T-Bones 2015 Annual Conference

Public Policy Symposium

Brad Coffey – AAOE
Bobby Hillert - TOA

October 9, 2015

www.toa.org
www.aaoe.net

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TOA's 2016 Annual Conference:
April 7-9 | Hyatt Lost Pines (Bastrop)

New Session:
Business of Orthopaedics
Friday Afternoon – April 8

Ancillary Services

New Payment Models
BPCI & CCJR Experience

Benchmarking Data for Practice Administrators

Managing Hospital Relationships

Utilizing Physician Assistants in Practices

Preliminary Faculty:

Jennifer Kinman
Texas Orthopedics

Michael Berkowitz
KSF Orthopaedic

Chris Kean
The San Antonio Orthopedic Group

Sani Mirza
The San Antonio Orthopedic Group

Barry Howell
Arlington Orthopedic Associates

David Teuscher, MD
AAOS President

Ken Kaminski, MD
Tyler – BPCI Experience

Sheila Peterson
Azalea Orthopedics

Adam Bruggeman, MD
San Antonio

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AAOE's 2016 Annual Conference
June 9 – 12 | San Francisco

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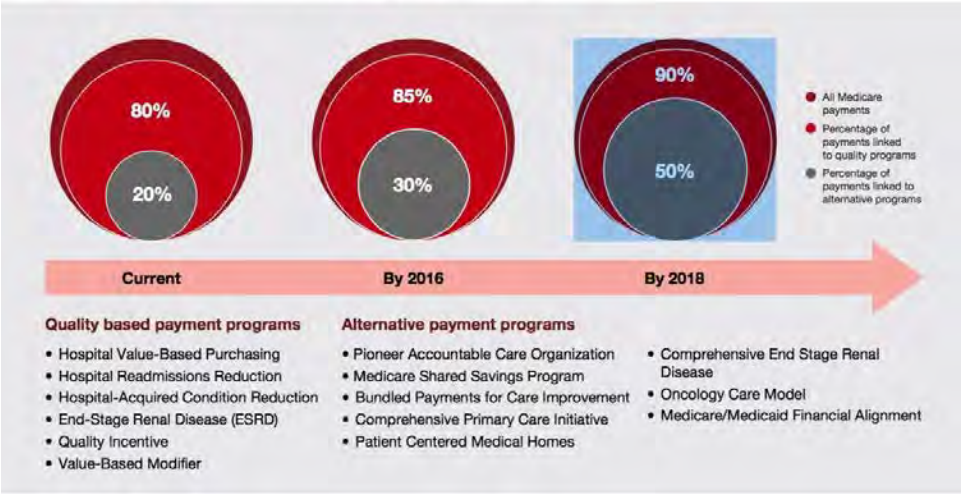
Washington, DC

Medicare: New Payment Models

4

CMS Payment Changes 2015-2018

Medicare's commitment towards quality-based payments grows.



Source: Morning Consult – 10.02.15

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Medicare CCJR: January 1, 2016 Start Date?

- CCJR is a **proposed** retrospective bundled payment for lower joint extremity replacements, THA/TKA (LEJR).
- The model will test a mandatory bundled payment program across a wide and varied geographic area.
- The model is:
  - For Medicare fee-for-service beneficiaries/patients;
  - Managed by a hospital;
  - Mandatory for five (5) years;
  - Affecting 75 metropolitan statistical areas (MSA) nationwide.

Texas Areas Affected

Austin/Round Rock

Beaumont/Port Arthur

Corpus Christi

Lubbock

Temple/Killeen

Tyler

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Medicare CCJR: Financial Risk Structure

- Hospital Bears financial risk and reward.
- CCJR bundled payment is retrospective, two-sided risk model.
  - All providers, including orthopaedic surgeons, will continue to bill and collect normal fee-for-service payments (*CCJR does not directly impact your revenue cycle*)
  - An episode target price is set for each hospital.
    - An episode is defined under CCJR as any total hip or total knee arthroplasty (could include hemiarthroplasty and trauma cases).
      - Episodes triggered when an inpatient hospitalization occurs for FFS beneficiary under MS-DRG 469 or 470.
      - Episodes include: Hospitalization and virtually all services within the 90 days post-discharge period.
  - At the end of the performance year, CMS will compare aggregate actual spending to aggregate target spending to determine is the hospital will:
    - Receive an additional payment from the shared savings, or
    - Be responsible for paying Medicare back.
  - Hospitals and providers are permitted to enter into risk-sharing agreements, meaning orthopaedic surgeons could be responsible for paying a portion of the repayment to Medicare.

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Medicare CCJR: Quality Performance

- Hospitals must meet minimum threshold on three (3) quality metrics:
  - Hospital level risk standardized complication rate for elective THA/TKA
  - Hospital level 30 day all cause readmission rate for elective THA/TKA
  - HCAHPS survey
- Thresholds will increase over the next five years (2016 – 2021)
- If quality metrics are not met, shared savings will not be distributed to the hospital.
- Hospitals can receive additional financial incentives by reporting patient-reported functional outcomes.
  - List is comprehensive (HOOS/KOOS, VR-12, PROMIS, etc.)
  - Reward is Medicare discount adjustment from 2% to 1.7%.
    - A $25,000 episode would equal $75.00 extra.

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Medicare CCJR:
January 1, 2016 Start Date?

Congressional Delay?

•AAOE and TOA worked with AAOS and the specialty societies to contribute congressional signatures to Congressman Tom Price's (R-GA) letter requesting a delay to the CCJR program.

- AAOE contributed 7 signatures of the 60 collected (11%).

Texas Signatures to Delay Letter:

Jeb Hensarling (R-Dallas)

Pete Sessions (R-Dallas)

Ruben Hinojosa (D-El Paso)

Kevin Brady (R-The Woodlands)

Mac Thornberry (R-Amarillo)

Brian Bilbray (R-Southeast Texas)

Louie Gohmert (R-Tyler)

Bill Flores (R-Waco/Bryan)

Pete Olson (R-Houston)

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Medicare:
Bundled Payment for Care Improvement (BPCI)

TOA's April 2016 Annual Conference
April 8 Panel on BPCI/CCJR

Adam Bruggeman, MD – Moderator

Jennifer Kinman – Texas Orthopedics (Austin)

Ken Kaminksi, MD– Tyler Joint Surgeon

Sheila Peterson – Azalea Orthopedics Case Manager

Barry Howell – Arlington Orthopedic Associates

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Medicare BPCI: Texas Participants

Texas Orthopedics, Sports & Rehabilitation Associates - Austin
BPCI Initiative: Model 2
Convening Organization: Accentcare Health Management

Fort Worth Brain & Spine Institute
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Texas Back Institute - Plano
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Texas Neurosurgery - Dallas
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Texas Orthopaedic & Sports Medicine - Tomball
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Arlington Orthopedic Associates
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Inpatient Physician Associates, LLC - Dallas
BPCI Initiative: Model 2
Convening Organization: Liberty Health Partners LLC

William F. Tucker, MD, PA - Dallas
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Quantum Emergency Physicians - Cleburne
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Quantum Hospital Medicine Services of Texas - Beaumont
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

Azalea Orthopedic & Sports Medicine - Tyler
BPCI Initiative: Model 2
Convening Organization: Signature Medical Group (St. Louis)

El Paso Orthopaedic Surgery Group - El Paso
BPCI Initiative: Model 2
Convening Organization: Remedy BPCI Partners

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Learn More About CMS' Bundled Payments Programs

AAOE, in partnership with Signature Medical Group (St. Louis, MO), is presenting an eight part webinar series to help participants understand the business of bundled payments.

•To learn more, visit www.aaoe.net/ccjr

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APM & MIPS:

Your Newest Medicare Abbreviations

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COFFEY TALK FROM THE HILL

Congressional Status:
House: Not in Session
Senate: Not in Session

AAOE
Government Affairs

A Service From AAOE Government Affairs Specialist Bradley Coffey, MA
Volume II, Issue XV

Inside this issue:

Senate Votes for SGR Repeal

April 14, 2015

In a late night vote, the United States Senate voted to repeal the Medicare Sustainable Growth Rate following House action on March 26. Votes began at 7:12 pm ET with six votes on six amendments. Three Democratic amendments and three Republican amendments were considered before voting on the legislation.

The amendments would have extended the funding available for the Children's Health Insurance Program, removed language prohibiting federal money used for abortion, repealed the Medicare therapy cap, stripped the bill of its exemption from congressional pay-as-you-go rules, stripped the legislation of the MIPS incentive money, and repeal the individual insurance mandate. All six amendments failed however, the vote on the PT amendment was close with 58 senators voting in favor of the amendment (this amendment needed 60 votes to pass) and 42 voting against.

When the time came to vote on the legislation, Senator Jeff Sessions (R-AL), an opponent of the legislation because it was not fully paid for, raised a point of order against the bill and forced the chamber to vote to exempt the bill from Senate rules requiring all legislation be paid for. After the point of order was waived by the chamber, voting began on the legislation itself. 15 minutes later, the Senate had voted 92—8 to repeal the SGR.

The final vote on C-SPAN as the Senate passed SGR repeal legislation.

The President signed the bill into law on April 16, 2015 at a signing ceremony in the Rose Garden at the White House.

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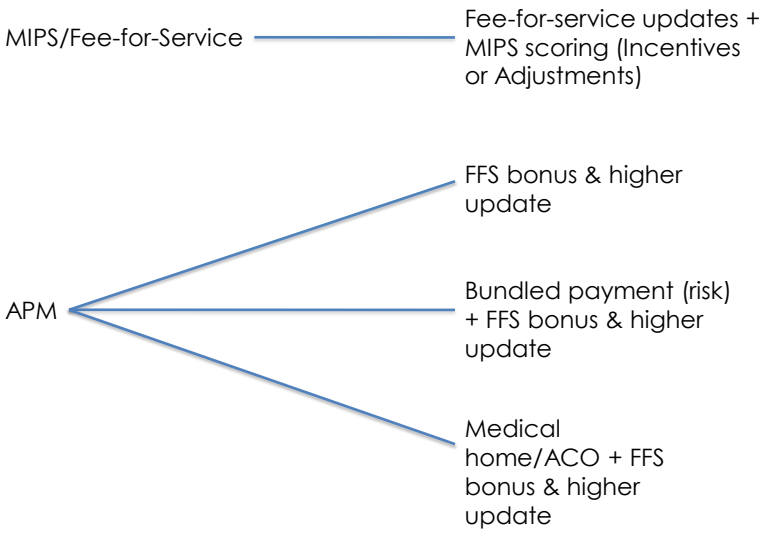
SGR Repeal (HR 2): Two Payment Models of the Future



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SGR Repeal (HR 2): Spring 2015 Efforts and FFS Payments

July 2015 through 2019
0.5 percent annual raise

2020 through 2025
No annual updates

2026 and beyond
Potential 1.0 percent payment increase for eligible alternate payment model (APM) participants, which focus on patient outcomes. 0.5 percent increase for others.

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SGR Replacement: Merit-based Incentive Payment (MIPS)

Three existing Medicare quality reporting programs (PQRS, VBM, and EHR MU) become one – MIPS.

- "More fairness, flexibility to earn significant bonuses." Final PQRS, MU, and VBM penalties would end in 2019.
- Measures include **quality**, **resource use**, **meaningful use**, and clinical practice improvements.
- 4 percent bonus in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and beyond.
- Negative payment adjustments: 4 percent (2019); 5 percent (2020); 7 percent (2021); and 9 percent (2022).
- 10 percent additional bonuses for exceptional performers.
- PQRS, VBM, and EHR MU will remain in place for hospitals. (2014 legislation.)

Easier for Physicians to Demonstrate True Quality of Their Care
Physicians would be provided targets at the start of each reporting period. MIPS scores would include four factors and be adjustable for individual physicians or group practices:

- Quality (PQRS – 30 percent).
- Resource use (VBM – 30 percent).
- Meaningful use (25 percent).
- Clinical practice improvement activities (15 percent).

Provider Scores Will be Publicly Reported on the Physician Compare Website.

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SGR Replacement: Merit-based Incentive Payment (MIPS) - Eligibility

First Two Years (2019 – 2021)

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Nurse Anesthetists

Succeeding Years (2022 +)

- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dietitians or Nutrition Professionals

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SGR Replacement: Alternative Payment Model (APM)

Two tracks for physicians to qualify for an APM bonus:

1.A physician's Medicare patient population must include 25 percent of patients from new payment models in order to receive the 5 percent bonus on FFS payments (2019 and 2020). The percentage increases to 50 percent in 2021 and 2022. Must assume risk (except for some exceptions with patient-centered medical homes).

1.Receiving a significant percentage of APM revenue combined with Medicare and other payers. This begins in 2021 and 2022 if 50 percent of payments are attributable to the sum of Medicare and other types of payers.

Qualifying participants are eligible for 5 percent bonuses in 2019 – 2024 on FFS payments if they assume financial risk and not subject to MIPS requirements. FFS would remain an option.

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SGR Repeal: Spring 2015 Efforts

Offsets:

- Affects beneficiaries premiums ("high" incomes).
- Phase out Medigap plans with no Part B deductibles for future beneficiaries.
- Extends DSH hospital cuts through 2025.
- Reimbursement rates altered for post-acute providers.
- Allows the government to withhold 100 percent of provider's delinquent taxes from their Medicare reimbursements.
- Restrict reimbursement increases scheduled in 2018 for home health providers, hospices, and nursing homes to 1 percent.

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SGR Repeal: Spring 2015 Efforts

Additional Elements:

- Extends federal payments to Tennessee hospitals that treat low-income patients.
- Assist large-scale makers of DME and prosthetic devices by penalizing "low-ball bidders."
- Site neutral payments were discussed as a potential offset. However, a major overhaul of payments based on setting was not included.
- Reverse elimination of 10- and 90-day global payments. Directs CMS to collect data over the next few years to study the issue again.
- Delay of two-midnights.
- Extension of therapy cap exceptions process.
- Gainsharing study.
- Telemedicine study.
- EHR interoperability by 2018.

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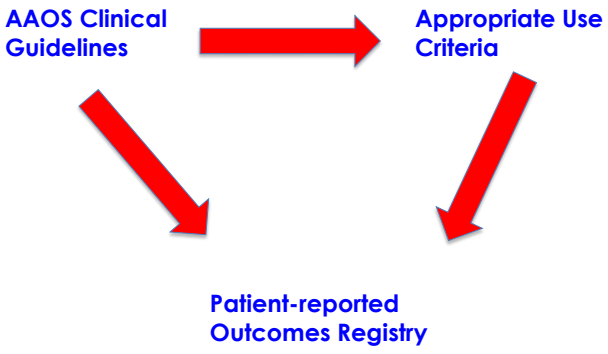
Patient-Reported Outcomes: The Future?



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Quality Reporting: Orthopaedic Initiatives

The focus is on patient-reported outcomes.

AAOE – Currently existing measures collected by Minnesota Community Measures. Proposal to CMS for inclusion in PQRS (eventually MIPS) at the end of 2015. (Focus on Process, Outcomes, and Cost/Resource Use)

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.

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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

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Washington, DC

Electronic Health Records (EHRs)

- Meaningful Use
- ICD-10

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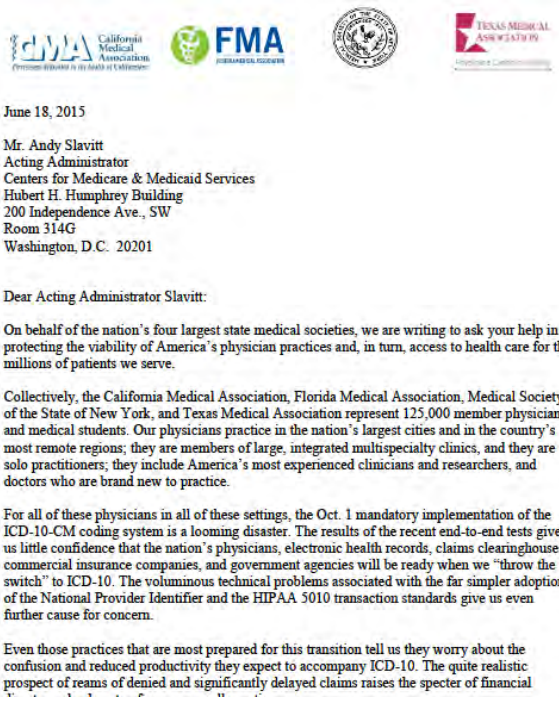

June 18, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Room 314G
Washington, D.C. 20201

Dear Acting Administrator Slavitt:

On behalf of the nation's four largest state medical societies, we are writing to ask your help in protecting the viability of America's physician practices and, in turn, access to health care for the millions of patients we serve.

Collectively, the California Medical Association, Florida Medical Association, Medical Society of the State of New York, and Texas Medical Association represent 125,000 member physicians and medical students. Our physicians practice in the nation's largest cities and in the country's most remote regions; they are members of large, integrated multispecialty clinics, and they are solo practitioners; they include America's most experienced clinicians and researchers, and doctors who are brand new to practice.

For all of these physicians in all of these settings, the Oct. 1 mandatory implementation of the ICD-10-CM coding system is a looming disaster. The results of the recent end-to-end tests give us little confidence that the nation's physicians, electronic health records, claims clearinghouses, commercial insurance companies, and government agencies will be ready when we "throw the switch" to ICD-10. The voluminous technical problems associated with the far simpler adoption of the National Provider Identifier and the HIPAA 5010 transaction standards give us even further cause for concern.

Even those practices that are most prepared for this transition tell us they worry about the confusion and reduced productivity they expect to accompany ICD-10. The quite realistic prospect of reams of denied and significantly delayed claims raises the specter of financial

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ICD-10: Washington, DC Action

Five Congressional Bills

- Ranged from ICD-10 elimination to an additional grace period to accepting both ICD-9 and ICD-10 codes.

July 6, 2015 Grace Period Announced

- CMS will reimburse for errors if they fall within the family range.
- Health plans have not followed.

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Meaningful Use

MU Stage II Modifications Rule Released in April.

- Still under Office of Management and Budget (OMB) review.
  - Expecting release any day now, most likely on a Friday.
- Proposed rule would have turned the 2015 reporting period into a 90-day period.
- Unclear if CMS will allow the reporting period to extend into 2016.

MU Stage III Proposed Rule Released in March.

- The proposed rule is also under OMB review.
- CMS has had considerable pressure from certain members of Congress to delay Stage III until the MIPS program is finalized.
- AAOE has supported legislation that would delay MU Stage III.
  - Flex-IT 2 Act

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Meaningful Use Stage III

CMS has Focused and Narrowed the Objectives for Meaningful Use to Eight Objectives

- Under proposed rule, core-menu objective structure is removed and all objectives are required.

TABLE 4: OBJECTIVES AND MEASURES FOR MEANINGFUL USE IN 2017 AND SUBSEQUENT YEARS

Program Goal/Objective	Delivery System Reform Goal Alignment
Protect Patient Health Information	Foundational to Meaningful Use and Certified EHR Technology* Recommended by HIT Policy Committee
Electronic Prescribing (eRx)	Foundational to Meaningful Use National Quality Strategy Alignment
Clinical Decision Support (CDS)	Foundational to Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment
Computerized Provider Order Entry (CPOE)	Foundational to Certified EHR Technology National Quality Strategy Alignment
Patient Electronic Access to Health Information	Recommended by HIT Policy Committee National Quality Strategy Alignment
Coordination of Care through Patient Engagement	Recommended by HIT Policy Committee National Quality Strategy Alignment
Health Information Exchange (HIE)	Foundational to Meaningful Use and Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment
Public Health and Clinical Data Registry Reporting	Recommended by HIT Policy Committee National Quality Strategy Alignment

*See, for example, sections 1848(o)(2) and (4) of the Act.

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Meaningful Use Stage III

Stage III Objectives

Objective	# of Measures	Requirement to Meet Objective
Protect Patient Health Information	1 measure	Measure must be successfully met
Electronic Prescribing	1 measure*	Measure must be successfully met
Clinical Decision Support	2 measures	Both measures must be successfully met
CPOE	3 measures	All 3 measures must be successfully met
Patient Electronic Access to Health Information	2 measures**	Both measures must be successfully met
Coordination of Care through Patient Engagement	3 measures	**Only 2 of 3 measures** must be successfully met
Health Information Exchange	3 measures	**Only 2 of 3 measures** must be successfully met
Public Health and Clinical Data Registry Reporting	*EPs*: 5 measures *Hospitals*: 6 measures	*EPs*: **Only 3 of 5 measures** must be successfully met *Hospitals*: **Only 4 of 6 measures** must be successfully met

**eRX measure is different for hospitals and EPs*
***Alternative versions of measures proposed for this objective for public comment*

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Meaningful Use Stage III

Align Program with Other Quality Reporting Programs.
•Aligning Hospital Inpatient Quality Reporting (IQR), Physician Quality Reporting System (PQRS), etc.
•All providers will report on a calendar year beginning in 2017.
Year Long Reporting Period Starting in 2017.
Optional in 2017, Mandatory for All Providers in 2018.
•Mandatory in 2018, regardless of prior participation in the meaningful use program.

Proposed Update to MU Timeline

First Payment Year	Required Stage of Meaningful Use and Length of Reporting Period						
	...	2015	2016	2017	2018	2019	2020+
2011		2	2	2 or 3	3	3	3
2012		2	2	2 or 3	3	3	3
2013		2	2	2 or 3	3	3	3
2014		1	2	2 or 3	3	3	3
2015		1	1	1, 2, or 3	3	3	3
2016			1	1, 2, or 3	3	3	3
2017				1, 2, or 3	3	3	3
2018+					3	3	3

2015 Edition CEHRT *required*

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Meaningful Use Stage III

CMS will align clinical quality measures with other quality programs (PQRS, VBM, etc.).

•CMS has yet to release those CQMs so providers and stakeholders have been asked to weigh-in on a policy issue without knowing its full scope.

Proposed rule continues to push interoperability of EHR systems.

•Congress has attempted to provide guidance on interoperability.

- 21st Century Cures – HR 6.
- Cassidy (R-LA) and Whitehouse (D-RI) Senate legislation on interoperability.
- Many of the solutions currently under consideration are focused on system to system connections and penalizing vendors and physicians for information blocking.
- Government Accountability Office report identified five hurdles to full interoperability:
  - Insufficiencies in health data standards;
  - Variation in state privacy rules;
  - Accurately matching patients' health records;
  - Costs associated with interoperability;
  - The need for governance and trust among entities.

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Austin, TX
Washington, DC

Hospitals & ASCs

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Hospital Relationships: TOA's 2016 Annual Conference

TOA's April 2016 Annual Conference
April 8 Panel on Hospital Relationships

Adam Bruggeman, MD – Moderator

Sani Mirza – The San Antonio Orthopedic Group

More Speakers TBA

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Washington, DC:
Four Key Issues for POHs

Tenet & USPI Merger
Approximately 30 POHs between the two companies.

September Expansion Waiver
McAllen POH joins two other POHs.

2016 Proposed Rule
Non-practicing physicians count against ownership threshold.

Kevin Brady's Hospital Finance Legislation
May allow POHs a limited window to expand.

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Austin, Texas:
Hospital Issues in Austin

Prompt Pay
Proposed legislation affected large orthopaedic groups. Unusual alliance.

End of Life Issues
Quieter issue in the 2015 Legislature. Led to Senator Bob Deuell's 2014 loss.

Medicaid 1115 Waiver
Texas asked CMS for $35B to cover uncompensated care in September 2015.

Hospital districts for "bed taxes."
1115 Waiver has led some districts to tax for-profit hospitals to draw down federal funding.

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Washington & Industry: Site Neutral Payments

Physicians

Cardiologists are the primary target of MedPAC and CMS

2015 Medicare modifier is tracking hospital-owned cardiology practices

ASCs

10.01.15 United Health

HOPD vs. ASC comparison in 21st Century Cures Act

Meaningful use

Hospitals

Hospital narrowly averted site-neutral payments as an offset for the spring 2015 SGR overhaul

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Washington, DC

Medicare's 2015 Proposals (Spring/Summer 2014):

- PFS
- ASCs/HOPDs
- Inpatient
- DME

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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.

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Medicare 2015 Proposal:
New ASC Spine Procedures

22551	Neck spine fuse & remove bel c2
22554	Neck spine fusion
22612	Lumbar spine fusion
63020	Neck spine disk surgery
63030	Low back disk surgery
63042	Laminotomy single lumbar
63045	Removal of spinal lamina
63047	Removal of spinal lamina
63056	Decompress spinal cord

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Washington, DC

Ancillary Services & Stark In-office Exemption

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Ancillary Services: TOA's 2016 Annual Conference

TOA's April 2016 Annual Conference
April 8 Panel on Ancillary Services

Adam Bruggeman, MD – Moderator

David Teuscher, MD – AAOS President

Jennifer Kinman – Texas Orthopedics

Barry Howell – Arlington Orthopedic Associates

Michael Berkowitz – KSF Orthopaedic

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Ancillary Opponents: "Alliance for Integrity in Medicine"

ACR American College of Radiology — Quality is Our Image

APTA American Physical Therapy Association

ACLA American Clinical Laboratory Association

ASCP American Society for Clinical Pathology

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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.

AARP Support for IOASE Restrictions

- AAOE Advocates met with the American Association of Retired Persons (AARP) to discuss the implications of the AARP's support for a bill to remove physical therapy and advanced imaging from the In-Office Ancillary Services Exception.
- The meeting resulted in the 35 million member organization **walking back** its support for the legislation.
- That legislation has not been reintroduced in the 114th Congress.


AAOE
Government Affairs

December 15, 2014

Ms. Joyce Rogers
Senior Vice President of Government Affairs
American Association of Retired Persons
601 E Street, NW
Washington, DC 20049

Dear Ms. Rogers,

On behalf of The American Association of Orthopaedic Executives' (AAOE) 1,400 members and the thousands of orthopaedic surgeons they serve, I am writing in response to your organization's decision to support efforts to remove physical therapy from the in-office ancillary services (IOAS) exception to the Stark Law.

We share the AARP's concern for ensuring Medicare remains a viable program for future beneficiaries. As practice administrators for the physicians who treat a significant portion of those beneficiaries, we also have their best interests in mind for both the cost and quality of care they receive. However, we strongly disagree with your assertions that physician self-referral leads to unnecessary services and higher cost.

Please reference the April 2014 Government Accountability Office's (GAO) study of physical therapy referrals between 2004 and 2010. In this study, self-referred physician-owned physical therapy services provided per 1,000 Medicare fee-for-service beneficiaries remained generally flat, while the number of non-self-referred independently-owned physical therapy services per 1,000 fee-for-service beneficiaries increased by 41 percent (from 903 services in 2004 to 1,275 services in 2010).[1] Consequently, expenditures for non-self-referred services jumped 57 percent, from $1.2 billion in 2004 to $1.9 billion in 2010.[2]

Further, this report found that orthopaedic surgeons practicing in both urban and rural areas were less likely to self-refer patients for unnecessary physical therapy services. This is significant because Medicare Part B currently reimburses on a fee-for-service schedule, meaning that the more services provided, the more Medicare must reimburse. With non-self-referring providers requesting more services than self-referring providers, your contention that removing physical therapy services, among others, from the in-office ancillary services exception will save "$6 billion over ten years" is very questionable. In fact, the 2009 Developing Outpatient Therapy Payment Alternatives (DOPTA) published by RTI International in 2013 found that between 2004 and 2009, physical therapy expenditures increased by 37 percent in independently-owned physical therapy practices while decreasing 38 percent in physician-owned settings.[3] In other words, receiving treatment in a physician-

[1] United States Government Accountability Office, Medicare Physical Therapy: Self-referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary, by Some Diagnoses, GAO-14-279 (Washington, D.C.: United States Government Accountability Office, 2014), 5.
[2] Ibid, 10
[3] RTI International, Developing Outpatient Therapy Payment Alternatives: 2006 Utilization Report, by Rhiannon Lotz-McDonald, Edward Orozet, and Barbara Gage (Research Triangle Park, NC: RTI International, 2013), 27

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Medicare Imaging: From Prior Authorization to AUCs

2014 SGR Patch Bill

- Beginning in January 2017, referring physicians must use physician-developed AUC for Medicare imaging. HHS must unveil the criteria in November 2015.
- Must consult with at least one clinical decision support mechanism – EHR technology, use of private sector clinical decision support that is independent from certified EHRs, or use a clinical decision support mechanism established by HHS.
- AUC outliers will be penalized beginning in 2020. (Based on data beginning in 2017.)
- Beginning January 1, 2016, CT scans conducted with non-compliant machinery will be cut by 5 percent.

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Washington, DC
Austin, TX
Industry

Provider & Licensing Issues

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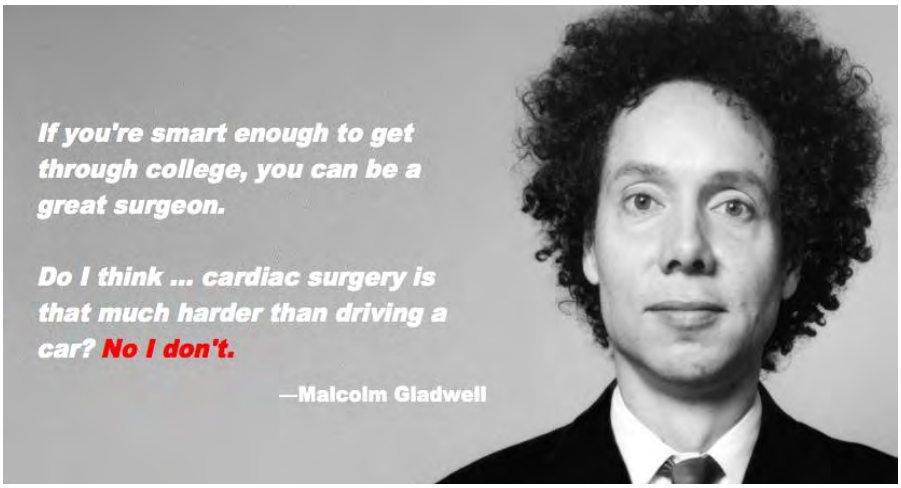

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Feb 2015 Supreme Court Ruling

- Court ruled that the North Carolina Dental Board violated the Sherman Act because its members were dentists who were not actively supervised by the state.
- Issue involved teeth whitening by non-dentists.
- "[The Sherman Act] does not authorize the states to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies."

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THE TEXAS TRIBUNE

Bills on Medical Authority Spark More Doc Fights

by Edgar Walters | April 21, 2015 | 4 Comments

Every two years, it seems, lawmakers are asked to recalibrate a few delicate balances

53

"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**."

54

2015 TX Legislature: Scope of Practice Issues

Nurse Practitioners
- No supervision proposed.

Anesthesia Assistants
- New license proposed. CRNA opposition.

Physical therapists
- Direct access and remove a medical diagnosis/referral.

Chiropractors
- Sports medicine issues – UIL sports medicine exams and concussion teams.

Podiatrists
- Parity for insurance payments and facility privileges.

Paramedics
- Work under physician supervision in emergency departments.

55

2015 TX Legislature: Provider ID Badges

SB 1753

- Require providers working in hospitals to wear ID badges that clearly state their occupations (physicians, podiatrists, nurses, physical therapists, etc.).
- **Podiatrists were the only provider group to speak against the legislation. They are concerned about being referred to as "podiatrist" as opposed to "doctor of podiatric medicine."**

56

Physical Therapy Direct Access

57

"To be honest, I like how my physical therapist spends more time with me than my orthopaedic surgeon does."

"How do other states handle this issue? If lots of other states allow it, then I don't have a problem."

What Lawmakers Tell Us

"All I ever hear is anecdotal evidence about why this is bad for patients. I need to see real evidence."

"This just seems to be a turf battle."

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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.

PT Direct Access: 2006 Study

1,000 randomly selected PTs were asked a collection of 12 hypothetical patient scenarios and asked to choose whether they would:

- Provide intervention.
- Provide intervention and refer.
- Refer on to a physician.

The decisions were based on criteria developed by physical therapists. Results demonstrated:

- PTs made all of the correct decisions 50 percent of the time.
- PTs were incorrect 13 percent of the time for musculoskeletal conditions.
- PTs were incorrect 12 percent of the time for noncritical emergency conditions.
- PTs were incorrect 21 percent of the time for critical emergency conditions.

(Jette DU et al, Physical Therapy 2006; 86(12))

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PT Direct Access – May 2015: House Calendars Committee Vote

Only two Calendars Committee members voted for HB 1263: Rep. Eddie Lucio III (D-Brownsville) and Rep. Eddie Rodriguez (D-Austin).

Seven members voted against HB 1263: Rep. Roberto Alonzo (D-Dallas), Rep. Sarah Davis (R-Houston), Rep. Charlie Geren (R-Fort Worth), Rep. Dan Huberty (R-Kingwood), Rep. Ken King (R-Canadian), Rep. Lyle Larson (R-San Antonio), and Rep. Debbie Riddle (R-Spring).

Two members voted present and did not vote: Rep. Todd Hunter (R-Corpus Christi) and Rep. Helen Giddings (D-Dallas).

Four members were not present (they may have purposely missed the vote): Rep. Byron Cook (R-Corsicana), Rep. Patricia Harless (R-Spring), Rep. Eric Johnson (D-Dallas), and Rep. Four Price (R-Amarillo).

62

OSMA, OOA File Suit Against Physical Therapy Law

Earlier this month, the OSMA and the Oklahoma Osteopathic Association joined together in filing a lawsuit challenging Oklahoma's state law that gives physical therapists direct access to patients, claiming it is a "special law." which violates the state

63

Austin, Texas

Allied Health Provider Licensing Issues

64

Allied Health Providers:
New Licensing Home: Texas Medical Board

- Athletic trainers, x-ray techs, orthotists.
- Key issue involves the Texas Medical Board having the final say over new x-ray standards. PAs and NPs became engaged.

65

Podiatrists:
2015 Texas Legislature Issues

- Considered medical privilege parity legislation.
- Introduced legislation parity for health plan methodology.

66

Physician Licensing Issues:

- Radiation CME
- Maintenance of Certification
- New Mexico court case

67

Texas Regulatory:
CME Radiation Requirement Eliminated

Eliminated in January 2015
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.

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Newsweek

The Ugly Civil War in American Medicine

BY **KURT EICHENWALD** / MARCH 10, 2015
12:04 PM EDT

69

New Mexico Legal Case
A Test of Texas' Medical Liability Law

A New Mexico court ruled that a New Mexico patient being treated in Lubbock by a Texas physician could sue under New Mexico's medical liability laws.

TOA and TMA have filed an amicus brief.

70

Austin, TX
Washington, DC

Sports Medicine

71

2015 TX Legislature: Mandatory EKGs Failed

72

Chiropractors & Sports Medicine:
Ms. America, D.C. Visits Austin on 04.28.15

HB 1231 would have added chiropractors to the list of providers who may serve on a school's concussion team. It failed.

SB 213 University Interscholastic League (UIL) sunset bill examined the issue of chiropractors providing pre-participation physical exams to athletes.

73

State & Federal
Sports Medicine Liability Legislation

Austin, TX – 2017 Legislation
Legislation will be introduced that will protect physicians who travel across state lines with their sports teams.

Congressional Legislation – H.R. 921
Federal effort to protect physicians who travel across state lines with their sports teams. Texas co-sponsors include:

- Jeb Hensarling (R-Dallas)
- Will Hurd (R-San Antonio)
- Beto O'Rourke (D-El Paso)
- Kenny Marchant (R-Dallas Area)
- Bill Flores (R-Bryan/Waco)
- Brian Babin (R-SE Texas)
- Pete Olson (R-Houston)

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Austin, Texas

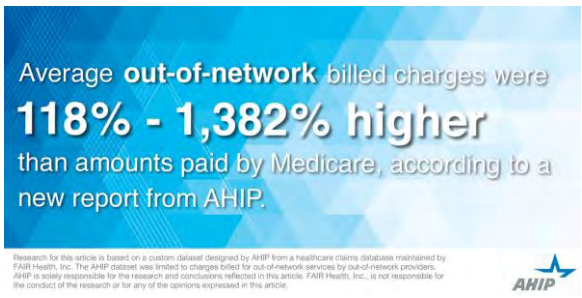
Managed Care Issues: 2015 Texas Legislature

75

Commercial Insurance & Balance Billing: Major Issue on the Horizon

New York state now ties some ER CPTs to a percentage of FAIR Health – April 2015.

California Assembly narrowly defeated AB 533, which would have taken balance billing away and tied physician's payments to a % of Medicare – 2nd half of 2015.



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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%

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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.

78

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

79

Balance Billing:
SB 481 – Signed into Law

Builds on HB 2256 (2009 Texas Legislature)

- HB 2256 created an informal teleconference/mediation process to settle balance bills of $1,000 or more for facility-based physicians.
- To date, 1,478 complaints were filed with the Texas Department of Insurance in the first nine months of 2014.
- Seventy-six percent of the complaints were filed by United HealthCare policyholders. Fifty-eight percent were related to hospitals and ASCs.
- Only a handful of the complaints went beyond the informal teleconference stage and into mediation.

SB 481 Keeps Focus on Facility-based Physicians & Lowers Threshold

- SB 481 would have lowered the balance bill threshold to $0.
- Final negotiation moved the trigger to $500.

80

Usual, Customary & Reasonable
HB 616

UCR Standard & Optional Balance Billing

•If an out-of-network (OON) provider agrees to waive a balance bill, HB 616 would require a commercial payer to reimburse the OON based on a percentage of FAIR Health or billed charges.

•New York state is the first state that has this requirement. Limited to certain CPT codes within emergency services.

FAIR HEALTH
Know Your Source

81

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.
• Certain key emergency physician CPT codes are exempt from the UCR mandate.
• 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.

82

Pricing Transparency: Not Introduced in 2015

- Several key lawmakers and members of organized medicine considered the idea of requiring all providers (dentists, physicians, mid-level providers, facilities, etc.) to post the prices for their most common services on a Web site.
- In exchange, balance billing would not be attacked.
- Major concerns from several physician groups.

83

Major Balance Bill Changes HB 1638 - Defeated

Removal of ability to send a balance bill to a patient

- HB 1638 did not receive a House Insurance Committee vote after TOA and other organizations became active.
- The bill would have removed the ability of physicians to send a balance bill to a patient. Instead, they would have had to have go into a mediation with the health plan.

84

Major Balance Bill Changes
HB 1638 - Defeated

Removal of ability to send a balance bill to a patient

- HB 1638 (Rep. John Smithee, R-Amarillo) did not receive a House Insurance Committee vote after TOA and other organizations became active.
- The bill would have removed the ability of physicians to send a balance bill to a patient for an emergency service in a hospital. Instead, they would have had to have go into a mediation with the health plan.

85

Notices to All Patients
HB 3102 - Defeated

Requirement to send estimates to all patients

- HB 3102 (Rep. John Frullo, R-Lubbock) did not receive a House Insurance Committee vote.
- The bill would have required all providers to send a notice about potential costs several business days prior to a service.

86

Telemedicine in Texas
Legislative/Regulatory Issues

Texas Medical Board Emergency Ruling

- Spring 2015.

2015 Texas Legislature

- Bills driven by Teladoc and health plans.

87

2015 TX Legislature:
Medicaid Issues

- Therapy cuts.
- Medicaid adequate networks – SB 760 (Senator Charles Schwertner, R-Georgetown).
- Medicaid OIG reform – SB 706 (Senator Chuy Hinojosa, D-McAllen)
- Medicaid in-office ancillary imaging study.
- Medicaid payment increase for primary care physicians removed.

Texas Medical Association's Medicaid Congress
We need your help on October 16.

88

Pharmacy Issues

89

Key Issues:
Schedule II & Texas Legislature

- Legislation moving through that will move oversight from DPS to Texas State Board of Pharmacy.
- DPS registration will be eliminated. Triplicate pads will remain.
- Suppliers worried about federal DEA issue.
- Optometrists attempting to be recognized as providers able to prescribe hydrocodone.
- Board of Pharmacy may have adequate database to track physicians who are "inappropriately" prescribing pain killers. I.e., too long after surgery.

90

2015 TX Legislature: Compound Pharmacies

Physician Ownership

- TMB does not have the authority to regulate physician ownership of compound pharmacies.
- SB 460 passed (Senator Charles Schwertner, R-Georgetown) and will require pharmacies to release their ownership information.

Workers' Comp

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

91

Payment Policy: New Commercial Insurance Models

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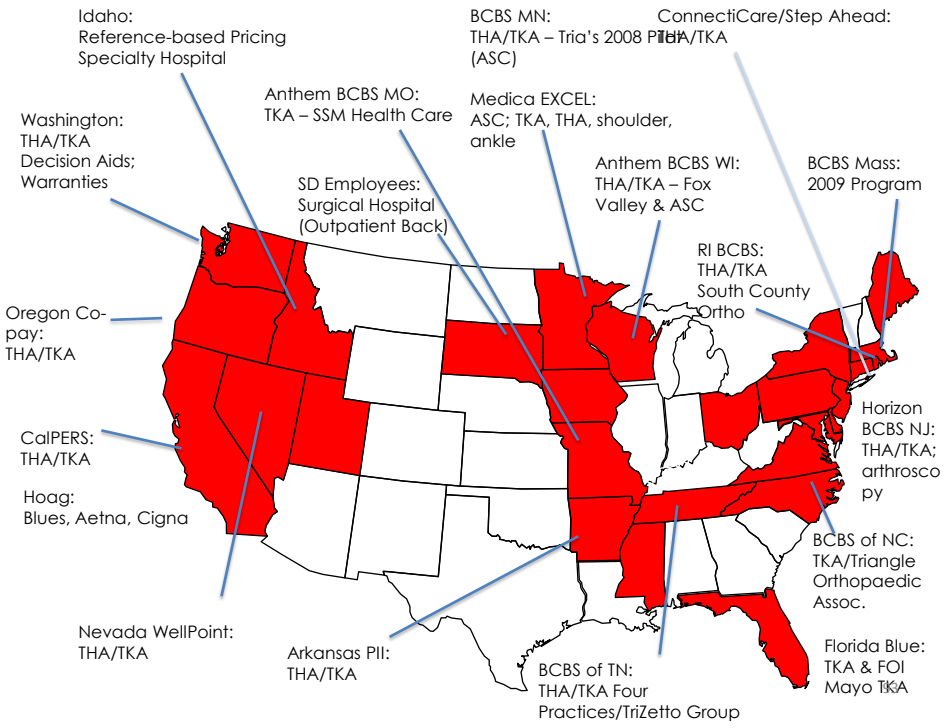

Reference Pricing

CalPERS & Anthem BlueCross Total Joints

CalPERS

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.

Anthem BlueCross

94

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?

95

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

96

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.

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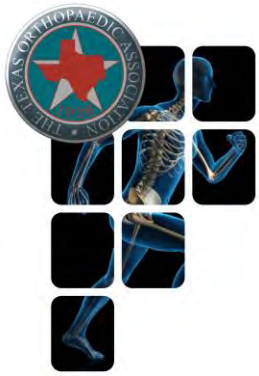

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