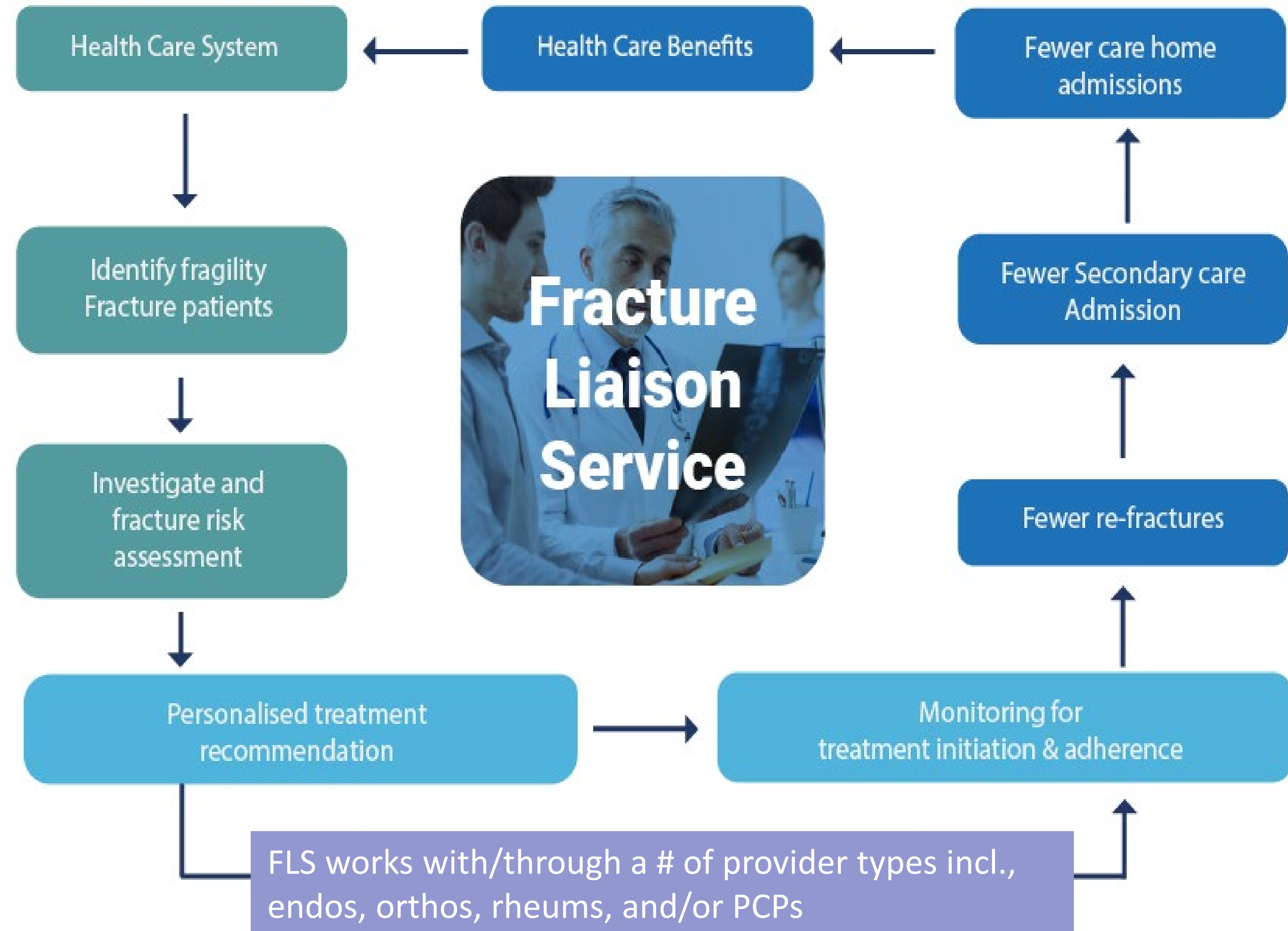
Coordinated care systems headed by a coordinator (a physician, nurse practitioner, physician assistant, or other health professional).

Delivers patient-centered secondary prevention of osteoporotic fractures.

Utilizes established protocols to ensure that osteoporotic fracture patients receive appropriate diagnosis, evaluation, secondary prevention, treatment, and support.

Patient assessment and follow-up care are generally prompted through a database-driven patient-specific timeline.

Can be adapted to a centralized care delivery model, incorporate telemedicine and operate as a "hub and spoke" care coordination and delivery system, or incorporate aspects of various care delivery models.



Proposed Rule Question #2: Can providers use existing HCPCS codes to capture cost of delivering evidence-based post-fracture care?

FLS Services Require:

QHP non-face-to-face time before (20 mins) and QHP/Staff time after (96 mins) initial visit;

Initial face-to-face encounter (53 minutes) and subsequent face-to-face visits (26 mins)

- E&M codes don't work well because the relatively complex services are performed *in advance of* the patient visit.
- Chronic care management codes don't work b/c clinician is solely focused on the single chronic condition of osteoporosis (rather than the required 'two or more chronic conditions') and b/c the complete set of FLS services is concentrated in about 45 days (rather than over a year);
- Principal care management codes are unavailable b/c patient often/may not have been diagnosed with osteoporosis prior to the initial visit, and b/c untreated osteoporosis is associated with subsequent fractures and increased mortality, the timeline for fracture risk can be relatively long (i.e., extending beyond 1 year)
- Transition care management codes require an inpatient transition, limiting potential utility to hip fracture patients and even this subset of patients are usually unable to receive FLS care within the 14-day timeframe following their inpatient stay.

Proposed Rule Question #2: Can providers use existing HCPCS codes to capture cost of delivering evidence-based post-fracture care?

FLS Services Require:

QHP's non-face-to-face time before (20 mins) and QHP/staff time after (96 mins);

Initial (53 mins) and subsequent (26 mins) face-to-face encounters

Initial (53 mins)	Subsquent (26 mins)
E&M codes still don't work well b/c they only capture a limited portion of the work, and b/c they require repeated higher level 5 coding	E&M codes DO work

Chronic care, principal care, and transition care management codes don't work for all the same reasons given on the prior slide.

Proposed Rule Question 3: Can Proposed New Codes close the care gap?

- GPOC1 does not address reimbursement deficiencies associated with the actual delivery of post-fracture care.
- Proposed advanced primary care management codes (GPCM1, GPCM2, and GPCM3) utility in post-fracture care would be severely limited as they are intended for use within advanced payment models and require the clinician to assume all primary care responsibilities for the patient. Moreover, while some post-fracture care programs are provided within PCP practices, ***most reside within other specialties, including orthopedics, rheumatology, and endocrinology.***
- Community Health Integration (CHI) codes – limited to patients with SDOH needs.
- Principal Illness Navigation (PIN) codes – helpful to hip fracture patients but our proposal is to prevent hip fractures
- AAOS agrees with BHOF. It "***does not believe that that any of the proposed G codes in the CY 2025 proposed rule describe the services of managing fractures under a treatment plan, allow for use of these codes when those services are provided, nor address the longitudinal care management that is required to manage patients' bone health and fracture prevention.***"

Stakeholders Coalesced Long Ago on Codes Supporting FLS Care, Buidling on CMS Precedent For Similar Care Gaps

- Create a specialty code for FLS (this would be in addition to any specialty within which the FLS resides, e.g., orthopedics, endocrinology, internal medicine, etc.)
- Assign an additional “G” code set for FLS services – all major bone health stakeholders have defined the FLS episode, crafted “descriptor(s) for FLS coding, and calculated the cost of care through provider interviews and cross-walk methodologies.
- CMS established no cost for this “G” code for already covered services
- **Supported by all major professional and patient groups.**
- **Need is greater due to new CMS TEAM model of care.**

BHOF – Bone Health and Osteoporosis Foundation
ASBMR – American Society for Bone and Mineral Research
AOA – American Orthopedic Association

Broad Set of Stakeholders Urge CMS Adoption of Reimbursement Codes for a Post-Fracture Episode of Care Delivered within a Fracture Liaison Service

- **American Academy of Nurse Practitioners (AANP)**
- **American Association of Hip and Knee Surgeons (AAHKS)**
- **American Association of Orthopaedic Surgeons (AAOS)**
- **American Academy of Physician Assistants (AAPA)**
- **American Bone Health (ABH)**
- **American Geriatric Society (AGS)**
- **American Orthopaedic Association (AOA)**
- **American Society for Bone and Mineral Research (ASBMR)**
- **American Society of Endocrine Physician Assistants (ASEPA)**
- **Bone Health and Osteoporosis Foundation (BHOF) (previously known as the National Osteoporosis Foundation (NOF)**
- **Fragility Fractures Alliance (FFxA)** – American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Association (AOA) & AOA Own the Bone, Orthopaedic Trauma Association (OTA), National Association of Orthopaedic Nurses (NAON), American Geriatrics Society (AGS), International Geriatric Fracture Society (IGFS), American Board of Orthopaedic Surgeons, U.S. Bone and Joint Initiative (UBJI)
- **International Society for Clinical Densitometry (ISCD)**
- **National Spine Health Institute (NSHI)**
- **North American Spine Society (NASS)**
- **Orthopaedic Trauma Association (OTA)**
- **The Endocrine Society (TES)**
- **US Bone and Joint Initiative (USBJI)**

Our “G” Code Proposal Builds on Precedent, Implements Solution for Findings from millions spent by NIH, Reduces Nursing Home Admissions, Reduces Opioid Use, & Aligns with WH Priorities for Women, Disparities/Inequities, and Use of Low Cost, High Value, Underutilized Services to Save Money and Improve Outcomes

- Aligns with the mission of the Biden Women’s Health Initiative – solves for a huge and costly care gap women live with today
- Also solves for disparities in the especially terrible outcomes for Black women
- Solves for the well-intentioned but misdirected CMMI effort to address high cost of hip fracture patients, the most vulnerable women in the fracture/osteoporosis space
- Solves for the millions NIH has spent in research grants, that when asked for the bottom line takeaway, NIH said – prevent secondary fractures
- Mirrors the same exact solution this CMS team has implemented when seeing similar stubborn care gaps not solved with existing codes