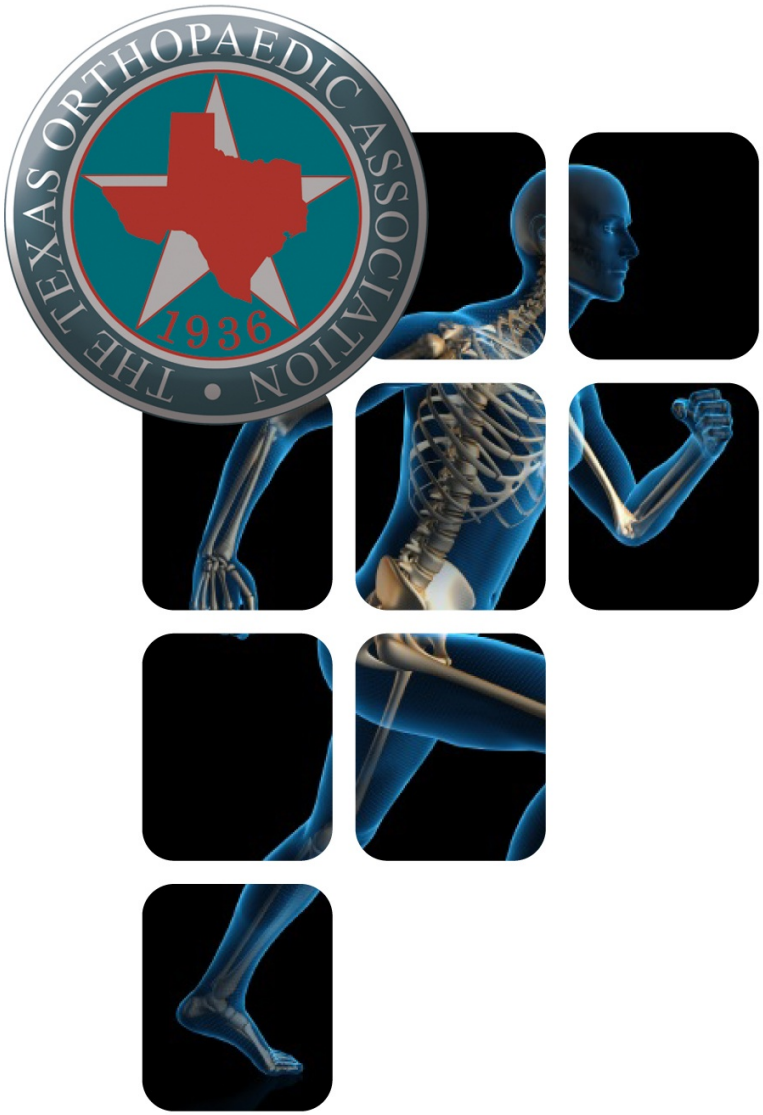


T Bones

October 2014

Bobby Hillert – Executive Director
Texas Orthopaedic Association

Bhillert@toa.org | 214.728.7672 m
www.toa.org

TOA Membership

- We need every orthopaedic surgeon to participate.

- Many orthopaedic groups have 100 percent participation.

TOPAC
TEXAS ORTHOPAEDIC POLITICAL ACTION COMMITTEE

Get Engaged

- Read TOA's newsletters to learn what is happening.

- Engage your lawmakers. It's easier than you think.

- Encourage your orthopaedic surgeons to write checks to TOPAC or individual lawmakers.

- Orthopaedic surgeons and administrators rarely engage TOA and AAOS. We need to hear what is happening in your practice.

TOPAC
TEXAS ORTHOPAEDIC POLITICAL ACTION COMMITTEE

What If TOA Doesn't Exist?

- No organization completely dedicated to orthopaedic public policy in Texas.

- Podiatrists, chiropractors, physical therapists, and other allied health providers would be performing medicine.

- A failed workers' comp system.

- Even worse commercial health insurance outlook.

TOPAC
TEXAS ORTHOPAEDIC POLITICAL ACTION COMMITTEE

Orthopaedic Landscape: AAOS 2013 Survey

Practice Type	Percentage
Private Practice – Orthopaedic Group	44%
Private Practice – Solo Practitioner	18%
Private Practice – Multi-specialty Group	9%
Academic Practice – Salary from Academic Institution	9%
Hospital/Medical Center – Salary from Hospital/Medical Center	3%
Military Practice – Salary from Military	2%
Pre-paid Plan/HMO – Salary from HMO	2%
Other	2%
Public Institution – Salary from Non-military Government	1%
Locus Tenens	1%

Medical Specialty Societies: A Changing Landscape

AAOS
American Academy of Orthopaedic Surgeons

Texas Medical Association

TheOrthoForum

Health Care Stakeholders in Austin

Providers	Non-providers	Lawmaker Physicians

Texas Medical Association
Physicians Caring for Texans

THA Texas Hospital Association

TORCH
Texas Organization of Rural & Community Hospitals

TAHP
Texas Association of Health Plans

Texas Association of Business

Texas Association of Benefit Administrators TABA

Texas Public Policy Foundation

Senator Charles Schwertner, MD
Orthopaedic Surgeon

Senator Bob Deuell, MD
Family Practice Physician

Senator Donna Campbell, MD
ER Physician/Ophthalmologist

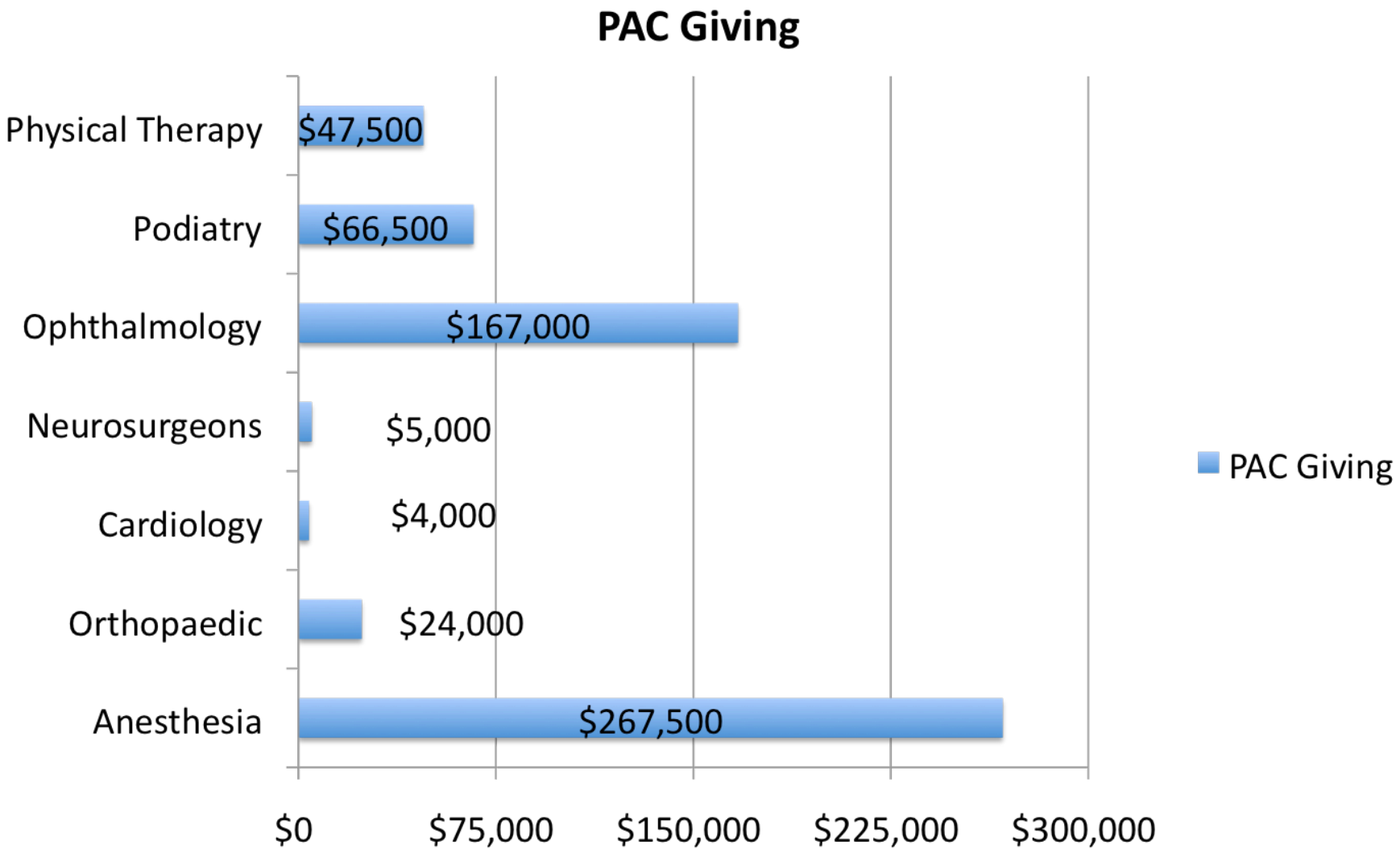
Rep. John Zerwas, MD
Anesthesiologist

Rep. Greg Bonnen, MD
Neurosurgeon

Rep. JD Sheffield, DO
Family Practice Physician

Political PACs: Part of the Election Process

2011 – 2012 cycle; approximate figures; source: Texas Ethics Commission



Key Lawmakers: Executive Branch

New governor, lieutenant governor, and attorney general for the first time in a decade.

Governor's Race
Wendy Davis - D
Greg Abbott - R

Lieutenant Governor's Race
Leticia Van de Putte – D
Dan Patrick – R

Attorney General's Race
Sam Houston – D
Ken Paxton - R

Managed Care Reimbursement Rates & Narrow Networks

Declining Rates & Networks: Potential Factors

Lack of insurance competition. Hawaii example.

Industry consolidation.

Employer pressure and increasing costs.

Plans tying rates to Medicare.

Declining Rates & Networks: Lawmaker/Regulatory Actions

Usual and Customary Standards. FAIR Health?

TDI Network Adequacy Rules. Winter 2013

Texas Employee Retirement System Hearings.

Price Transparency.

Lawsuits.

Balance Bill/Out-of-Network
Texas Legislature – September 2014

Center for Public Policy Priorities
September 2014 Texas Legislature Hearing on Balance Billing

Insurer	Annual % of Dollars Billed Out-of-network for ER Physician Services at In-network Hospitals	% of In-network Hospital with No In-network Emergency Room Physicians
United	68%	45%
Humana	42%	56%
Blue Cross Blue Shield	41%	21%

Balance Bill/Out-of-Network
Employee Retirement System

September 2014 Texas House State Affairs Hearing

Rep. Byron Cook (R-Corsicana): I'm still troubled. **Balanced billing went from $125 to 161 million**. **Out of network coverage went from $78 to 329 million.**

ERS Executive Director Bishop: If costs continue to go up, we will have to tap into the contingency fund. **If that runs out, there will have to be design changes in the health plans.** Turner noted that health care costs are going up, regardless of whether the state is contracting with United.

Mediation rights for balanced billing cases were mentioned. Out-of-network physicians are an industry problem, Bishop said, not just an ERS problem.

New York Times
"After Surgery, $117,000 Bill for Doctor He Didn't Know"

The article mentions that New York just enacted legislation (which we supported) to address the problem of "surprise" medical bills. The new law requires disclosure by out-of-network physicians as to costs of needed care and additional physicians involved, and creates a new arbitration process between insurers and physicians that removes patients from the dispute. This should remedy the situations faced by the patients presented in the article.

I encourage patients to check www.fairhealthconsumer.org for estimates of medical procedures. **Many surprise medical bills are a result of insurance companies' greed through slashing what they will pay in-network physicians, creating minimal networks and limiting coverage for out-of-network care. The law requires insurers to offer adequate networks and out-of-network coverage options.**

ANDREW J. KLEINMAN
President, Medical Society of the State of New York
Westbury, N.Y., Sept. 21, 2014

Balance Bill/Out-of-Network
New York State

Emergency Medical Services and Surprises Bill (New York State)

- Health plans must use an "independent database," which will be FAIR Health, for developing out-of-network reimbursements.
- The law addresses this problem by requiring health plans that offer group coverage with out-of-network benefits to offer at least one plan that reimburses at 80 percent of the UCR.
- October 22 webinar that is open to the public.
- A workgroup consisting of physicians and health plans will determine if FAIR Health is an appropriate database for determining out-of-network methodology.

Texas PPO Network Adequacy – 2013

- Requires plans to use a U&C standard when no in-network provider is available or emergency care.
- Neither defines the benchmarking database nor what percentage should be used.

Affordable Care Act in 10 Slides

ACA: Sections

I. Quality, Affordable Health Care for all Americans

II. Role of Public Programs

III. Improving the Quality and Efficiency of Health Care

IV. Prevention of Chronic Disease and Improving Public Health

V. Health Care Workforce

VI. Transparency and Program Integrity

VII. Improving Access to Innovative Medical Therapies

VIII. Class Act

IX. Revenue Provisions

ACA:
Section I

I. Quality, Affordable Health Care for All Americans

- New health plan requirements.
- Exchange.

ACA:
Section II

II. Role of Public Programs

- Medicaid expansion.
- Primary care physician bonuses.

ACA:
Section III

III. Improving the Quality and Efficiency of Health Care

- Hospital VBP.
- PQRS provisions.
- LTCH, inpatient rehab, and hospice quality reporting.
- Plans for VBP for SNF and home health.
- **VBP modifier under the Medicare PFS.**
- Payment adjustment for conditions acquired in hospitals.
- Misvalued codes under Medicare PFS (3134).
- **Medicare Shared Savings Program (3022).**
- **National Pilot Program on Payment Bundling (3023).**
- Hospital Readmissions Reduction Program.
- **Extension of Gainsharing Demonstration (3027).**
- Independent Payment Advisory Board.

ACA:
Section IV

IV. Prevention of Chronic Disease and Improving Public Health

- Removal of Barriers to Preventive Services in Medicare.
- Advancing Research and Treatment for Pain Care Management (4305).

ACA:
Section V

V. Health Care Workforce

- Primary care.

ACA:
Section VI

VI. Transparency and Program Integrity

- **Physician owned hospital limitations.**
- Reporting of physician ownership interests.
- **Patient Centered Outcomes Research (PCORI).**
- **Expansion of the Recovery Audit Contractor (RAC) Program.**
- **Prohibition on False Statements and Representations (6601).**

ACA:
Section VII

VII. Improving Access to Innovative Medical Therapies

- Approval Pathway for Biosimilar Biological Products.
- 340B Drug Program.

ACA:
Section VIII

VII. CLASS Act

- No longer with us.

ACA:
Section IX

IX. Revenue Provisions

- Excise Tax on High Cost Employer-sponsored Health Coverage.
- Additional potential tax on HSAs.
- Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers.
- Annual Fee on Medical Device Manufacturers and Importers.
- Annual Fee on Health Insurance Providers.
- Additional Hospital Insurance Tax on High-income Taxpayers.
- Qualifying Therapeutic Discovery Project Credit.

Provider/ Licensing Issues

2015 TX Legislature: Physical Therapy

2015 Texas Legislature

Direct Access

- PTs' top priority.
- Opposed by organized medicine.
- June 2014 GAO report on overuse.

Commercial Insurance

- PTs concerned by co-pays and limits on visits by health plans.

Industry Issues

- Self-guided exercises.

Physical Therapy: June 2014 GAO Report

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.

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 PT 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 the services provided through the plan of care.

2015 TX Legislature: Podiatry

2015 Texas Legislature

Hospital Credentialing

- Podiatrists' top priority.
- Would require hospitals to treat DPMs same way as MD/DO.
- Hospitals would not be able to prevent DPMs from performing ankle procedures.

Insurance Parity

- Podiatrists want to require health plans to reimburse podiatrists by using the same methodology as orthopaedic surgeons.

Industry Issues

- Approved expedited credentialing for podiatrists with health plans in the 2013 Legislature. Health plans are not pleased with the result.
- Podiatrists believe that they are not performing ankle procedures. Instead, they are going through the ankle to get to the foot.
- Refer to TOA's spring 2014 magazine for an overview of the scope issue.

2015 TX Legislature: Chiropractors

2015 Texas Legislature

UIL Physical Exams

•Rep. Four Price (R-Amarillo) removed chiropractors from the list of acceptable providers from UIL physical exams in the 2015 Sunset Report. Will be a major issue in 2015.

Other Issues

• Will continue pushing scope issues such as offering physical exams to school bus drivers, chiropractors employing physicians, and other issues.

Industry Issues

• Ongoing lawsuit with TMA.

2015 TX Legislature: Orthotics/Orthotists

2015 Texas Legislature

Who Can Fit

- Still worth watching.
- Orthotists introduced a fall 2014 regulatory rule that would have allowed physicians to supervise an orthotist assistant.
- The orthotists' intent was to require manufacturers' reps, athletic trainers, etc. to become licensed as an orthotist assistant.
- TOA/TMA killed the proposal.

2015 Medicare Proposal

- DME/dialysis proposal over the summer would categorize any braces fit by a manufacturers' representative as "off-the-shelf."
- Only AAOE offered feedback.

Comment: Concerning new proposed language at §821.10(b)(1) related to allowing a licensed physician to supervise a licensed assistant, **two commenters oppose the proposed change which would have allowed the board to discipline a supervising licensed physician based on acts or omissions by a licensed assistant under his/her supervision**. The comment asserted that the proposed rule exceeds the board's legal authority to impose a disciplinary action, since a licensed physician is not licensed by the board.

Response: The board agrees with the commenter and has entirely removed the proposed change which would have allowed a licensed physician to supervise a licensed assistant.

Texas Regulatory:
CME Radiation Requirement

May 1, 2013 (effective date); physicians have two years to complete

- Physicians that currently perform FGI procedures must complete 8 hours of radiation safety awareness training within two years from effective date of the rule. Radiologists and radiation oncologists are exempt from this requirement.

- In addition to the 8 hour Category 1 CMEU, the physician must receive a minimum of 1 hour fluoroscopic machine training provided by a radiologist, licensed medical physicist or a physician that has completed the entire radiation safety awareness training.

Pharmacy Issues

Key Issues: Hydrocodone

2015 Texas Legislature

DPS to Board of Pharmacy

•Potential for pain killer rules to move to Board of Pharmacy in 2015 Legislature.

• Suppliers (see under "federal policy") worried about DEA issue.

• Board of Pharmacy may have adequate database to track physicians who are "inappropriately" prescribing pain killers. I.e., too long after surgery.

• DPS doesn't have ability to delay the switch to Schedule II for hydrocodone; will take a legislature change.

Workers' Comp

•Still a top priority at DWC.

Federal Policy

• Schedule II hydrocodone October.

• Texas DPS released guidance (see Sep 17, 2014 TOA eConnect).

• McKesson, Cardinal, Amerisource Bergen, CVS, etc. worried about DEA attacks on pharmacies that fill too many pain killer prescriptions.

2015 TX Legislature: Compound Pharmacies

2015 Texas Legislature

Physician Ownership

- TMB does not have the authority to regulate physician ownership of compound pharmacies.
- Possible issue in 2015.

Workers' Comp

- Carriers name compound pharmacies one of their top DWC concerns.

Federal Policy

- Continued scrutiny.

Orthopaedic Sub-specialties

Austin & Washington: Spine

2015 Texas Legislature

Scoliosis Screening

- May be pushed by school nurses again in 2015.
- Governor Perry vetoed a 2013 bill that would have removed the school screening mandate.
- TOA pointed out to major fall 2013 study led by Stuart Weinstein, MD of the University of Iowa.

Federal Policy/Industry Issues

- Spine procedures permitted in ASCs in 2015.
- It does not go far enough to necessarily be effective.

Austin & Washington:
Total Joints – New Reporting

Medicare's FY 2015 Payment Policy (Finalized – May 13 eConnect)

The Affordable Care Act (ACA) created three pay-for-performance programs for hospitals: value-based purchasing (VBP), readmissions (Inpatient Quality Reporting), and hospital-acquired conditions.

Medicare is proposing to add a new hospital-level risk-standardized complication rate following elective THA/TKA for the hospital VBP program. It would be a 30-month performance period for FY 2019 and a 36-month performance period for FY 2020.

CMS provided commentary on page 616 reminding stakeholders that THA/TKA measure data were posted on the Medicare *Hospital Compare* Web site in December 2013 and the THA/TKA is part of the IQR program in FY 2015.

Austin & Washington:
Total Joints – The RUC

POLITICOMAGAZINE

The Secret Committee Behind Our Soaring Health Care Costs
August 20, 2014 | Politico Magazine

Medicare's FY 2014 Inpatient Policy – By Louis Stryker, MD

The cuts recommended by the RUC in May 2013 were much deeper than those adopted by CMS:

10 percent for total hip arthroplasty and 16 percent for total knee arthroplasty. The fact that these cuts did not occur is a testament to the advocacy efforts exposing the flawed process by which these recommendations were reached. CMS specifically cited the advocacy work of specialty societies in deciding to not endorse the RUC recommendations.

Payment Policy:
Medicare's 2015 Proposals:

- PFS
- ASCs/HOPDs
- Inpatient
- DME

Medicare:
Key Issues for the CY 2015 PFS Proposal

Hospital-employed Practices

- A new modifier to track utilization of hospital-owned physician services.
- MedPAC has been concerned about hospital-employed cardiologists.

Global Surgery Codes

- Zero-day proposal.
- CMS cited a recent OIG study on orthopaedics.

Imaging

- CMS asks for guidance on use of image-guided injections (ultrasound).
- Potential elimination of secondary interpretations of x-rays.
- CMS identified "mis-valued" codes – x-rays of the knee included.

Primary Care

- Chronic care management.
- Payment for non-face-to-face chronic care management.

PQRS

- Clarification.
- Back pain measure eliminated.

ACOs

- Potential help for providers who have "topped out" ACO measures.

Payment Policy: The Future of FFS (Failed SGR Overhaul)

Michael Porter: Policymakers Watching Closely

Michael Porter: Incremental Fixes Don't Work

- Attacking fraud.
- Reducing errors.
- Enforcing practice guidelines.
- Making patients better "consumers."
- Implementing EHRs.

Michael Porter: Maximizing Value for Patients

- Must focus on patient outcomes and consists of six interdependent components:

    - Organizing around patients' medical conditions rather than around physician specialties.
    - Measuring costs/outcomes for each patient.
    - Developing **bundled prices** for the full episode.
    - Integrating care across separate facilities.
    - Expanding geographic reach.
    - Building an enabling IT platform.

MedPAC 2005 Report (POHs)

"It is time for the Medicare program to start to differentiate among providers when making payments."

Initially limited to Part C plans and dialysis, MedPAC's 2005 report called for VBP and other types of new payment models for facilities and physicians.

MedPAC's 2005 Report on POHs: The Future of FFS?

"It is time for the Medicare program to start to differentiate among providers when making payments."

Initially limited to Part C plans and dialysis, MedPAC's 2005 report called for VBP and other types of new payment models for facilities and physicians.

SGR Patch – April 1, 2014
The Future of FFS

Cuts Diverted
- April 1, 2014 – March 31, 2015

ICD-10 Delayed
- Until at least October 1, 2015

"Mis-valued" RVUs - Cuts
- Opposed by most specialty societies.
- An offset that will have an unclear and permanent future.

AUCs – Fights off IOAS Exemption Issue?
- **Appropriate Use Criteria (AUC)** for imaging services as of January 2017. Must consult with at least one clinical decision support mechanism – HER technology, use of private sector clinical decision support that are independent from certified EHRs, or use a clinical decision support mechanism established by HHS.

- **Prior authorization** begins January 2020 for outliers. Based on data beginning in 2017.

SGR Overhaul (H.R. 4015/S. 2000): The Future of FFS

FFS Stability: 2014 - 2018

- 0.5 percent increase each year through 2018.

New Quality Bonuses/Penalties: 2019 - 2023

- Freezes FFS.
- To receive Medicare increases, you must participate in MIPS or APM programs (see next slide).

FFS Increases Again: 2024 and Beyond

- Another 0.5 percent increase each year begins again in 2023.
- Providers participating in approved alternate payment models will have their 0.5 percent increased to 1.0 percent each year.

Sequestration Remains

- 2 percent sequestration cuts still alive until 2022.

SGR Replacement:
Two New Quality Initiatives (Bonuses & Penalties)

Merit-Based Incentive Payment (MIPS) – Quality Payments

12 percent bonus in 2018?

- Three existing Medicare quality reporting programs (**PQRS**, **VBM**, and **EHR MU**) become one – MIPS.
- Measures include **quality**, **resource use**, **meaningful use**, and clinical practice improvements.
- Clinical practice activities component begins in 2018.
- 4 percent penalty/bonus in 2018; 5 percent in 2019; 7 percent in 2020; and 9 percent in 2021.
- Potential for triple bonuses. (12 percent in 2018?)
- The 2 percent sequestration remains through 2022.
- PQRS, VBM, and EHR MU will remain in place for hospitals.

Alternate Payment Model (APM) Bonus

5 percent bonus for APM participation; The MIPS Alternative

- A physician's Medicare patient population must include 25 percent of patients from new payment models in order to receive the 5 percent bonus.
- Will eventually grow to requiring 75 percent of patients to be in the new payment models (ACOs, episode of care, etc.

SGR Overhaul

Timeline: Penalties/Bonuses

2014 - 2018	2018	2019	2020	2021
• **0.5%** increase each year for current FFS program. • PQRS, VB, and EHR MU penalties end 12.31.17 • **2%** sequestration cut	•MIPS begins •**4%** MIPS +- • FFS **flat** • 3 x 4% = **12%** bonus? • **5%** APM instead of MIPS • **2%** sequestration cut	•**5%** MIPS +/- • FFS **flat** • 3 x 5% = **15%** bonus? • 5% APM instead of MIPS • **2%** sequestration cut	•**7%** MIPS +/- • FFS **flat** • 3 x 7% = **21%** bonus? • **5%** APM instead of MIPS • **2%** sequestration cut	•**9%** MIPS +/- • 3 x 9% = **27%** bonus? • **5%** APM instead of MIPS • FFS **flat** • **2%** sequestration cut

SGR Replacement: Other Key Issues

Gainsharing

- Directs HHS to report on how a permanent hospital-physician gainsharing program can occur.

AUC for Advanced Diagnostic Imaging

- Beginning in 2017, payments prohibited to physicians who do not meet approved clinical support tools.
- Appropriate Use Criteria (AUC) developed by physician groups. 5 percent of physicians who do not meet standards may be subject.

Quality Measures

- CMS must publish a comprehensive quality measure development plan by May 1, 2015.
- 0.5 percent: CMS will have additional authority for adjustments regarding misvalued services in Medicare.
- Specialty societies will have input on quality measures.

Telemedicine

- Asks the General Accounting Office to report on telemedicine.

Penalties

- Still in effect for MU, PQRS, Value-based until December 31, 2017.
- $500 million available for the MIPS bonuses. Therefore, must offset those bonuses with penalties to low-performers.

Payment Policy: New Medicare Payment Models

ACOs:
The First Wave (Sep 2014)

Four takeaways from The Corporate Advisory Board Company

1. Despite the growth of participants, overall success rate remains steady at one in four

The new MSSP results closely mirror the interim results for the 2012 ACOs that CMS reported in January. Even after adding in the 114 ACOs that launched in 2013, **the percentage of ACOs qualifying for a bonus remained near 25%**. This reinforces the fact that developing an effective ACO in a lengthy process—and that becoming a formal ACO is just one step toward becoming an effective population health manager.

2. ACOs are becoming more effective over time

The new MSSP results include three launch groups: April 2012, July 2012, and January 2013. Among the ACOs with available data, **ACOs that joined the program earlier were more likely to qualify for a bonus**; 32% of the April 2012 ACOs earned bonuses versus 19% of the January 2013 ACOs. For organizations that earned bonuses, the rewards were larger for the longer established ACOs (average of $8 million for April 2012 versus $3.5 million for January 2013), although this is influenced by having a longer initial performance period.

ACOs:
The First Wave (Sep 2014)

3. Quality reporting really pays in MSSP

Four ACOs generated over $33 million in savings but **earned $0 in bonus payments because they failed to report quality measures**. Being able to both meet and report the program's quality measures is critical to earning a bonus in MSSP.

4. Success in population health and MSSP are not equal

The list of MSSP participants includes organizations with deep experience managing both populations and risk-based payments—but their prior experience didn't always translate to a shared savings bonuses. Success in MSSP is heavily influenced by the mechanics of the programs, meaning that factors like the attribution methodology and annual update benchmarking can outweigh successful care management.

Pioneer ACOs:
Data Published 10.08.14

Plus North Texas ACO

- Dropped out.
- Demonstrated the highest first year increase in spending with costs growing 5.2 percent higher than projected.

Franciscan Alliance

- Left the program in September 2014.
- Reported 6 percent gross savings in year 1 and shared in $6.67 million in shared savings.
- Left the program because of no share in the savings in the second year.

BPCI:
January 1, 2015

Some of the key highlights from CMS's July 31 announcement include (TOA's August 8, 2014 eConnect):

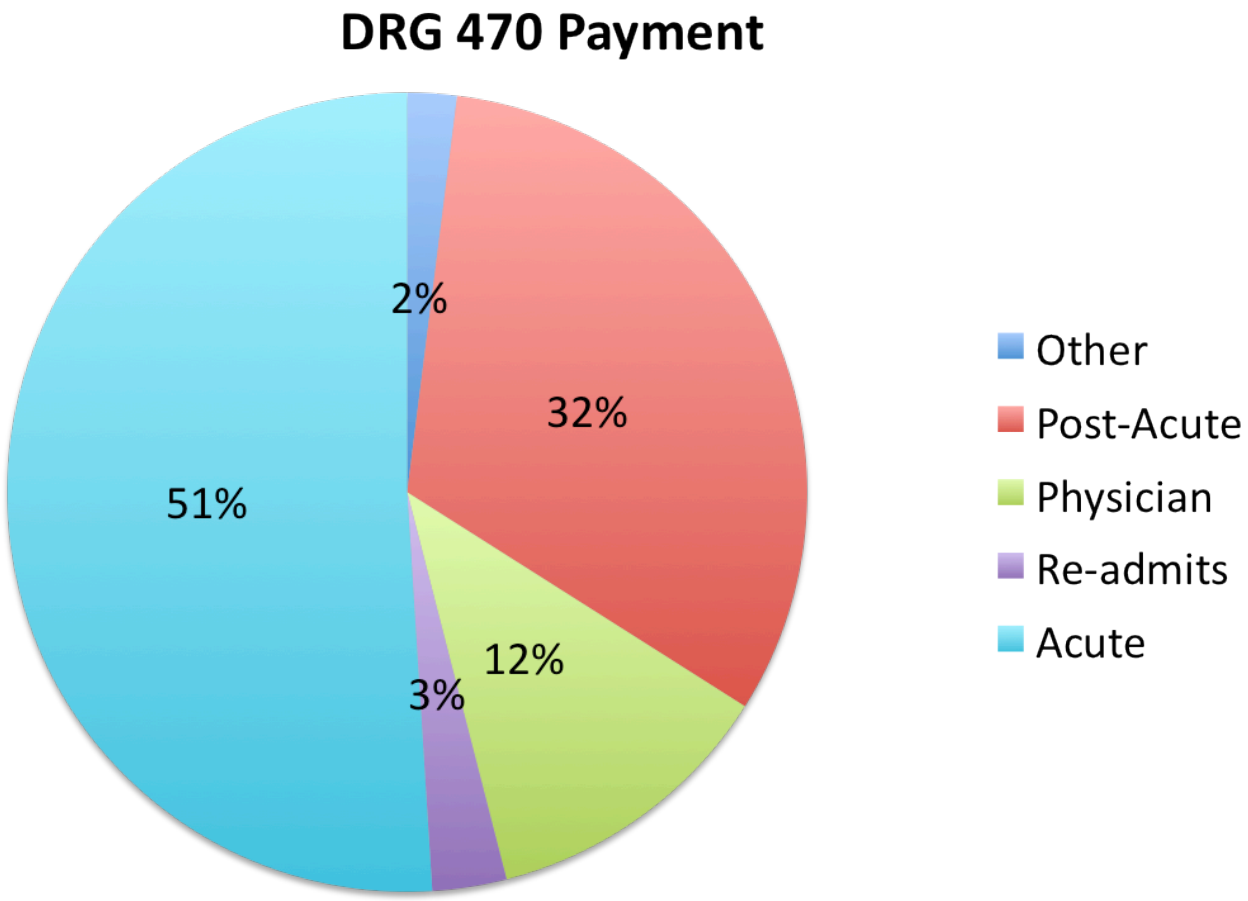
The the number of providers participating in Phase 1, which is the non-risk bearing stage ("preparation period"), will triple to 6,534. They will have to progress to Phase 2 in order to receive bundled payments.

Only a handful of hospitals actually participate in Models 1 and 4. (Click here to see TOA's PowerPoint that outlines each model.)

The two most popular models for hospitals (and eventually physicians) are Models 2 and 3. These use retrospective models.

Model 3 focuses on post-discharge care, which is why so many physicians and rehab providers have signed up for this one.

Bundled Payments:
A Bundle's Anatomy



Source: Dobson DaVanzo (Brian Parsley TOA Apr 2014 Presentation)

Bundled Payments:
Rehab & Readmissions – Bozic Part 1

Bundled Payments in TJA: Targeting Opportunities for Quality Improvement

Kevin J. Bozic, MD, MBA; Lorrayne Ward, MBA, MPP; Thomas P. Vail, MD; Mervyn Maze, MD

CONCLUSIONS

- Payments for TJA procedures vary widely depending on the type of procedure, patient co-morbidities, discharge disposition, and readmission rates.
- Post-discharge care accounted for over 35% of total episode payments, and there was substantial variation in post- discharge costs across patients and procedures.
- Care redesign efforts should be targeted at optimizing post- acute care and reducing unplanned readmissions (98% of payments).
- Our results may be more applicable to an urban referral practice setting.

http://health.universityofcalifornia.edu/files/2013/05uc_health_innovation_center_colloquium_poster_2013_bozic.pdf

Bundled Payments:
Rehab & Readmissions – Bozic Part 2

MS-DRG	# of Surgical Cases	Acute Rehab Facility	SNF	Long Term Care Facility	% of Patients Discharged to Post-acute Care Facility
462	6	4	1	0	83%
466	9	0	4	1	56%
467	47	6	20	0	55%
468	19	1	6	0	37%
469	23	4	11	0	65%
470	146	16	47	1	44%
Total	250	34	89	2	50%

IRF vs. SNF:
MedPAC's June 2014 Report

The analysis examined three potential conditions for a site neutral payment in the IRF/SNF setting - total joint replacements, hip/femur procedures, and strokes. In a site-neutral payment scenario, SNFs and IRFs would receive the same payment for selected conditions if Congress and Medicare believe that the condition does not require a more advanced (and more expensive) setting.

MedPAC's June analysis concluded:
"**We found that the patients and risk- adjusted outcomes for the orthopedic conditions were similar and represent a strong starting point for a site- neutral policy.** Patients receiving rehabilitation services after a stroke were more variable, and more work needs to be done to narrow the definition of cases that require IRF- level care. Waiving certain IRF rules for the conditions selected would allow IRFs to vary the services they furnish to patients and put them on equal footing with SNFs."

Medicare payments to IRFs would be reduced by four percent if IRF payments are reduced to SNF payment levels for specific conditions, according to the MedPAC analysis.

Medicare Spending on Post-acute Care During 90-day Bundle (5% of 2007 & 2008 claims)

Condition	Medical or Surgical	# of Episodes	Mean	25th Percentile	75th Percentile	Ratio of 75th to 25th Percentile
Stroke	**Medical**	**10,740**	**$20,411**	**$6,856**	**$30,300**	**4.4**
Simple pneumonia	Medical	20,780	$10,567	$2,787	$15,082	5.4
Coronary bypass	Surgical	2,276	$6,539	$1,887	$7,957	4.2
Heart failure	Medical	15,376	$9,301	$2,319	$12,379	5.3
Major small/ bowel	Surgical	6,180	$8,169	$2,176	$10,528	4.8
Joint	Surgical	29,627	$9,752	$4,006	$13,277	3.3
Hip/femur procedures	**Surgical**	**7,814**	**$22,052**	**$13,244**	**$30,045**	**2.3**
Fractures hip/ femur	**Medical**	**2,066**	**$17,392**	**$9,044**	**$23,854**	**2.6**
Kidney/urinary tract	Medical	10,133	$13,048	$3,909	$19,771	5.1
Septicemia	Medical	4,961	$13,532	$3,861	$20,116	5.2
Average						4.3

Medicare Spending on Bundles: SNF vs. HHA vs. IRF

Condition	HHA	SNF	IRF	Ratio of IRF to SNF Spending	Ratio of SNF to HHA Spending
Stroke	$13,344	$33,266	$40,881	1.2	2.5
Simple pneumonia	$12,403	$26,597	$39,166	1.5	2.1
Coronary bypass	$39,708	$52,554	$60,677	1.2	1.3
Heart failure	$13,881	$30,984	$45,516	1.5	2.2
Major small/ bowel	$25,658	$39,443	$48,933	1.2	1.5
Joint	**$17,712**	**$28,013**	**$32,891**	**1.2**	**1.6**
Hip/femur procedures	**$17,177**	**$38,324**	**$40,770**	**1.1**	**2.2**
Fractures hip/ femur	**$9,980**	**$26,947**	**$32,200**	**1.2**	**2.7**
Kidney/urinary tract	$11,597	$27,613	$37,739	1.4	2.4
Septicemia	$16,516	$32,961	$47,081	1.4	2.0
Average				1.3	2.1

Federal BPCI:

Four Models

Model 1 – A type of **gain-sharing**. Hospitals paid a discount on IPPS and physicians continue to be paid separately. Gain-sharing permitted in some instances. Stems from 2003 Part D bill.

Only National Examples: NJ Hospital Assn & Kansas Surgery & Recovery Center

Open

Model 2 - **Episode includes inpatient stay and all related services**. Ends either 30, 60, or 90 days after hospital discharge. Choose up to 48 different clinical condition episodes.

Texas Examples: San Antonio Baptist – 2 episodes.

Open

Model 3 – **Hospital stay not included.** Episode **triggered** by acute care hospital stay and begins with post-acute services (SNF, inpatient rehab facility, LTAC, or HHA). Must begin within 30 days of discharge. Thirty, 60, or 90 day sets. Select 48 different clinical episodes.

Texas Examples: Encompass Home Health (Dallas-based)/Remedy Partners – 48 episodes.

Open

Model 4 – Medicare will make a single, prospectively determined **bundled payment** to the hospital that includes all services for the inpatient stay. Readmissions within 30 days included in bundle.

Texas Examples: Valley Baptist (Harlingen/Brownsville)

More Than Bundled Payments & ACOs:

New Medicare Payment Models – Part 1

Open

Center for Medicare & Medicaid Innovation Center/Independent Payment Advisory Board (IPAB) – Innovation Center open. IPAB not engaged yet.

Specialty Practitioner Payment Model– Outpatient disease management likely to be a bundled payment.

Closed

Medicare Health Care Quality Demonstration – 2003 law; 5 groups participating in new payment laws. Ends in 2015.

Closed

Physician Group Transition Demonstration– Already closed, extended the PGP Demonstration from 2010, which was the first P4P initiative for physicians in Medicare. PGP included 10 physician groups (approximately 500 physicians and 22,000 beneficiaries). MedPAC cited increased quality. However, it could not quantify cost savings at this point in time.

Patient Centered Medical Home– Primary care practice receives a small PMPM payment (type of capitation).

More Than Bundled Payments & ACOs:

Three Gainsharing Projects

Closed **Medicare Hospital Gainsharing Demonstration –** Two hospital system demonstration that ended in 2011; mandated by the 2005 budget deficit act.

Closed **Physician Hospital Collaboration Demonstration –** Project created by the 2003 Part D law.

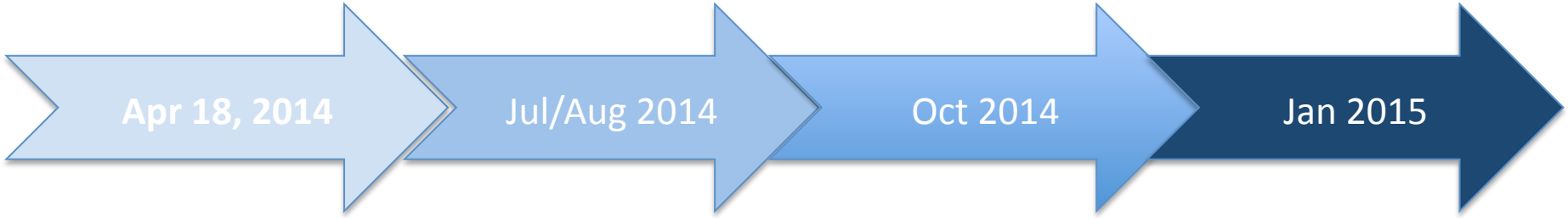
Closed **Acute Care Episode (ACE)** – Gain Sharing Competitive bidding, shared savings. Over $1 million dollars in savings in San Antonio and sooner than expected payments.

"Hillcrest (Tulsa) made a slight profit on the 415 patients — 295 cardiac and 120 orthopedic — that it treated through Sept. 30, 2009. Hillcrest officials say their orthopedic cases are up 2 percent this year and cardiac cases are up 27 percent, but they don't know whether that's because of the bonuses or the fact that the hospital just spent millions to improve its facilities."

Federal Payment Models

Bundled Payments for Improvement Program (BPCI)

October 1, 2013: Hospitals began leading BPCI projects
January 2015: Physician groups begin leading BPCI projects.



CMS Data Consent Form request due; gives practices three years of data.

Final approval by CMS of new physician groups.

Final submissions to CMS of providers included in the gain-sharing program.

Program start date.

Federal BPCI:

179 MS-DRGs Grouped into 48 Bundles

Orthopaedics

Major joint replacement of the lower extremity

Hip & femur procedures except major joint

Spinal fusion (non-cervical)

Revision of the hip or knee

Lower extremity & humerus procedure except hip, foot, femur

Fractures femur and hip/pelvis

Amputation for MSK/CT or endocrine/nutrition or circ disorder

Back & neck except spinal fusion

Cervical spinal fusion

Major joint upper extremity

Combined anterior posterior spinal fusion

Complex non-cervical spinal fusion w/ spinal curv/malig/infxn/9+fusion

Removal of devices (both hip/femur & other

Knee procedures w/ and w/o infection

Medical non-infectious orthopaedic problems (sprains, strains, back pain)

Cardiology

CHF

Percutaneous coronary intervention

Cardiac arrhythmia

AMI discharge alive

Pacemaker

Cardiac defibrillator

Chest pain

Transient ischemia

Pacemaker Device replacement or revision

AICD generator or lead

Pulmonary

Simple pneumonia/Respiratory infections

COPD, bronchitis/asthma

Other Respiratory

Internal Medicine

UTI

Nutritional & misc metabolic disorders

Peripheral vascular disorders (medical)

Atherosclerosis

Cardiothoracic Surgery

Cardiac Valve

CABG

Major cardiovascular procedure

Neurology

Stroke w/ and w/o tpa

Syncope & collapse

Other

Sepsis

Major bowel

Cellulitis

GI hemorrhage

GI obstruction

Renal failure

Esophagitis, gastroenteritis & misc digestive disorders

Other vascular

Red blood cell disorders

Diabetes

2015 BPCI:
Key Takeaways from Summer 2014

•The number of providers participating in Phase 1, which is the non-risk bearing stage ("preparation period"), will triple to 6,534.

• Those in the non-risk bearing stage will have to progress to Phase 2 in order to receive bundled payments.

• Only a handful of hospitals participate in Models 1 and 4.

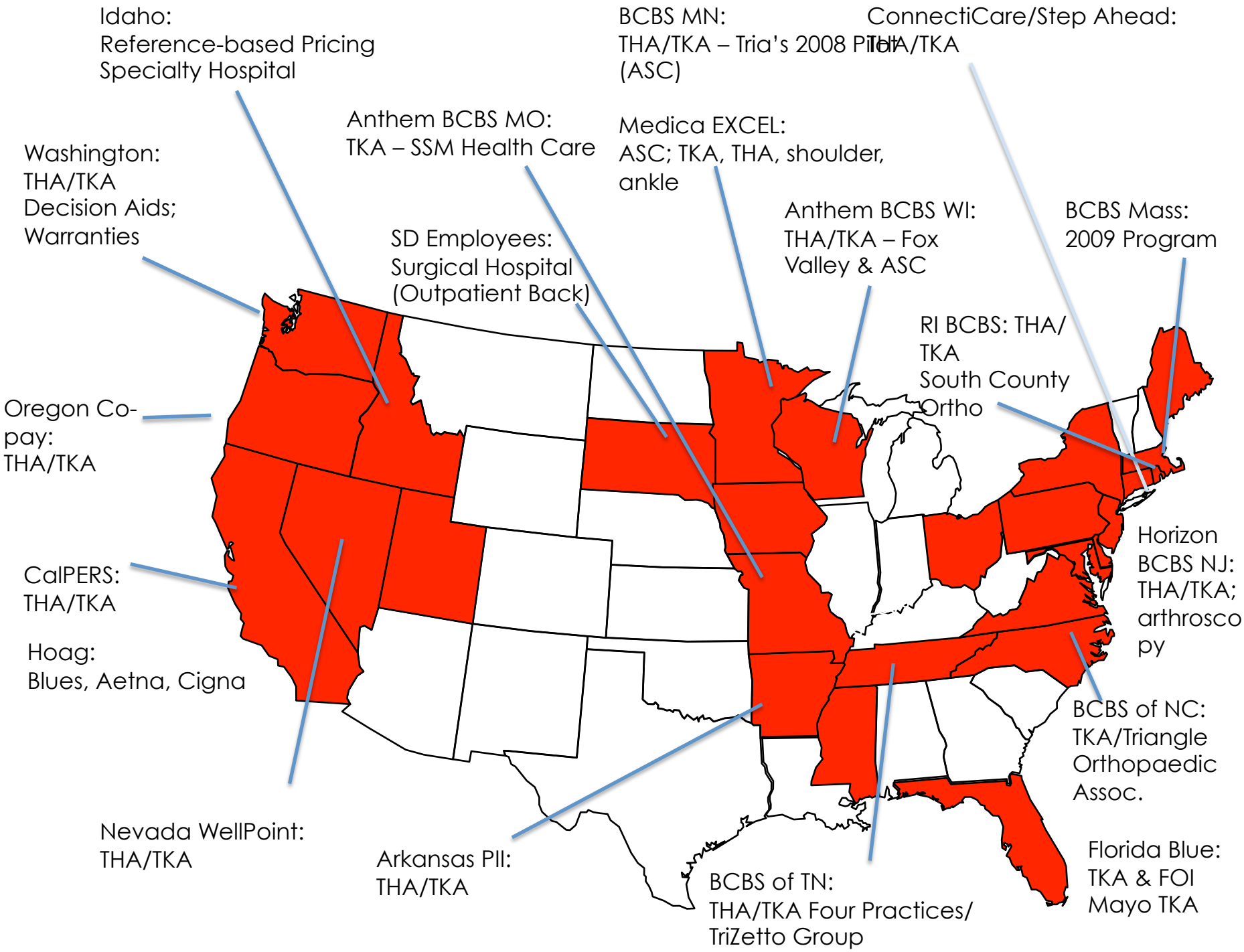
• The two most popular models for hospitals (and eventually physicians) are Models 2 and 3. Retrospective models.

• Model 3 focuses on post-discharge care, which is why so many physicians and rehab providers have signed up for it.

2015 Medicare PFS Proposal: Key Takeaways

- Zero-day global surgery codes. AAOS engaged.

Payment Policy: New Commercial Insurance Models


Idaho:
Reference-based Pricing
Specialty Hospital
BCBS MN:
THA/TKA – Tria's 2008 Plan
(ASC)
ConnectiCare/Step Ahead:
THA/TKA
Anthem BCBS MO:
TKA – SSM Health Care
Medica EXCEL:
ASC; TKA, THA, shoulder,
ankle
Washington:
THA/TKA
Decision Aids;
Warranties
Anthem BCBS WI:
THA/TKA – Fox
Valley & ASC
BCBS Mass:
2009 Program
SD Employees:
Surgical Hospital
(Outpatient Back)
RI BCBS: THA/
TKA
South County
Ortho
Oregon Co-
pay:
THA/TKA
Horizon
BCBS NJ:
THA/TKA;
arthrosco
py
CalPERS:
THA/TKA
Hoag:
Blues, Aetna, Cigna
BCBS of NC:
TKA/Triangle
Orthopaedic
Assoc.
Nevada WellPoint:
THA/TKA
Arkansas PII:
THA/TKA
BCBS of TN:
THA/TKA Four Practices/
TriZetto Group
Florida Blue:
TKA & FOI
Mayo TKA

New Commercial Models
ACOs in Texas

- ACOs predominant in the Texas market.
- Independent physicians?
- Future bundles?

New Commercial Models
"First of Its Kind Partnership"

Anthem Blue Cross partnership with seven California hospital systems:

- UCLA Health
- Cedars-Sinai
- Good Samaritan
- Huntington Memorial
- MemorialCare Health
- PIH Health
- Torrance Memorial Health

Reference Pricing

CalPERS & Anthem BlueCross Total Joints

Enrollee responsible for difference in price between reference and actual price. This is for THA/TKA. Spinal fusion/lower back disorders difficult to implement. Diagnostic imaging and a deeper study of price variation to be considered in the future.

Muscle/bone disorders highest source of CalPERS cost – 13 percent.

Began January 1, 2011.

Forty-six facilities met quality, cost, and geographic requirements. (Expanded to 61 hospitals.)

Threshold facility payment of $30,000 for routine single knee and hip joint replacement hospital stays.

Reference Pricing
CalPERS & Anthem BlueCross Total Joints

Positives:

13% Decrease in THA price.

21% Decrease in TKA price.

No Change Out-of-pocket costs didn't change.

Negatives

21% Twenty-one percent of patients switched to facilities that weren't their first choice.

Geographic What if the reference is only available in distant urban areas?

California:
Integrated Healthcare Association

2006 – Value-Based Purchasing of Medical Devices Project.

2009 – Bundled payment pilot project began.

2010 – Federal government awarded IHA a grant to expand the project. Hoag, UCLA, and Cedars-Sinai worked with Blue Shield, Cigna, Aetna, and HealthNet.

2012 – IHA was a Facilitator Convener for CMS's BPCI program.

Bundles in the States: Wellpoint

Maine (Local)
- All orthopaedic surgeries.
- Cardiac procedures (general, including CABG)

Missouri, Nevada, and Wisconsin
- TKA
- THA

New Hampshire
- Colonoscopy

Bundles in the States:
Tennessee State Innovation Initiative

Patient Centered Medical Homes

Retrospective Episodes of Care

- 75 episodes will be introduced over five years.
- First wave includes: Total hip and knee replacements including diagnostics (e.g. imaging and laboratory tests), professional and facility fees, medical device(s), physical therapy and other forms of post-acute care, pharmaceuticals, and treatment of any complications and/or related readmissions.
- Providers will continue to receive their current fee-for-service payments as they do now, but will be paid an additional amount if they consistently provide high-quality care at a lower cost than other providers in the state.

Long Term Services and Supports

THA/TKA:
Oregon's Added Co-pays for Orthopaedics

Facing a budget shortfall in 2011, Oregon's two employee health plans implemented a value-based insurance design (VBID) on five orthopaedic "preference sensitive" procedures, including THA/TKA. This resulted in additional $500 co-pays for each procedure.

Episodes of Care & Medical Homes: Arkansas Payment Improvement Initiative

Participants:
Arkansas Medicaid | WalMart | QualChoice | Arkansas BCBS | State Employee & Public Health Plans

	Wave 1 Episodes	Principal Accountable Provider
Hip/knee replacements	Surgical procedure plus all related claims from 30 days prior to procedure to 90 days after.	•Orthopaedic surgeon. •Hospital.
Perinatal (non ICU)	•Pregnancy-related claims for mother from 40 weeks before to 60 days after delivery. •Excludes neonatal care.	•Delivering provider. • If separate providers perform prenatal care and delivery, both providers are PAPs.
Acute/post-acute CHF	•Hospital admission. •Care within 30 days of discharge.	•Hospital.

Decision Aids: Washington State

Shared Decision Making (SDM) Legislation

2007 (SB 5930) – Pilot project mandating the Washington State Health Care Authority to implement an SDM demonstration project.

Analysis from the AHRQ's Innovations Exchange:

- During an 18-month test of the program, **41 percent** of eligible patients with **hip osteoarthritis** and **28 percent** with **knee osteoarthritis** received a decision aid.
- "[The] decline in surgeries tended to occur among those who did not receive the aid, and hence appear to have been driven by the intense provider education, training, and monitoring efforts that were part of this program, rather than distribution and use of the aids themselves."
- "**The decline in surgery was concentrated in those not receiving the aid**. In fact, those who viewed the aid were more likely to undergo surgery than those who did not (44 percent more likely for hip replacement and 103 percent for knee replacement). Post-implementation conversations with orthopedic surgeons suggest that this somewhat counterintuitive finding stems from their decision to be selective about who received an aid. Although Group Health leaders encouraged distribution to all patients, at least some of the doctors decided not to distribute them to those they thought were a long way from requiring surgery, such as patients presenting with osteoarthritis for the first time."

Washington State:
Knee/Hip Warranties

Dr. Robert Bree Collaborative:

Developing recommendations for a warranty for total knee and total hip replacements. Analysis by Bree Collaborative of the 2011 CHARS dataset suggest that a statewide implementation of the TKR/THR surgery warranty could reduce hospital reimbursement by as much as $1.5 million per year.

Washington State: Knee/Hip Warranties

These reductions in reimbursement would result from an estimated 153 readmissions following TKR/THR for conditions covered in the warranty and therefore ineligible for additional payment.

Assumptions

- 80% of TKRs/THRs are performed on patients with a diagnosis of osteoarthritis
- Patients only had one complication per readmission (every complication was assumed to be a different readmission)
- Average cost of a readmission for a complication following TKR/THR is $9,6001

CHARS Findings Used for Calculation

- 165 TKR patients and 141 THR patients were readmitted due to complications included in the warranty
- 58.5% of TKR patients and 67.0% of THR patients were readmitted to the same hospital that performed the index surgery

Calculation

Estimated savings = (# of TKR/THR patients readmitted due to warranty complications)*(% of TKRs/THRs due to osteoarthritis)*(% Readmitted to Same Hospital)*(Estimated Cost of Readmission)

Estimated reduction in reimbursement for TKRs = $740,768

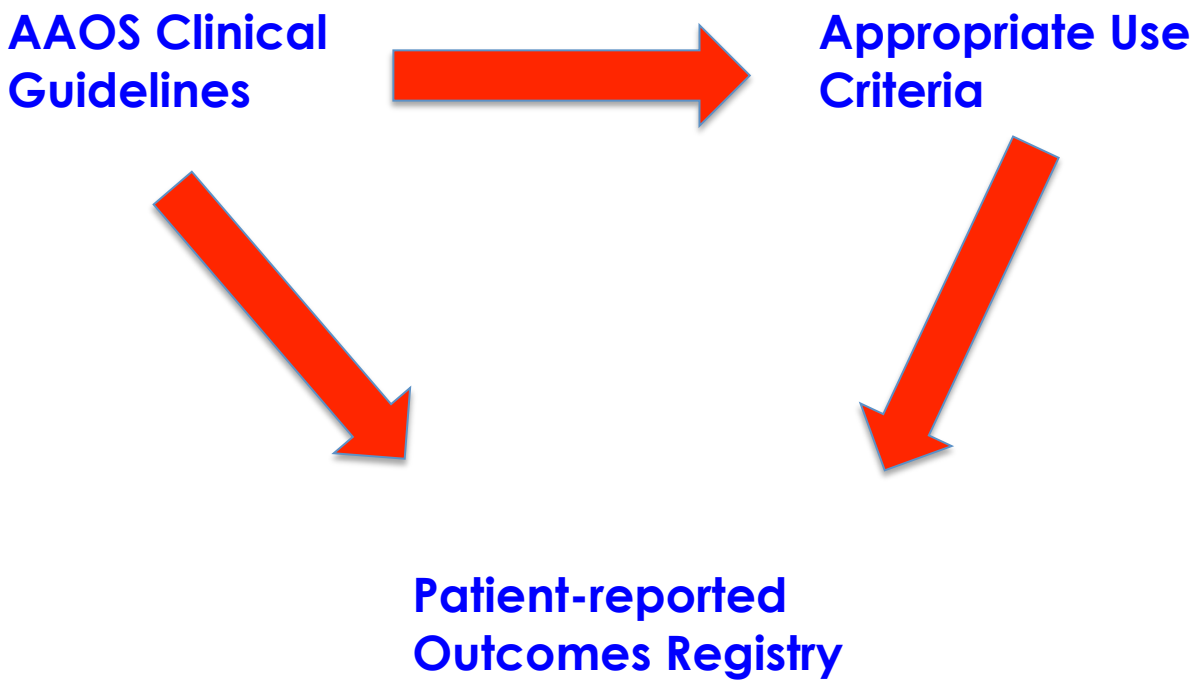
Estimated reduction in reimbursement for THRs = $724,228

Total reduction in reimbursement = $1,464,996

Patient-reported Outcomes

Patient-Reported Outcomes: The Future

Dr. Bernard Morrey's presentation at TOA's 2014 Annual Meeting.



Quality Reporting:

Orthopaedic Initiatives

The focus is on patient-reported outcomes.

The Orthopaedic Forum – Large orthopaedic groups with data managed by Oberd.

MOON/MARS Project – NIH-funded studies at Vanderbilt. Multicenter Orthopaedic Outcomes Network (MOON) that looks at ACL reconstruction. Multicenter ACL Revision Study (MARS).

PROMIS – Patient-Reported Outcomes Measurement System managed by the federal government. A PROMIS PF CAT for Lower Extremity Trauma simply consists of four questions for the patient and takes 44 seconds to complete. Other questionnaires are 46 questions and take 6 minutes.

Musculoskeletal Outcomes Registry – Univ. of Utah.

Michigan Surgical Quality Collaborative – The Blues, hospitals, and surgeons.

Children's GI

Musculoskeletal Outcomes Registry – University of Utah.

Patient-Reported Outcomes: Current Examples

American Joint Replacement Registry Hospitals – Texas

- Baylor All Saints Medical Center – Fort Worth
- Baylor Medical Center at Carrollton
- Baylor Medical Center at Garland
- Baylor Medical Center at Irving
- Baylor Medical Center at McKinney
- Baylor Medical Center at Waxahachie
- Baylor Medical Center at Grapevine
- Baylor Medical Center at Plano
- Baylor University Medical Center – Dallas
- Doctors Hospital at Renaissance – Edinburg
- Harlingen Medical Center
- Memorial Hermann Memorial City – Houston
- Memorial Hermann Southwest Hospital – Houston
- Nix Health – San Antonio
- Scott & White Memorial Hospital – Temple
- Texas Health Presbyterian Hospital Plano
- Texas Spine& Joint Hospital – Tyler
- University of Texas Southwestern Medical Center - Dallas