TEXAS ORTHOPAEDIC ASSOCIATION

Established 1936

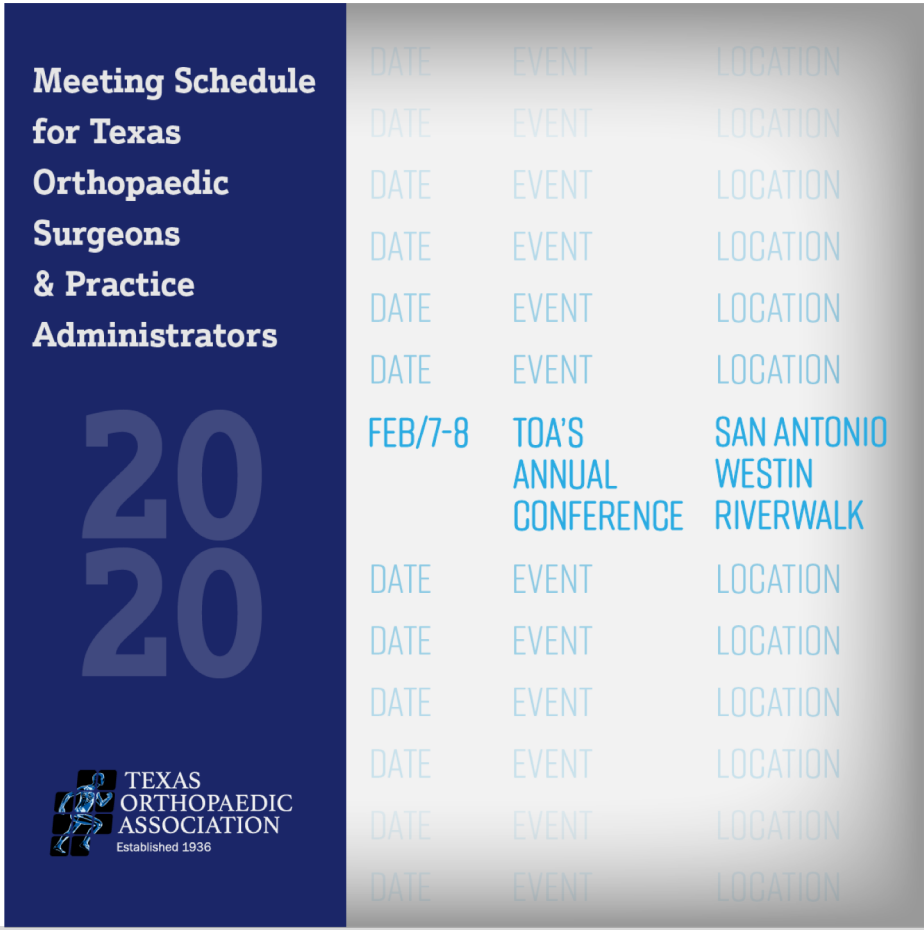
State & Federal Policy Considerations for Orthopaedics in Texas

Frisco, Texas| September 20, 2019 | T-Bones 2019 Annual Conference

www.toa.org | Bobby@toa.org

TOA's 2020 Annual Conference February 7-8 in San Antonio

- Strategic Planning Seminar with Darren Smith (Friday Morning)
- Mike McCaslin of the OrthoForum (Friday Afternoon)
- A Look at OrthoCarolina (Friday Afternoon)
- Coding Course with Karen Zupko & Assoc. (Friday)
- Friday Night Party at the Pearl Stable
- Thursday Visit to the Military's Center for the Intrepid



TOA Overview What TOA Can & Can't Do

01 TOA Has a Ceiling

- Limited resources.
- Relies on volunteers to form positions/develop stances.

02 Advocacy

- Only organization that dedicates 100 percent of its advocacy efforts to Texas orthopaedic surgeons and their patients.

03 Intelligence

- TOA has the ability to collect public policy information about the industry that often cannot be found elsewhere.

04 Industry Branding

- TOA focuses on three different segments: policymakers, other members of the health care industry, and the general public.

Austin vs. Washington Apples & Oranges

Washington, DC Major Health Laws Are Rare

114th Congress 2015-16

Comprehensive Addiction & Recovery Act

21st Century Cures Act

- ASC vs. HOPD transparency.

115th Congress 2017-18

Childhood Cancer Survivorship, Treatment, Access & Research Act of 2018

SUPPORT for Patients & Communities Act

- Mandatory e-Prescribing.
- Opioid limits avoided.

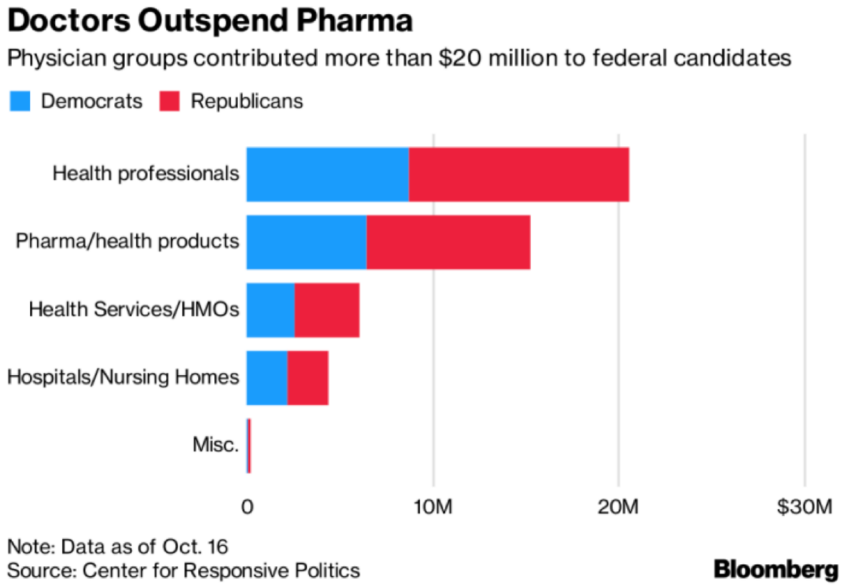
Medicare Extenders

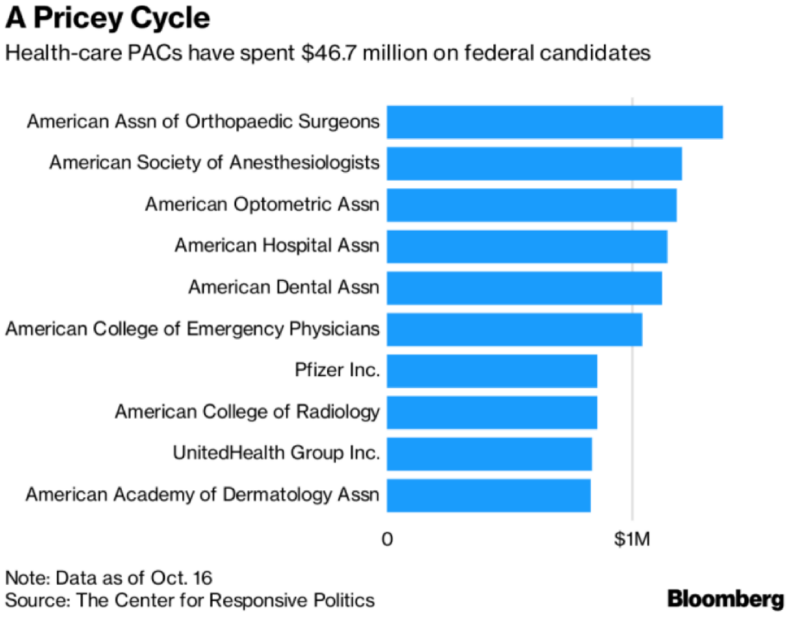
116th Congress 2019-20

Pandemic & All-Hazards Preparedness & Advancing Innovation Act of 2019

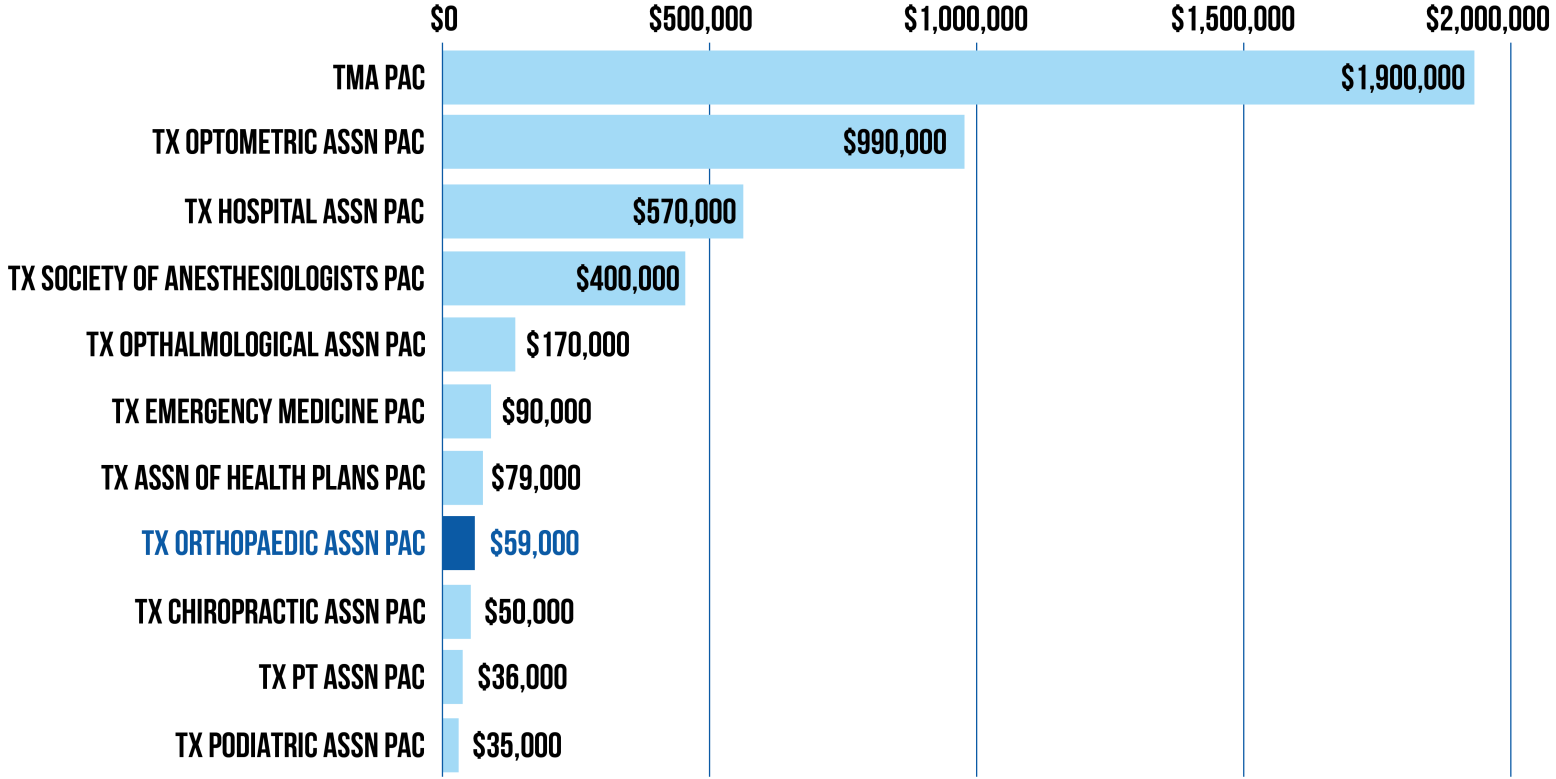
Health-Care Companies Pour $46.7 Million Into Midterm Vote

Bloomberg **Blake Dodge**, Bloomberg • October 29, 2018





2017-2018 TEXAS HEALTHCARE PAC FUNDRAISING

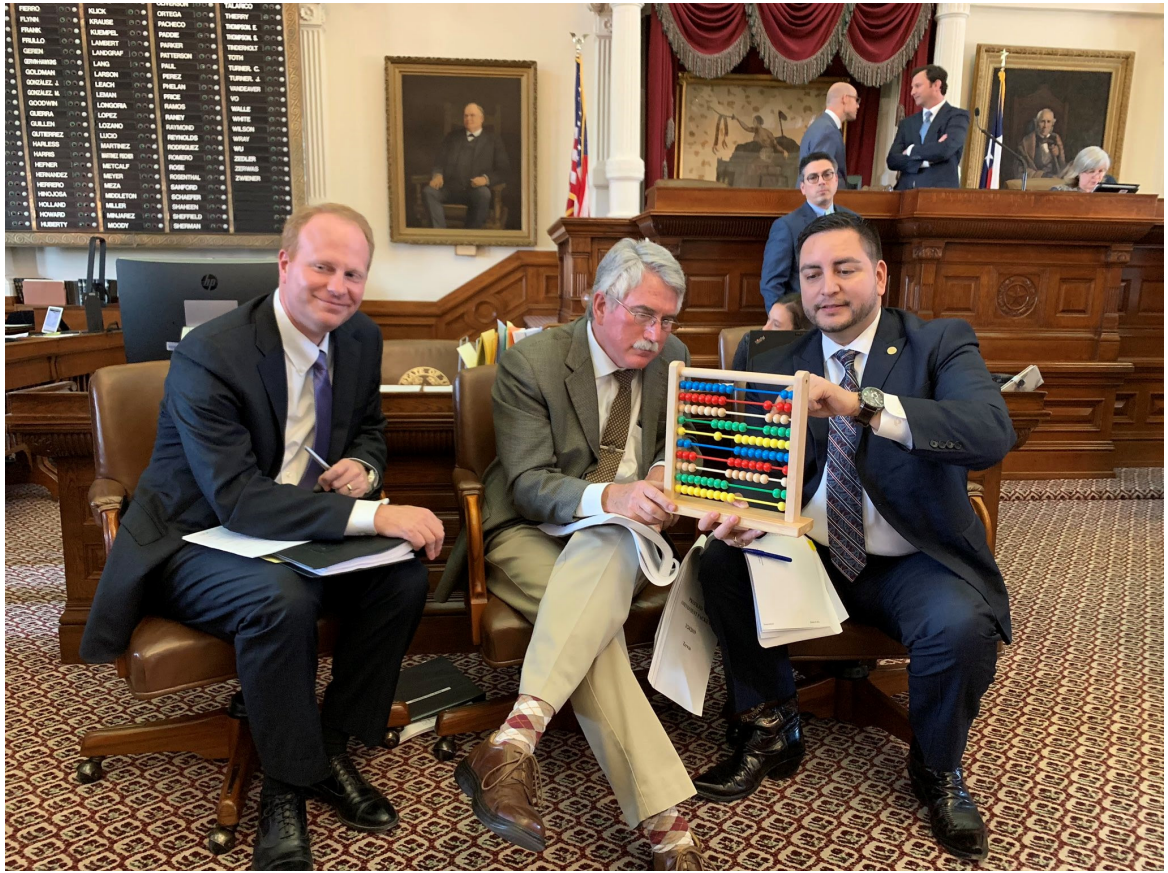


*FIGURES BASED ON 2017-18 CONTRIBUTIONS MADE BY MEMBERS TO EACH PAC; PER TEXAS ETHICS COMMISSION DATA. NUMBERS ARE APPROXIMATE.

2019 Texas Legislature The "Big" Issues (& Some Health Issues)

- Budget
- Property Tax Reform
- Education Funding
- Tobacco 21
- Low THC Cannabis
- Opioids
- Ban on Surprise Billing
- Mental Health

The Budget The Legislature's Only Requirement



Legislative Strategy The Power of Grassroots

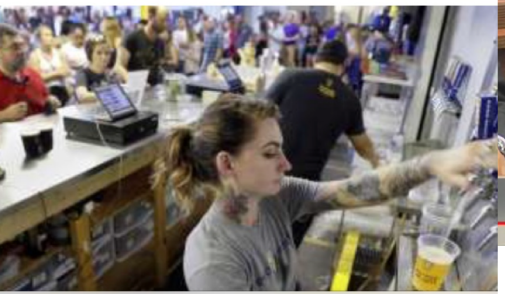
Craft Beer vs. Beer/Liquor Distributors | Grassroots vs. Cities

HOUSTON CHRONICLE

LIFESTYLE

Cheers y'all. Beer-to-go unanimously passes in Texas Senate.

Maggie Gordon | on May 23, 2019



harles Schwertner @DrSchwertner · May 7

/e heard testimony on the TABC Sunset Bill. I am proud to support the "Bee
›" provision & the **craft beer** industry in **Texas** over out-of-state corporatio
ıat work to prevent competition. I support the TX tradition of supporting sm
usinesses & low regulation! #txlege

Austin Statesman @statesman · May 9

From @JTiloveTX: It turns out that the Texas House hates **red light cameras** more than it hates Jonathan **Stickland**

It turns out that the Texas House hates red light cameras more than i...

Hello Austin:The Quorum Report's Scott Braddock was ready when the big moment arrived Tuesday night.[gh:blockquote class="twitter-tweet" data-

statesman.com

Lawmakers to consider historic change to liquor store ownership rules in Texas - The changes would raise the current cap from 5 to 250, end the family ownership rules

TEXAS ORTHOPAEDIC ASSOCIATION Established 1936

Scott Braddock
@scottbraddock

Following

On a vote of 66 to 71, the Texas House rejects designating rescue dogs and cats as the official state pets of Texas #TxLege

5:39 PM - 24 Apr 2019

Effective? Probably Not

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Collaboration Why Work Together?

Team-Based Approach

Ancillary Ownership Opponents "Alliance for Integrity in Medicine"

Past Washington, DC efforts to remove ancillary services from a physician's office.

ACR® AMERICAN COLLEGE OF RADIOLOGY

QUALITY IS OUR IMAGE

APTA American Physical Therapy Association

ACLA American Clinical Laboratory Association

TAKE AIM AT SELF-REFERRAL — ALLIANCE FOR INTEGRITY IN MEDICARE

ASCP American Society for Clinical Pathology

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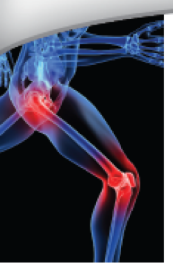
CARE COORDINATION:
The Future of Health Care



A landmark report by the Institute of Medicine in 1999 cited the fragmented health care system, focused on silo-based care, as a leading cause of medical mistakes. The report served as an impetus for patients, payers, physicians, and policymakers to call for coordinated care models that feature all members of the health care team working together in a team-based model. Ultimately, patients benefit from the higher quality and greater efficiency that can be generated by coordinated care models.

Musculoskeletal health problems are among the most prevalent and debilitating health challenges that Americans face. In fiscal year 2017 alone, 31.5 percent of the insureds in Employees Retirement System of Texas (ERS) and 23.8 percent of the insureds in the Teacher Retirement System of Texas (TRS) had a diagnosis for a musculoskeletal injury or condition.

Physicians Lead Innovation:
Corporations Should Not Stand in the Way of Successful Physician-Owned Hospitals

Physicians have always led innovation in America's hospitals. Physicians, such as the Mayo Brothers in Minnesota, created some of the nation's first hospitals. Today, physician-owned hospitals allow the professional with the greatest health care expertise – the physician – to play a governing role in how health care is delivered at hospitals.

In its 2005 analysis of physician-owned hospitals, the Medicare Payment Advisory Commission (MedPAC) commented to Congress on why physicians own hospitals: "Physicians wanted to control decisions made about the patient-care areas of hospitals so they could improve the quality of care provided, improve their productivity, and make the hospital more convenient to them and their patients."

TOA supports efforts by Congress through the Hospital Competition Act (H.R. 506), which would lift the Affordable Care Act's ban on physician-owned hospitals. Congress placed a provision in the Affordable Care Act that prohibits physicians from owning new hospitals after 2010. The provision was created by corporate interests as a tool to limit the competition that is created by physicians who own hospitals, despite the fact that many of these corporate interests actually partner with thousands of physicians in physician-owned ambulatory surgery centers.

Bundled Payments & Orthopaedic Surgeons:
Shifting from Volume to Value

Hip and knee replacements are highly successful surgeries that get people back to work and doing the things that they love to do. From a policy standpoint, these surgeries create a number of measurable data points, which resulted in a logical place to start for Medicare's bundled payments in the Bundled Payment for Care Improvement (BPCI) program in 2013.

Bundled payments create incentives for greater quality and efficien in ways that cannot be achieved in the fragmented care model, whi features different providers working in silos. Bundled payments require all types of providers – from physicians to nurses to physical therapists – to work together in a coordinated-care model requires t team to measure themselves on a single platform with a set of goal These models allow the team to share in the savings that are achiev through the coordinated care approach.

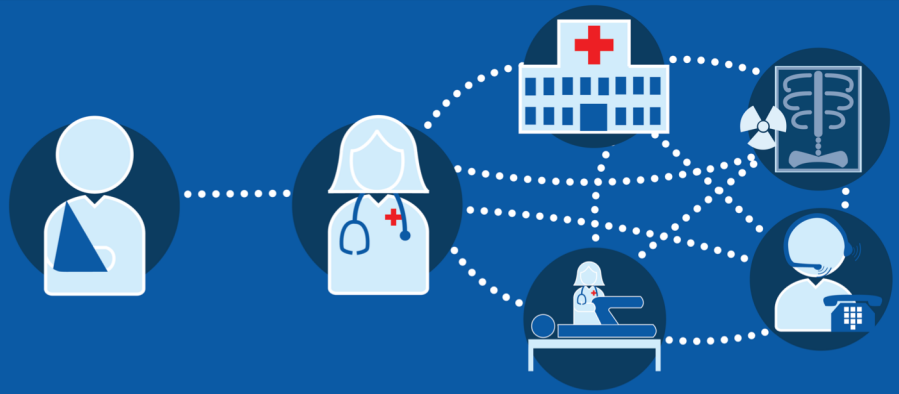
Hundreds of Texas orthopaedic surgeons are currently leading bund for a number of orthopaedic related Medicare and commercial insurance payment models for hips, knees, shoulders, and more. Th members of the bundled payment team go beyond the surgeon. M teams feature a case manager who is responsible for working with t patient throughout the entire episode of care: from the initial visit t least a month following the surgery.

The multidisciplinary solution found in some of the orthopaedic bundles even goes beyond a patient's physical health. For example the Dell Medical School at the University of Texas screens orthopae patients for behavioral health conditions such as anxiety and depressing that could be contributing to a patient's pain. If any thes conditions are detected, they advise the patients to see the in-hous therapists before committing to a surgery.

Physical Therapy:
The Importance of Coordinated Care

A groundbreaking study released by the U.S. General Accountability Office (GAO) in June 2014 found that orthopaedic surgeons who offered physical therapy services in their offices produced lower costs for the Medicare program when compared to physical therapy services that were performed independent of an orthopaedic surgeon. The study demonstrated that the coordination of care between a physical therapist and an orthopaedic surgeon creates outstanding value for the patient through lower costs and high-quality therapy.

PUTTING THE PATIENT 1st : TEAM BASED CARE



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Nate Mesko @NMeskoMD · Apr 27

Why is it always important to get 2 views on every X-ray? One view doesn't always tell the whole story!!! @orthobullets @ABOSortho @AAOSmembers

Physical Therapy GAO Report June 2014

The total number of self-referred PT services showed essentially no increase from 2004 to 2010, whereas non-self-referred services increased by 41 percent.

Self-referring family practice and internal medicine providers in urban areas, on average, generally referred more PT services than their non-self-referring counterparts.

Self-referring orthopaedic surgeons, on average, generally referred fewer PT services than non-self-referring orthopaedic surgeons

The GAO's Conclusion Physical Therapy Referral

According to the GAO report, "…**non-self-referred PT services can be performed by providers who can directly influence the amount, duration, and frequency of services**," which could explain why the study found more rapid growth in the PT units billed by non-self-referred physicians.

As an example, physical therapists in an orthopaedic office will provide treatment as ordered by the physician. Although subject to state legislation, PT providers working in freestanding offices or clinics can expand their services provided through the plan of care.

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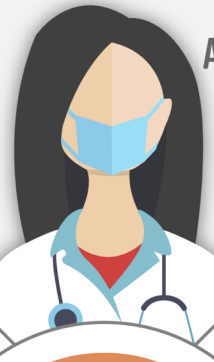
THE ORTHOPAEDIC WEEK: A 24-HOUR, SEVEN-DAY-A-WEEK COMMITMENT

The musculoskeletal system is made up of more than 200 skeletal bones, connective tissue, and over 300 skeletal muscles. The musculoskeletal system's complex nature is why orthopaedic surgeons complete years of training before they are deemed qualified to begin independent practice.

Taking care of patients' musculoskeletal injuries, conditions, and diseases represents a time-consuming endeavor to ensure that patients have the best musculoskeletal care possible.

Every orthopaedic surgeon features a different schedule. This estimate is based on a 40-year-old orthopaedic surgeon in private practice in San Antonio.



PATIENT AVAILABILITY

24 HOURS, 7 DAYS PER WEEK AVAILABLE TO RESPOND TO A PATIENT.

CLINIC HOURS

20 HOURS PER WEEK.

OPERATING ROOM

20 HOURS PER WEEK.

HOSPITAL ROUNDS

3 HOURS PER WEEK.

PATIENT COMMUNICATION

5 TO 10 HOURS OF ANSWERING E-MAILS, RETURNING PHONE CALLS, CONFERENCES, AND FOLLOW-UP CALLS.

DOCUMENTATION

15 TO 20 HOURS PER WEEK OF REVIEWING THERAPY NOTES, REVIEWING LABS, SIGNING NOTES, AND EHR ISSUES.

ON CALL

1 - 3 DAYS PER WEEK (24 HOURS ON CALL FOR EACH CALL DAY). AND THE HOURS VARY FROM WEEK TO WEEK.

TEACHING RESIDENTS

4 HOURS PER WEEK OF CLINIC SUPERVISION/TEACHING, 8 HOURS PER WEEK OF OPERATING ROOM SUPERVISION/TEACHING, AND 1.5 HOURS DEDICATED TO CONFERENCE EACH WEEK.

CONTINUING EDUCATION

1-2 HOURS PER WEEK (JOURNALS, VIDEOS, AND QUESTIONS) AND ADDITIONAL COURSES THROUGHOUT THE YEAR.

ORGANIZED MEDICINE

AT LEAST 1 HOUR PER WEEK DEDICATED TO BUSINESS MEETINGS WITH THE PRACTICE AND FACILITIES. IN ADDITION, MANY ORTHOPAEDIC SURGEONS VOLUNTEER WITH MEDICAL SOCIETIES TO PROMOTE CLINICAL EDUCATION AND SOUND PUBLIC POLICY.

VOLUNTEER EFFORTS

MANY ORTHOPAEDIC SURGEONS VOLUNTEER AS TEAM PHYSICIANS FOR FOOTBALL TEAMS. OTHERS PROVIDE FREE SURGERY THROUGHOUT THE WORLD.

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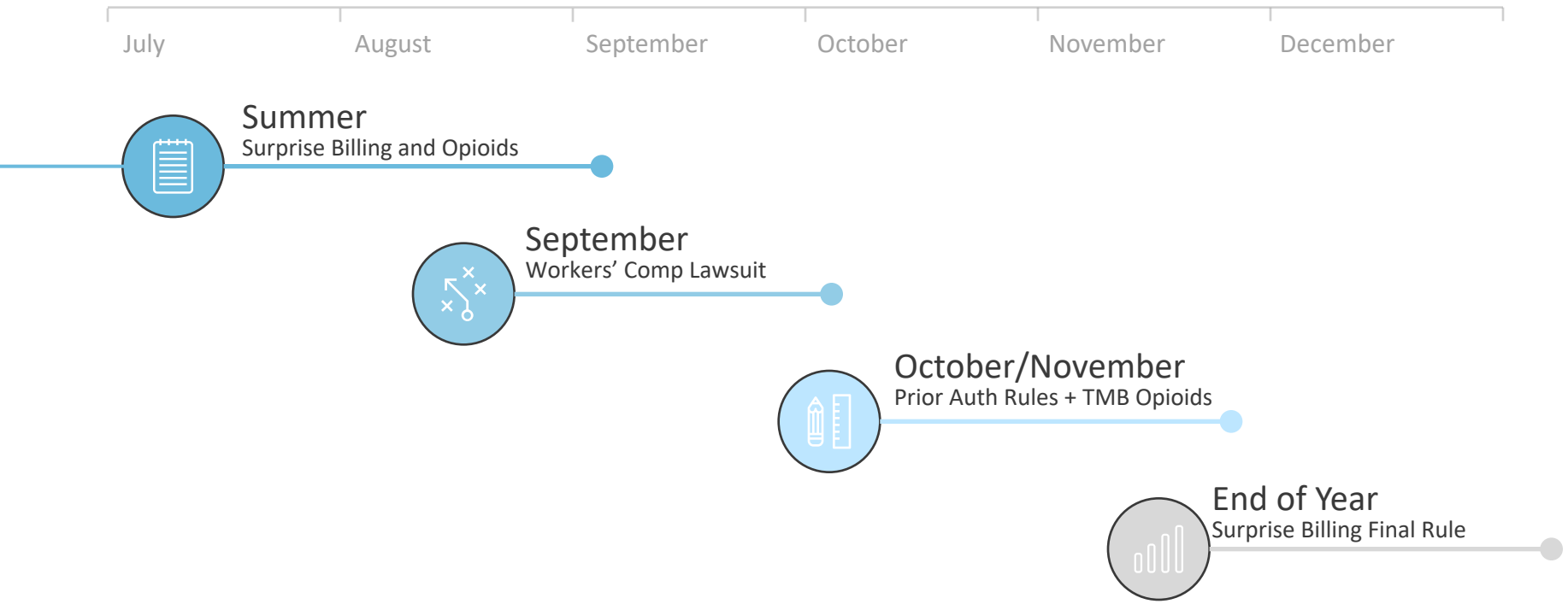
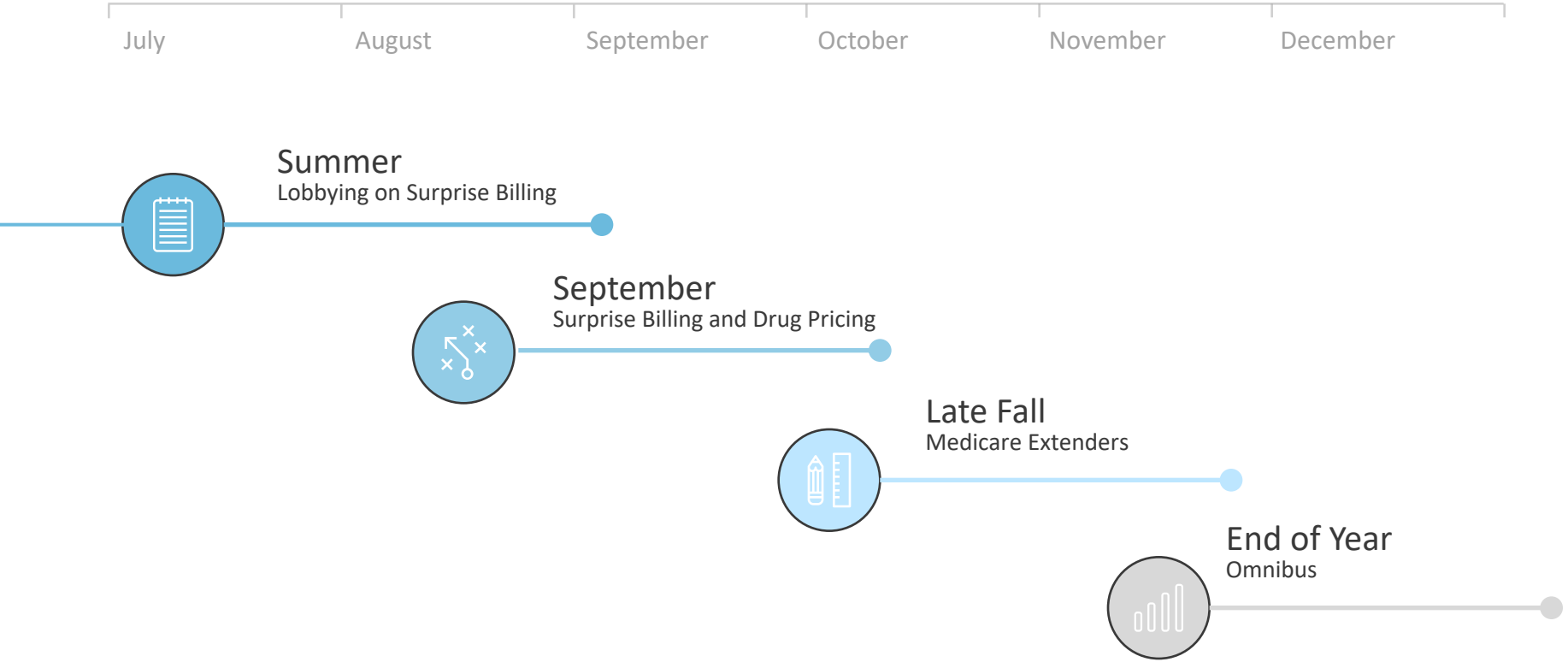
Austin What About the Rest of 2019?

Austin What About the Rest of 2019?



Washington What About the Rest of 2019?

Washington What About the Rest of 2019?



Employment Private Practice Site Neutral Payments

MedPAC Provided a Preview in 2013

Congress's November 2, 2015 Budget Deal

Medicare's CY 2018 Payment Proposal for Check-ups

No New Proposals in Medicare's 2020 Payment Proposals

Austin: Employed Physician Protection Law

Summary: End-of-Year Omnibus Legislation in Congress?

May 2019 Physician Employment

AMA
AMERICAN MEDICAL ASSOCIATION

Policy Research Perspectives

Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees

Merritt Hawkins 2019 Survey

Nephrology	
2019	$1,789,062
2016	$1,260,971
2013	$1,175,000
2010	$696,888
2007	$865,214
2004	$1,121,000
2002	$1,704,326

Neurology	
2019	$2,052,884
2016	$1,025,536
2013	$691,406
2010	$907,317
2007	$557,916
2004	$924,798
2002	$1,030,303

Neurosurgery	
2019	$3,437,500
2016	$2,445,810
2013	$1,684,523
2010	$2,815,650
2007	$2,100,000
2004	$2,406,275
2002	$2,364,864

Obstetrics/Gynecology	
2019	$2,024,193
2016	$1,583,209
2013	$1,439,024
2010	$1,364,131
2007	$1,413,436
2004	$1,903,919
2002	$1,643,028

Ophthalmology	
2019	$1,440,217
2016	$1,035,577
2013	$725,000
2010	$1,662,832
2007	$725,000
2004	$842,711
2002	$584,310

Orthopedic Surgery	
2019	$3,286,764
2016	$2,746,605
2013	$2,683,510
2010	$2,117,764
2007	$2,312,168
2004	$2,992,022
2002	$1,855,944

Otolaryngology	
2019	$1,937,500
2016	$1,066,221
2013	$825,757
2010	N/A
2007	N/A
2004	N/A
2002	N/A

Pediatrics	
2019	$1,612,500
2016	$665,972
2013	$787,790
2010	$856,154
2007	$697,516
2004	$860,600
2002	$690,104

MEDPAC 2013 Site Neutral Preview

Orthopaedics – MedPAC's initial report on the subject indicated that orthopaedic specialty hospitals would take the greatest hit.

Cardiology – "In 2013, Medicare pays 141 percent more for a level II echocardiogram in an OPD than in a freestanding physician's office."

66 services reduced to physician office levels – MedPAC identified 66 services (mostly diagnostic services with a few procedures) that could save Medicare $900 million on an annual basis:

- Bone density: axial skeleton (APC 288)
- Level II neuropsychological testing (APC 382)
- Level II echocardiogram without contrast (APC 269)
- Level II extended electroencephalography (EEG), sleep, and cardiovascular studies (APC 209)

12 groups reduced to an ASC payment rate – MedPAC identified 12 groups that could save Medicare $600 million on an annual basis:

- Nine eye procedure groups.
- Two nerve injection groups.
- On skin repair group.

August 07, 2018

AAOS Supports CMS Site Neutrality Expansion Rule

Washington, DC—American Association of Orthopaedic Surgeons (AAOS) President David Halsey, MD, today issued the following statement in response to the inclusion of site-neutrality expansion to previously exempt off-campus providers by the Centers for Medicare and Medicaid Services (CMS) in its Calendar Year (CY) 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System newly proposed rule:

"Increasing accessibility to affordable, quality musculoskeletal care is the highest priority for the AAOS—especially as the cost for services and basic patient visits at hospital outpatient facilities continues to rise. Therefore, the Association strongly supports the newly proposed measure to expand site-neutral payments to previously exempted off-campus facilities."

"While we recognize that payment variation by site is part of CMS' overall payment system, economic inefficiencies are created when these natural variations become inflated. The variation in the Medicare payment system has resulted in inefficient care, increased consolidation of physician practices into hospital systems, and increased costs to Medicare patients who face higher co-pays for outpatient services compared to services provided in an office setting. Thus, payment variation has an important impact on patient choice."

"By equalizing payments between physician offices and off-campus provider-based departments (PBD) and helping to reduce the cost disparity, the OPPS rule will save patients an estimated $150 million in lower copayments. More importantly, it will empower patients to make their own health care decisions such as choosing the site of service that is most convenient. These benefits, in addition to an increased service cost transparency, are critical to the patient-centered care we strive to provide. The Association commends CMS for this long-overdue and much needed effort."

# # #

PAI Backs Medicare Move Toward Site-Neutral Payments

By Joey Berlin

A Texas Medical Association-backed not-for-profit is on board with efforts to reverse current Medicare policy that pays more for the same service when it's provided in a hospital outpatient department versus a physician's office.

TMA and other physician groups have complained for years that the site-of-service payment differential is unfair and that it needlessly drives up Medicare costs. The American Hospital Association and hospitals around the country have mobilized to keep their advantage.

OP-ED CONTRIBUTOR

Medicare Proposal to Better Align Payments Deserves Broad Support

RANDY BROUN | AUGUST 2, 2017 | 05:00 AM

When it comes to health care services, many Americans assume that the government pays for health care the same way consumers pay for products in the retail setting. A consumer buying a bag of chips at Grocery Store A would expect to pay a comparable price for that exact same bag of chips at Grocery Story B three blocks away. In most cases, this would be true.

The same cannot be said for America's health care system. Under current payment policies, a Medicare patient pays dramatically different costs for the exact same outpatient procedures delivered in different settings. For the administration of chemotherapy drugs, for example, the current Medicare payment to a hospital outpatient facility is more than double the rate paid to a

2015 Site Neutral Payments

November 2, 2015 Congressional Budget Deal

- November 2, 2015 budget deal created a site neutral Medicare payment policy for any new off-campus, provider-based department after this date. (Practices that are at least 250 yards away from the parent hospital's campus.)
- Existing off-campus PBDs were grandfathered. CMS proposed additional guidance in July 2016.
- Dedicated freestanding emergency departments are exempt.

Hospital Reaction Medicare's CY 2017 HOPD / ASC Proposal

From Modern Healthcare's July 9, 2016 article on the subject.

"Hospitals are livid about the Obama administration's plans to eliminate their Medicare payments for services at new off-campus outpatient departments, saying it largely ignores the intent of Congress and will limit access to care."

Modern Healthcare

Summer 2016 Proposal Site Neutral Payments

Controversy surrounding Medicare's CY 2017 Proposal

- Medicare would no longer pay hospitals the current OPPS rates if they relocate or rebuild grandfathered outpatient facilities. ***The November 1, 2016 final rule allowed for relocations in case of "extraordinary circumstances."***

- If a hospital has a change of ownership, the grandfathered status would continue if the new owners accept the existing Medicare provider agreement from the prior owner.

- Grandfathered off-campus PBDs would not be allowed to bill for the higher OPPS rate for certain services if they did not bill for these services prior to November 2, 2015.

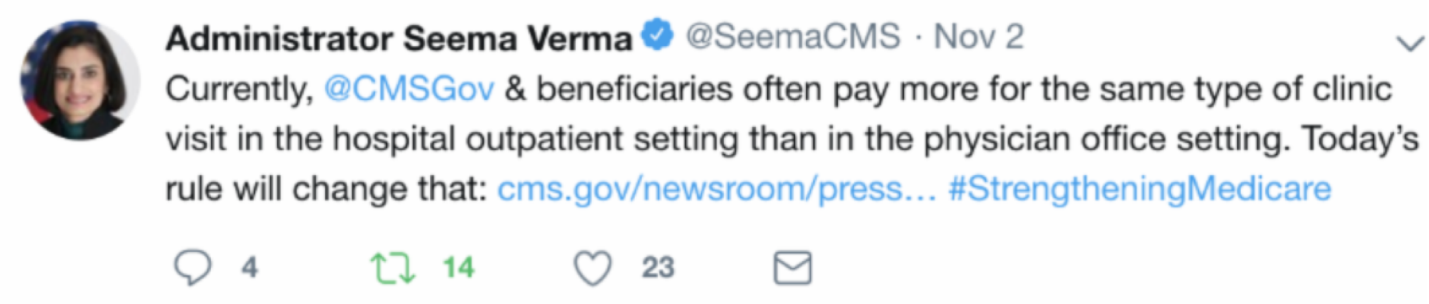
Summer 2017 Proposal Site Neutral Payments

Further Cuts Proposed by CMS for 2018

- Congress used the 21st Century Cures Act to exempt hospital outpatient departments that were in development when the site-neutral law took effect.
- For off-campus sites that were not mid-build, CMS pays half of hospital rates.
- CMS proposed to pay only 25 percent of hospital rates for 2018 in its CY 2018 payment proposal this summer.
- Hospital stakeholders noted that CMS does not have the 2017 data on payments to off-campus departments, which CMS said "are needed to guide potential changes to [CMS's] general approach."

Summer 2018 Proposal Medicare Check-ups

Medicare's CY 2019 HOPD/ASC Proposal



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Summer 2018 Proposal Medicare Check-ups

Medicare's CY 2019 HOPD/ASC Proposal

New site neutral payment service: G0463

"… which is often higher than the payment that would have been made if a similar service had been furnished in the physician office setting. Therefore, the current site-based payment creates an incentive for the misallocation of capital toward higher cost sites of care that could result in higher costs for providers, taxpayers, beneficiaries, and the Medicare program. Likewise, the differences in payment rates have unnecessarily shifted services away from the physician's office to the higher paying hospital outpatient department. **We believe that the higher payment that is made under the OPPS, as compared to payment under the PFS, is likely to be incentivizing providers to furnish care in the hospital outpatient setting rather than the physician office setting. In 2012, Medicare was paying approximately 80 percent more for a 15-minute office visit in a hospital outpatient department than in a freestanding physician office.** Under current policy, Medicare still pays more using the G-code for a clinic visit than it would under the PFS."

Site Neutral Payments Additional CMS Comments

Summer 2018 Proposal for CY 2019

We have heard that many off-campus departments converted from physicians' offices to hospital outpatient departments, without a change in either the physical location or a change in the acuity of the patients seen. To the extent that similar services can be safely provided in more than one setting, we do not believe it is prudent for the Medicare program to pay more for these services in one setting than another. We believe the difference in payment for these services is a significant factor in the shift in services from the physician's office to the hospital outpatient department, thus unnecessarily increasing hospital outpatient department volume and Medicare program and beneficiary expenditures.

We consider the shift of services from the physician office to the hospital outpatient department unnecessary if the beneficiary can safely receive the same services in a lower cost setting but is instead receiving services in the higher paid setting due to payment incentives. We believe the increase in the volume of clinic visits is due to the payment incentive that exists to provide this service in the higher cost setting. Because these services could likely be safely provided in a lower cost setting, we believe that the growth in clinic visits paid under the OPPS is unnecessary. Further, we believe that capping the OPPS payment at the PFS-equivalent rate would be an effective method to control the volume of these unnecessary services because the payment differential that is driving the site-of-service decision will be removed. In particular, we believe this method of capping payment will control unnecessary volume increases as manifested both in terms of numbers of covered outpatient department services furnished and costs of those services.

Site Neutral Payments CMS's Questions for the Future

Summer 2018 Proposal for CY 2019

- Should prior authorization be considered as a method for controlling overutilization of services?
- For what reasons might it ever be appropriate to pay a higher OPPS rate for services that can be performed in lower cost settings?
- Several private health plans use utilization management as a cost-containment strategy. How might Medicare use the authority at section 1833(t)(2)(F) of the Act to implement an evidence-based, clinical support process to assist physicians in evaluating the use of medical services based on medical necessity, appropriateness, and efficiency? Could utilization management help reduce the overuse of inappropriate or unnecessary services?

New Employed Physician Protection in Texas 2019 Legislature

HB 1532 Was Signed by the Governor

- H.B. 1532 requires the Texas Medical Board to accept and process complaints against a health organization certified under Section 162.001(b) for alleged violations of the corporate practice of medicine act. S.B. 1985 also requires health organizations certified under Section 162.001(b) to file a biennial report with the Texas Medical Board that must include certain information about the administration of the organization and the organization's executives.
- The corporate practice of medicine (CPOM) doctrine was developed by the American Medical Association in the 19th century to protect the integrity of the medical profession in several ways, first by distinguishing between professional physicians and unqualified persons seeking to offer medical care, and, second, by restricting corporate influence on a physician's independent medical judgment. The doctrine in different iterations was incorporated into the laws of various states, and while many states have abandoned CPOM, Texas maintains the doctrine as a means to insulate the doctor-patient relationship from pecuniary pressures.
- Interested parties note that state law requires the chief medical officer of the health care organization to immediately report to the board any instance in which the chief medical officer reasonably believes a physician's independent medical judgment was compromised or a physician was punished for reasonably advocating patient care. The parties contend that in practice some chief medical officers have failed to report such matters to the board and that, as a result, physicians have been punished for reasonably advocating medical care for their patients. Unfortunately, the physician's professional and economic livelihood may have already been compromised through the chief medical officer's failure to report a matter, leaving the physician with no recourse to remedy the situation. H.B. 1532 seeks to address this issue.

Austin & Washington Commercial Insurance

Out-of-Network

In-Network

TEXAS ORTHOPAEDIC ASSOCIATION
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Austin & Washington Out-of-Network & Network Issues

SB 1264 – Austin

Benchmark Price – Washington

Prior Authorization & Utilization Review – Austin

Texas Department of Insurance's October 1 Call for Feedback

Prompt Pay - Austin

The Washington Debate New York/Texas vs. California Approach

RAND CORPORATION
OBJECTIVE ANALYSIS. EFFECTIVE SOLUTIONS.

California Rules to Limit Surprise Medical Bills Are Working, but Influence Insurer-Provider Bargaining

FOR RELEASE
Monday
August 12, 2019

A California law that limits the size of bills from out-of-network physicians for care delivered in hospitals appears to be protecting patients' financial liability, but has shifted bargaining leverage in favor of insurance plans and had potential unintended consequences such as encouraging more consolidation among physician practice groups, according to a new RAND Corporation study.

Implemented in July 2017, the law appears to be successfully protecting patients from surprise medical bills from out-of-network physicians when they have nonemergency care delivered at in-network hospitals. Patients are now only required to pay in-network cost sharing.

Media Resources

RAND Office of Media Relations
(703) 414-4795
(310) 451-6913
media@rand.org

Researcher Spotlight

Erin L. Duffy
Adjunct Policy Researcher

Erin Duffy is an adjunct policy researcher at RAND. Her current research focus is consumer financial liability for

The Washington Debate ERISA Implications

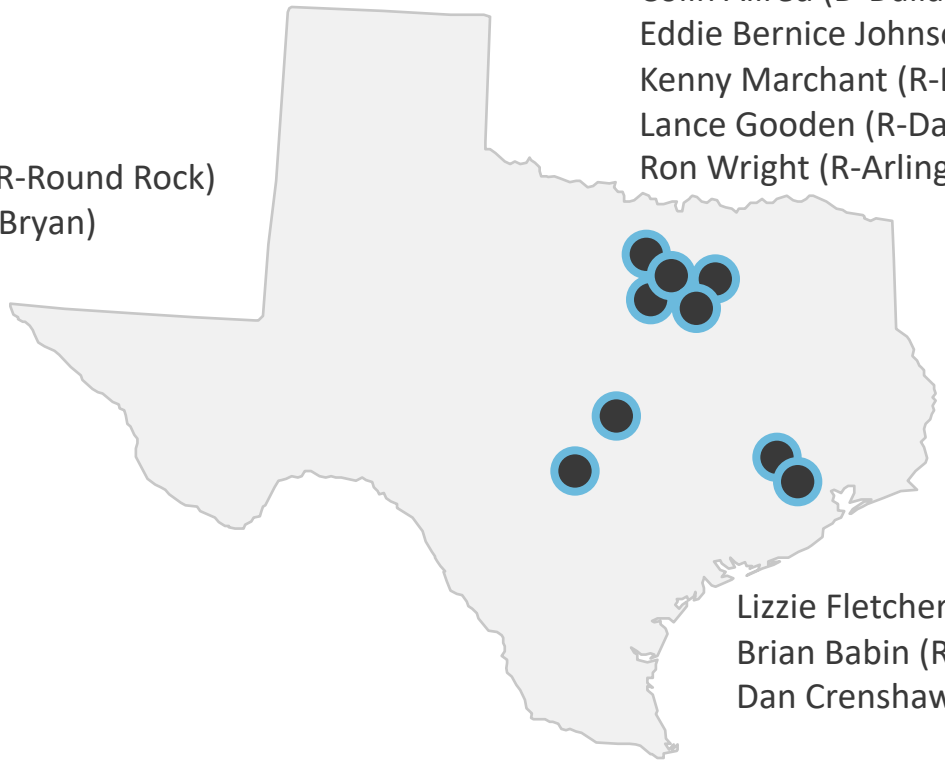
Two Issues: Threshold Price + Arbitration

HR 3502 Texas Co-Sponsors

88 Across the Nation (09.16.19)

Colin Allred (D-Dallas)
Eddie Bernice Johnson (D-Dallas)
Kenny Marchant (R-Dallas)
Lance Gooden (R-Dallas)
Ron Wright (R-Arlington)

John Carter (R-Round Rock)
Bill Flores (R-Bryan)



Lizzie Fletcher (D-Houston)
Brian Babin (R-Woodville)
Dan Crenshaw (R-Houston)

Texas Senate passes legislation to prevent surprise medical bills with arbitration, mediation

Surprise medical bills happen when out-of-network health care providers and insurance companies can't agree on the price of a medical treatment, leaving the patient to pick up the amount insurance won't pay.

BY ELIZABETH BYRNE APRIL 16, 2019 8 PM

REPUBLISH

Exclusive: the new bipartisan House bill to stop surprise medical bills, explained

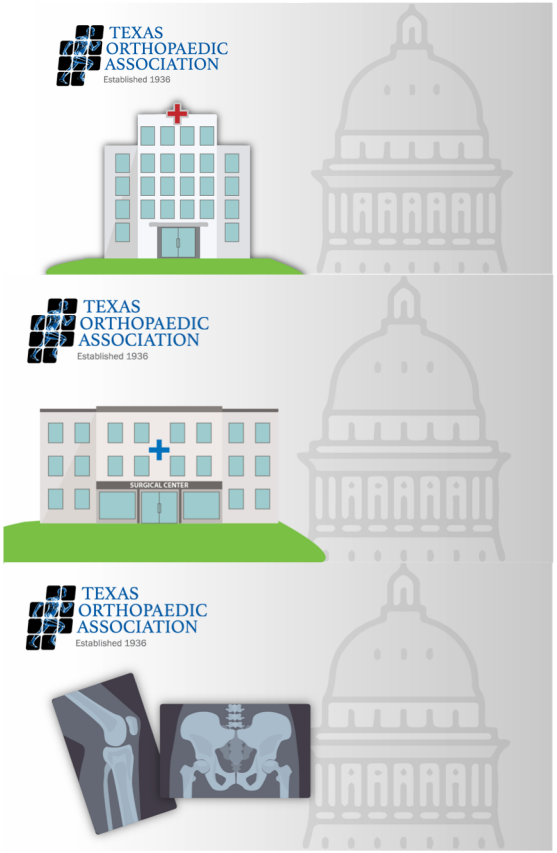
The bipartisan push to end surprise medical bills is ramping up.

By Dylan Scott | @dylanlscott | dylan.scott@vox.com | May 14, 2019, 10:15am EDT

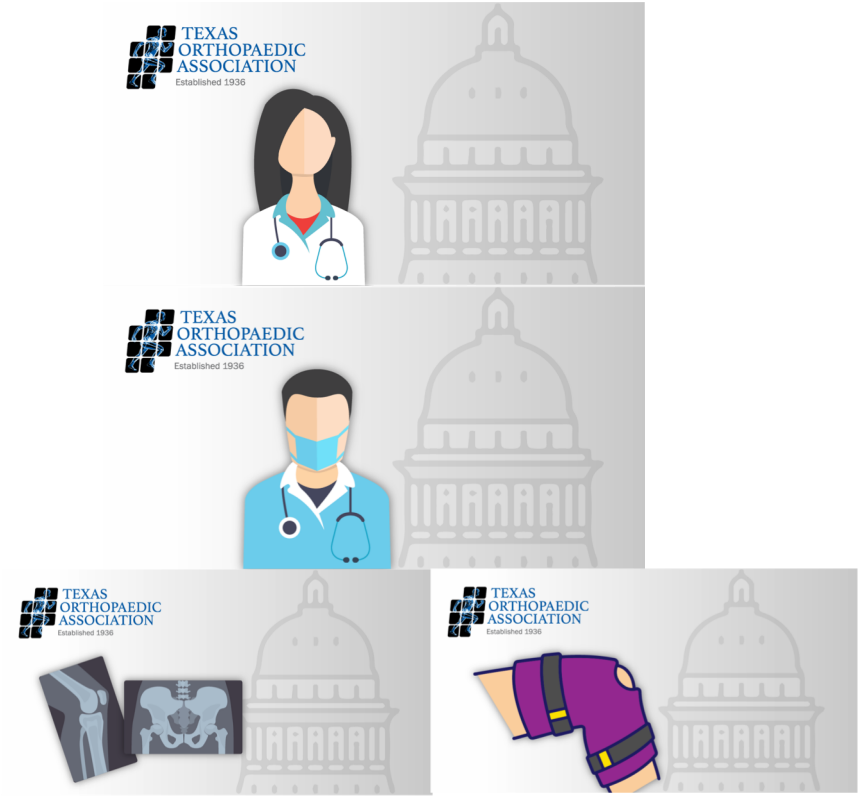
Surprise medical bills could prompt rare bipartisan action in Congress

By JENNIFER HABERKORN MAY 21, 2019 | 8:25 AM | WASHINGTON

Texas Mediation



Texas Arbitration



SB 1264 in Texas Tom Oliverson, MD (right) & Sen. Kelly Hancock

Texas Surprise Billing The "Non-Emergent" Exception

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

July 15, 2019

VIA ELECTRONIC MAIL to comments@tdi.texas.gov

Commissioner Kent Sullivan
Texas Department of Insurance
333 Guadalupe Street
Austin, Texas 78701

Re: Stakeholder Meeting on SB 1264

Dear Commissioner Sullivan:

I am writing on behalf of the Texas Orthopaedic Association (TOA) to provide stakeholder comments on the upcoming rule related to SB 1264. TOA was founded in 1936 as a voluntary organization that seeks to ensure outstanding musculoskeletal care for Texas patients. Approximately 1,400 Texas orthopaedic surgeons are TOA members.

Issue 1: Nonemergency Exemption

- *Should TDI rules define timelines for how much advance notice consumers must be given before receiving a service that may result in a balance bill?*

TOA believes that it could be harmful to create an arbitrary deadline regarding when a patient must be presented with a notice regarding estimated charges prior to a service. It is true that many nonemergency surgeries may be scheduled several weeks in advance. However, it is also important to note that many musculoskeletal injuries require immediate attention, such as surgery, within a few days of the injury for proper healing. While these cases may need immediate attention, they are still defined as "nonemergency" and elective in nature, and it is critical to not delay these surgeries with a subjective deadline for a disclosure. As a result, TOA believes that it is appropriate to follow SB 1264 as it is written in statute to simply provide the disclosure prior to the surgery.

In addition, it is important to note that informed consent disclosures related to potential risks surrounding a surgery do

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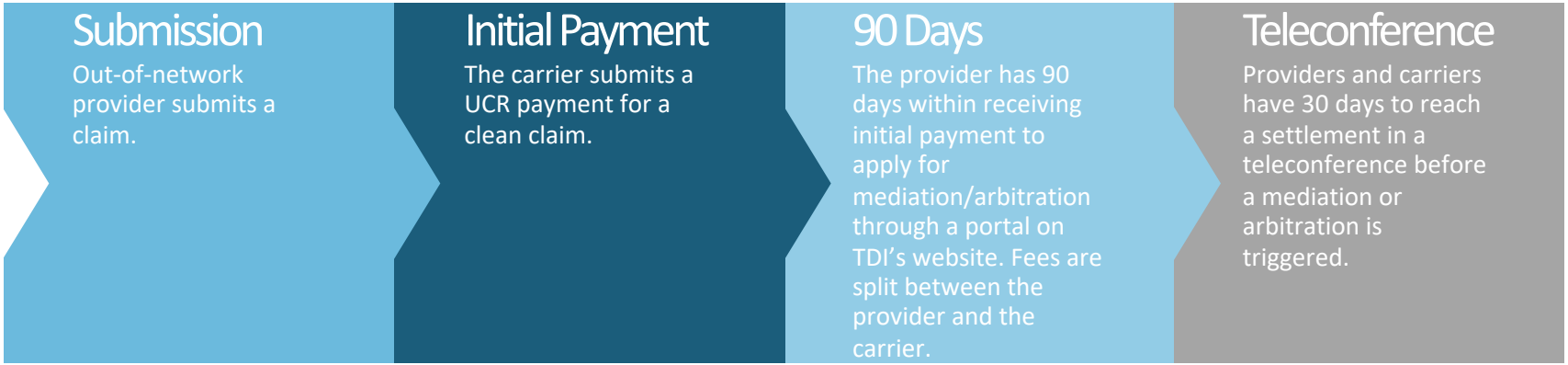
DISPUTE RESOLUTION PROCESS



Internal Appeals Process

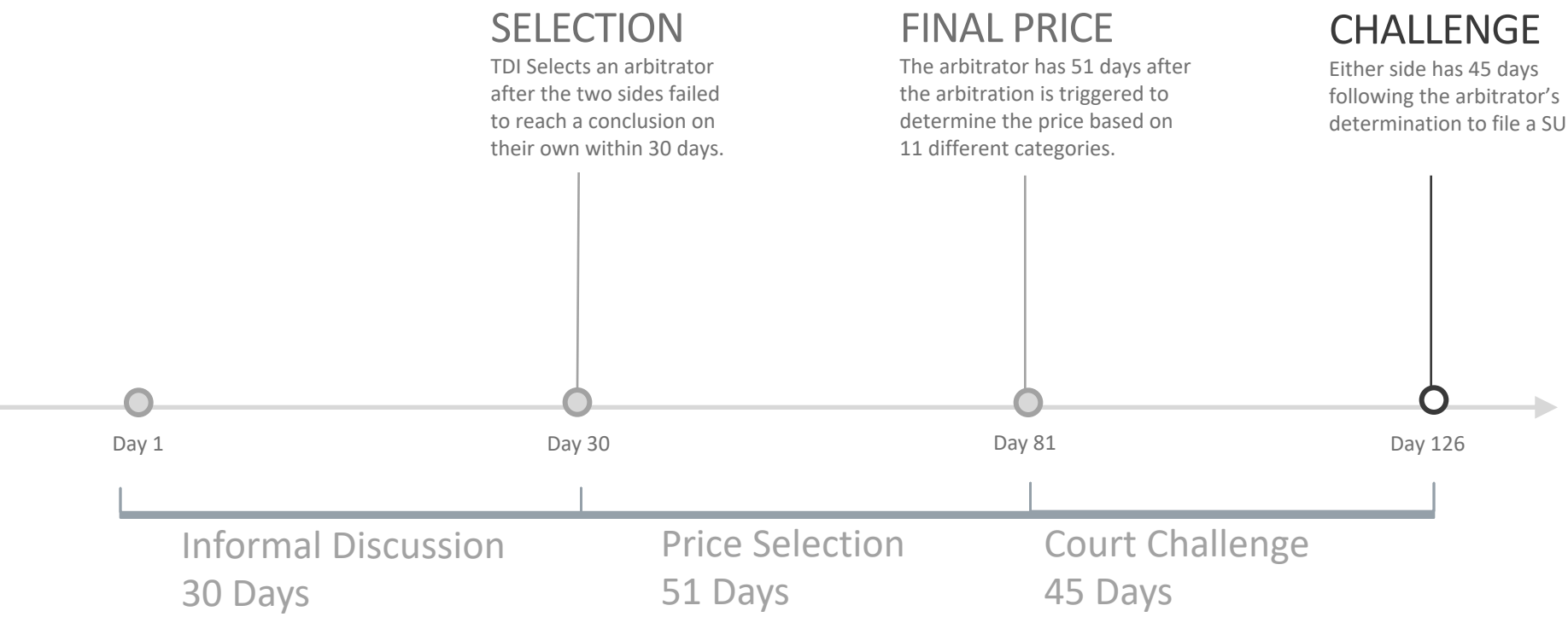
Providers may appeal to a carrier's internal appeals process for denials of coverage.

Bundles

Physicians may bundle disputed payments up to $5,000 if they are with the same carrier. No individual claim within that bundle may be more than $1,500.

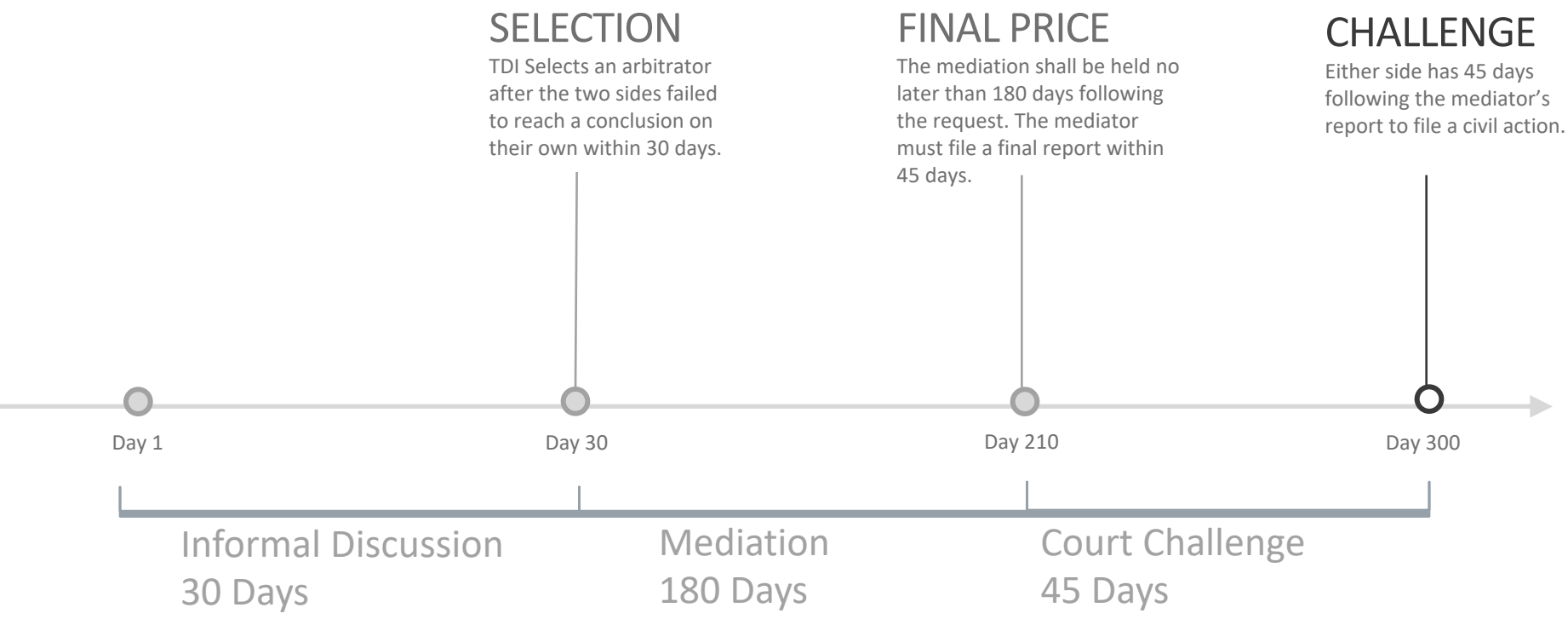
Timeline Arbitration Under Texas Law

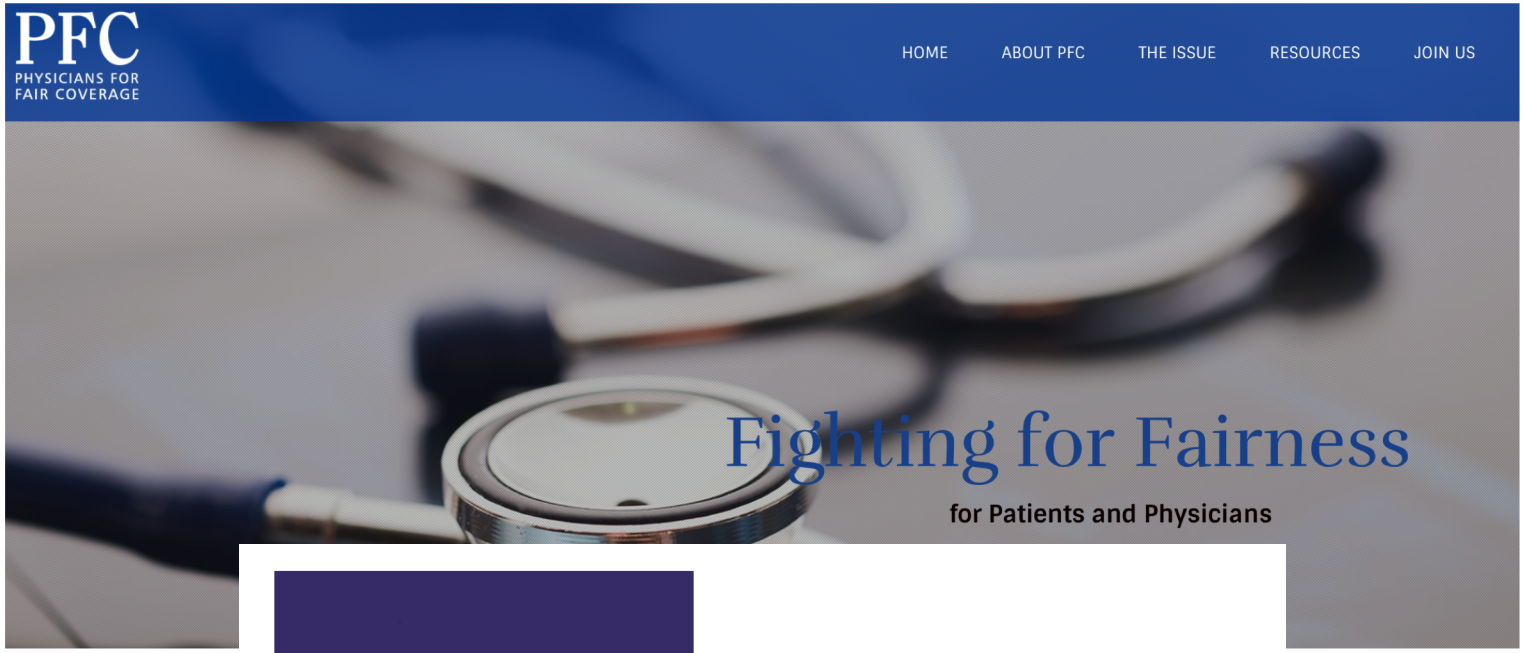
Physicians & Midlevels



Timeline Mediation Under Texas Law

Facilities

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Texas and Balance Billing: A Review

- **2009 Law (HB 2256)** allows patients to enter into an informal teleconference and potential mediation with a facility-based physician for an out-of-network balance bill of $1,000 or more.
- **2015 Law (SB 481)** lowers the threshold to $500.It applies to anesthesiologists, emergency physicians, radiologists, neonatologists, pathologists, and assisting surgeons.
- **2017 Law (SB 507)** expands mediation to almost every type of out-of-network emergency are provider that balance bill and all non-network facility-based providers at network hospitals.

Balance Billing Mediation Results in Texas

Texas Association of Health Plans – January 2018 Chart

Balance Billing Mediation Results in Texas

Data Presented by the Texas Department of Insurance in January 2018

Mediation Requests Summary as of January 8, 2017

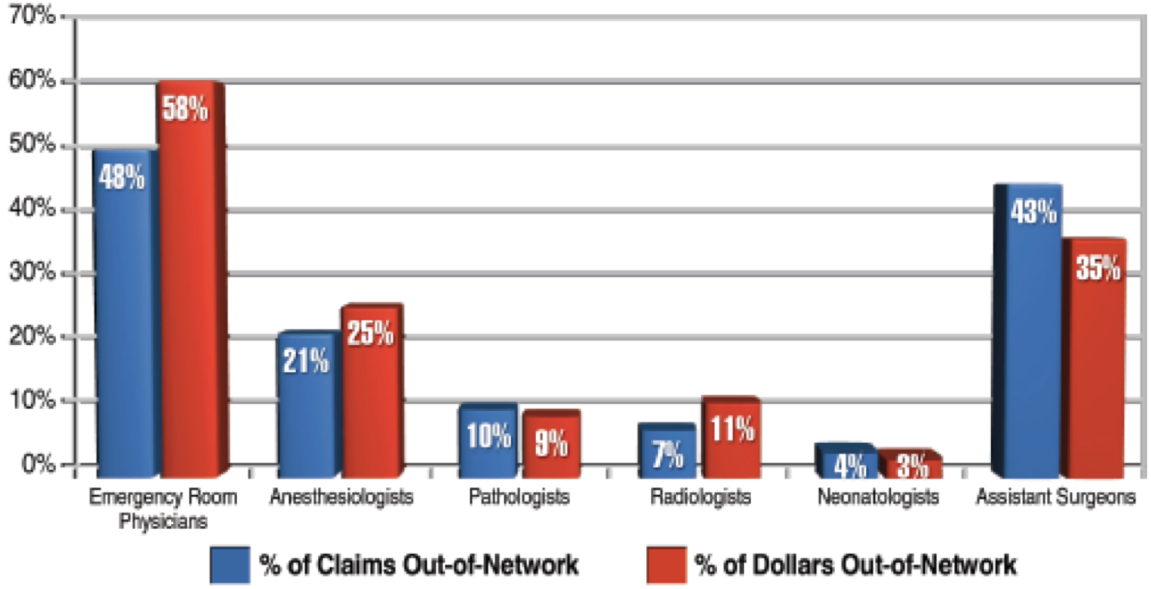
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018 YTD
Total Number Received*	0	17	17	13	43	686	977	1,504	2,064	814
Mediation Billed Amount**							$242,234.35	$4,228,521.02	$7,109,670.07	$2,393,037.10
Mediation Paid Amount***							$49,324.50	$713,952.43	$1,101,827.19	$180,254.55
Total Settled via Teleconference					42	597	879	1,396	1,926	392
Requests pending outcome of Teleconference****									14	405
Total Referred to SOAH	0	0	0	0	1	89	98	108	124	17
Number Received - $1,000 and over								1,150	1,501	521
Number Received - $500-$999*****								268	319	141
Number Received - $499 amount or below								27	17	8
Number Received - Did not qualify******								59	227	144
Total Number Received								1,504	2,064	814

Balance Billing Texas Assn of Health Plans Data

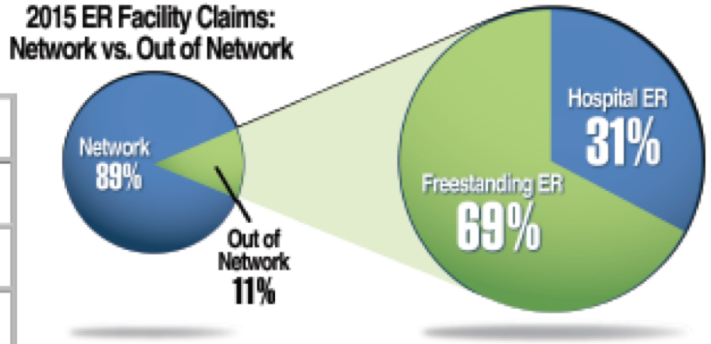
May 2016; Three Large Texas Health Plans – 2015 Claims Data

Emergency Services Are The Largest Problem

Percent of Claims & Dollars Out of Network: Hospital Based Physicians–2015



Out of Network Emergency Facility Claims: 2015



Out of 300
In-network Hospitals
there are
ZERO
In-network
ER Doctors Available!

Source: CPPP

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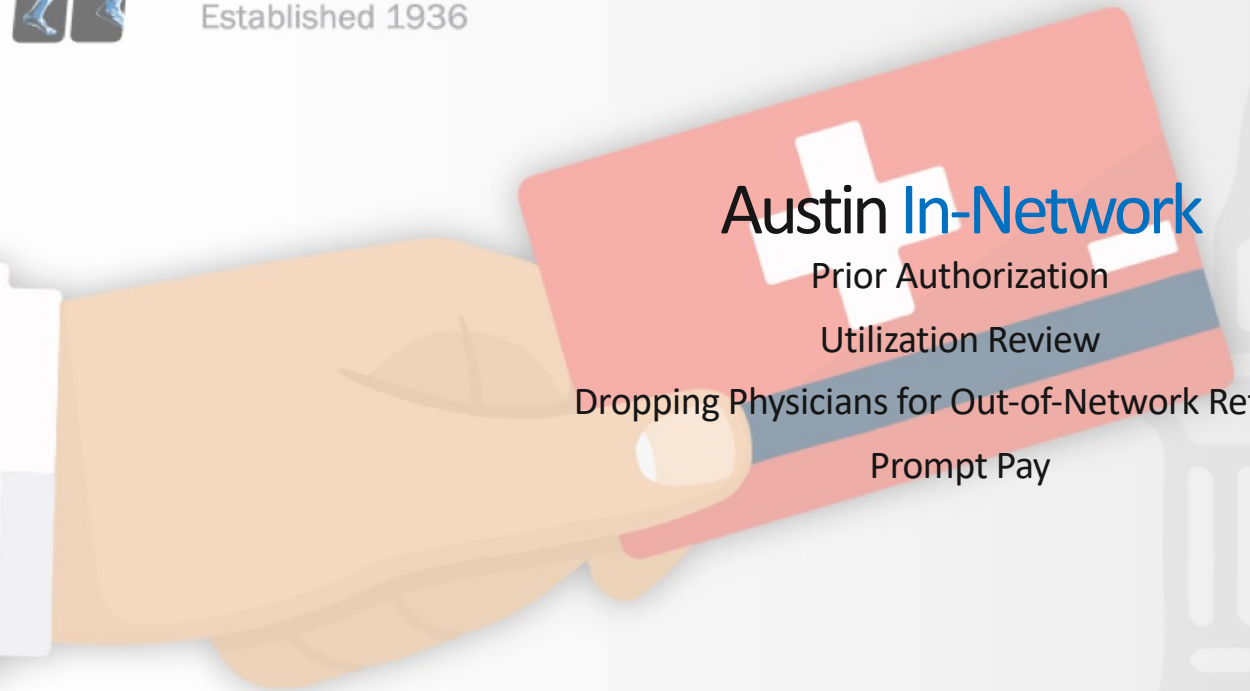

Austin In-Network

Prior Authorization

Utilization Review

Dropping Physicians for Out-of-Network Referrals

Prompt Pay

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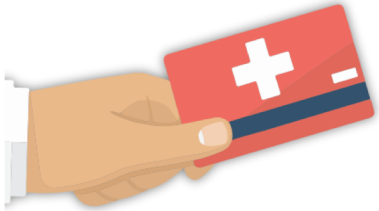
TEXAS LAWMAKERS INTRODUCE BILLS TO MAKE HEALTH CARE MORE EFFICIENT FOR TEXANS

Texas lawmakers recently introduced several bills that would address the health plans' unnecessary delays that are resulting in delays for patients. The Texas Orthopaedic Association strongly supports these bills.



Make the prior authorization process easier for patients and physicians.

HB 2327 and **SB 1186** would require HMOs to provide details to patients and physicians about what factors are used to determine a prior authorization formula. In addition, physicians who routinely have their prior authorizations approved would be exempt from further prior authorizations under a process that is set up by TDI.

Promote greater patient choice.

Some health plans have dropped physicians from their networks for referring patients to out-of-network providers. In some cases, the most appropriate provider for that service may have no choice but to be out of network. **HB 2367** would prohibit health plans that engage in this practice from bidding on state contracts.

Ensure that health plan reviewers have expertise regarding the reviewed service.

HB 2387 and **SB 1187** would require health plans to use a physician of a similar specialty for utilization reviews regarding a particular service.

Ensure that patients have accurate network directories.

HB 1880 and **SB 1188** would require health plans to update their network directories every two days. In addition, TDI would be required to perform network adequacy examinations at least every two years for PPO products.

Give patients information about their physicians' network status and expected financial liability.

HB 2520 and **SB 1740** would require health plans to tell the patient ahead of time about the network status of the physicians and the patient's expected financial liability for an approved prior authorization.

No prior authorization for in-network physicians.

If a health plan trusts a physician to be in the network, the plan should trust the physician's judgment and not add unnecessary barriers that delay treatment. **HB 3232** would prohibit utilization

Legislative Advertising Authorized by:
Bobby Hillert
Texas Orthopaedic Association | 401 W. 15th Ste

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Established 1936

October 1 Deadline Texas Department of Insurance's Call for Feedback

TDI Texas Department of Insurance

A fresh look at insurance rules

Insurance Commissioner Kent Sullivan announced a new initiative earlier this year to identify rules that need to be updated or changed. We're now ready to hear from you about rules that need work. Are there rules that make compliance unreasonably difficult? Is the text ambiguous or out of date? Does it seem inconsistent with statute?

The review will be a three-stage process:

1. Stakeholders are asked to submit a brief statement for each rule they're requesting to change or update.
2. TDI will review all submissions and will announce the selection of a limited number of rule proposals for more detailed review and comment. TDI will request additional information, including suggested text revisions, for these submissions.
3. After reviewing the additional information, TDI will determine the submissions that move forward to formal rule projects. These will go through TDI's normal rule process, which allows for opportunities for public comment.

Network Issues What Passed in Austin

2019 Texas Legislature

Network Adequacy for PPOs

- HB 3911 by Rep. Hubert Vo (D-Houston) and Sen. Donna Campbell, MD (R-New Braunfels).

Network Directory Lists

- SB 1742 by Sen. Jose Menendez (D-San Antonio) and Rep. Julie Johnson (D-Dallas).
- Clearly identify specialties and facilities that are in a plan's network.

Prompt Payment & Utilization Review Transparency

- HB 2327, SB 1186, HB 2387 and SB 1187 Rep. Greg Bonnen, MD (R-Friendswood) and Sen. Dawn Buckingham, MD (R-Lakeway).
- "Gold standard" plus transparency for prior authorization requirements.
- Same or similar specialty for utilization review.
- Some forms of these bills were amended to SB 1742.

Network Issues What Fell Short in Austin

2019 Texas Legislature

Prudent Layperson Standard for Emergencies

- HB 1832 by Rep. Julie Johnson (D-Dallas) and Sen. Donna Campbell, MD (R-New Braunfels).

Non-Medical Switching

- HB 2099 by Rep. Stan Lambert (R-Abilene) and Sen. Donna Campbell, MD (R-New Braunfels).
- The bill would have prohibited a plan from changing a patient's drug coverage upon plan renewal for patients with chronic care needs.

Prompt Payment in 2019 Attempts for Change?

HB 1914 in the Texas House

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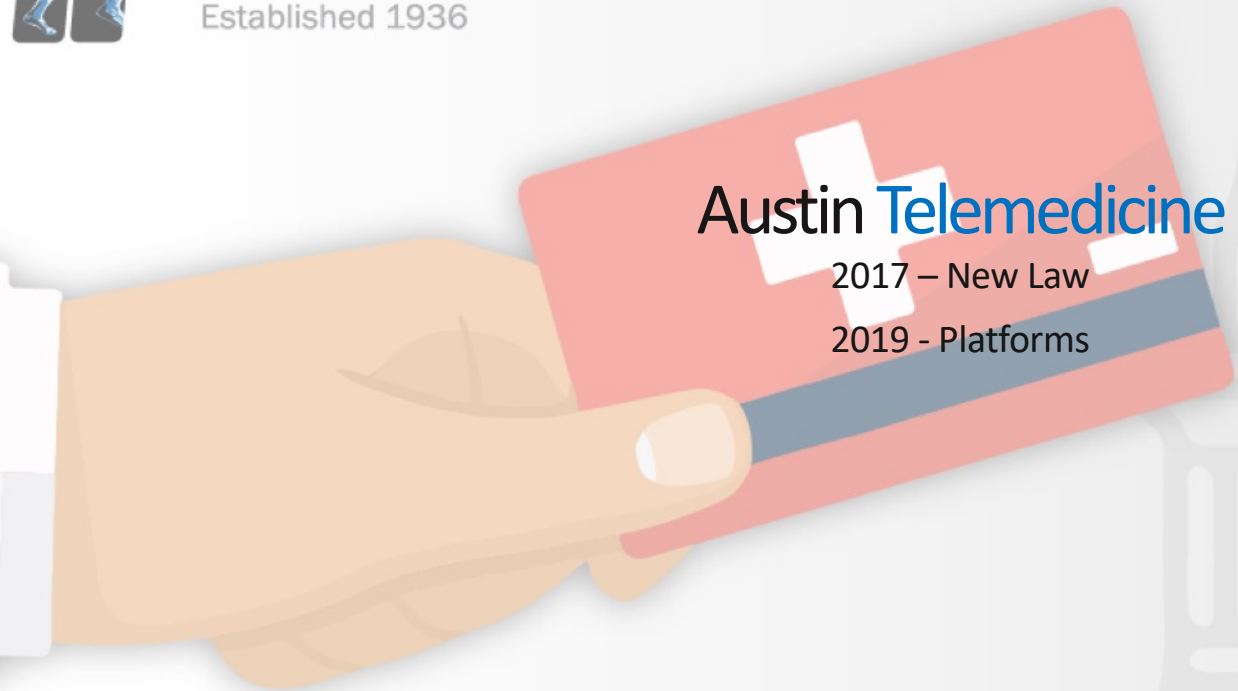

Austin Telemedicine

2017 – New Law

2019 - Platforms

Telemedicine Building on the 2017 Law

2019 Texas Legislature

Telemedicine for Rural Hospitals

- HB 871 by Rep. Four Price (R-Amarillo) would allow a hospital located in a rural county (< 30,000) to use telemedicine to satisfy a Level IV designation related to a physician's availability.

The Platform of a Physician's Choice

- The rule-making process did not result in a physician being able to use a telemedicine platform of her choice.
- HB 3345 and SB 1265 (Rep. Four Price, R-Amarillo and Sen. Dawn Buckingham, MD, R-Lakeway) would allow a physician to use the platform of her choice in the commercial market.
- HB 870 and SB 670 would do the same for the Medicaid market.

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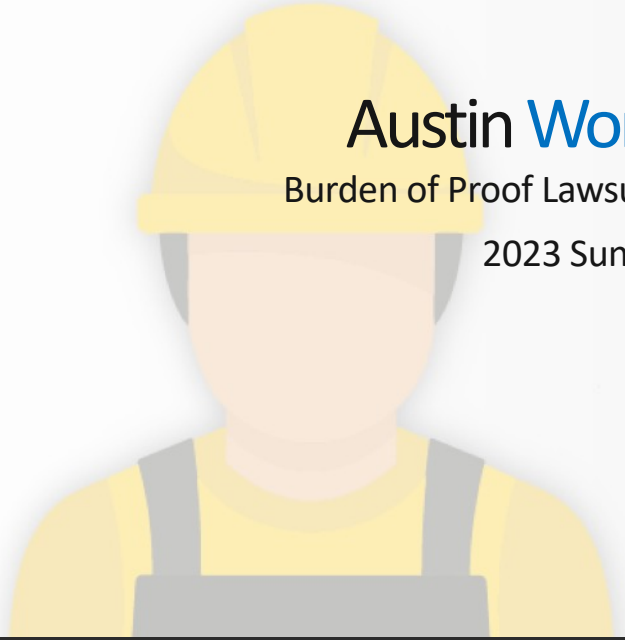

Austin Workers' Comp

Burden of Proof Lawsuit & TOA's Amicus Brief

2023 Sunset Review

Texas Supreme Court TOA's Amicus Brief

September 16, 2019

No. 19-0533

IN THE SUPREME COURT OF TEXAS

PATIENTS MEDICAL CENTER,
Petitioner,

V.
FACILITY INSURANCE CORPORATION, Respondent.

On Petition for Review from the Third Court of Appeals, Austin, Texas
Appeal No. 03-17-00666-CV

BRIEF OF AMICUS CURIAE, TEXAS ORTHOPAEDIC ASSOCIATION
IN SUPPORT OF PETITIONER

ANDREA SCHWAB, JD, CPA
LAW OFFICE OF ANDREA I SCHWAB, PLLC
4601 Spicewood Springs Road
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Telephone: 512.229.6010
Facsimile: 512.532.6540
ATTORNEY FOR AMICUS
TEXAS ORTHOPAEDIC ASSOCIATION

Physicians & Facilities Pricing Transparency

Federal Activity

2019 Texas Legislature

D HEALTHCARE CEO
The Business of Healthcare in North Texas

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Just How Much Does a Knee Replacement Cost in North Texas?

12/28/2018 | *by Will Maddox* | Share Post

Texas Orthopaedic Association

Patient Perception of Surgeon Reimbursement:

It's Not What You May Think

Medicare Reimbursement for Orthopaedic Surgeons: Patients Are Greatly Surprised

A total hip or knee replacement may be one of the most complicated medical services that a patient receives. Not surprisingly, patients believe that the orthopaedic surgeon who performs the complicated surgery should be reimbursed accordingly for his or her services.

However, patients may be shocked to learn that their perceived value of an orthopaedic surgeon's services for a total hip or knee replacement is dramatically lower than Medicare's actual reimbursement for the service.

A 2012 study in The Journal of Arthroplasty studied 1,120 patients' perspectives of orthopaedic surgeon reimbursement. On average, the patients thought that surgeons **should receive $13,332** for a total knee replacement surgery. Patients **estimated that the actual Medicare reimbursement was $7,196 for the surgeon**. The patient estimations were not even close to the **actual Medicare surgeon reimbursement of $1,470 for a total knee replacement.**

After sharing these numbers with the study participants, 70 percent of the patients indicated that the Medicare reimbursement was "much lower" than what it should be.

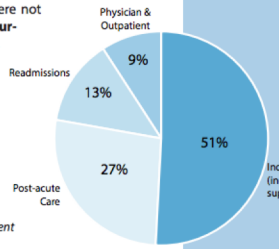


Chart Source: The Advisory Board analysis of Medicare data for Major Joint Replacement of the Lower Extremity.

Surgeons Are Only a Small Piece of the Payment

Patients are often surprised to learn that a surgeon's payment is only a small percentage of the total payment for a service. In the example of a total hip or knee replacement, payments to surgeons and their related services were only 9 percent of the total cost for a hip or knee replacement.

Meanwhile, the index admission, which includes hospital and implant costs, made up 51 percent of the cost. The remaining costs of an average Medicare total hip or knee bundle were related to post-acute care and readmissions.

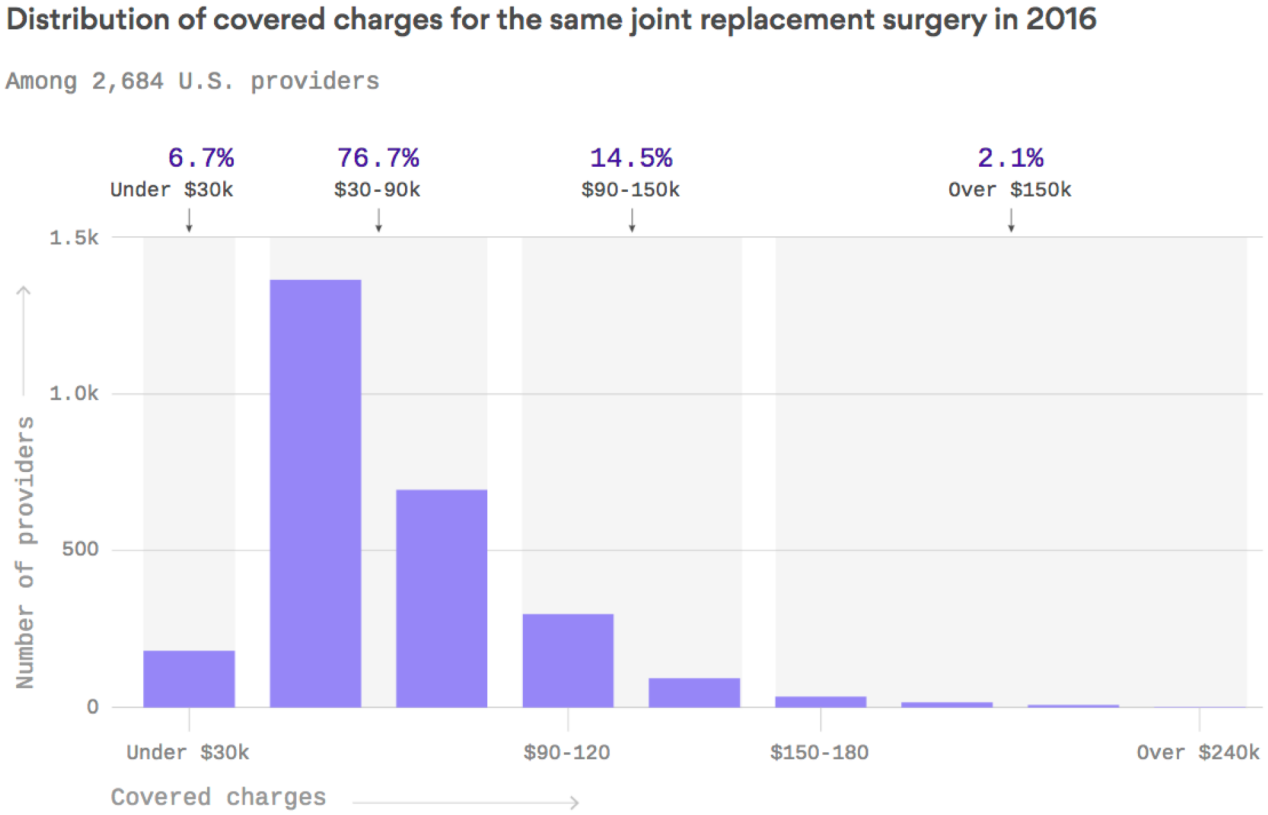
TEXAS ORTHOPAEDIC ASSOCIATION Established 1936

BUSINESS

What Does Knee Surgery Cost? Few Know, and That's a Problem

The price we pay for health care often has little connection to what it actually costs. One hospital decided to investigate.

Source: Axios



Data: Centers for Medicare & Medicaid Services; Chart: Chris Canipe/Axios

Source: Axios

Providers where the cost of joint replacement surgery increased most

Change from 2015 to 2016

PROVIDER	2016 PRICE	CHANGE FROM 2015
St. Francis Medical Center Trenton, N.J.	$135.4k	+76.8%
Community Howard Regional Health Kokomo, Ind.	79.2k	+73.6%
Baylor Scott and White Surgical Hosp. at Sherman Sherman, Texas	48.0k	+64.6%
Central Iowa Healthcare Marshalltown, Iowa	42.5k	+59.6%
Lutheran Medical Center Brooklyn, N.Y.	115.0k	+55.5%
Healthalliance Hospitals Leominster, Mass.	47.4k	+48.5%
Highland Hospital Oakland, Calif.	114.1k	+43.2%
Arrowhead Regional Medical Center Colton, Calif.	96.3k	+42.6%
Abrazo Scottsdale Campus Phoenix, Ariz.	75.4k	+41.6%
Arizona Spine and Joint Hospital Mesa, Ariz.	60.9k	+40.1%

Data: Centers for Medicare & Medicaid Services; Chart: Chris Canipe/Axios

Medicare Pricing Transparency 2018 Proposals

Medicare's Inpatient Hospital and Physician Fee Schedule Proposals for 2019; Begins in January 2019

"Under current law, hospitals are required to establish and make public a list of their standard charges. In the fiscal year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule, CMS announced it is updating its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet. However, CMS is still seeking information from the public regarding barriers preventing providers and suppliers from informing patients of their out-of-pocket costs; what changes are needed to support greater transparency around patient obligations for their out of pocket costs; what can be done to better inform patients of these obligations; and what role providers of health care services and suppliers should play in this initiative."

Consumer Credit Reporting & "Surprise Bills" 2019 Law

SB 1037 Enacted by the Texas Legislature

"Prohibits a consumer reporting agency, except as provided by Subsection (b) (relating to the authorization of a consumer reporting agency to furnish a consumer report that contains certain information), from furnishing a consumer report containing information related to certain items, including a collection account with a medical industry code, if the consumer was covered by a health benefit plana t the time of the event giving rise to the collection and the collection for an outstanding balance, after copayments, deductibles, and coinsurance, owed to an emergency care provider or a facility-based provider for an out-of-network benefit claim."

THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

CONSUMER DATA INDUSTRY ASSOCIATION, Plaintiff, V. STATE OF TEXAS THROUGH KEN PAXTON, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE STATE OF TEXAS, Defendant.	§ § § § § § § § § § § §	CIVIL ACTION NO.: 1:19-cv-00876

PLAINTIFF'S ORIGINAL VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT, PRELIMINARY, AND PERMANENT INJUNCTIVE RELIEF

COMES NOW Plaintiff, Consumer Data Industry Association ("CDIA"), and files this Original Complaint for Declaratory Judgment, Preliminary, and Permanent Injunctive Relief, regarding the statute enacted by the 86th Regular session of the Texas Legislature as S.B. 1037, captioned "Relating to Limitations on the Information Reported by Consumer Reporting

Pricing Transparency in Austin Health Plan Recommendations

Little Action in the 2019 Texas Legislature

- "Require health care providers and facilities to post their billed charges for their most commonly billed services."
- "Require health care providers and facilities to supply patients with a 'good faith' estimate of how much elective (non-emergency) health care services would cost individuals."
- "Require health care providers and facilities to disclose their network status."
- "Require health care providers and facilities to provide consumer advance warnings of billed charges that exceed 250 percent of the Medicare rate for the same service (or item) in the same geographic area."
- "Study facility and observation fees and which providers should appropriately be able to charge them."
- "Limit FSER and 'micro hospitals' Facility Fees and Observation Fees."
- Require DSHS to collect discharge data from FSERs.'
- "Consider giving the attorney general authority to bring action against providers who charge consumers 'unconscionable' charges."
- "Allow health plans to more easily share quality and value data with consumers and providers participating in their network."

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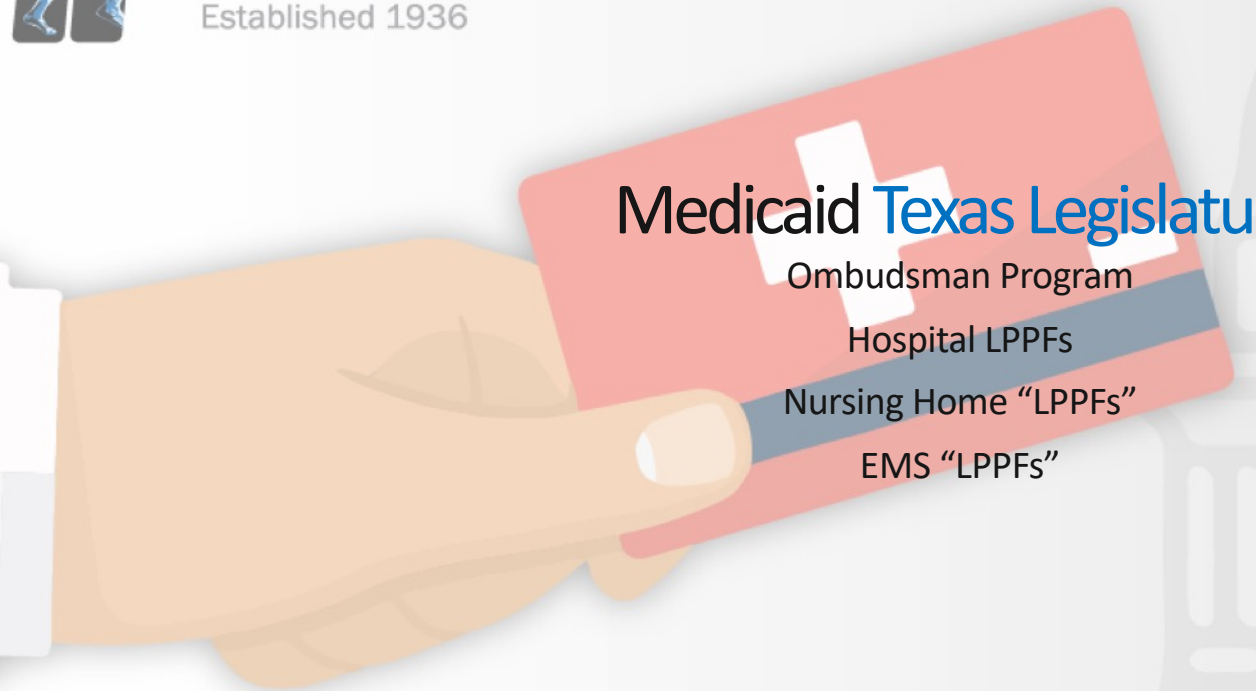


Medicaid Texas Legislature

Ombudsman Program

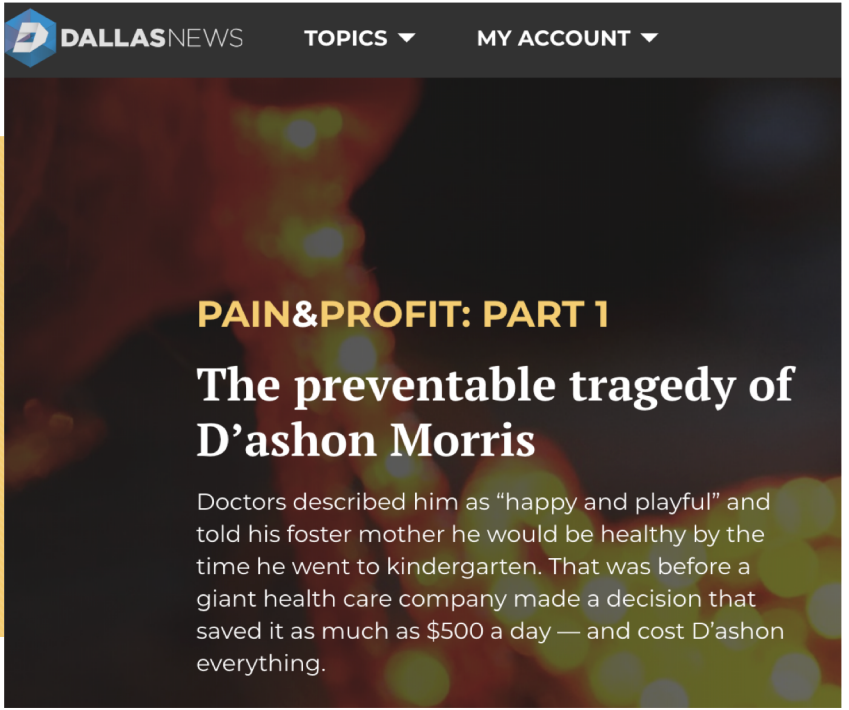
Hospital LPPFs

Nursing Home “LPPFs”

EMS “LPPFs”

2019 Texas Legislature SB 1105 and SB 1207

Medicaid Managed Care Oversight and Prior Authorization Timelines; SB 1105 Didn't Pass



Medicaid Overview

2019 Texas Legislature

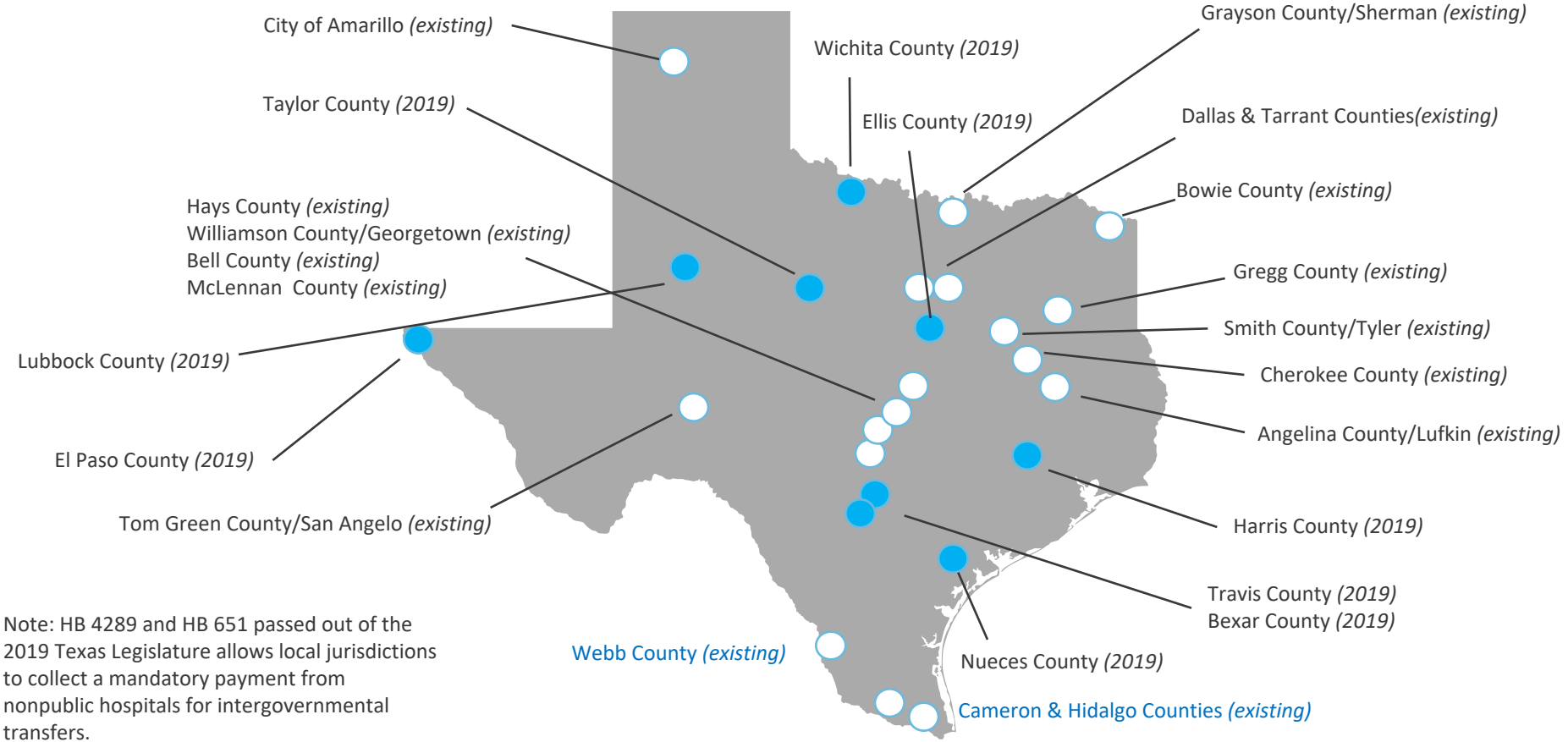
No Physician Medicaid Rate Increases A continuing theme.

Cost Containment Measures In a continuing theme, the budget contains a $350 million cost containment measure (general revenue) and $900 million in all funds.

Mental Health $100 million appropriated to establish the Texas Mental Health Consortium (it requires the passage of SB 11 or SB 10). The budget also appropriates $1.5 million for child/adolescent psychiatry fellowships.

Ombudsman Program ~~SB 1105~~/SB 1207 Medicaid managed care oversight and prior authorization timelines.

Hospital LPPFs 2019 Legislation



Note: HB 4289 and HB 651 passed out of the 2019 Texas Legislature allows local jurisdictions to collect a mandatory payment from nonpublic hospitals for intergovernmental transfers.

Nursing Home LPPFs Continued Defeats in Austin

Divided Industry

TribTalk | PERSPECTIVES ON TEXAS

A publication of The Texas Tribune

SPONSOR CONTENT

What's in a NFRA? A granny tax

By George Linial, LeadingAge Texas, March 24, 2017

Gov. Greg Abbott, in his State of the State address to the Legislature, said "the only good tax is a dead tax." This

Austin & Washington Prescription Drugs

Drug Pricing
Pharmacy & PBM Issues
Physician Dispensing
Opioids

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

Texas Legislature & Washington Drug Pricing & Pharmacy Issues

Gag Clauses

Physician Dispensing in Texas

Drug Prices – Texas Legislature

PBM Issues

Austin Stakeholders Pharmacies

Texas Pharmacy Business Council

TPA TEXAS Pharmacy Association
Together Pharmacy Advances

TEXAS FEDERATION OF DRUG STORES
"The Voice of Chain Pharmacy in the State of Texas"

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Pharmacy Leaders. Transforming Patient Care.

ALLIANCE of Independent Pharmacists of TEXAS
The Voice of Independent Pharmacy in Texas

Congress Gag Clause for Pharmacists

Congressman Michael Burgess, MD Comments

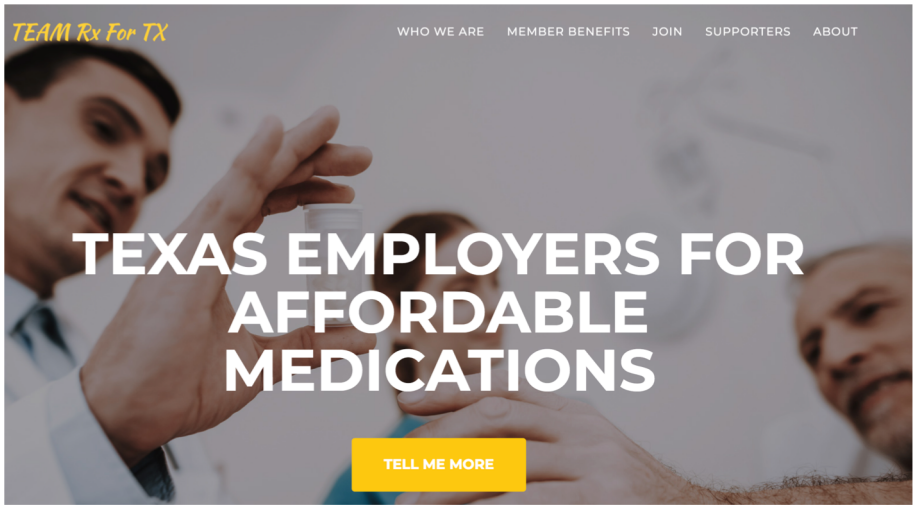
- Congressman Burgess: The bill is “essential in both lowering drug costs for individuals and freeing the pharmacist to do what many consider the right thing.”
- Patients are required to request information from pharmacists about whether out-of-pocket drug costs would be cheaper than purchasing the drug through insurance.

Physician Dispensing Laws 2019 Texas Legislature Bill

TEXAS ACADEMY OF FAMILY PHYSICIANS

INCREASING PATIENT ACCESS AND ADHERENCE TO PRESCRIPTION DRUGS IN TEXAS

Physician Provision of Prescription Drugs



TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

2019 Texas Legislature Drug Pricing

HB 2536

Texas Association of Health Plans @txhealthplans · 16h

The #txlege acted today to keep #prescriptiondrugcosts down by passing HB 2536 by Rep. @TomOliverson, R-Cypress, which requires drug pricing transparency by drug manufacturers, health plans and pharmacy benefit managers (PBMs). Read our full release here: tahp.it/2W30dIH

Texas Association of Health Plans
@txhealthplans

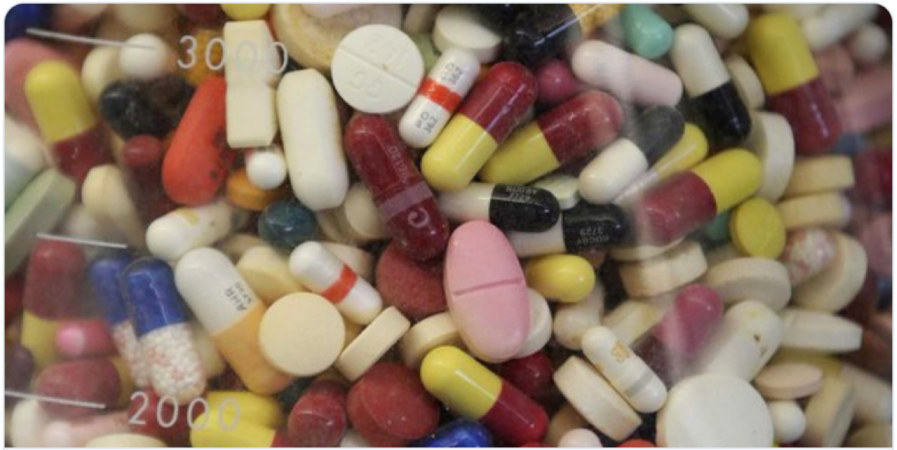
Follow

The bill requires drug manufacturers to submit a report to @TexasHHSC when they have a price increase for a specific drug of at least 40% in its wholesale acquisition cost in the preceding 3 calendar years or at least 15% in the previous calendar year. #txlege

6:45 PM - 24 May 2019

Sarah Davis @SarahforHD134 · 8h

Texas House passed one of the nation's toughest drug-pricing bills. But will it stand?



Texas House passed one of the nation's toughest drug-pricing bills. …

Consumer advocates celebrate as pharmaceutical lobby gears up for Thursday hearing in Texas Senate.

houstonchronicle.com

2019 Texas Legislature HB 2536 & Drug Prices

Health Plan Issue; Pending the Governor's Decision

- Requires drug manufacturers to submit a report to HHSC when a specific drug's price increases by 40 percent of its wholesale acquisition cost in the preceding three calendar years or at least 15 percent in the previous calendar year.
- HHSC will be required to provide online reports.
- PBMS and health plans must submit annual reports to the Texas Department of Insurance that include aggregated rebates, fees, and price protection payments collected from drug manufacturers for PBMS and the names of the 25 most frequently prescribed drugs, percent increase in annual net spending for drugs, and percent increase in premiums attributable to drugs for health plans.

2019 Texas Legislature HB 3388 & Medicaid

Pending the Governor's Decision; Medicaid Managed Care and PBMs

- It removes the current maximum allowable cost requirement and replaces it with a new reimbursement that the MCO or PBM must comply with as a condition of contract retention and renewal with HHSC.
- It requires an MCO/PBM reimbursement for prescription drugs to be tied to the National Average Drug Acquisition Cost (NADAC) methodology to provide pharmacists and the public with a clear and transparent system for the reimbursement of prescription drugs in Medicaid.

2019 Texas Legislature HB 1455 & Audit Practices

Pharmacist Issue; Pending the Governor's Decision

John Hickman @hickmanjd · 40m

Passing HB 1455 will continue to help protect independent pharmacies from unfair audit practices. HB 2817 will help independent pharmacies stay in business. Vote HB 2817 out of **B&C** Committee **#txlege**

> **Dawn Buckingham** @DrBuckinghamTX
>
> Looking out for independent pharmacies, passing HB 1455 in the TX Senate. #sd24 #txlege #86thLegislature bit.ly/2HE2BeY

2019 Texas Legislature PBM Legislation: HB 2817 & HB 2231

HB 2817 Was the Major Vehicle and Ran out of Time; HB 2817 Took Some Concepts from HB 2231

- HB 2817 and HB 2231 ran out of time.
- Protect patients' ability to have their local pharmacy mail or deliver medications to them.
- Prevent PBMs from retroactively reducing payments after a claim is adjudicated, except as a legitimate audit outcome.
- Forbid PBMs from paying their own pharmacies at a rate that is higher than what they reimburse their network pharmacies for the same products.
- Prohibit PBMs from requiring pharmacies to attain credentialing or certification requirements beyond what the state and federal governments require.
- Require PBMs to clearly state in their network contracts the specific services and procedures a pharmacy may deliver and the corresponding payment amounts for them.

2019 Texas Legislature Pharmacy Scope of Practice

SB 1056 – Pharmacist Drug Therapy Management

- Sent to the governor for consideration.
- It amends the Occupations Code to include among the conditions under which a delegation by a physician to a properly qualified and trained pharmacist acting under adequate physician supervision of the performance of specific acts of drug therapy management may include the implementation or modification of a patient's drug therapy under a protocol that the delegation follows a diagnosis, initial patient assessment, and drug therapy order by the physician and that the pharmacist maintains a copy of a protocol for inspection until at least the seventh anniversary of the expiration date of the protocol.

Flu Treatment & Additional Vaccine

- Several bills would have expanded pharmacists' scope of practice to allow them to treat the flu and have expanded vaccine authority.
- The initiatives failed.

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

Texas Legislature & Washington Opioids

New Texas Initiatives

Opioids What Does the CDC's a Seven-Day "Limit" Mean?

2016

CDC Guidelines for Primary Care

Opioids for chronic pain: The CDC's 12 recommendations

J Fam Pract. 2016 December;65(12):906-909

Author(s): Doug Campos-Outcalt, MD, MPA

Author and Disclosure Information

The Centers for Disease Control and Prevention has issued 12 recommendations to help clinicians prescribe an optimal and safe course of treatment for patients.

2019

New England Journal of Medicine

Perspective

No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

Article Metrics

5 References

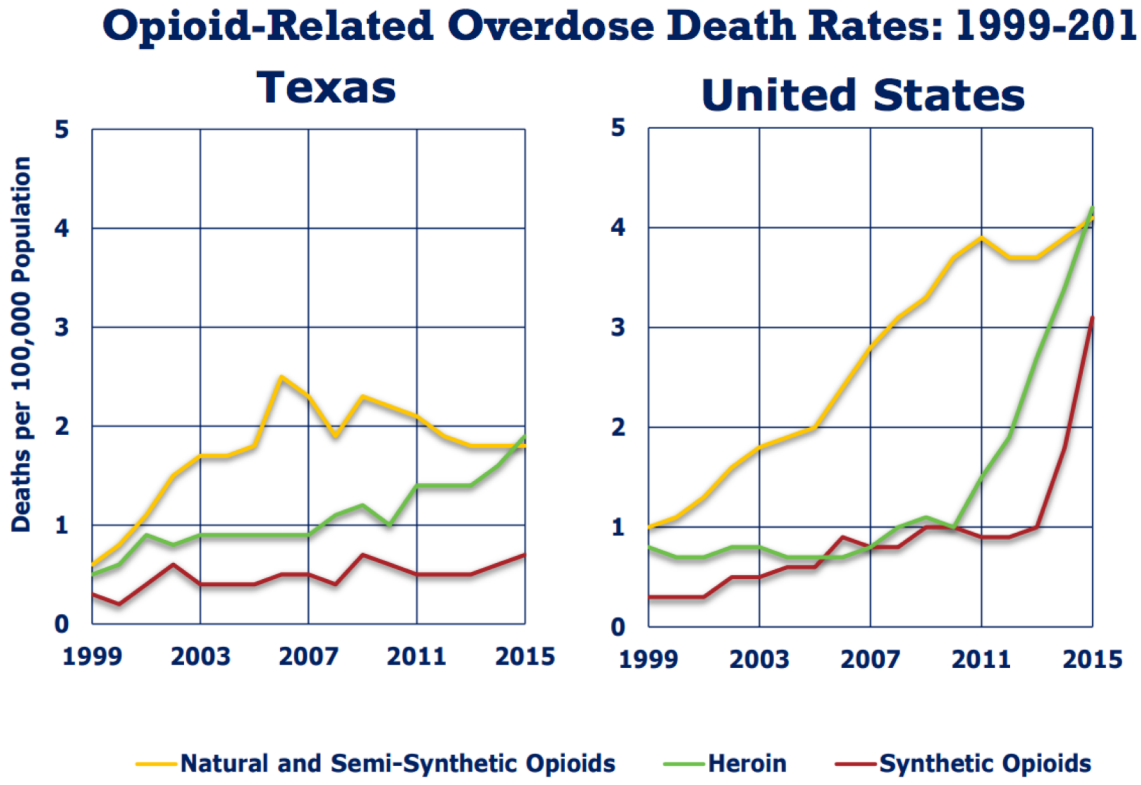
SINCE THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016,[1] the medical and health policy communities have largely embraced its recommendations. A majority of state Medicaid agencies reported having implemented the guideline in fee-for-service programs by 2018, and several states passed legislation to increase access to nonopioid pain treatments.[2] Although outpatient opioid prescribing had been declining since 2012, accelerated decreases — including in high-risk prescribing — followed the guideline's

HEALTH

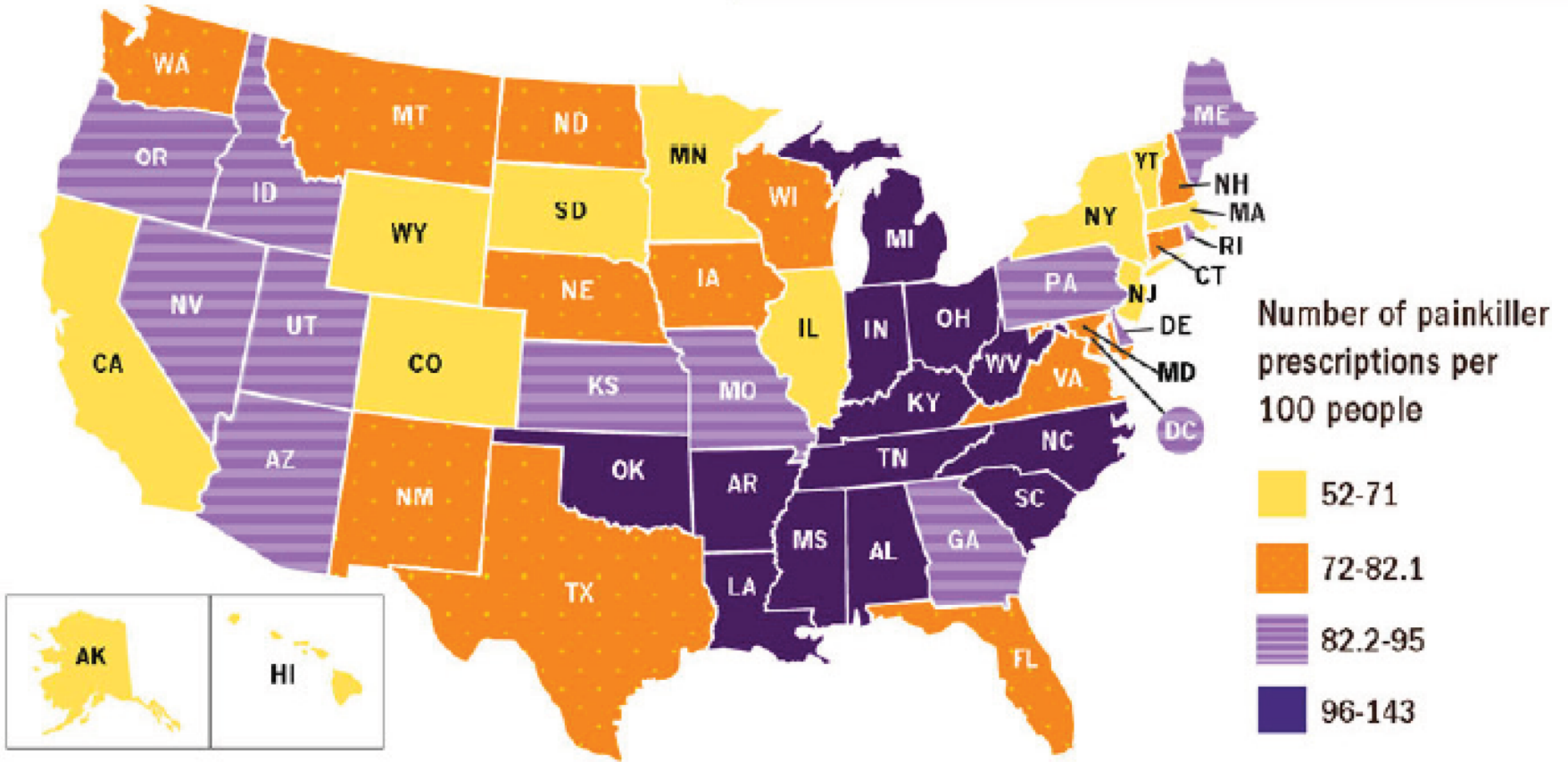
Faced with an outcry over limits on opioids, authors of CDC guidelines acknowledge they've been misapplied

By ANDREW JOSEPH @DrewQJoseph *and* ED SILVERMAN @Pharmalot / APRIL 24, 2019

Opioid Epidemic: Overdose Trends



Some states have more painkiller prescriptions per person than others.



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

In 2012[2]

- Prescribing rates in Texas for both opioid pain relievers and benzodiazepine sedatives fell 10 percent and 21 percent, respectively, below the national average.
- Texas ranked lowest in the nation in rates of prescribing high-dose opioid pain relievers.
- Texas ranked lowest in the nation in rates of prescribing long-acting/extended release opioid pain relievers.

From 2013 to 2015 opioid prescriptions per-capita in Texas fell faster than in 48 other states.[3]

From 2013 to 2014, the number of filled prescriptions for opioids in Texas fell by 3.3 percent.[4]

1 Centers for Disease Control and Prevention, Injury Prevention & Control: Opioid Overdose, Dec. 20, 2016 www.cdc.gov/drugoverdose/data/prescribing.html

2 Centers for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. *MMWR* 2014; 63(26):563-568. www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm?s_cid=mm6326a2_w

3 www.nytimes.com/2016/05/21/health/opioid-prescriptions-drop-for-first-time-in-two-decades.html?_r=1

4 IMS Health, 2015

Pain Management Removal from VBP Program

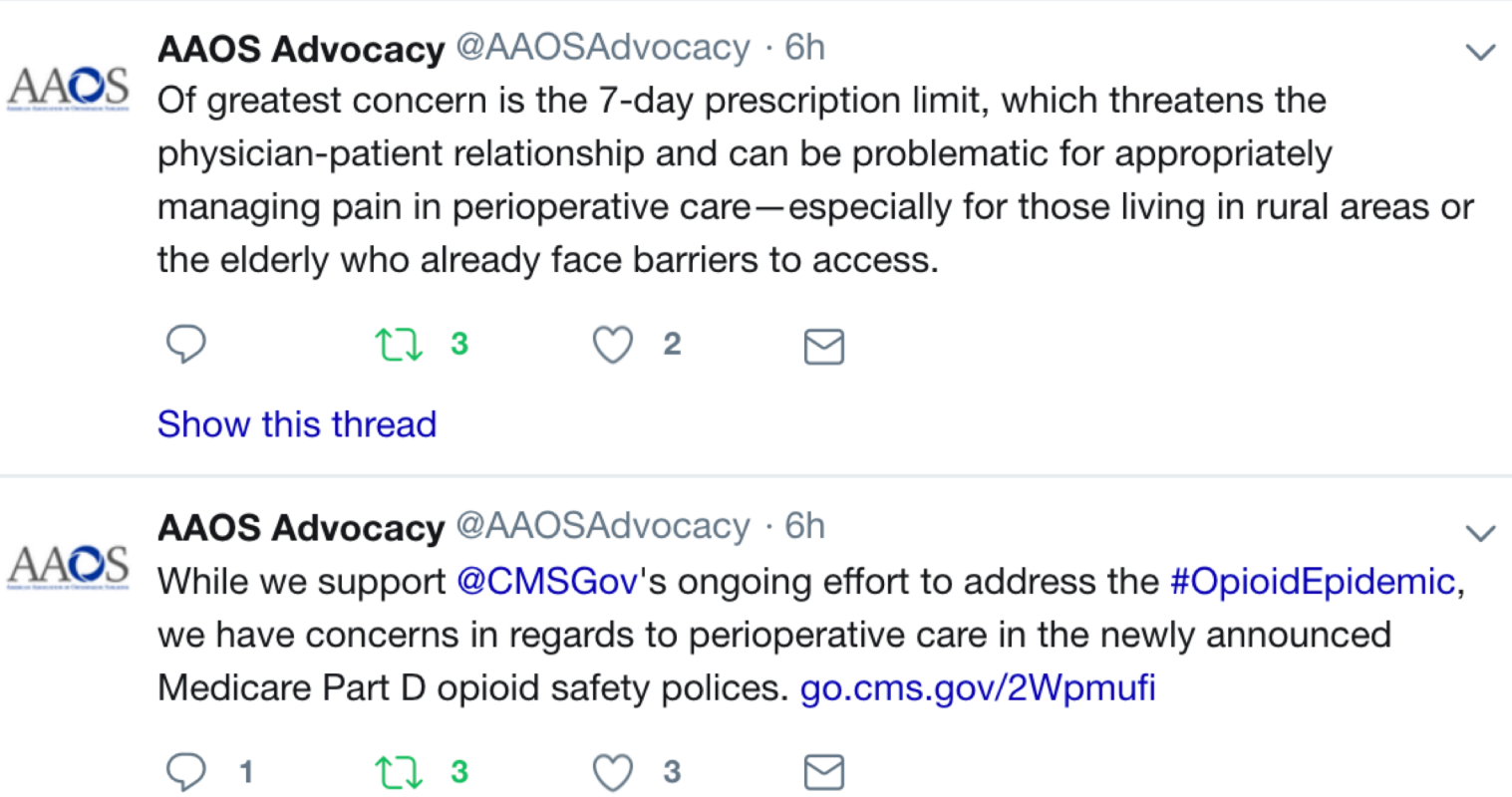
CY 2017 HOPD/ASC Proposal

”Although CMS is not aware of any scientific studies that support an association between scores on the pain management dimension questions and opioid prescribing practices, we are proposing to remove the pain management dimension of the HCAHPS survey for purposes of the Hospital VBP Program in an abundance of caution.”

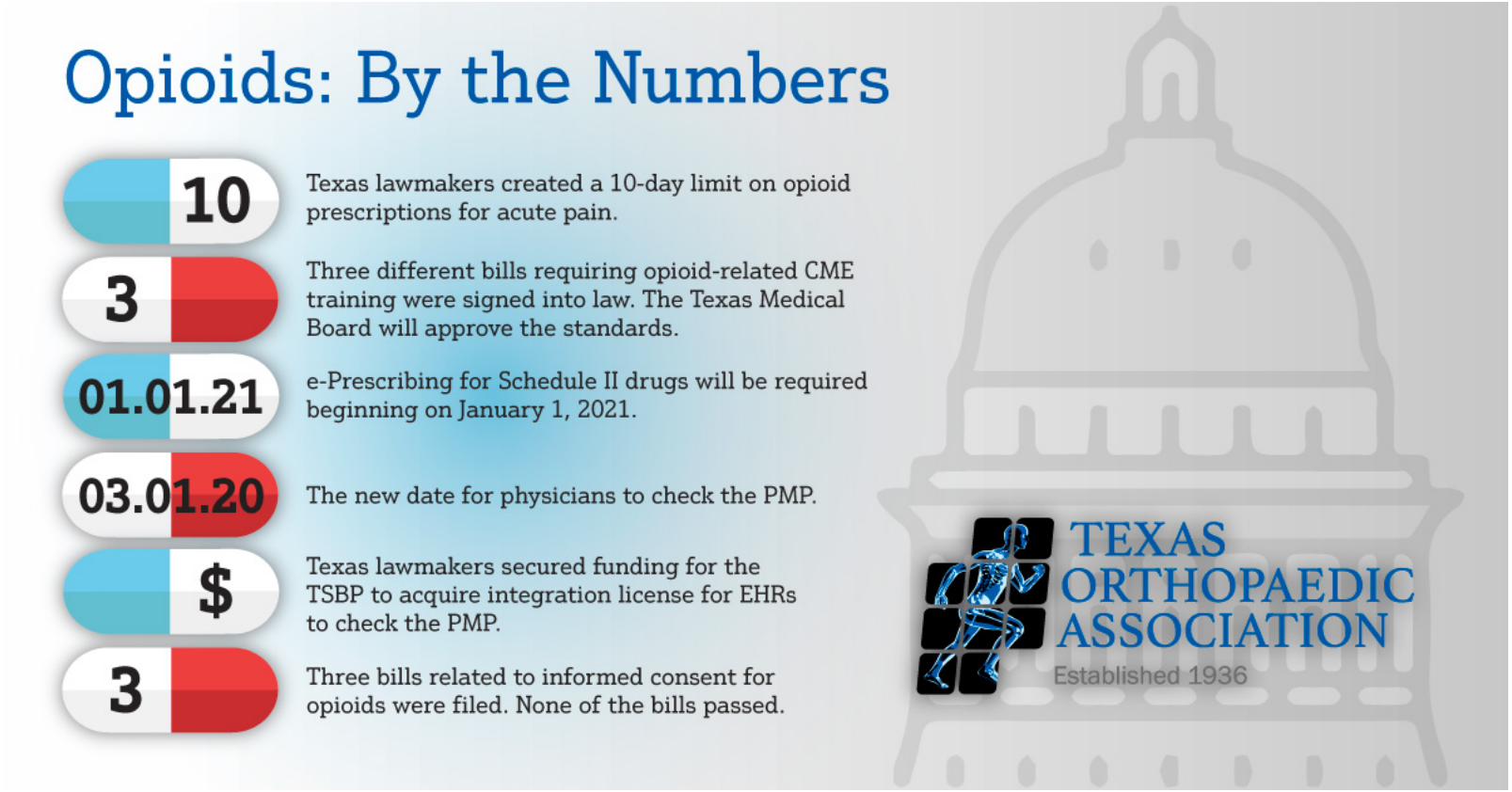
“While CMS is developing alternative pain management questions, HCAHPS survey data on all dimensions of care, including pain management, will continue to be publicly reported under the Hospital Inpatient Quality Reporting (IQR) Program in recognition that pain control is an important aspect to delivering quality care.”

HCAHPS
Hospital Care Quality Information from the Consumer Perspective

Medicare AAOS Response to Part D Opioid Limits



New Opioid Laws State of Texas



2019 Texas Legislature Opioid Limits, CME & e-Prescribing

HB 2174 (Rep. John Zerwas, MD, R-Richmond) & SB 1233 (Sen. Lois Kolkorst, R-Brenham)

- **Ten-day limit.** The original proposal called for seven days.
- Two hours of **CME** in opioid prescribing for physicians.
- **Mandatory e-prescribing** for Schedule II controlled substances in 2021 (Medicare implementation date).

TEXAS ORTHOPAEDIC ASSOCIATION
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HB 2174 & SB 1233:

Lack Important Exceptions for Musculoskeletal Surgeries & Injuries

HB 2174 and **SB 1233** would place seven-day limits on Schedule II drugs, which are often necessary to help patients recover from serious musculoskeletal injuries and surgeries. Some patients may benefit from more than seven days on these drugs to alleviate the pain due to serious musculoskeletal injuries and surgeries.

"Although 7 days appears to be more than adequate for many patients undergoing common general surgery and gynecologic procedures, prescription lengths likely should be extended to 10 days, particularly after common neurosurgical and musculoskeletal procedures, recognizing that as many as 40% of patients may still require 1 refill at a 7-day limit."

Scully RE, Schoenfeld AJ, Jiang W, et al. Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures. JAMA Surg. 2018;153(1):27–43. doi:10.1001/

Lawmakers' Ask

HB 2174 and **SB 1233** wisely recognize that certain cancer and hospice patients may need a supply of Schedule II drugs for more than seven days by creating an exemption for these patients. It is critical for the bills to add a similar exception for serious musculoskeletal injuries and surgeries.

Why a Seven-Day Limit Requires Exceptions

Despite the use of multimodal pain protocols, an alternative to an opioid for a painful injury or surgery does not always exist. An anti-inflammatory drug is not a good alternative for those with gastric or kidney problems. Similarly, with liver conditions, the use of acetaminophen (Tylenol) is not a good alternative.

In addition, it is critical to note that some serious musculoskeletal surgeries, such as lower extremity joint replacement surgery, may benefit from a prescription of approximately 14 days to alleviate pain. In addition, multi-trauma and pelvic fractures may benefit from more than 14 days. For these types of surgeries, limiting Schedule II drugs to seven days could result in:

- Unnecessary trips to the emergency department to control the pain.
- Unnecessary trips to the physician's office to acquire another prescription when the patient should be at home recovering.

Other examples of serious musculoskeletal injuries and surgeries that may require more than seven days include:

- Foot and ankle surgeries – such as ankle fractures, total ankle replacements, and foot reconstructive procedures – require patients to be non-weight bearing and rely on crutches, walkers, or wheelchairs for a minimum of two to three weeks. Additionally, the patient's leg is elevated to reduce swelling, control pain, and optimize wound healing. The first post-operative visit is typically at the two-week mark. Forcing a patient to come to the office early for a prescription refill may jeopardize their outcome due to the unnecessary travel. While a telephone call for a refill at the seven-day mark may seem like a logical solution, most surgeons would prefer to see the patient in person to ensure that nothing has changed before adding a new prescription.
- High-energy injuries, such as pelvic and femur fractures, create tremendous pain. Fractures in all groups of patients can be treated non-operatively or operatively, and this may require a narcotic prescription of seven days or more.
- Surgical correction for scoliosis and other multi-level spinal surgeries are extremely painful and often require a narcotic response for greater than seven days.
- Complex reconstructive procedures – which may include osteotomies, deformity correction, limb lengthening procedures, and hip/pelvis procedures – require proper pain management to allow for early mobilization. This also avoids harmful side effects, including arthrofibrosis and blood clots.
- Patients who undergo rotator cuff surgery often require two weeks of narcotic medication and are prohibited from driving while in a restrictive sling. This particularly affects elderly patients in rural areas who live alone and have long, expensive, and painful taxi rides to the pharmacy.

CME Education Three Different Laws

HB 2174

Rep. John Zerwas, MD (R-Richmond)

"… related to approved procedures of prescribing and monitoring controlled substances" that is approved by regulatory bodies.

HB 2454

Rep. Four Price (R-Amarillo)

"…reasonable standards of care, identification of drug-seeking behavior in patients, and effectively communicating with patients regarding the prescription of an opioid or other controlled substance."

HB 3285

Rep. JD Sheffield, DO (R-Gatesville)

"…best practices, alternative treatment options, and multi-modal approaches to pain management that may include physical therapy, psychotherapy, and other treatments."

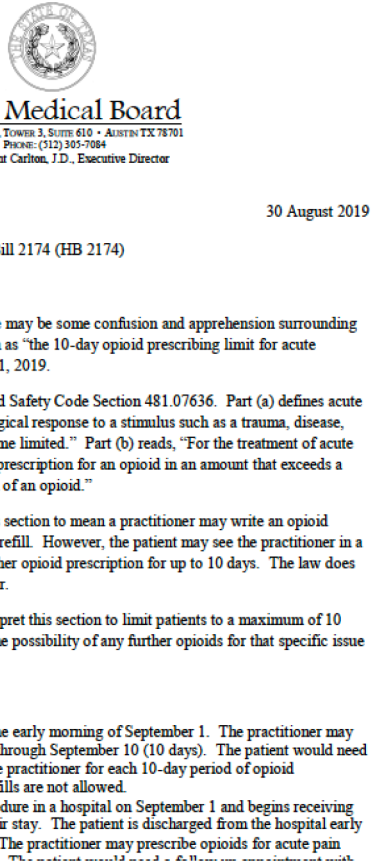
Ten-Day Limits Texas Medical Board Interpretation

The Texas Medical Board does not interpret this section to limit patients to a maximum of 10 days of opioids for acute pain without the possibility of any further opioids for that specific issue or "episode of care."

Examples:

1. A patient has a fracture during the early morning of September 1. The practitioner may prescribe opioids or acute pain through September 10 (10 days). The patient would need a follow up appointment with the practitioner for each 10-day period of opioid prescriptions for acute pain. Refills are not allowed.

2. An inpatient has a surgical procedure in a hospital on September 1 and begins receiving opioids for acute pain during their stay. The patient is discharged from the hospital early in the morning of September 6. The practitioner may prescribe opioids for acute pain through September 15 (10 days). The patient would need a follow up appointment with the practitioner for each 10-day period of opioid prescriptions for acute pain. Refills are not allowed.



Texas Medical Board
333 Guadalupe, Tower 3, Suite 610 • Austin TX 78701
Phone: (512) 305-7084
Stephen Brint Carlton, J.D., Executive Director

30 August 2019

SUBJECT: Initial Guidance on House Bill 2174 (HB 2174)

To Whom It May Concern,

The Texas Medical Board is aware there may be some confusion and apprehension surrounding House Bill 2174 (HB 2174), also known as "the 10-day opioid prescribing limit for acute pain". HB 2174 is effective September 1, 2019.

The new language is found in Health and Safety Code Section 481.07636. Part (a) defines acute pain as "the normal, predicted, physiological response to a stimulus such as a trauma, disease, and operative procedures…[which] is time limited." Part (b) reads, "For the treatment of acute pain, a practitioner may not: (1) issue a prescription for an opioid in an amount that exceeds a 10-day supply; or (2) provide for a refill of an opioid."

The Texas Medical Board interprets this section to mean a practitioner may write an opioid prescription for up to 10 days without a refill. However, the patient may see the practitioner in a follow up appointment and receive another opioid prescription for up to 10 days. The law does not limit how many times this may occur.

The Texas Medical Board does not interpret this section to limit patients to a maximum of 10 days of opioids for acute pain without the possibility of any further opioids for that specific issue or "episode of care".

Examples:

1. A patient has a fracture during the early morning of September 1. The practitioner may prescribe opioids for acute pain through September 10 (10 days). The patient would need a follow up appointment with the practitioner for each 10-day period of opioid prescriptions for acute pain. Refills are not allowed.
2. An inpatient has a surgical procedure in a hospital on September 1 and begins receiving opioids for acute pain during their stay. The patient is discharged from the hospital early in the morning of September 6. The practitioner may prescribe opioids for acute pain

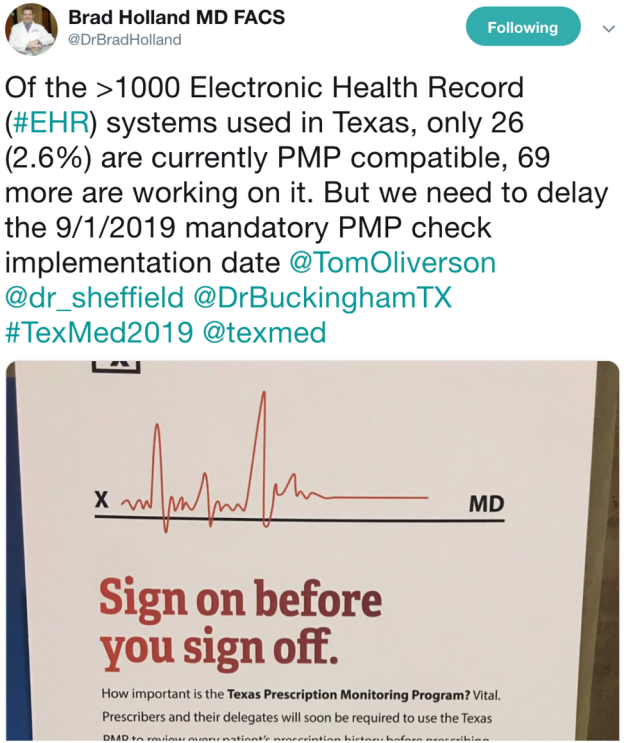
2019 Texas Legislature Other Opioid Initiatives

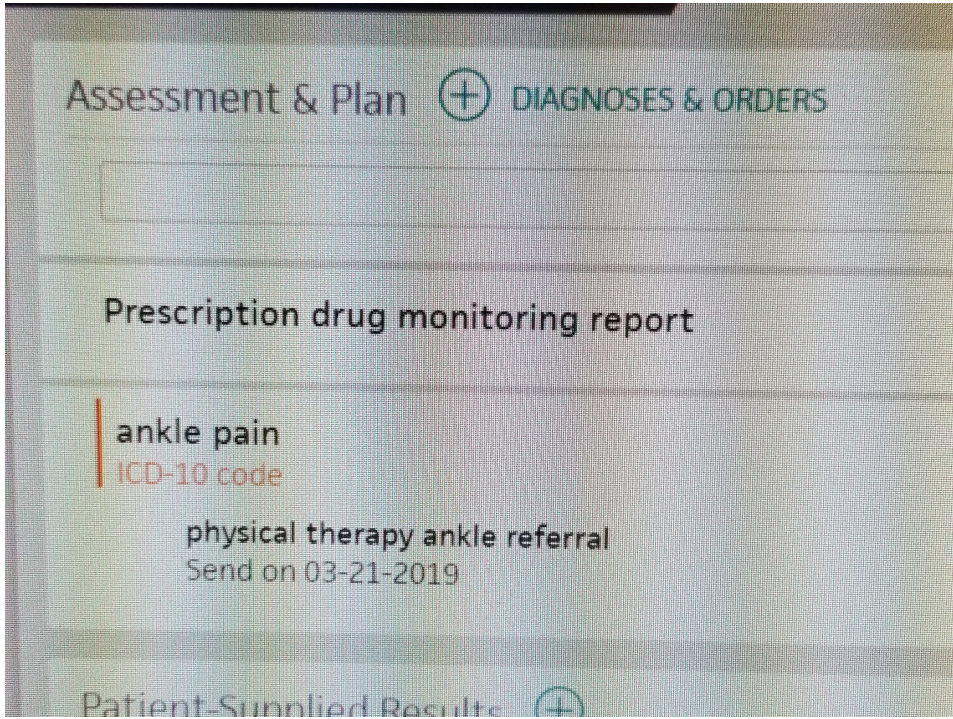
Over a Dozen Bills Were Filed

- **Opioid Risk Discussion** - HB 2710 (Rep. Ana-Maria Ramos, D-Richardson) – The bill would require physicians to document a discussion regarding the risks associated with opioids. *The bill did not pass.*
- **Informed Consent & Standards of Care** - HB 2811 (Rep. Four Price, R-Amarillo) – The bill would have created a lengthy "standard of care" set of guidelines for physicians to follow. *The bill did not pass.*
- **Parental Waiver** – HB 2085 (Rep. Jay Dean, R-Longview) – The bill would create a "non-opioid directive" for parents. *The bill did not pass.*
- **Disposal Locations** – The bill by Rep. Jay Dean (R-Longview) would direct the Texas State Board of Pharmacy and pharmacies/hospitals to keep lists of drop-off locations. *The bill passed.*
- **Prescription Monitoring Program** – HB 3284 (Rep. JD Sheffield, DO, R-Gatesville) included an initiative to delay the mandate to check the state's prescription monitoring program until March 1, 2020. *The bill passed.*

Doctor Shopping Texas' Prescription Monitoring Program

09.01.19 Effective Date Now Becomes 03.01.20





Medicare's CY 2019 ASC Proposal Exparel

Summer 2018 Proposal

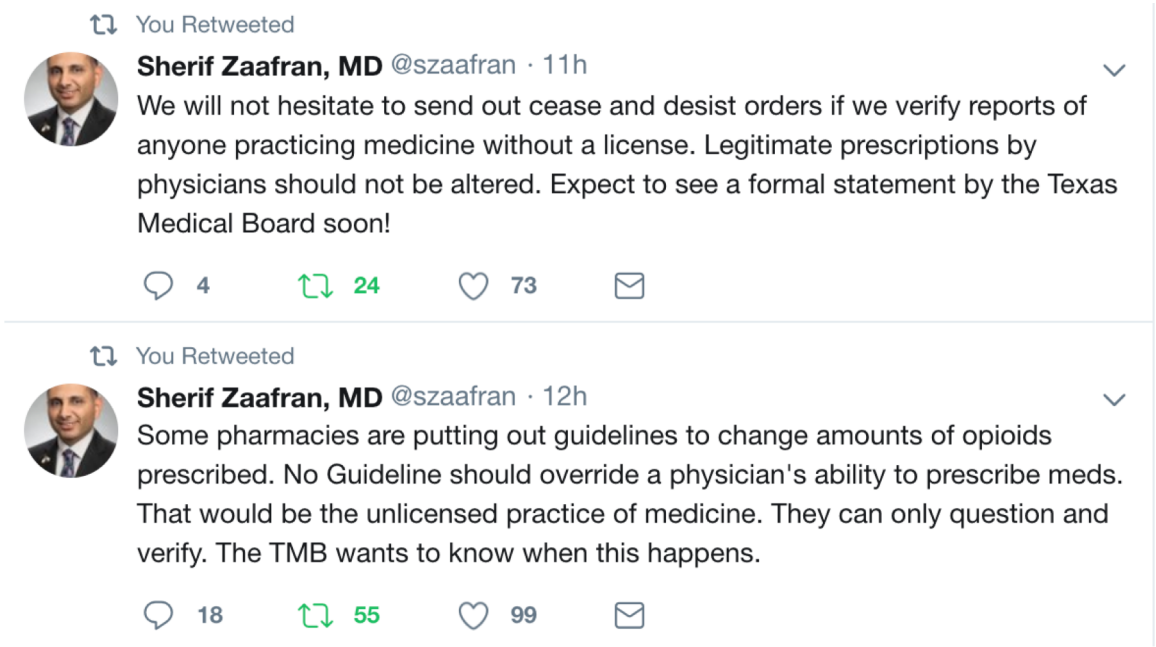
CMS proposed to include a separate payment for non-opioid pain management drugs that serve as a "supply" when used in an ASC surgery.

CMS provided commentary regarding HCPCS code C9290 (Exparel), which is the code that meets the proposed criteria.

AAOS's September 2018 Comments

- "The AAOS supports incentives to increase the availability of non-opioid alternatives for pain management. For example, there has been some success with intravenous acetaminophen, as an alternative to opioids, but high cost may limit its use. Also, we greatly encourage other effective forms of pain management, such as regional nerve blocks, icing wraps, transcutaneous stimulators, and topical analgesics."

Notify the TMB Are Pharmacists Changing Your Rx?



TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

Physician & Allied Health Provider Licensing Issues

Texas Medical Disclosure Panel – New Forms

Scope of Practice

Texas' Professional Liability Law

Texas Medical Disclosure Panel & New Forms January 1, 2020 (Look at TOA's Newsletter)

MEMORANDUM

Note: The information contained in this memo is provided for informational purposes only, and should not be construed as legal advice on any subject matter. Consult with your attorney for legal advice.

To: TOA Reference File

From: Andrea I. Schwab, JD, CPA

Date: 8/28/19

RE: Surgery Consent

A physician must obtain informed consent prior to performing a procedure. In the past, consent was required for risks and disclosures that a physician in a certain community would deem material. Now, a claim based on failure to obtain informed consent is governed by section 74.101 of the Texas Civil Practice and Remedies Code, which provides:

> In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

TEX. CIV. PRAC. & REM. CODE ANN. § 74.101.

The Legislature therefore requires the standard for informed consent to be based on a "reasonable person" standard--those risks that would influence a reasonable person in deciding whether to consent to a recommended medical procedure. Expert medical testimony would be required to determine whether disclosure is required, and if so, how much disclosure is required. *Peterson v. Shields*, 652 S.W.2d 929, 931 (Tex. 1983).

Ministers, English Professors, Physicians, Optometrists, Chiropractors What Is a "Doctor"?

Is this person a medical doctor?[1]	Yes (%)	No (%)	Not sure (%)
Dentist	61	33	6
Podiatrist	67	22	11
Optometrist	47	43	10
Psychologist	43	50	7
Doctor of nursing practice	39	50	11
Chiropractor	27	63	10

American Medical Association's 2018 "Truth in Advertising" Campaign.

Ministers, English Professors, Physicians, Optometrists, Chiropractors What Is a "Doctor"?

Patients strongly prefer physicians to lead the health care team

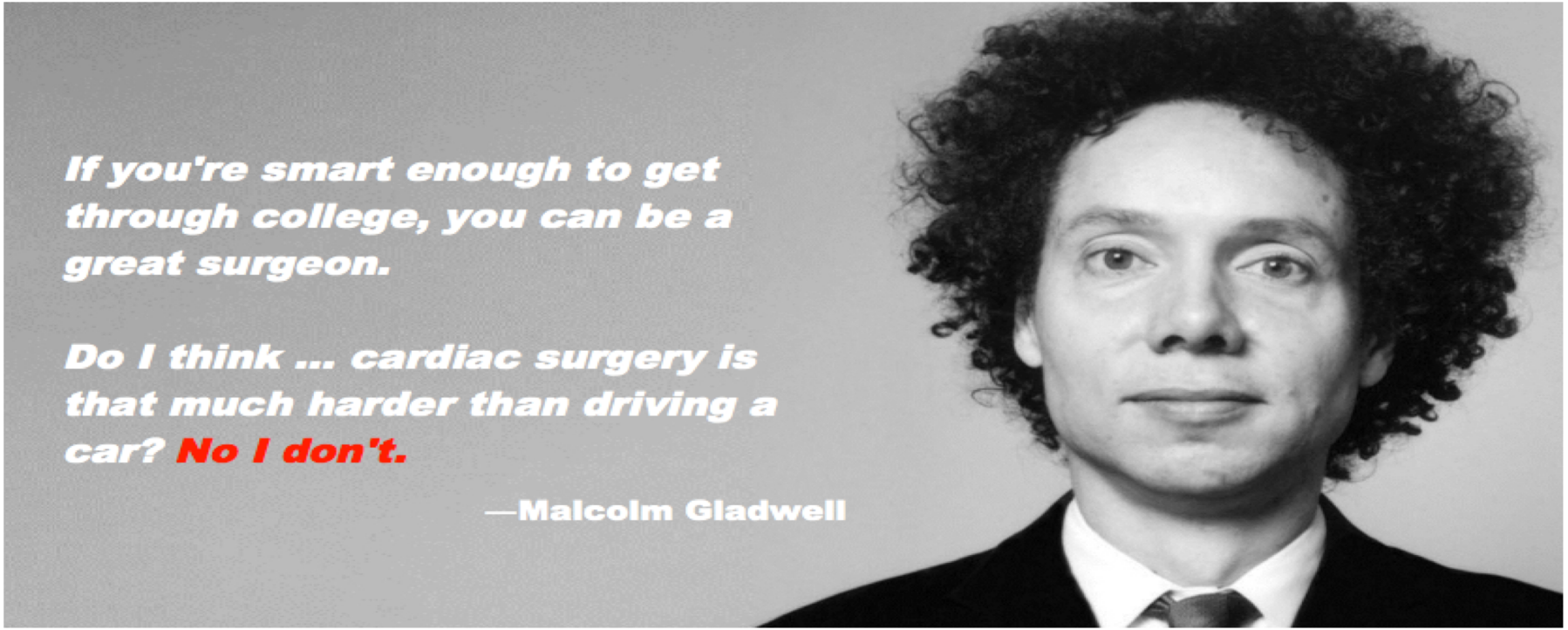
Should only a MD or DO be allowed to perform the following procedures or should other health care professionals be allowed to perform this specific activity?[1]	Only a MD or DO (%)	Both equally/ either one (%)	Don't know (%)
Amputations of the foot	89	4	7
Surgical procedures on the eye that require the use of a scalpel	89	5	7
Facial surgery such as nose shaping and face lifts	85	7	8
Treat chronic pain by prescribing drugs or other substances that have a high potential for addiction or abuse	60	32	8
Write prescriptions for medication to treat mental health conditions such as schizophrenia and bi-polar disorder	63	28	9
Order and interpret diagnostic imaging studies like X-rays and MRIs	41	52	7
Administer and monitor anesthesia levels and patient condition before and during surgery	61	30	9
Commit individuals for psychiatric care against their wil	63	24	13

American Medical Association's 2018 "Truth in Advertising" Campaign.

Who Is a "Doctor" in Texas? Healing Art Identification Act

- While the Act identifies several types of practitioners who may identify themselves as various types of "doctor," the statute establishes more limited boundaries for use of the terms "physician" and "surgeon."

- According to this law, **only those licensed by the Texas Medical Board (TMB) holding either a doctor of medicine or doctor of osteopathy degree may identify themselves as a "physician" or "surgeon."**


If you're smart enough to get through college, you can be a great surgeon.
Do I think ... cardiac surgery is that much harder than driving a car? No I don't.
—Malcolm Gladwell

"Scope of practice bills as a matter of policy matter is something that **conservatives and some liberals can make common cause** about because, on the one hand, it **increases access to care, which liberals like**, and on the other hand, it can lower the cost of care and **remove barriers to entry, which conservatives like**," said John Davidson, a health care policy analyst at the Texas Public Policy Foundation, a conservative think tank. "It's an opportunity for both sides to work together."

THE TEXAS TRIBUNE

"Proponents of legislation expanding so-called scope of practice – generally widening the number of people who can perform routine tasks – say it would help **alleviate the state's doctor shortage** and note that many of the bills have bipartisan co-authors."

"But opponents of these kinds of bills – especially the Texas Medical Association, which represents doctors, and the Texas Dental Association, which represents dentists – say they **jeopardize patient safety by placing too much trust in people who lack the necessary medical training**."

THE TEXAS TRIBUNE

"Safety is at risk": Future of Texas plumbers' licensing and regulation uncertain after legislative impasse

> Some plumbers are calling for a special session after the Texas House ended the state plumbing code and a plumbing regulation agency that has dozens of employees.

BY **ELIZABETH BYRNE** MAY 28, 2019 6 PM

Texas & Independent Nurse Practitioners 2019 Legislation

Coalition for Health Care Access

Supports full practice authority for APRNs

Texas's outdated laws prevent advanced practice registered nurses (APRNs) from providing health care to the full extent of their licensure and training. Right now, APRNs must sign a delegation agreement with a collaborating physician in order to practice, even though that physician is not required to be on site where the APRN practices or see any of the APRN's patients.

This delegation agreement adds to health care bureaucracy and red tape, takes time away from patients, and comes with overhead costs for businesses and providers. Twenty-four states, the VA, and all branches of the military have repealed these laws to expand access to care to patients. **We urge Texas to do the same.**

This year, Chairwoman Stephanie Klick is introducing a full practice authority bill that would remove these barriers by

- Providing a pathway to full practice for nurse practitioners, certified nurse midwives and clinical nurse specialists after at least one year of work experience under a delegating physician.
- Increasing the required continuing education requirements for APRNs from 21 to 48 hours, the equivalent of physician continuing education requirements.
- Expanding access to primary care.

The bill makes no changes to APRN scope of practice.

AARP Real Possibilities
TEXAS ASSOCIATION OF BUSINESS The Texas State Chamber
University Health System
TORCH
APRN Alliance
Texas Public Policy Foundation
CTD Coalition of Texans with Disabilities
CENTER for PUBLIC POLICY PRIORITIES
NLAC Nursing Legislative Agenda Coalition
THE HEARTLAND INSTITUTE FREEDOM RISING
NAMI Texas National Alliance on Mental Illness
LeadingAge Texas
R Street Free markets. Real solutions.
Methodist Healthcare Ministries OF SOUTH TEXAS, INC. "Serving Humanity to Honor God"
THE TEXAS SILVER-HAIRED LEGISLATURE
TEXAS BUSINESS LEADERSHIP COUNCIL
TEXAS IMPACT people of faith working for justice
Veterans Deserve Care
YOUNG CONSERVATIVES OF TEXAS

Physical Therapy Direct Access in Texas HB 29

15 Business Days

- Fellowship- or residency-trained PT.

10 Business Days

- All other PTs.*

Patient Disclosure

- Patient signature.

Podiatry Is the Ankle Part of the Foot?

Texas Legislature Optometry Surgical Privileges?

HB 1798, SB 1223 & HB 3505 Failed in the 2019 Texas Legislature

Is a Physician Assistant… An Assistant?

The American Academy of Physician Assistants (AAPA) approved a policy in May seeking to remove state regulations that "require a PA to have and/or report a supervisory, collaborating, or other specific relationship with a physician … [and seeking to establish] autonomous state boards with a majority of PAs as voting members to license, regulate and discipline PAs, or for PAs to be full voting members of medical boards." With this move, AAPA is moving forward with its push to eliminate the formal supervisory relationship between physicians and PAs.

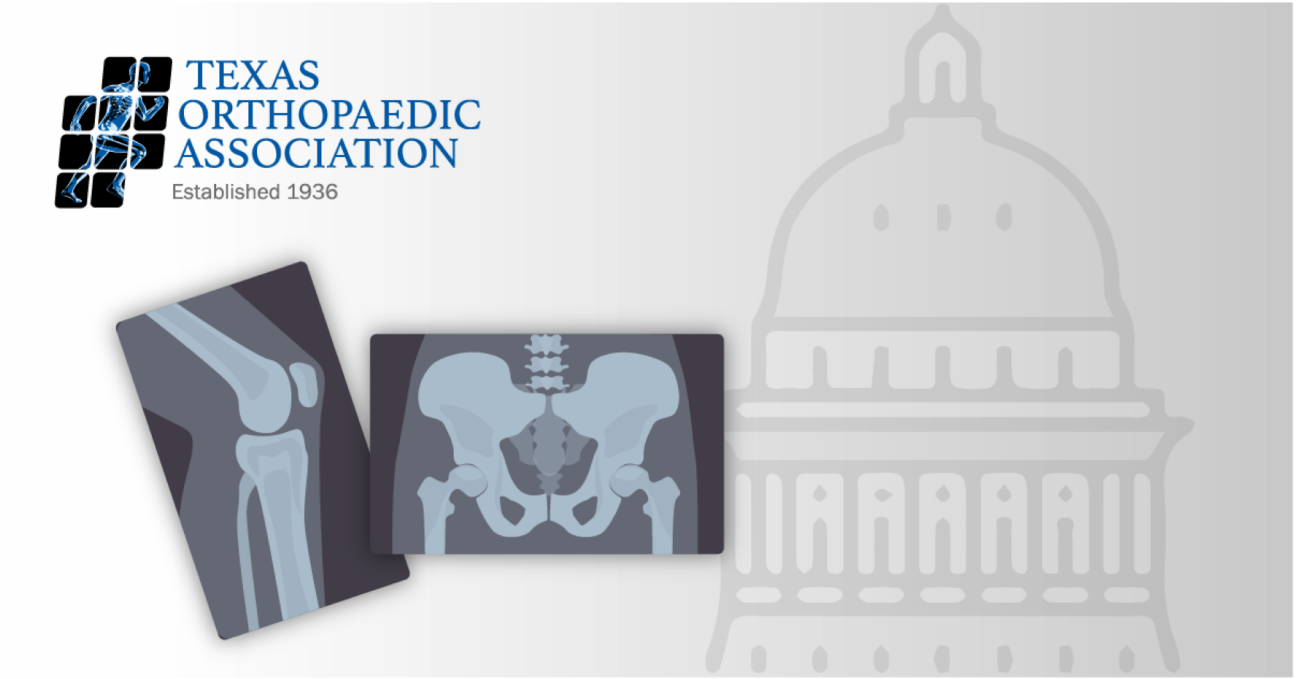
The move provoked strong opposition from the American Medical Association (AMA) House of Delegates in June. An AMA committee report labeled this as "anticipated legislation to move PAs into a more autonomous role" since state medical boards currently have authority over PAs.

AAPA is branding the effort as "Optimal Team Practice" with an overarching goal of removal of state laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice. In addition, the new policy advocates for the establishment of autonomous state boards with a majority of PAs as voting members to license, regulate and discipline PAs, or for PAs to be full voting members of medical boards. Finally, the policy says that PAs should be eligible to be reimbursed directly by public and private insurance for the care they provide. According to AAPA, "Optimal Team Practice" resembles, but is not the same as, full practice authority, which nurse practitioners have been pursuing.

AAOS in the States

Mid-Levels Question Regarding Imaging Delegation

January 2019 Rule Proposal Pulled | September 20, 2019, Proposal Expected



Chiropractors What Is Neurological?

REQUEST:

TCA requests that interested stakeholders (namely TMA, the Texas Orthopaedic Association, and TCA, with the guidance of Chairman Schwertner and his staff) meet to discuss the potential for compromise legislation concerning the practice of chiropractic as it relates to the nerve/neurological issue presented in litigation. TCA's hope is that all parties can work together to achieve a result that provides clarity into the conditions appropriate for a chiropractor to treat.

TCA recognizes that the parties may have concerns about the breadth of chiropractic scope, and specifically that inclusion of nerves or a neurological component within chiropractic scope may lead to chiropractors treating a variety of neurological disorders. TCA believes that the practice of chiropractic should include a neurological component, but agrees that such a component should have clear, well-defined limitations to prohibit chiropractors from treating neurological disorders that are not also disorders of the musculoskeletal system. For example, sciatica (often defined as "pain in the distribution of the sciatic nerve") includes a neurological component and is a condition for which patients often seek chiropractic care; while Alzheimer's disease is a neurological condition that would be inappropriate for a chiropractor to treat.

Texas Chiropractic Association 2019 Legislature Request

TCA would welcome the opportunity to discuss these concerns related to chiropractic scope and believes such discussions could lead to legislation that enables chiropractors to treat conditions that have a neurological component, like sciatica, while also providing clear limitations. TCA expects that this dialogue would include two or three face-to-face meetings between stakeholders, with any remaining discussions being conducted by phone and email.

POTENTIAL LEGISLATIVE SOLUTION:

TCA has prepared the following language as a potential legislative solution to this issue:

- Amend Occupations Code 201.002(a) (definitions within the Chiropractic Act) to include a definition of "neuromusculoskeletal" as:
  - "Neuromusculoskeletal" means pertaining to the musculoskeletal and nervous systems in relation to disorders that manifest themselves in both the musculoskeletal and nervous systems, including disorders of a biomechanical or functional nature.
- Amend Occupations Code 201.002(b) (scope of practice within the Chiropractic Act) as follows:
  - A person practices chiropractic under this chapter if the person:
    - (1) uses objective or subjective means to diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and neuromusculoskeletal system of the human body;
    - (2) performs nonsurgical, nonincisive procedures, including adjustment and manipulation, to improve the subluxation complex or the biomechanics of the neuromusculoskeletal system;

RATIONALE FOR THIS POTENTIAL LEGISLATIVE SOLUTION:

- The definition of "neuromusculoskeletal" above comes from the World Health Organization's *WHO Guidelines on Basic Training and Safety in Chiropractic*.

Anesthesiologists vs. CRNAs Corpus Christi

Does Hospital Plan to Give CRNAs Autonomy?

By David Doolittle

The Texas Society of Anesthesiologists (TSA) is questioning a Corpus Christi hospital's decision to replace its long-time anesthesiology team with a group it says appears ready to give certified registered nurse anesthetists (CRNAs) more autonomy than Texas law allows.

Earlier this year, Christus Spohn Health System terminated its contract with Gulf Shore Anesthesiology, a group of 30 physician anesthesiologists and 15 nurse anesthetists who had been with the hospital for more than 60 years. The hospital then announced in May it had awarded the contract to EmergencHealth, whose

Texas Medical Board Attorney General Request - Anesthesia

March 26, 2019 Request

1(a). Is providing anesthesia the practice of medicine?

(b). When a physician delegates the providing and administration to a Certified Registered Nurse Anesthetists (CRNAs) does the Texas Medical Board, via the Medical Practice Act, have continuing regulatory authority over a physician's decision and process for delegating that authority to a CRNA?

2. Does the CRNA have independent authority to administer anesthesia without delegation by a physician?

KEN PAXTON
ATTORNEY GENERAL of TEXAS

RQ-0278-KP
Go to:
https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2019/pdf/RQ0278KP.pdf

Received: Tuesday, March 26, 2019

Re: Regulatory authority over the administration of anesthesia when delegated by a physician to a nurse anesthetist

Requestor: Sherif Zaafran, M.D.
President
Texas Medical Board
Post Office Box 2018
Austin, Texas 78768-2018

Anesthesia Attorney General Answers

September 2019 Answers

1(a). Is providing anesthesia the practice of medicine? "The practice of medicine includes the provision of anesthesia by a licensed physician. However, pursuant to subsection 301.002(2)(G) of the Occupations Code, when a certified registered nurse anesthetist administers anesthesia pursuant to a physician's delegation, such act falls within the scope of professional nursing."

(b). When a physician delegates the providing and administration to a Certified Registered Nurse Anesthetists (CRNAs) does the Texas Medical Board, via the Medical Practice Act, have continuing regulatory authority over a physician's decision and process for delegating that authority to a CRNA? "The Legislature authorized the Texas Medical Board to take disciplinary action against a physician who delegates professional medical acts to a person whom the physician knows or should know is unqualified to perform the acts. Thus, the Board possesses regulatory authority over a physician's desire to delegate the providing and administration of anesthesia to a certified registered nurse anesthetist."

2. Does the CRNA have independent authority to administer anesthesia without delegation by a physician? "A certified registered nurse anesthetist does not possess independent authority to administer anesthesia without delegation by a physician."

Attorney General Decision September 5, 2019

TSA Governmental Affairs @GovtAffairsTsa · Sep 5

Thank you to @TXAG @KenPaxtonTX for recognizing anesthesia is the practice of medicine and CRNAs do NOT practice independently. TX Medical Board can discipline MDs not supervising b/c the nurses can't practice independently. #anesth19

7 10

TxANA @CrnaTxANA · Sep 5

Regarding whether the TMB has regulatory authority over the delegated act, the opinion only cites the TMB's authority over a physician's decision to delegate, not the performance of the act itself. 3/

1 4

Show this thread

TxANA @CrnaTxANA · Sep 5

In brief, when CRNAs provide anesthesia care, it is the practice of nursing, not medicine. 2/

1 2 5

Show this thread

TxANA @CrnaTxANA · Sep 5

AG Paxton sides with TxANA, maintaining the status quo for CRNAs and the patients we serve, ensuring access to anesthesia care. #txlege 1/

1 6 16

Anesthesia Anesthesiologist Assistants' Licensure

2015 Map; Legislation to Be Heard on Thursday

Maintenance of Certification Texas Legislature

SB 1148 Was Signed into Law in 2017

SB 1148 (Sen. Dawn, Buckingham, MD, R-Austin) prohibits facilities and health plans from discriminating against a physician based on his or her maintenance of certification status.

A “compromise” in the final days of the Legislature will allow a medical staff to vote whether a facility should be required to require MOC or not. However, at least one hospital system has said that an individual hospital’s decision is not valid.

This Issue Views 22,647 | Citations 0 | Altmetric 58

Viewpoint FREE

August 22/29, 2017

Maintenance of Certification and Texas SB 1148

A Threat to Professional Self-regulation

David H. Johnson, MD[1]

» Author Affiliations | Article Information

JAMA. 2017;318(8):697-698. doi:10.1001/jama.2017.10127

During the 2017 legislative session Texas lawmakers voted to approve Senate bill (SB) 1148 entitled "Relating to Maintenance of Certification by a Physician or an Applicant for a License to Practice Medicine in This State."[1] SB 1148 was intended to restrict the use of maintenance of certification (MOC) as a credential for hospital privileging, to wit: "a hospital, institution, or program that is licensed by this state, is operated by this state or a political subdivision of this state, or directly or indirectly receives

Lawsuits 2019 Texas Legislature

Exceptions to the Willful and Wanton Standard

HB 2362 by Rep. Moody (D-El Paso) and Rep. Price (R-Amarillo).

Indexing the Non-Economic Damage Cap

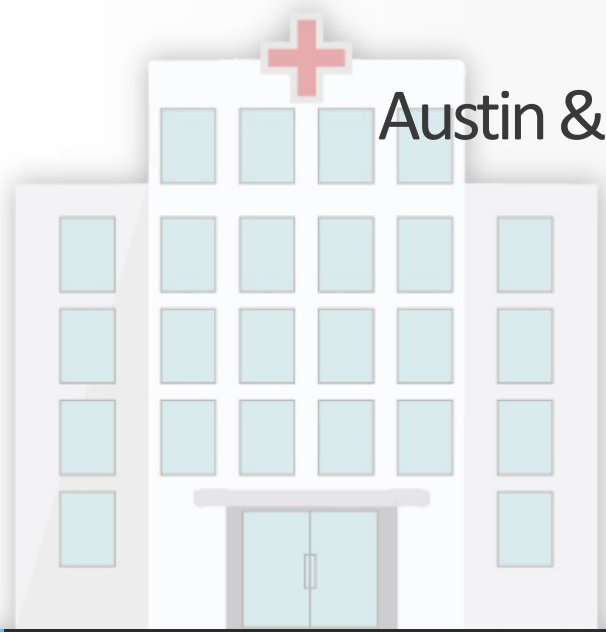
HB 765 by Rep. Wu (D-Houston). Retroactive to September 1, 2013, the bill would increase the non-economic damage cap by 36 percent from $250,000 to $339,899.

Willful and Wanton The Filed Legislation

HB 2362 would remove the existing emergency care willful and wanton standard in the following scenarios:

- When the patient arrives in either the hospital's emergency department or obstetrical unit in stable condition regardless of whether the patient later suffers an emergency.
- When the patient has been stabilized or is capable of receiving non-emergency treatment even if the patient later suffers an emergency.
- When a patient is treated in an obstetrical unit for a non-obstetric emergency.
- When the patient's treatment is unrelated to the original medical emergency.
- If the patient's emergency is caused, in whole or in part, by a health care provider, regardless of how insignificant the contribution is to the overall emergency.

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936



Austin & Washington Facilities

Hospitals

ASCs

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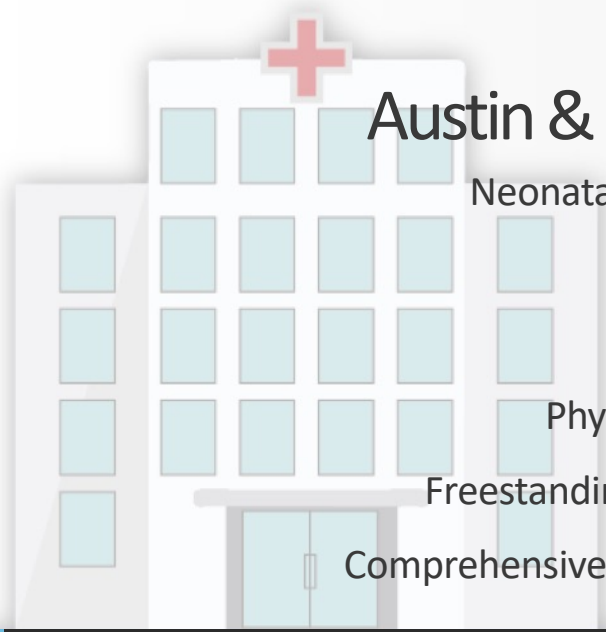


Austin & Washington Hospitals

Neonatal Levels of Care Designation

Rural Hospitals

Mergers

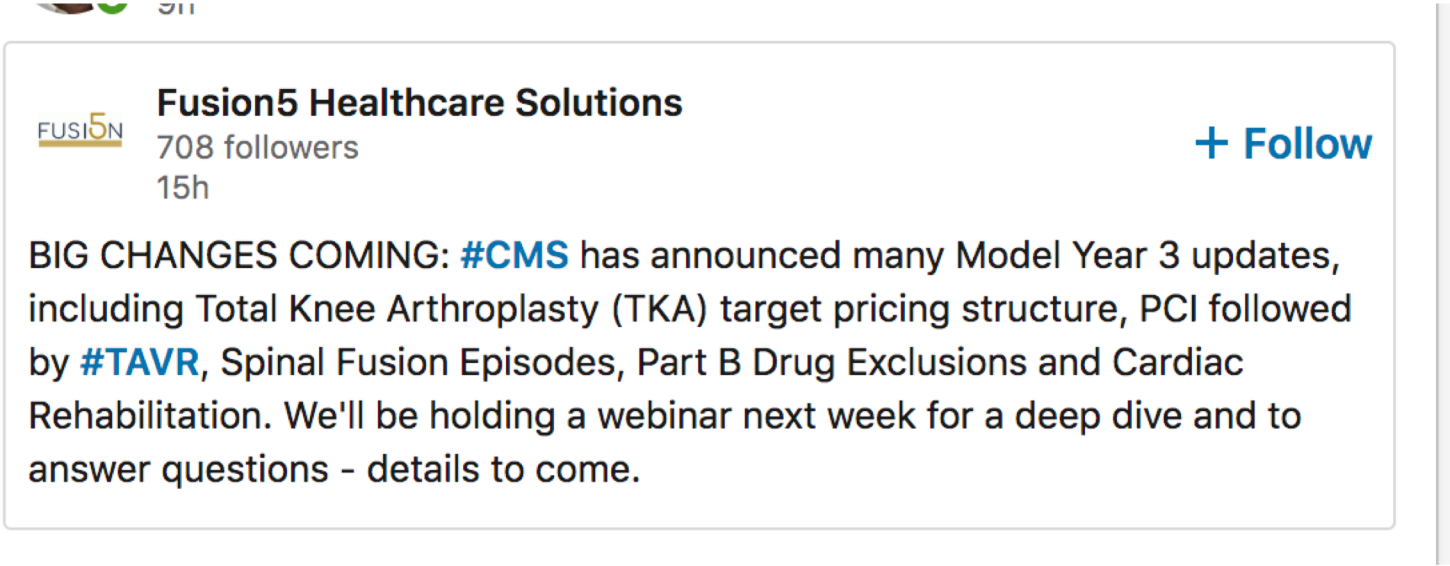
Physician-Owned Hospitals

Freestanding Emergency Medical Centers

Comprehensive Center for Joint Replacement (CJR)

BPCI-A | CJR Extension? Summer 2019 Hints

AGENCY: HHS-CMS **RIN:** 0938-AU01 **Status:** Pending Review
TITLE: Comprehensive Care for Joint Replacement Model Three Year Extension and Modifications to Episode Definition and Pricing (CMS-5529-P)
STAGE: Proposed Rule **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 08/22/2019 **LEGAL DEADLINE:** None



Two Expansion Avenues Physician Owned Hospitals

Michael Burgess, MD @michaelcburgess · Jun 4

I introduced bipartisan legislation alongside @RepGonzalez to lift the ACA's ban on physician-owned hospitals - restoring doctors' freedom to innovate and serve their patients. It's a privilege to carry on former Rep. Sam Johnson's work on this issue.

New Hospital Definition Guidance 09.06.17

CMS Released New Guidance on Medicare's Hospital "Definition" in September

- Provider-based off-campus emergency departments.
- Number of inpatient beds in relation to the size of the facility and services offered. For example, a facility with 4 inpatient beds that has 6-8 operating rooms, 20 ED bays, and a 10-bed ambulatory surgery outpatient department is not likely primarily engaged in inpatient care.
- The volume of outpatient surgical procedures compared to inpatient surgical procedures.
- If the facility considers itself to be a "surgical" hospital, are procedures mostly outpatient? Does the information indicate that surgeries are routinely scheduled early in the week, and does it appear this admission pattern results in all or most patients being discharged prior to the weekend?
- Patterns and trends in the ADC by the day of the week.
- Staffing patterns.
- How does the facility advertise itself in the community? Is it advertised as a "specialty" hospital or "emergency" hospital?

Levels of Care Designation Neonatal and Maternal Care

Overview

Created by the 2013 Texas Legislature. The neonatal levels of care designation become effective on June 9, 2016.

2019 Activity

SB 749/HB 3269 would create a process through which a hospital may appeal to an independent third party regarding the level of care designation assigned to the hospital.

Hospital Mergers State Authority

HB 3301 Passed; San Angelo

H.B. 3301 amends the Health and Safety Code to provide for a merger agreement among two or more hospitals located within a county that contains two or more hospitals and that has a population of:

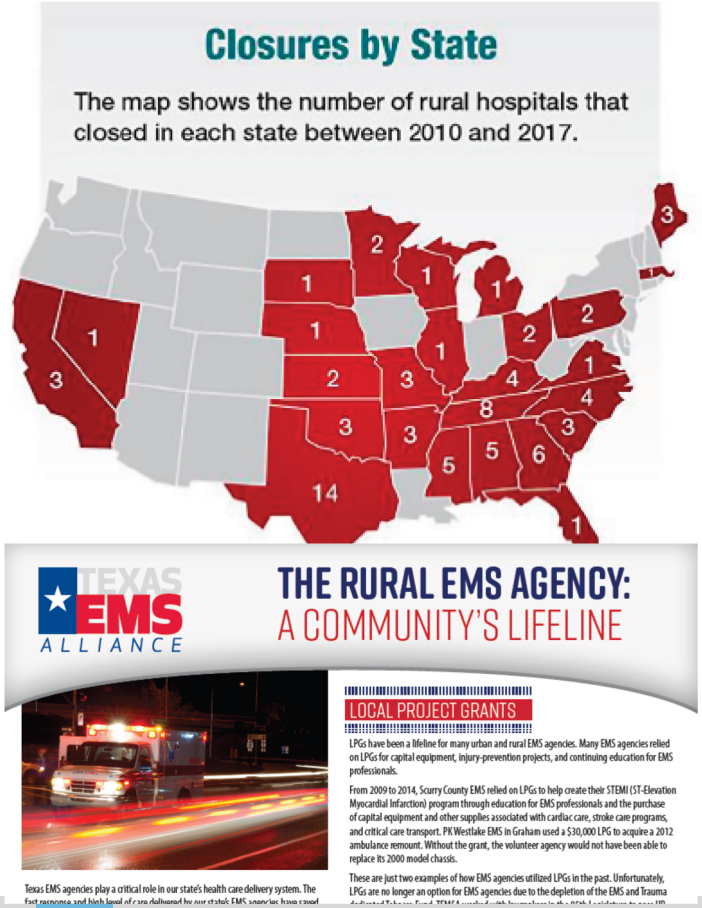
- less than 100,000 and is not adjacent to a county with a population of 250,000 or more; or
- more than 100,000 and less than 150,000 and is not adjacent to a county with a population of 100,000 or more.

H.B. 3301 authorizes two or more hospitals to negotiate and enter into a merger agreement, subject to approval by the Health and Human Services Commission (HHSC), and requires HHSC to issue a certificate of public advantage governing the merger agreement for the agreement to receive immunity under the bill's provisions. The bill defines "merger agreement" or "merger" as an agreement among two or more hospitals for the consolidation by merger or other acquisition or transfer of assets by which ownership or control over substantially all of the stock, assets, or activities of one or more previously licensed and operating hospitals is placed under the control of another licensed hospital or hospitals or another entity that controls the hospitals.

H.B. 3301 requires each hospital to submit an annual report to HHSC and sets out the required contents of the report. The bill requires HHSC to require a hospital to adopt a plan to correct a deficiency in the hospital's activities if HHSC determines that an activity of the hospital does not benefit the public and no longer meets the prescribed standard. The bill sets out provisions relating to:

- certain requirements related to the corrective action plan;
- an annual supervision fee capped at $75,000;.

Rural Hospitals 2019 Texas Legislature



Overview

Due to hospital closures, EMS is the only health care provider in some rural communities.

2019 Activity

SB 1444 & HB 3934 – Rural hospital collaborative.

SB 1621 – "Limited services rural hospital" license.

HB 871 – Telemedicine to satisfy a Level IV trauma facility.

SB 170 – The bill will reinforce and clarify into state statute the longstanding policy and practice in Texas to pay rural hospitals their actual and documented cost to treat Medicaid patients.

THE TEXAS TRIBUNE

Texas has more than 200 freestanding ERs. Lawmakers just passed bills to combat patient confusion and price gouging.

> One bill awaiting action by the governor will require freestanding emergency rooms to clearly disclose the in-network health plans they accept and the fees patients may be charged.

BY **ELIZABETH BYRNE** JUNE 3, 2019 12 AM

TEXAS ORTHOPAEDIC ASSOCIATION
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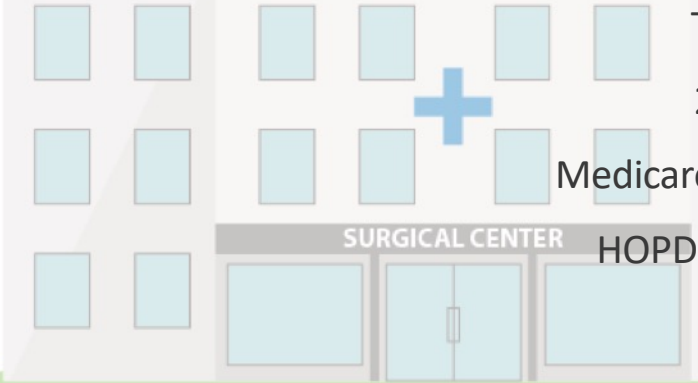
Washington & Austin ASCs + Medicare's 2020 ASC/HOPD Medicare Proposal



Timeshare ASCs in Texas?

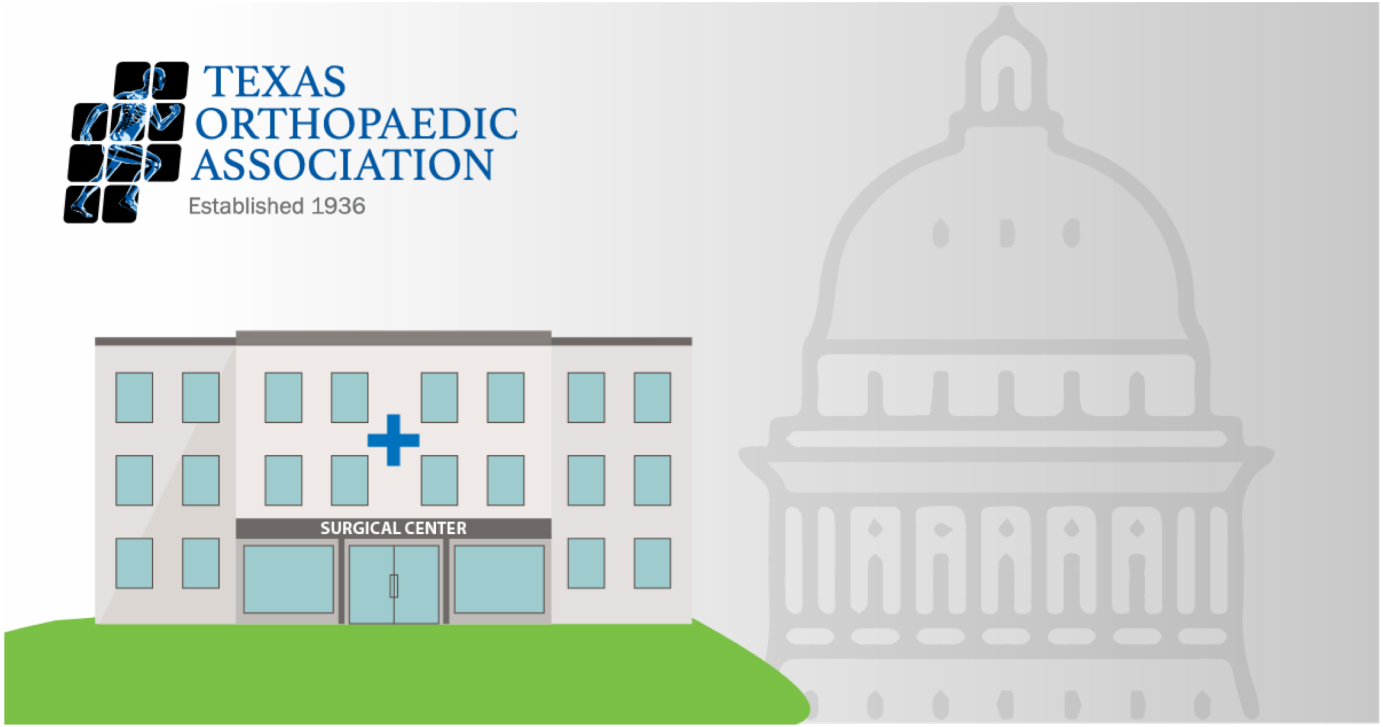
2018: A Big Year for ASCs

Medicare's 2020 Payment Policy Proposal

HOPD vs. ASC Price Comparison Tool

Timeshare ASCs? Not Addressed in the 2019 Texas Legislature

Approved by Medicare; Requires State Approval



ASCs Texas Data

20 Highest Volume Orthopaedic ASCs in Texas; 07.01.16 – 06.30.17 Data

Orthopaedic Surgery Center of San Antonio – 5,571

Texas Orthopedics Surgery Center (Austin) – 4,012

Texas Spine & Joint Hospital (Tyler) – 3,012

Christus Spohn Corpus Christi Outpatient Surgery – 2,709

MH Surgery Center Woodlands Parkway – 2,442

Texas Midwest Surgery Center (Abilene) – 2,320

Northstar Surgical – Dept of Lubbock Heart – 1,919

Houston Methodist Willowbrook Outpatient – 1,753

Baylor Surgicare at Oakmont (Fort Worth) – 1,920

Covenant High Plains Surgery Center (Lubbock) – 1,713

Hyde Park Surgery Center (Austin) – 1,635

Methodist ASC – North Central (San Antonio) – 1,580

TX Health Orthopaedic (Flower Mound) – 1,559

Baylor Surgicare at Carrollton – 1,533

Executive Surgery Center (Tomball) – 1,507

Mother Frances Hospital Outpatient (Tyler) – 1,502

Baylor Surgicare (Dallas) – 1,501

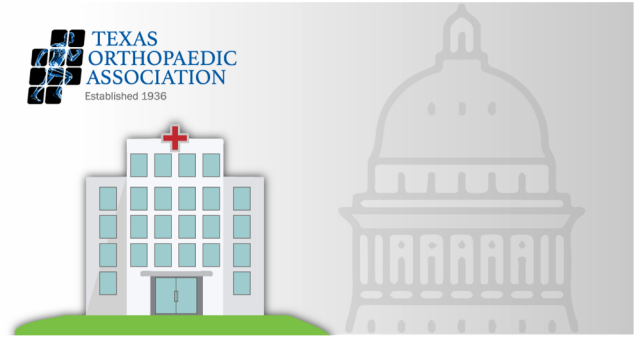
Memorial Hermann Surgery Center Med Center – 1,448

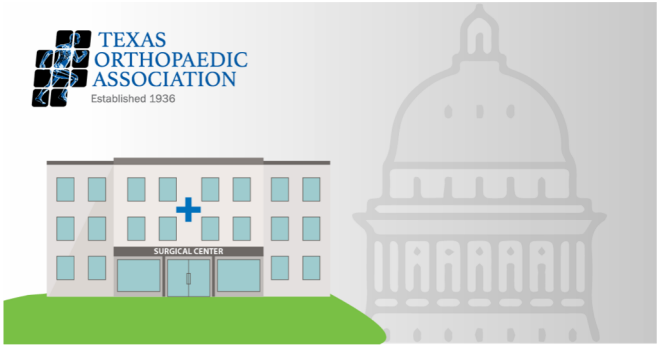
Doctors Hospital at Renaissance Outpatient – 1,422

Surgery Center for Special Surgery (SA) – 1,346

Medicare A Big Year for ASCs in 2018

Major Shift by Medicare





- Medicare payment parity.
- Services shifting to ASCs.
- Prior authorization for certain hospital services.
- ASC vs. HOPD pricing transparency tool.
- Transfer agreements.
- Lower device intensity threshold.

The Widening Payment Gulf Parity … Finally: Medicare's 2019 Payment Proposal

2019 Through 2023; CPI-U vs. OPPS Market Basket Update

	ASC	HOPD
Inflation update factor	2.8%	2.8%
Productivity reduction mandated by the ACA	0.8% percentage points	0.8 percentage points
Additional reduction mandated by the ACA	N/A	0.75 percentage points
Effective update	2%	1.25%
Conversion factor	$46.500	$79.546

Medicare's Continued Emphasis Comments in the CY 2020 Proposal

"This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting."

- Medicare's commentary in the CY 2020 rule proposal.

ASC Transfer Agreements Medicare's September 2018 Proposal

Conditions of Participation; Addresses Transfer Agreements and H&P

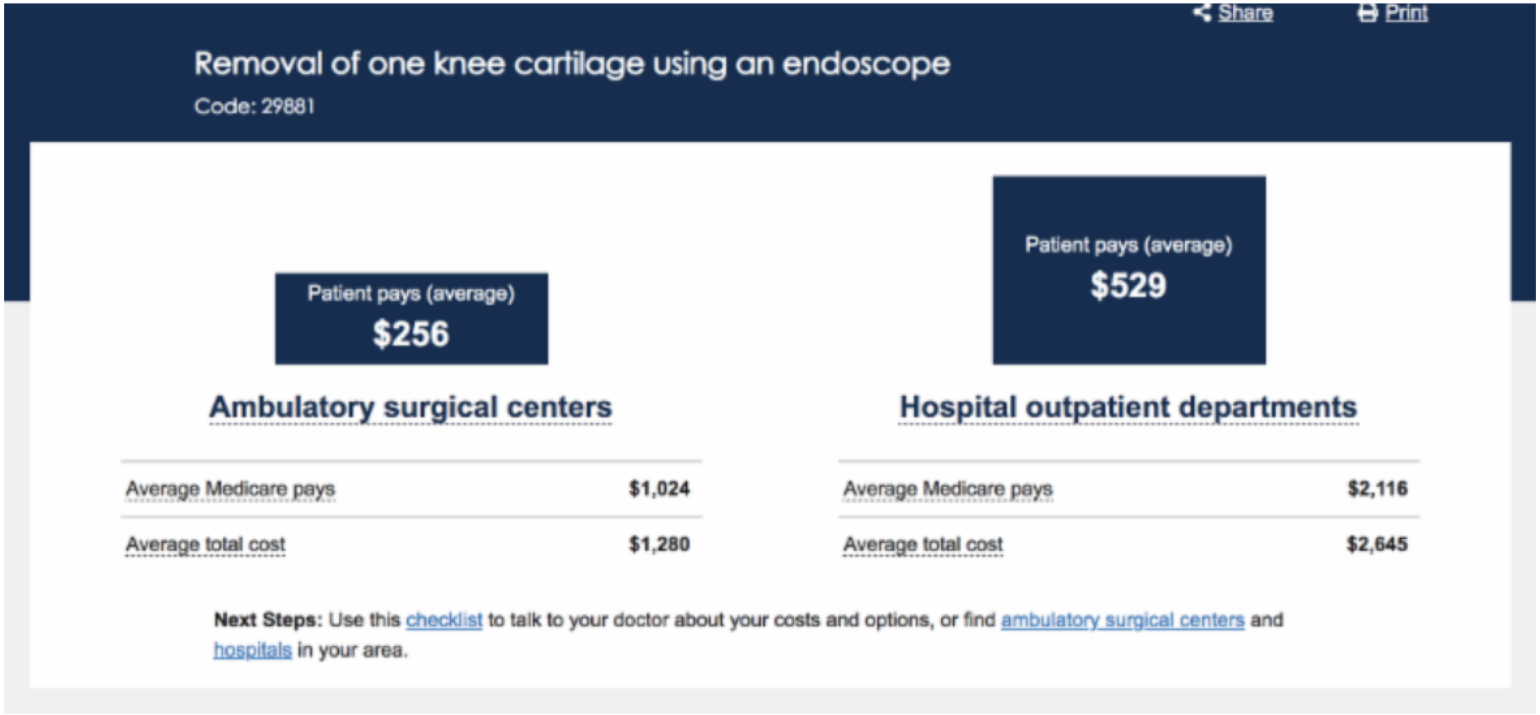
- CMS would remove the requirement for ASCs to have a written transfer agreement with a hospital that meets certain Medicare requirements or require physicians performing services in an ASC to have admitting privileges in a certain hospital. EMTALA would prevail.
- CMS would remove the requirement for a physician to conduct a complete H&P on a patient not more than 30 days before the date of the scheduled surgery.

Lower Device Intensity Threshold Medicare's 2019 Proposal

ASCs

- Proposed to be lowered to 30 percent (from 40 percent).
- Orthopaedic services would witness the greatest effect.

Medicare's ASCs vs. HOPD Price Comparison Tool 21st C. Cures Act



Shift to ASCs AAOS & The Joint Commission

AAOS is working with The Joint Commission to co-brand ASC certifications.

September 26, 2018

American Academy of Orthopaedic Surgeons and The Joint Commission collaborate to help further standardize care and quality improvement in hip and knee replacement surgeries

ROSEMONT, Ill. (September 26, 2018)—The American Academy of Orthopaedic Surgeons (AAOS) has announced collaboration with The Joint Commission to incorporate AAOS clinical expertise into standards development and performance measurement requirements for Total Hip and Knee Replacement (THKR) Certification. The Joint Commission established the voluntary advanced certification in 2016 for accredited hospitals, critical access hospitals and ambulatory surgery centers (ASCs) seeking to elevate the quality, consistency and safety of their services and patient care.

Through the new collaboration, the AAOS and The Joint Commission will jointly oversee scientific issues, performance measurement, quality improvement activities, education, data sharing and research related to the certification—with continued commitment to constantly assessing and evaluating quality for the safety and benefit of orthopaedic patients. This includes, as of January 1, 2019, implementation of a new THKR certification requirement for hospitals and ASCs to participate in a national registry, like the American Joint Replacement Registry (AJRR), to further help standardize care and quality improvement in hip and knee replacements.

Awarded for a two-year period, the THKR certification addresses the growing number of patients undergoing total hip or total knee replacement surgeries, and increases focus on clinical evidence-based patient care as it relates to pain management, quality of life issues, functional limitation in mobility and return to normal daily activities. It provides hospitals and ASCs performing orthopaedic procedures with a framework and pathway for improving patient outcomes by:

- establishing a consistent approach to care, reducing variation and the risk of error;
- supporting collaboration of teams across the continuum of care; and,
- demonstrating commitment to a higher standard of clinical service.

New ASC Services Medicare's 2019 Proposal

Focus Was on Cardiology

- Anesthesia code related to knee arthroplasty (01402) was proposed to be removed from the inpatient only list.
- Aligns with the late 2017 decision to remove TKA from the inpatient only list.

We also are proposing to remove the procedure described by CPT code 01402 from the IPO list. After reviewing the clinical characteristics of the procedure described by CPT code 01402, we believe that this procedure meets criteria 3 and 4. This procedure is typically billed with the procedure described by CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)), which was removed from the IPO list for CY 2018 (82 FR 52526). We are seeking public comment on whether the procedure described by CPT code 01402 meets criteria 3 and 4 and whether the procedure meets any of the other five criteria for removal from the IPO list.

Medicare's ASC/HOPD Payment Proposal Summary Calendar Year 2020

Released in the Summer of 2019

- TKA would be added to the ASC-payable list. Previously removed from the inpatient only (IPO) list.
- THA would be removed from the IPO list.
- Would remove additional spine services from the IPO list.
- Would create prior authorization for certain non-musculoskeletal services. (Would not be able to be performed in the hospital setting.)

Inpatient Only vs. ASC Payable List Medicare's CY 2020 Proposal

	Already Removed from IPO ASC Payable (Proposed)	Proposed Remove from IPO
TKA - 27447	✓	
THA - 27130		✓
Spine – 22633, 22634, 63265, 63266, 63267 & 63268		✓
Allograft Knee - 29867	✓	
Cardiology – 92920, 92921, 92928, 92929, C9600 & C9601		✓

Prior Authorization in Medicare? Medicare's CY 2020 Proposal

01 Blepharoplasty

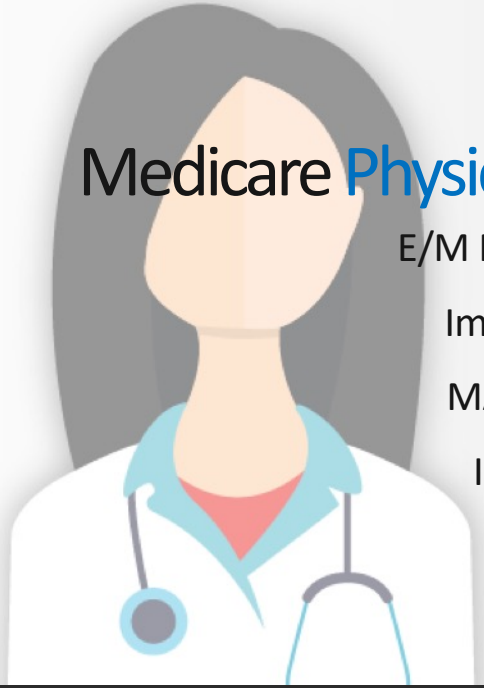
02 Botulinum Toxin Injections

03 Panniculectomy

04 Rhinoplasty & Vein Ablation

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936



Medicare Physician Fee Schedule

E/M Proposal

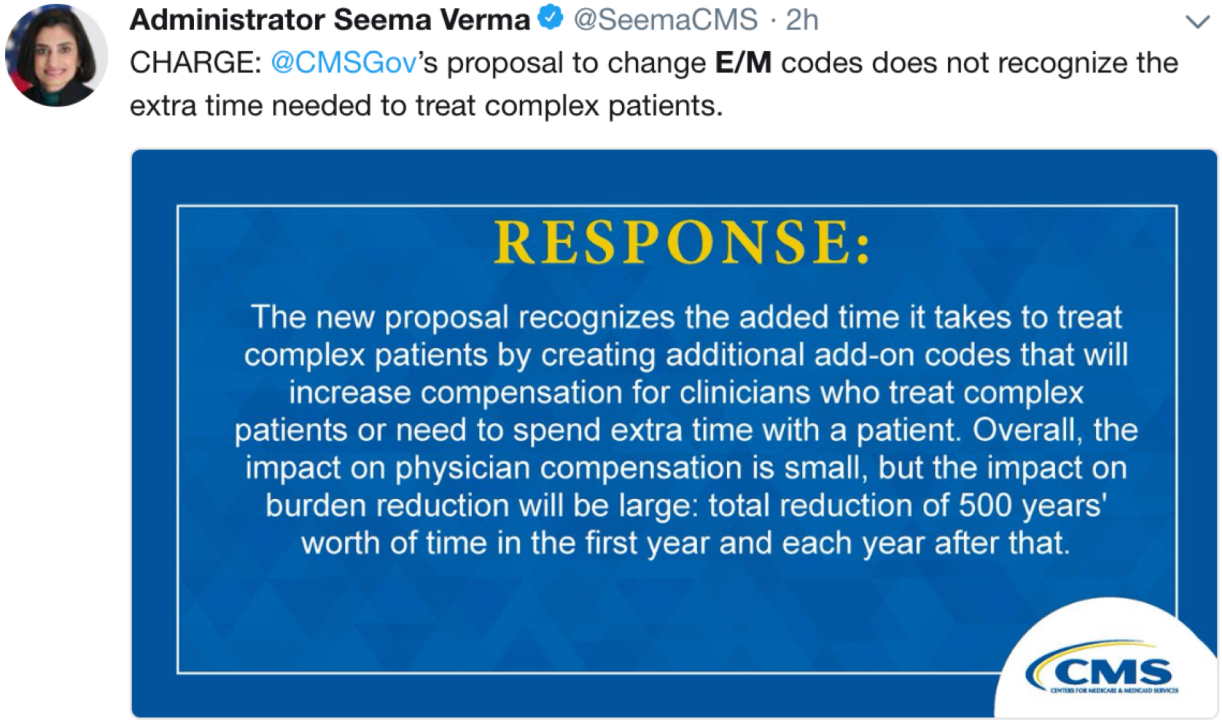
Imaging

MACRA

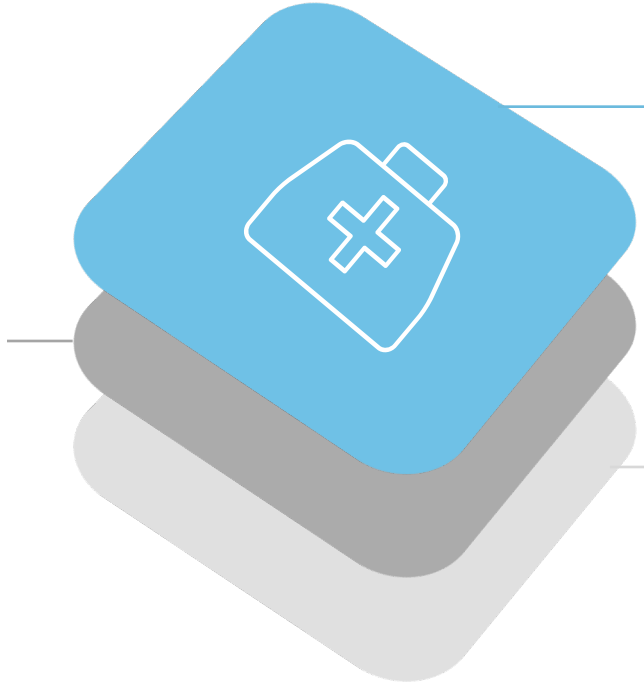
IPAB

Medicare's CY 2019 **Proposal** E/M

The Same Payment for Level 2 - 5



Continued E/M Activity Medicare's CY 2020 Proposal



2020 Proposal

- 5 Levels (Established)
- 4 Levels (New)
- Adjust Payments Based on the AMA's two committees

2019 Final

- Level 1
- Level 2-4 Collapsed
- Level 5

2019 Proposal

- Level 1
- Level 2-5 Collapsed
- Add-ons

"Incident to" Billing for PAs Not Found in Medicare's Proposal

MedPAC's 2019 Recommendation

Improving Medicare's payment policies for Advanced Practice Registered Nurses and Physician Assistants

by MedPAC Staff | Feb 15, 2019

The Commission recommends Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) bill Medicare directly, eliminating "incident to" billing for their services.

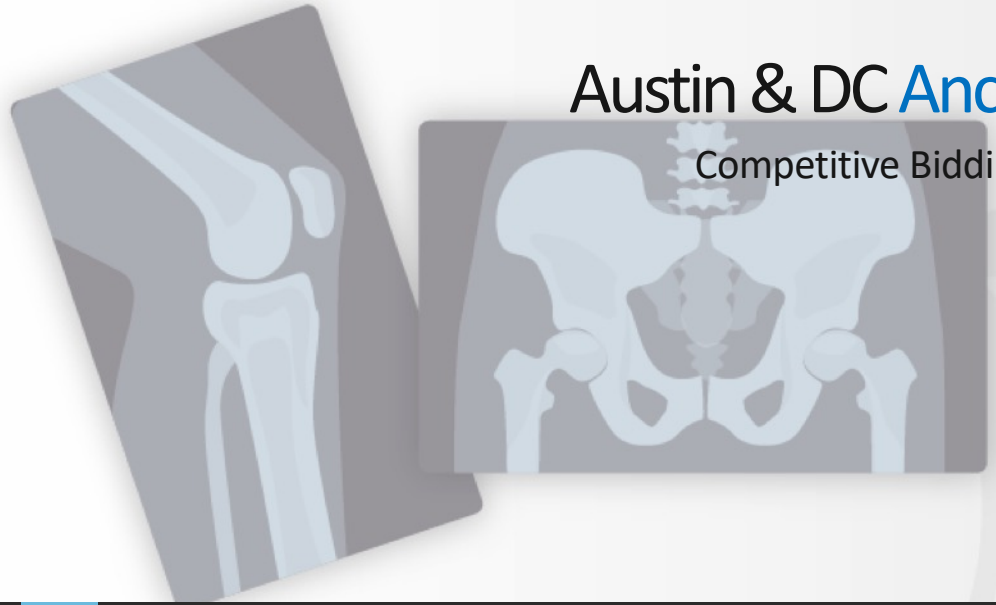
Commission recommendations

To improve Medicare's payment policies for APRNs and PAs, the Commission recommended:

1. The Congress require APRNs and PAs to bill the Medicare program directly, eliminating "incident to" billing for services they provide; and

2. The Secretary refine Medicare's specialty designations for APRNs and PAs.

TEXAS ORTHOPAEDIC ASSOCIATION
Established 1936



Austin & DC Ancillaries

Competitive Bidding

MedPAC Discussion Competitive Bidding Expansion?

September 5, 2019

Statutory Authority? – MedPAC Commissioners discussed the option of directing CMS to seek statutory authority from Congress to expand competitive bidding to DMEPOS at their discretion.

Imaging? – MedPAC suggested expanding equipment into new areas and looking at imaging.

American Orthotic and Prosthetic Association – Fears regarding custom orthotics.

Back/Knee Braces DME Medicare's Competitive Bidding Process

December 2018 Proposal

Additions to the CBP? – Back and knee braces currently are not part of Medicare's CBP.

Price and Supplier Concerns – Prices could decrease. In addition, a number of current providers could be eliminated.

2021 – Back and knee braces will be included in Medicare's competitive bidding for DME.

BILL OF THE MONTH

Price Of A Brace Brings Soccer Player To His Knees

After a sports injury, Esteban Serrano owed $829.41 for a knee brace purchased with insurance through his doctor's office. The same kind of braces sell for less than $250 online, he says.

By Paula Andalo
MARCH 26, 2019

REPUBLISH THIS STORY
DISPONIBLE EN ESPAÑOL

TOA's 2020 Annual Conference February 7-8 in San Antonio

- Strategic Planning Seminar with Darren Smith (Friday Morning)
- Mike McCaslin of the OrthoForum (Friday Afternoon)
- A Look at OrthoCarolina (Friday Afternoon)
- Coding Course with Karen Zupko & Assoc. (Friday)
- Friday Night Party at the Pearl Stable
- Thursday Visit to the Military's Center for the Intrepid