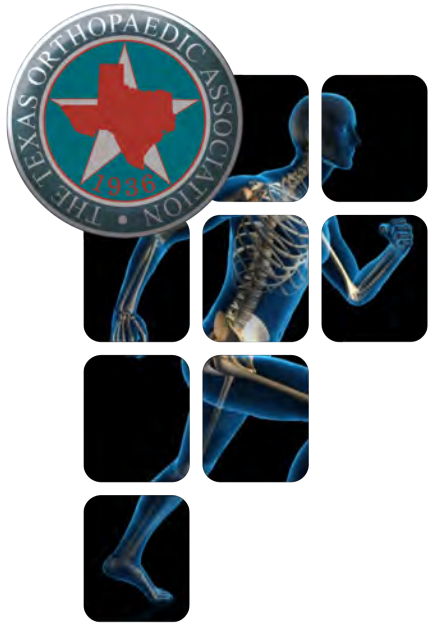
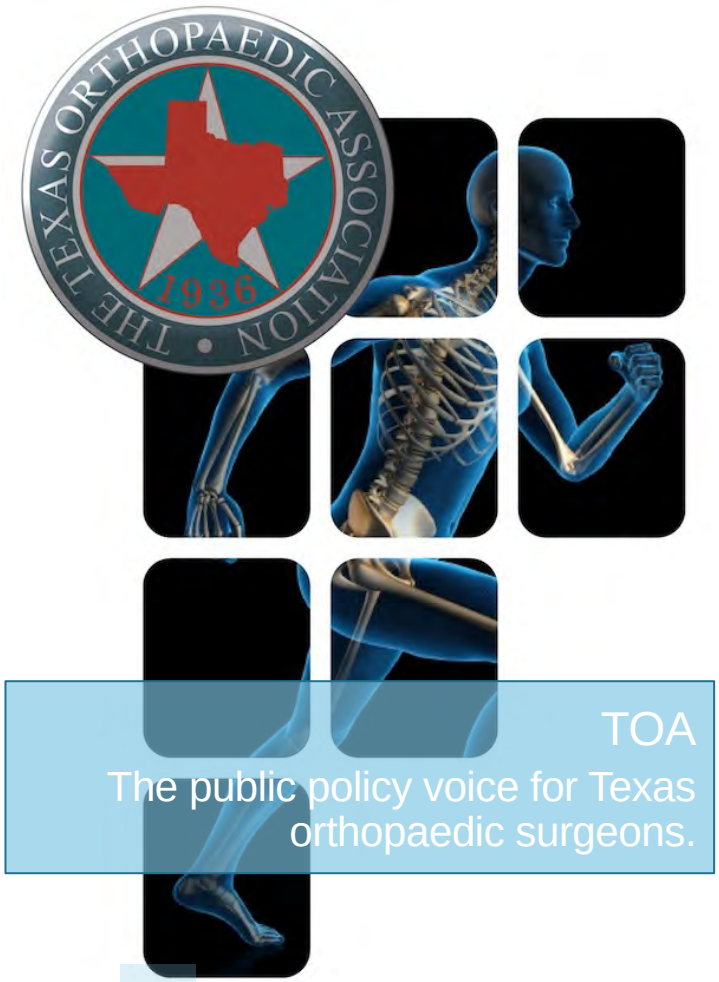


TOA'S ADVOCACY WORK IN 2017

Texas Orthopaedic Association | September 22, 2017

www.toa.org | Bobby@toa.org


FORT WORTH STOCK YARDS
Texas
Orthopaedic Association's
ANNUAL CONFERENCE
HILTON - FORT WORTH
APRIL 13-14, 2018



TOA

The public policy voice for Texas orthopaedic surgeons.

HEALTH CARE IS ONE OF THE MOST REGULATED INDUSTRIES IN AMERICA.

And orthopaedics is one of the most regulated specialties. Laws and regulations touch on every aspect of an orthopaedic surgeon's practice.

Therefore, orthopaedic surgeons have no choice but to engage in the public policy process. Otherwise, opponents will take advantage of orthopaedic surgeons' absence and define musculoskeletal issues by using their own terms.

The American Orthopaedic Society for Sports Medicine

SUCCESSFUL ADVOCACY PARTNERSHIPS

AAOS
American Academy of Orthopaedic Surgeons

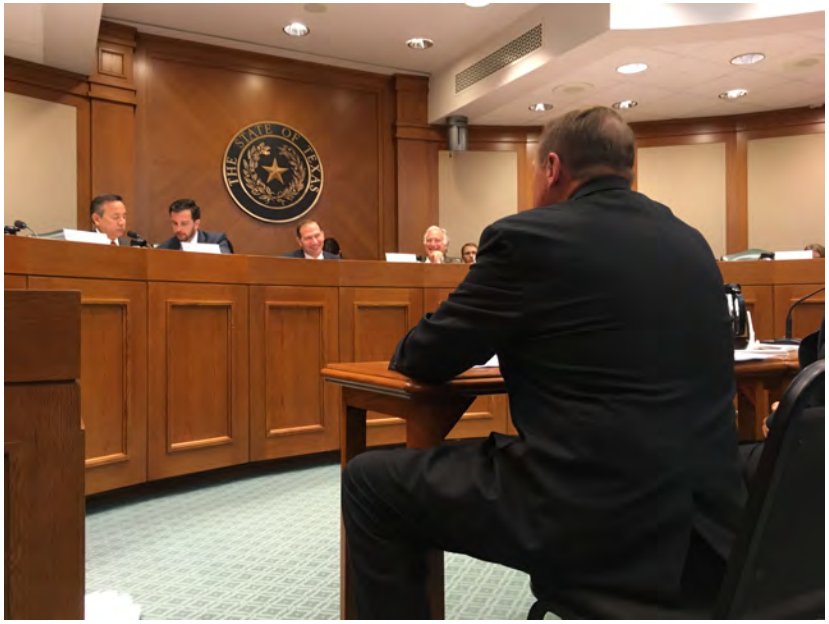
Texas Medical Association

HEALTH CARE 85TH TEXAS LEGISLATURE

Texas Medical Assoc. @texm... · 5h

Count 'em. Six. Six! That's how many bills Dr David Teuscher testified on, for, or against at #TxLege today. Photo credit: @TomOliverson

1 2



FEDERAL PAC $ TOP POLITICAL GIVING

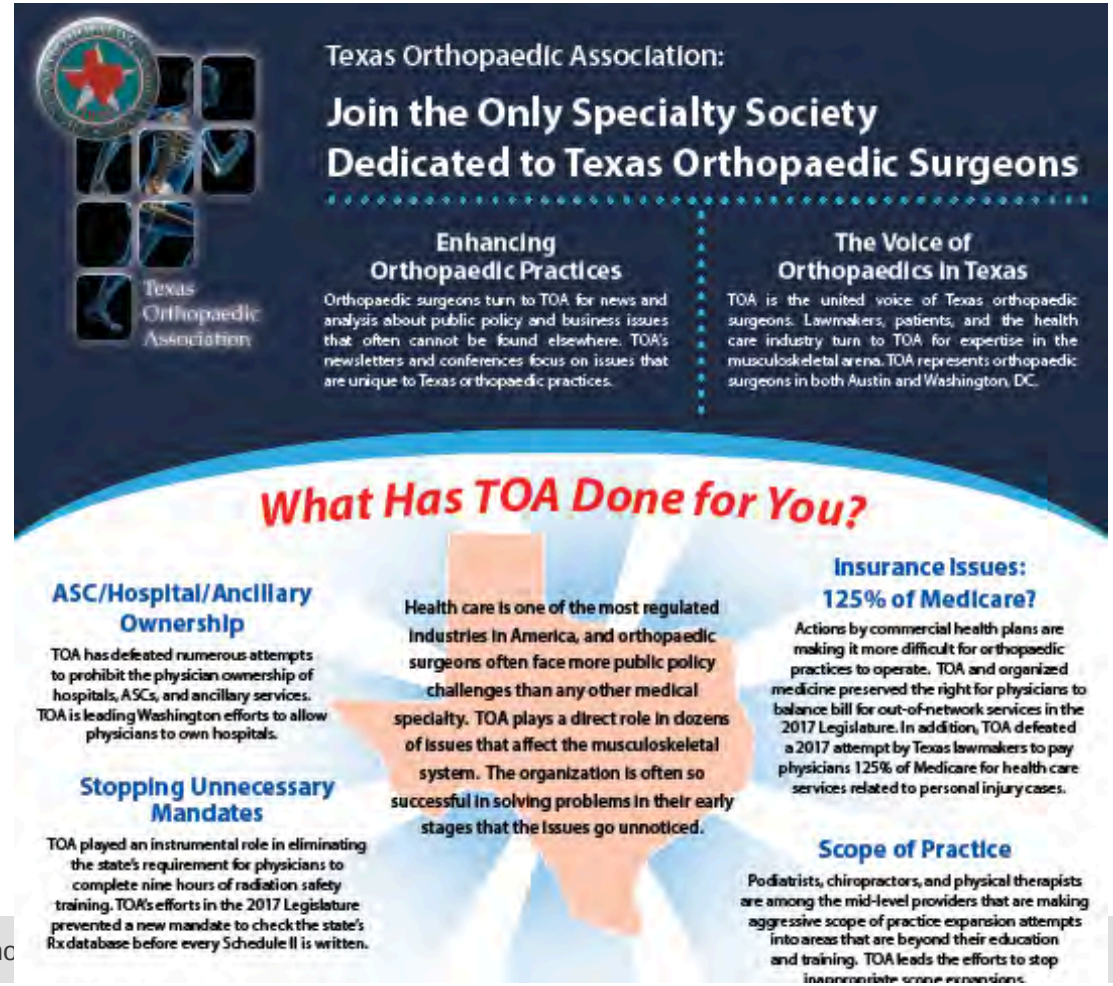
MARCH 7, 2016 DATA

1. Leon Medical Centers - $2.5M	11. American Hospital Assn - $720,553
2. Cooperative of American Physicians $1,356,355	12. American College of Emergency Physicians $650,950
3. Jackson Healthcare - $1,183,811	13. Amgen - $635,731
4. Clinical Medical Services - $1,005,400	14. Sanofi - $633,559
5. AAOS PAC - $900,400	15. American College of Rad. - $565,250
6. Pfizer - $831,800	16. Celegene Corp - $552,710
7. American Society of Anesthesiologists $810,450	17. Border Health (TX) - $540,000
8. D.E. Shaw Research - $755,246	18. Davita - $535,812
9. UnitedHealth - $755,246	19. American Acad. Dermatology - $531,700
10. American Dental Assn - $730,573	20. BCBS Assn - $526,715

TOA REPRESENTING ALL ORTHOPAEDIC SURGEONS

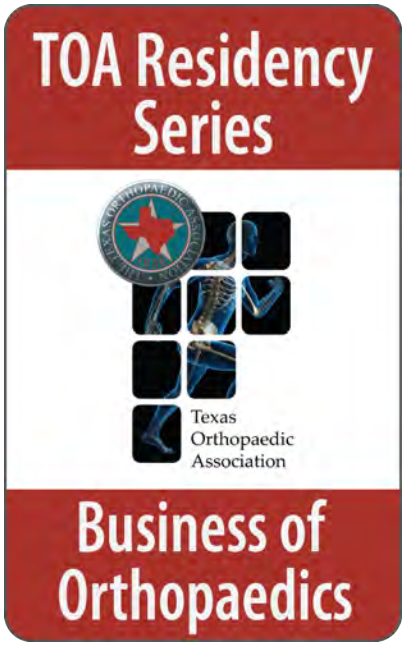
The future of private practice affects every type of orthopaedic practice model in Texas: private, hospital employed, and academic. Hospitals and academic entities often base salaries on market value, and what the market will pay you in a private practice setting is an important factor.

ORGANIZED ORTHOPAEDICS WHAT IF TOA DOESN'T EXIST?



FUTURE OF ORTHOPAEDICS IN TEXAS OUR RESIDENTS

- **TOA surveyed 82 Texas orthopaedic residents.** The survey examined residents' knowledge of business and public policy issues.
- **Will this provide a glimpse into the future of physician employment?** The study will be published in the fall of 2016.
- **Eugene Stautberg, MD of UTMB.** Fifth year resident who is on TOA's board of directors and is the study author.



A RESIDENT'S FIRST EMPLOYMENT OPPORTUNITY…

Survey based on 82 responses from Texas orthopaedic residents; Spring 2016

19%	8%	39%	27%	8%
Academic	**Hospital Group**	**Private**	**Undecided**	**Other**

AWARENESS OF BUNDLED PAYMENTS FOR TKA/THA

Survey based on 82 responses from Texas orthopaedic residents; Spring 2016

37%	39%	11%	11%	2%
Not Familiar	Somewhat Familiar	Familiar	Moderately Familiar	Very Familiar

RESIDENTS' CONFIDENCE IN NEGOTIATING FIRST CONTRACT

Based on 82 resident responses to TOA's spring 2016 resident survey

54%	43%	4%	0%
No Confidence	**Some Confidence**	**Much Confidence**	**Absolute Confidence**

WASHINGTON A NEW ADMINISTRATION

All Eyes Are on Regulatory Rules

WASHINGTON: SEPTEMBER DEADLINES

CHIP Reauthorization by the end of September; five-year deal reached.

Finalize Premiums ACA plans have until September 27.

Stabilize Insurance Markets Senate HELP Committee has expressed an interest.

Government Funding Was to expire at the end of September; extended until December. The “debt ceiling” bill could be a health policy vehicle.

Hurricane Relief Hurricane Harvey relief passed in early September.

ACA OVERHAUL 09.30.17 RECONCILIATION: EXPIRES

WASHINGTON: THE REST OF 2017

Medicare's HOPD/ASC Final Rule Late October/November

Medicare's Physician Payment Policy Final Rule Late October/November

Omnibus/Debt Ceiling Legislation Congress typically ends each year with an omnibus bill that incorporates all of the spending bills. The 2015 version affected physician employment.

Medicare Surveyors New guidance regarding what defines a hospital.

DC INDEPENDENT PAYMENT ADVISORY BOARD

Congressional Legislation– Legislation exists to eliminate IPAB.

2018?– Medicare trustees predicted in 2016 that IPAB would be triggered in 2018. CMS's Chief Actuary missed the April 30, 2017 target for an announcement. Ultimately, we learned that IPAB would not be triggered over the summer.

Exemptions – Hospitals and hospices are exempt until 2020. It may not "ration" care, raise premiums, increase cost sharing for beneficiaries, or restrict benefits or eligibility. Medicare Part C and D may be the primary targets.

Drug Prices – If IPAB had been triggered, could it have been President Trump's opportunity to lower drug prices?

CMMI DETERMINING THE FUTURE?

CMMI "NEW DIRECTION" ANNOUNCED ON 09.20.17

U.S. House and Senate Notification
Wednesday, September 20, 2017

To: **Congressional Health Staff**

From: **Office of Legislation**
Centers for Medicare & Medicaid Services

Re: **Innovation Center New Direction**

Today, the Centers for Medicare and Medicaid Services (CMS) issued a Request for Information (RFI) from the Center for Medicare and Medicaid Innovation (the Innovation Center).

The RFI seeks feedback on a new direction for the Innovation Center to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The RFI outlines new guiding principles for model design and seeks comments for potential new models in the following eight focus areas:

- Expanded Opportunities for Participation in Advanced Alternative Payment Models (APMs);
- Consumer-Directed Care & Market-Based Innovation Models;
- Physician Specialty Models;
- Prescription Drug Models;
- Medicare Advantage (MA) Innovation Models;
- State-Based and Local Innovation, including Medicaid-focused Models;
- Mental and Behavioral Health Models; and
- Program Integrity.

The RFI's comment period closes on November 20, 2017.

WASHINGTON FACILITIES

Physician-owned Hospitals and ASCs

ASC TEXAS DATA

20 Highest Volume Orthopaedic ASCs in Texas; July 2015 – June 2016 DSHS Data

Orthopaedic Surgery Center of San Antonio – 5,465

Texas Orthopedics Surgery Center (Austin) – 4,180

Texas Spine & Joint Hospital (Tyler) – 3,006

MH Surgery Center Woodlands Parkway – 2,571

Christus Spohn Corpus Christi Outpatient Surgery – 2,545

Texas Midwest Surgery Center (Abilene) – 2,524

MH Surgery Center TX Medical Center – 2,096

Texas Ambulatory Surgical Center (Houston) – 1,925

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

TX Health Orthopaedic Surgery (Flower Mound) – 1,662

Baylor Surgicare at Carrollton – 1,579

Kelsey Seybold Clinical ASC (Houston) – 1,555

Methodist ASC North Central (San Antonio) – 1,529

Methodist Willowbrook Hospital Outpatient (Houston) – 1,514

Baylor Surgicare (Dallas) – 1,498

Hyde Park Surgery Center (Austin) – 1,437

The Center for Special Surgery TCA (SA) – 1,427

Northstar Surgical Center (Lubbock) – 1,362

ROC ASC (Houston) – 1,332

Central Park Surgery Center (Austin) – 1,307

ASCS & MEDICARE CY 2018 PROPOSED RULE

CMS did ask for comments on payment reform for ASCs, including the collection of cost data that could be used to create a new rate update system for ASCs. The ASC industry did oppose mandatory cost reporting for ASCs under the Affordable Care Act's original proposal. (The cost reporting mandate was later dropped.)

ASCS & PRICING CY 2018 PROPOSED RULE

HOPD vs. ASC Price Transparency in Early 2018

Last year's 21st Century Cures Act included a provision that requires CMS to provide price transparency related to estimated payment amounts for services in HOPDs and ASCs. The idea is to demonstrate that ASCs may have a lower cost. CMS indicated that the website should be available in early 2018.

Texas Medical Assoc. 12/25/14
Draft bill from @SamsPressShop and @RepKevinBrady would relax restrictions on **physician-owned hospitals** (p 73) ow.ly/GcoyY

FAH @FedAmerHospital 12/3/14
Self-referral to **physician-owned hospitals**: Recipe for increased utilization and higher Medicare costs. fahpolicy.org/?p=1354

Chip Kahn @chipkahn 12/3/14
FAH looks at legislative threat of weakening self-referral to **physician-owned #hospitals** law. fahpolicy.org/?p=1354

FAH @FedAmerHospital 12/3/14
Existing law protects patients, businesses, and taxpayers from self-referral to **physician-owned #hospitals**. fahpolicy.org/?p=1354

PHYSICIAN-OWNED HOSPITALS WASHINGTON

Vicente Gonzalez (D-McAllen)

Roger Williams (R-Austin)

Pete Sessions (R-Dallas)

Sheila Jackson Lee (D-Houston)

Michael Burgess (R-Denton)

John Carter (R-Georgetown)

Jeb Hensarling (R-Dallas)

Pete Olson (R-Houston)

Joe Barton (R-DFW)

Bill Flores (R-Waco/Bryan)

Ted Poe (R-Houston)

Mac Thornberry (R-Panhandle)

Brian Babin (R-Houston)

Blake Farenthold (R-Corpus Christi)

Henry Cuellar (D-Laredo/San Antonio)

Filemon Vela (D-Brownsville)

Lamar Smith (R-San Antonio/Austin)

Jodey Arrington (R-Lubbock)

H.R. 1156 – Cong. Sam Johnson (R-Richardson)
S. 1133 – Sen. James Lankford (R-Oklahoma)

AAOS
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

PHYSICIAN HOSPITALS OF AMERICA | PHA

PHYSICIAN-OWNED HOSPITALS 2017 AND BEYOND

Medicare's Request for Comments – Inpatient & HOPD Payment Rules

"We are seeking public comments on the appropriate role of physician-owned hospitals in the delivery system. We are also seeking public comments on how the current scope and restrictions on physician-owned hospitals affects healthcare delivery. In particular, we are interested in comments on the impact on Medicare beneficiaries."

NEW HOSPITAL DEFINITION GUIDANCE 09.06.17

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

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

MEDICARE ASC POLICY THA & TKA IN 2018?

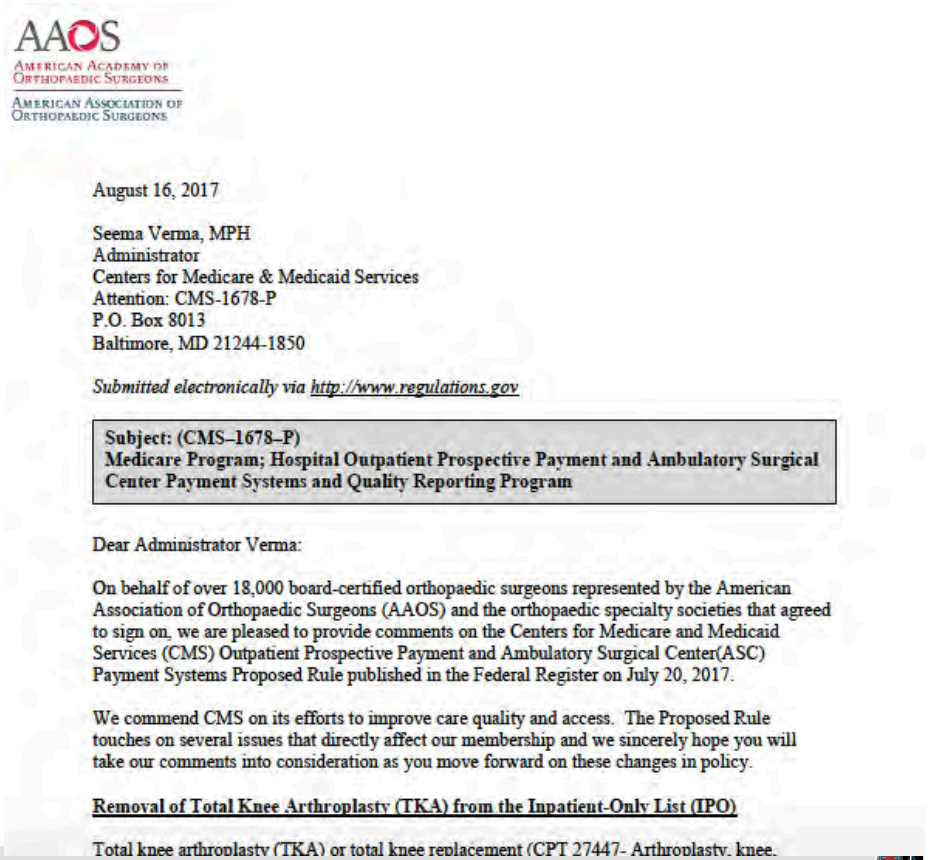
AAOS Comment Letter – September 2017

"The AAOS calls for clear criteria for surgical site selection."

"Another unintended consequence of forcing care into the outpatient setting becomes apparent when commercial payers follow CMS, the healthcare market leader."

"An outpatient TKA procedure would be appropriate only for carefully selected patients who are in excellent health, with no or limited medical comorbidities and sufficient caregiver support."

"The AAOS is currently developing outcomes measures to assist optimal selection of the ideal candidate for these procedures."



AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

August 16, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1678-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov

Subject: (CMS–1678–P)
Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Program

Dear Administrator Verma:

On behalf of over 18,000 board-certified orthopaedic surgeons represented by the American Association of Orthopaedic Surgeons (AAOS) and the orthopaedic specialty societies that agreed to sign on, we are pleased to provide comments on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment and Ambulatory Surgical Center(ASC) Payment Systems Proposed Rule published in the Federal Register on July 20, 2017.

We commend CMS on its efforts to improve care quality and access. The Proposed Rule touches on several issues that directly affect our membership and we sincerely hope you will take our comments into consideration as you move forward on these changes in policy.

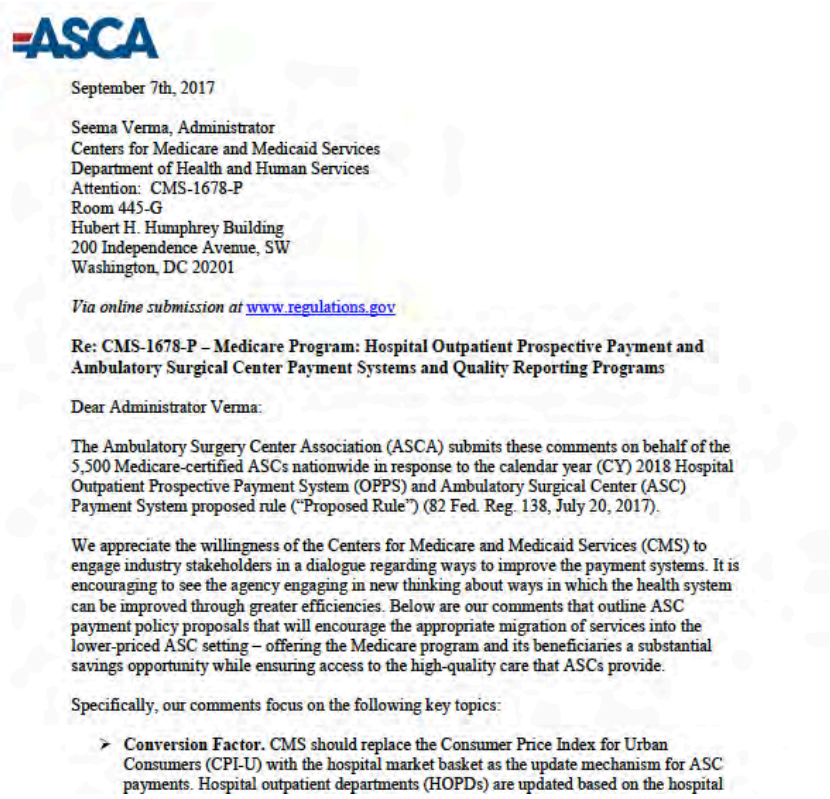
Removal of Total Knee Arthroplasty (TKA) from the Inpatient-Only List (IPO)

Total knee arthroplasty (TKA) or total knee replacement (CPT 27447- Arthroplasty, knee,

ASC INDUSTRY COMMENTS 2018 PROPOSAL

ASC Association Comment Letter – September 2017

"Surgical care in too many markets continues to be provided predominantly in hospitals, which we attribute to Medicare's failure to pay competitive rates to ASCs. This lack of migration comes at a high price to the Medicare program, the taxpayers who fund it, and the beneficiaries who needlessly incur higher out-of-pocket expenses."



ASCA

September 7th, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via online submission at www.regulations.gov

Re: CMS-1678-P – Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Administrator Verma:

The Ambulatory Surgery Center Association (ASCA) submits these comments on behalf of the 5,500 Medicare-certified ASCs nationwide in response to the calendar year (CY) 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule ("Proposed Rule") (82 Fed. Reg. 138, July 20, 2017).

We appreciate the willingness of the Centers for Medicare and Medicaid Services (CMS) to engage industry stakeholders in a dialogue regarding ways to improve the payment systems. It is encouraging to see the agency engaging in new thinking about ways in which the health system can be improved through greater efficiencies. Below are our comments that outline ASC payment policy proposals that will encourage the appropriate migration of services into the lower-priced ASC setting – offering the Medicare program and its beneficiaries a substantial savings opportunity while ensuring access to the high-quality care that ASCs provide.

Specifically, our comments focus on the following key topics:

- **Conversion Factor.** CMS should replace the Consumer Price Index for Urban Consumers (CPI-U) with the hospital market basket as the update mechanism for ASC payments. Hospital outpatient departments (HOPDs) are updated based on the hospital

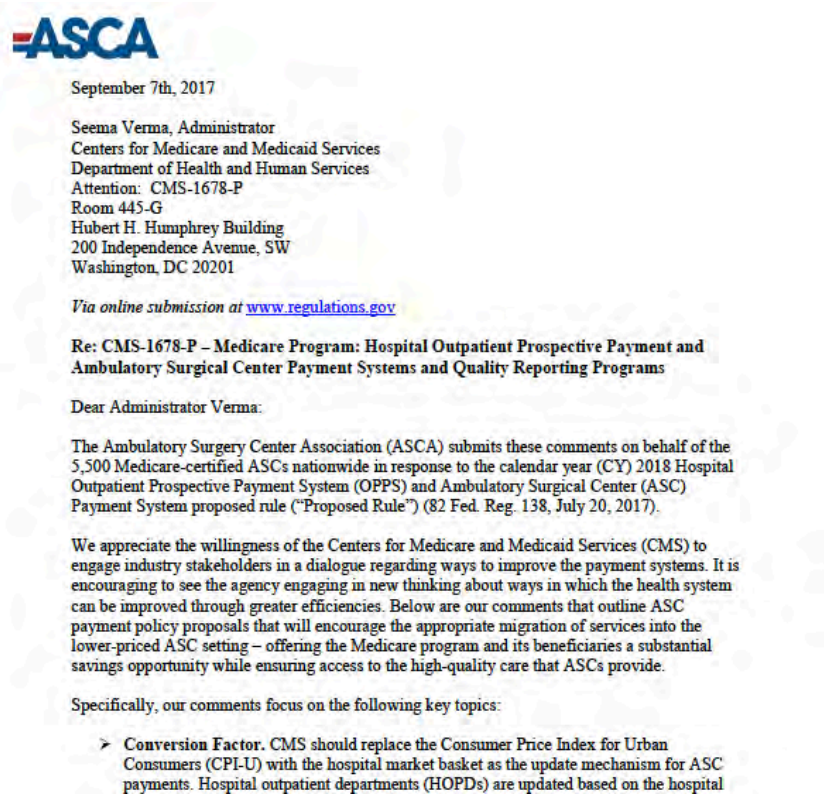
ASC INDUSTRY COMMENTS 2018 PROPOSAL

ASC Association Comment Letter – September 2017

"CMS should expand the definition of surgical codes and should reimburse ASCs for all surgical codes for which it reimburses HOPDs."

"CMS should remove TKA, PHA and THA from the Medicare inpatient-only list and add these codes to the ASC-payable list."

"CMS should lower the device-intensive threshold to 30 percent to enable migration of services into the less-expensive ASC setting."



ASCA

September 7th, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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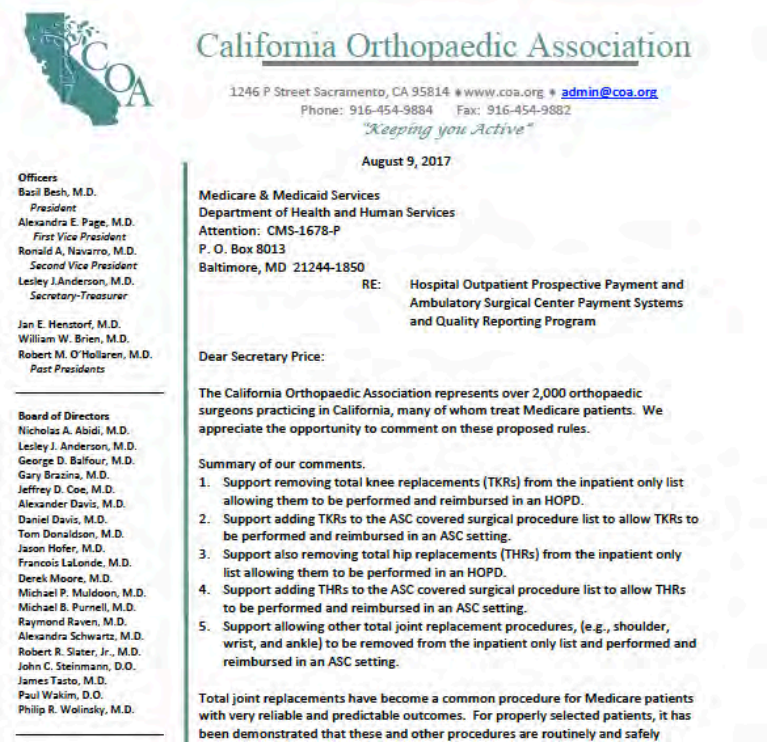
- **Conversion Factor.** CMS should replace the Consumer Price Index for Urban Consumers (CPI-U) with the hospital market basket as the update mechanism for ASC payments. Hospital outpatient departments (HOPDs) are updated based on the hospital

CALIFORNIA COMMENTS 2018 PROPOSAL

California Orthopaedic Association Comment Letter – September 2017

"Moving total joint replacement procedures to an out-patient setting (HOPD or ASC) presents a huge potential savings for the Medicare program. Research from the University of Berkeley found ASCs saved the Medicare program and its beneficiaries $7.5 billion from 2008-2011. This same study projects an additional savings of $7.6 billion over the next 10 years. This is without even considering the potential savings of total joint replacement procedures being performed in an outpatient setting."



California Orthopaedic Association

1246 P Street Sacramento, CA 95814 ⁕ www.coa.org ⁕ admin@coa.org
Phone: 916-454-9884 Fax: 916-454-9882
"Keeping you Active"

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August 9, 2017

Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
P. O. Box 8013
Baltimore, MD 21244-1850

RE: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Program

Dear Secretary Price:

The California Orthopaedic Association represents over 2,000 orthopaedic surgeons practicing in California, many of whom treat Medicare patients. We appreciate the opportunity to comment on these proposed rules.

Summary of our comments.

1. Support removing total knee replacements (TKRs) from the inpatient only list allowing them to be performed and reimbursed in an HOPD.
2. Support adding TKRs to the ASC covered surgical procedure list to allow TKRs to be performed and reimbursed in an ASC setting.
3. Support also removing total hip replacements (THRs) from the inpatient only list allowing them to be performed in an HOPD.
4. Support adding THRs to the ASC covered surgical procedure list to allow THRs to be performed and reimbursed in an ASC setting.
5. Support allowing other total joint replacement procedures, (e.g., shoulder, wrist, and ankle) to be removed from the inpatient only list and performed and reimbursed in an ASC setting.

Total joint replacements have become a common procedure for Medicare patients with very reliable and predictable outcomes. For properly selected patients, it has been demonstrated that these and other procedures are routinely and safely

AAOS COMMENTS ADDITIONAL ASC SERVICES

AAOS Comment Letter – September 2017

AAOS recommended removing the following services from the inpatient only list and adding them to the ASC Medicare allowable list for 2018:

- Total Ankle Arthroplasty (TAA) or Total Ankle Replacement (TAR) (CPT 27702)
- Revision Total Ankle Arthroplasty (CPT 27703)
- Total Shoulder Arthroplasty (CPT 23472)
- Shoulder Hemiarthroplasty (CPT 23470)

ASC & SPINE 2016 & 2017 ASC MEDICARE CODES

2016 and 2017 HOPD/ASC Proposals

CY 2016 Proposal

- 22551
- 22554
- 22612
- 63020
- 63030
- 63042
- 63045
- 63047
- 63057

CY 2017 Proposal for Spine

- 22840
- 22842
- 22845
- 22858

* Removal from inpatient only list.

PAIN MANAGEMENT REMOVAL FROM VBP PROGRAM

CY 2017 HOPD/ASC Proposal

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

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

HCAHPS
Hospital Care Quality Information from the Consumer Perspective

MEDICARE BUNDLED PAYMENTS

New Voluntary Payments in 2018?


US Census Division Pricing
Bundle: Major joint replacement of the lower extremity
Drg: Maj Lower Joint w/o MCC w/o MCC
Years: 2015
Archway Health
State
Msa Name
TX
Dallas-Fort Worth-A..
Houston-Sugar Land..
San Antonio, TX MSA
Austin-Round Rock, ..
TX NONMETROPOLI..
Tyler, TX MSA
Lubbock, TX MSA
Amarillo, TX MSA
Killeen-Temple-Fort ..
College Station-Brya..
El Paso, TX MSA
Brownsville-Harling..
Corpus Christi, TX M..
McAllen-Edinburg-M..
Abilene, TX MSA
Waco, TX MSA
Longview, TX MSA
Beaumont-Port Arth..
Victoria, TX MSA
Wichita Falls, TX MSA
Texarkana, TX-Texar..
San Angelo, TX MSA
Sherman-Denison, T..
Odessa, TX MSA
Midland, TX MSA
Laredo, TX MSA
0
500
1000
1500
2000
2500
3000
3500
4000
4500
Anchor Ip Stays
$0
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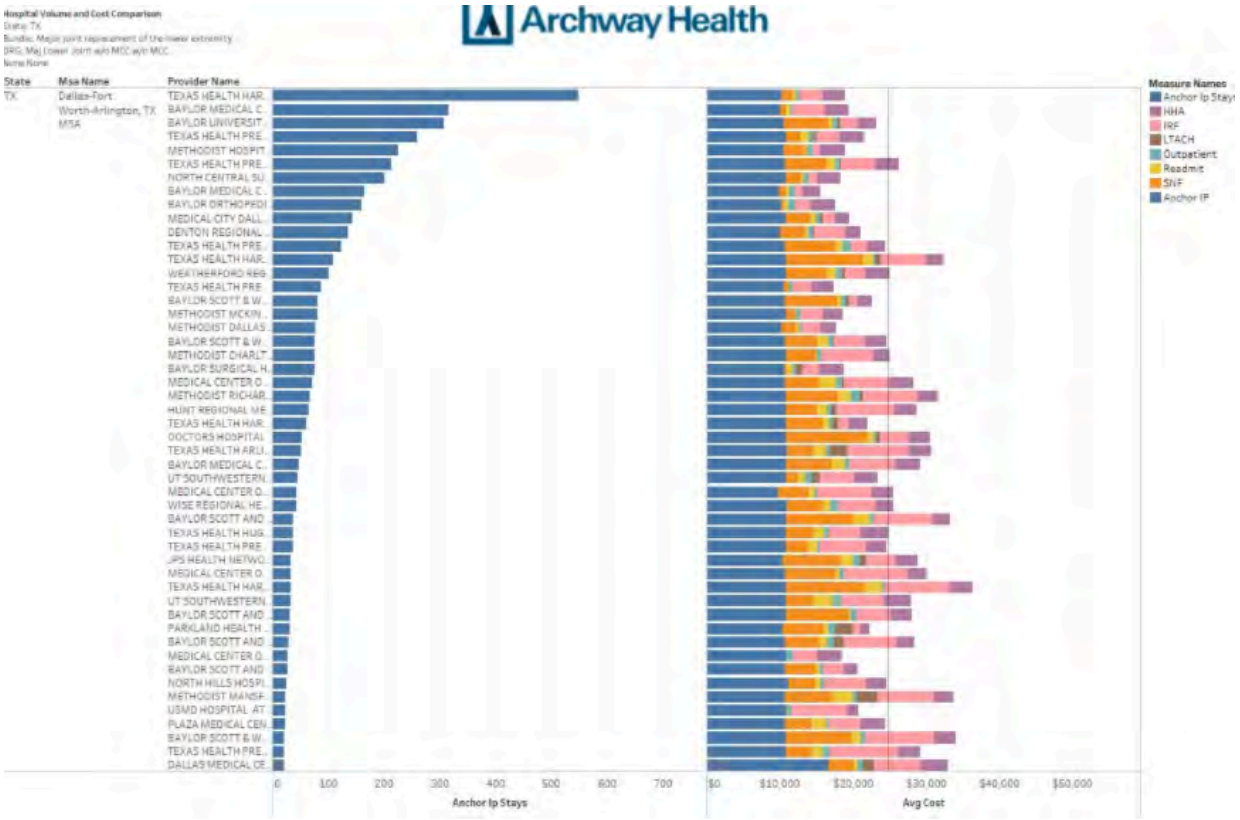
$10,000
$15,000
$20,000
$25,000
Avg Cost
Average
Measure Names
Anchor Ip Stays
HHA
IRF
LTACH
Readmit
SNF
Anchor IP


Hospital Volume and Cost Comparison
State: TX
Bundle: Major joint replacement of the lower extremity
DRG: Maj Lower Joint w/o MCC w/n MCC
Name None
Archway Health
State
Msa Name
Provider Name
TX
Dallas-Fort Worth-Arlington, TX MSA
TEXAS HEALTH HAR..
BAYLOR MEDICAL C..
BAYLOR UNIVERSIT..
TEXAS HEALTH PRE..
METHODIST HOSPIT..
TEXAS HEALTH PRE..
NORTH CENTRAL SU..
BAYLOR MEDICAL C..
BAYLOR ORTHOPEDI..
MEDICAL CITY DALL..
DENTON REGIONAL..
TEXAS HEALTH PRE..
TEXAS HEALTH HAR..
WEATHERFORD REG..
TEXAS HEALTH PRE..
BAYLOR SCOTT & W..
METHODIST MCKIN..
METHODIST DALLAS..
BAYLOR SCOTT & W..
METHODIST CHARLT..
BAYLOR SURGICAL H..
MEDICAL CENTER O..
METHODIST RICHAR..
HUNT REGIONAL ME..
TEXAS HEALTH HAR..
DOCTORS HOSPITAL..
TEXAS HEALTH ARLI..
BAYLOR MEDICAL C..
UT SOUTHWESTERN..
MEDICAL CENTER O..
WISE REGIONAL HE..
BAYLOR SCOTT AND..
TEXAS HEALTH HUG..
TEXAS HEALTH PRE..
JPS HEALTH NETWO..
MEDICAL CENTER O..
TEXAS HEALTH HAR..
UT SOUTHWESTERN..
BAYLOR SCOTT AND..
PARKLAND HEALTH..
BAYLOR SCOTT AND..
MEDICAL CENTER O..
BAYLOR SCOTT AND..
NORTH HILLS HOSPI..
METHODIST MANSF..
USMD HOSPITAL AT..
PLAZA MEDICAL CEN..
BAYLOR SCOTT & W..
TEXAS HEALTH PRE..
DALLAS MEDICAL CE..
0
100
200
300
400
500
600
700
Anchor Ip Stays
$0
$10,000
$20,000
$30,000
$40,000
$50,000
Avg Cost
Measure Names
Anchor Ip Stays
HHA
IRF
LTACH
Outpatient
Readmit
SNF
Anchor IP

BPCI SEPTEMBER 2016 STUDIES

- "In the first 21 months of the BPCI initiative, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than for those provided in comparison hospitals, without a significant change in quality outcomes." – JAMA September 19, 2016
- In the second annual evaluation of Models 2-4 report data, 11 out of the 15 clinical episode groups showed potential Medicare savings. – CMS

JAMA The Journal of the American Medical Association

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Original Investigation | September 19, 2016

INNOVATIONS IN HEALTH CARE DELIVERY

Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes FREE ONLINE FIRST

Laura A. Dummit, MSPH[1]; Daver Kahvecioglu, PhD[2]; Grecia Marrufo, PhD[1]; Rahul Rajkumar, MD, JD[3]; Jaclyn Marshall, MS[1]; Eleonora Tan, PhD[1]; Matthew J. Press, MD, MSc[2]; Shannon Flood, MS[2]; L. Daniel Muldoon, MA[2]; Qian Gu, PhD[4]; Andrea Hassol, MSPH[4]; David M. Bott, PhD[2]; Amy Bassano, MA[2]; Patrick H. Conway, MD, MSc[2]

[+] Author Affiliations

JAMA. Published online September 19, 2016. doi:10.1001/jama.2016.12717 Text Size: A A A

Article Figures Tables Supplemental Content References

ABSTRACT

BUNDLED PAYMENTS SUMMARY

Events Since January 2017

CJR cut in half. August 2017 announcement cut the CJR mandate in half; Texas cities remain.

Episode of care mandate eliminated. CMS's 2017 SHFFT model payment for surgical hip/femur services was delayed; eliminated in August 2017.

New voluntary, physician-led bundles? "Building on the BPCI initiative, the Innovation Center expects to develop new voluntary bundled payment model(s) during CY 2018 that would be designed to meet the criteria to be an advanced APM."

MEDICARE OTHER MUSCULOSKELETAL ISSUES

AAOS Efforts

CR X-RAYS 10% CUTS

7% in 2018 and 10% in 2023

2015 Omnibus Appropriations Bill. Included these cuts.

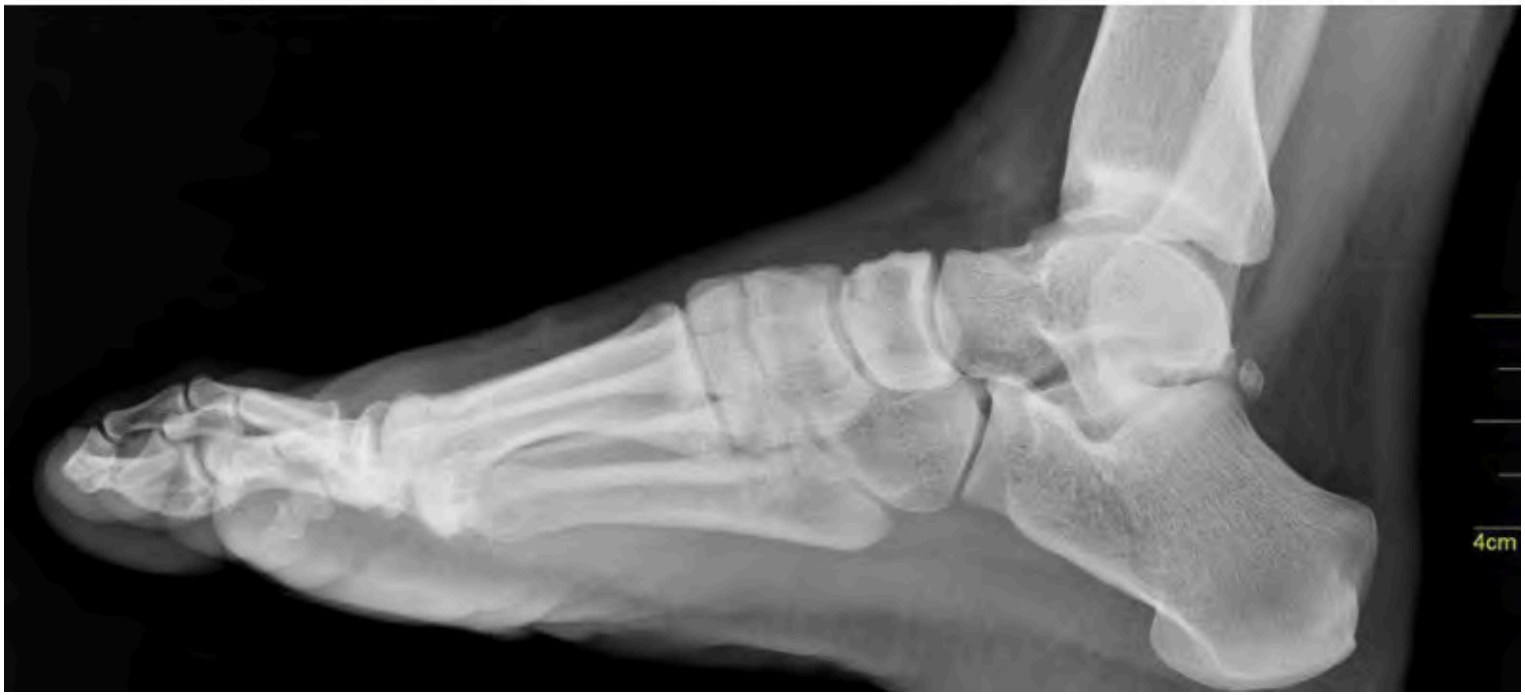
Incentive for Upgrades to Digital Radiography (DR). That was Congress' intention.

Little Feedback Provided to AAOS. TOA only heard from two orthopaedic practices that expressed a concern. AAOS needed feedback to provide to Congress.

MEDICARE FY 2018 HOSPITAL INPATIENT POLICY

Finalized; 50% Payment Increase by Moving TAA from DRG 470 to DRG 469

Ankle industry rallies behind Medicare pay raise



DATA COLLECTION GLOBAL SURGICAL PACKAGES

Medicare's 2017 Physician Fee Schedule Proposal – July 2016 Release

- **New G codes.** CMS is proposing new G codes to report visits furnished during a global period in order to create a better valuation of global packages. AAOS and TOA asked orthopaedic surgeons to complete a survey in August 2016. **Texas is exempt – December 2016 decision.**
- **CMS tried to eliminate 10- and 90-day bundles in 2015.** Congress quickly restored the bundles in the MACRA legislation in spring 2015.

PT EVALUATION CODES COMPLEXITY

Medicare's 2017 Physician Fee Schedule Proposal – July 2016 Release

- **New evaluation codes for complexity.** The new codes will recognize varying levels of complexity in evaluations.
- **No new payments yet.** The new levels of complexity will not be paid yet. "Given our concerns regarding appropriate valuation, work neutrality, and potential upcoding; however, we do not believe that making different payment based on the reported complexity for these services is, at current, advantageous for Medicare or Medicare beneficiaries."
- **Potentially misvalued codes.** Medicare recognized 10 physical therapy codes that it believes may be misvalued:

- Electronic stimulation
- Ultrasound therapy
- Therapeutic exercises
- Neuromuscular re-education
- Aquatic therapy/exercises
- Gait training therapy
- Manual therapy (1/regions)
- Therapeutic activities
- Self-care management training
- Electronic stimulation (other than wound)

APPROPRIATE USE CRITERIA IMAGING

Medicare's 2017 Physician Fee Schedule Proposal – July 2016 Release

- **June 30, 2017.** Deadline for CMS to release clinical decision support mechanism (CDSM).
- **January 1, 2018.** No earlier than this date, professionals will be required to consult with AUC through a qualified CDSM.
- **January 1, 2020.** Outliers will be subject to prior authorization beginning in 2020 for the following areas:
  - Chest pain
  - Abdominal pain
  - Headache, traumatic and non-traumatic
  - Low back pain
  - Suspected stroke
  - Altered mental status
  - Cancer of the lung
  - Cervical or neck pain

AUC IMAGING CY 2018 PROPOSAL

Released in July 2017

- **January 1, 2018 to January 1, 2019.** CMS proposed a delay to use 2019 as an "educational and operations testing period."
- **January 1, 2020.** Claims denials and reimbursement penalties would begin.
- **CDS as a Bonus for ACI.** Proposal to add clinical decision support as a MIPS bonus for advancing care information.
- **Clinical Decision Support Mechanisms (CDSMs) Approved.** Seven qualified as of June 2017. Nine received preliminary qualification.

EMPLOYMENT & OUTPATIENT SITE NEUTRAL

MedPAC

Congress' November 2, 2015 Budget Deal

Medicare's CY 2018 Payment Proposal

MEDPAC 2013 SITE NEUTRAL PREVIEW

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

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

66 services reduced to physician office levels – MedPAC identified 66 services (mostly diagnostic services with a few procedures) that could save Medicare $900 million on an annual basis:
- Bone density: axial skeleton (APC 288)

- Level II neuropsychological testing (APC 382)
- Level II echocardiogram without contrast (APC 269)
- Level II extended electroencephalography (EEG), sleep, and cardiovascular studies (APC 209)

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

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

2015 SITE NEUTRAL PAYMENTS

November 2, 2015 Congressional Budget Deal

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

CHAIRMAN BRADY'S LEGISLATION SPRING 2016

H.R. 5273 Failed to Move in the Last Congress

- Addressed the November 2, 2015 Congressional budget deal.
- Stalled in the Senate – did not help physician-owned hospitals.
- The bill would have grandfathered in hospital acquisitions of physician practices that were "in development" on November 2, 2015.
- Certain cancer hospitals would have been exempted from the off-campus HOPD "prohibition."
- Organizations opposing H.R. 5273 included AAOS, American Assn of Neurological Surgeons, American Society of General Surgeons, Congress of Neurological Surgeons, the OrthoForum, and Physician Hospitals of America.

HOSPITAL REACTION CY 2017 OPPS / ASC PROPOSAL

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

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

SUMMER 2016 PROPOSAL SITE NEUTRAL PAYMENTS

Controversy surrounding Medicare's CY 2017 Proposal

- Medicare would no longer pay hospitals the current OPPS rates if they relocate or rebuild grandfathered outpatient facilities. ***The November 1, 2016 final rule allowed for relocations in case of "extraordinary circumstances."***
- If a hospital has a change of ownership, the grandfathered status would continue if the new owners accept the existing Medicare provider agreement from the prior owner.
- Grandfathered off-campus PBDs would not be allowed to bill for the higher OPPS rate for certain services if they did not bill for these services prior to November 2, 2015.

SUMMER 2017 PROPOSAL SITE NEUTRAL PAYMENTS

Further Cuts Proposed by CMS for 2018

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

OP-ED CONTRIBUTOR

Medicare Proposal to Better Align Payments Deserves Broad Support

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

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

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

MACRA 2018 GUIDANCE

2018 Regulatory Rules by the Administration

MACRA 2018 GUIDANCE

CMS Proposed Some Changes

June 30, 2017 – 2018 Updates to the Quality Payment Program

Low-volume Threshold. Exclude individual MIPS eligible clinicians with < $90,000 in Part B allowed charges or < 200 Part B beneficiaries.

Two-year Lag. AAOS expressed concerned regarding the two-year lag between the performance and payment years.

Virtual Groups. New proposals for solo and small practices to form virtual groups.

60% Data Completeness Threshold. AAOS commented that the increase to 60 percent for 2019 may be too much, too soon.

AUSTIN TEXAS LEGISLATURE

Deadlines Deadlines Deadlines

STATE PUBLIC POLICY IMMEDIATE HORIZON

Designated Doctors Upcoming rule to bring more physicians into the system.

Telemedicine & Workers' Comp New opportunities.

Compound Drugs & Workers' Comp Increased scrutiny.

New Payment Models for State Employees Patient reported outcomes and bundled payments may be on the horizon for state employees.

Scoliosis Screening New screening rules for spinal screening.

Texas Medical Board Rule on out-of-state team physicians.

Elections Engagement in political races.

AUSTIN CHALLENGING NEW LANDSCAPE

Nurse Practitioner – Independent Practice

Senate Health Committee

Chairman Charles Schwertner, MD

Physical Therapy – Direct Access

Senate Business & Commerce Committee

Chairman Kelly Hancock

TEXAS SENATE THREE PHYSICIANS

Charles Schwertner, MD
Georgetown

Orthopaedic Surgeon

Dawn Buckingham, MD
Austin

Ophthalmologist

Donna Campbell, MD
New Braunfels

Emergency Physician

TEXAS HOUSE FOUR PHYSICIANS

John Zerwas, MD
Houston

Anesthesiologist

Tom Oliverson, MD
Houston

Anesthesiologist

JD Sheffield, DO
Gatesville

Family Physician

Greg Bonnen, MD
Friendswood

Neurosurgeon

TEXAS LEGISLATURE: A GAME OF DEADLINES

March 10 (60th Day) Last day to file a bill (some exceptions).

May 8 (119th Day) Last day for House committees to report House bills.

May 9 (120th Day) Last day for the House to distribute its last House Daily Calendar with House bills. (Requires a 36-hour layout of daily calendars before consideration.)

May 11 (122nd Day) Last day for the House to consider House bills (11:59 p.m.).

May 21 (132nd Day) Last day for the House to distribute its last House Daily House Calendar with Senate bills.

May 29 (140th Day) Final day of the 85th Texas Legislature.

AUSTIN COMMERCIAL INSURANCE

Prompt Pay

Balance Billing

Freestanding EDs

Patient Reported Outcomes

Step Therapy Protocols

Provider Directory – Network Adequacy

2015 BALANCE BILLING: A REVIEW

SB 481 was signed into law in 2015

- **2009 law (HB 2256)** allows patients to enter into an informal teleconference and potential mediation with a facility-based physician for an out-of-network balance bill of $1,000 or more.
- **SB 481 (2015)** was signed into law and lowers the threshold to $500.
- It applies to anesthesiologists, emergency physicians, radiologists, neonatologists, pathologists, and assisting surgeons.

BALANCE BILLING 2017 LEGISLATURE

Stakeholder draft shared with TOA in January; Senator Kelly Hancock (R-DFW Mid-Cities)

The Issue

The 2015 Texas Legislature passed a law that lowered the threshold for patients to challenge a balance bill (from $1,000 to $500) from a facility-based physician (anesthesiologists, ER physicians, radiologists, pathologists).

Texas health plans do not have the political power to ban balance billing for emergency services (this happened in Florida and California). However, the plans would like to eliminate the usual, customary, and reasonable (UCR) payment rate for out-of-network situations in which an in-network provider is not available (emergencies and specialists).

Likely Outcome

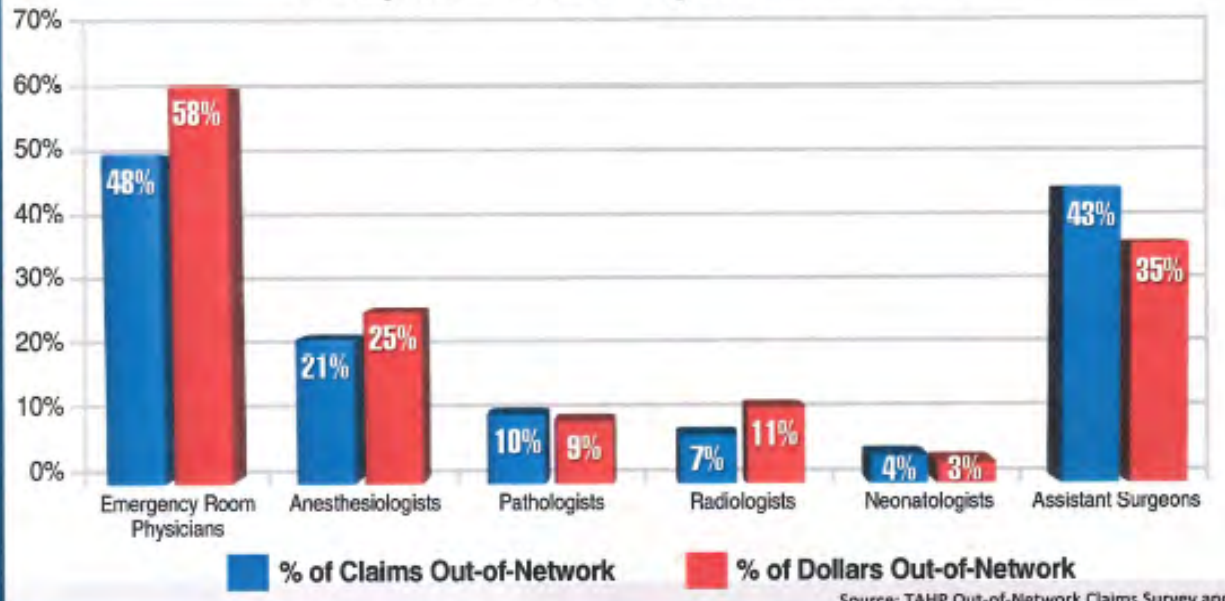
$500 Threshold Applied to Everyone. SB 507 and a step therapy protocol bill will be the only major commercial insurance bills to pass.

UCR bills had little traction. Many bills that would have tied out-of-network rates to a percentage of FAIR Health were filed. However, they had little traction. "Case closed" on the out-of-network issue in Texas for a while.

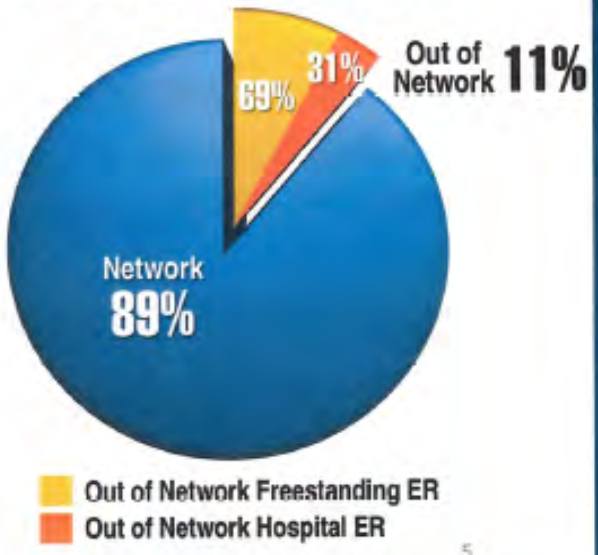
Numerous attacks on freestanding EDs. Many bills involving freestanding emergency medical centers were filed.

Emergency Services Are The Top Surprise Billing Problem: 2015

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



Emergency Room Facility Claims: Network vs. Out of Network



Source: TAHP Out-of-Network Claims Survey and Analysis of Three Large Texas Health Plans: 2015 Claims; May 2016

FREESTANDING ER TEXAS LANDSCAPE

Three Different Models in Texas

Hospital

- Some operators acquire a hospital license from DSHS and serve as an "emergency hospital."
- It may take federal patients (Medicare, Medicaid, and TriCare).

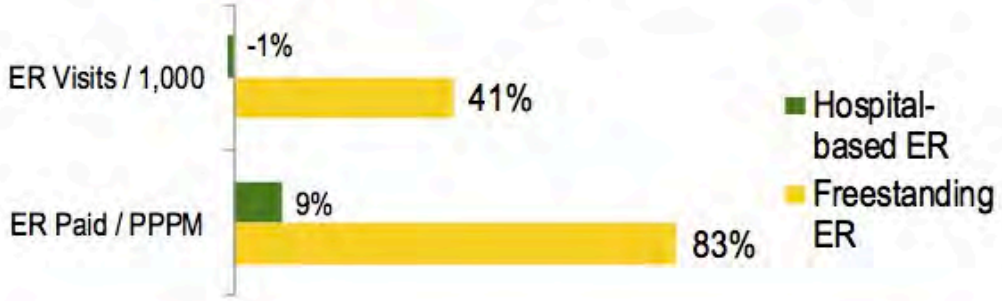
Satellite HOPD

- Satellite HOPDs operate under the parent hospital's license.
- Medicare's 35-mile rule. Texas does not require additional licensing.
- First Choice transitioned their DFW facilities into satellites in early November.
- Site neutral payments and the future.

Independent FEMC

- Texas created the nation's first and only state license in 2009.
- Not recognized by Medicare.

Changes in cost and use of HealthSelect emergency room care *(compared to FY15)*



Non-specified chest pain is #1 reason to visit the ER			
	Billed per visit	Allowed per visit	Plan paid per visit
Hospital-based ER	$8,648	$3,938	$2,260
Freestanding ER	$6,844	$5,959	$4,982

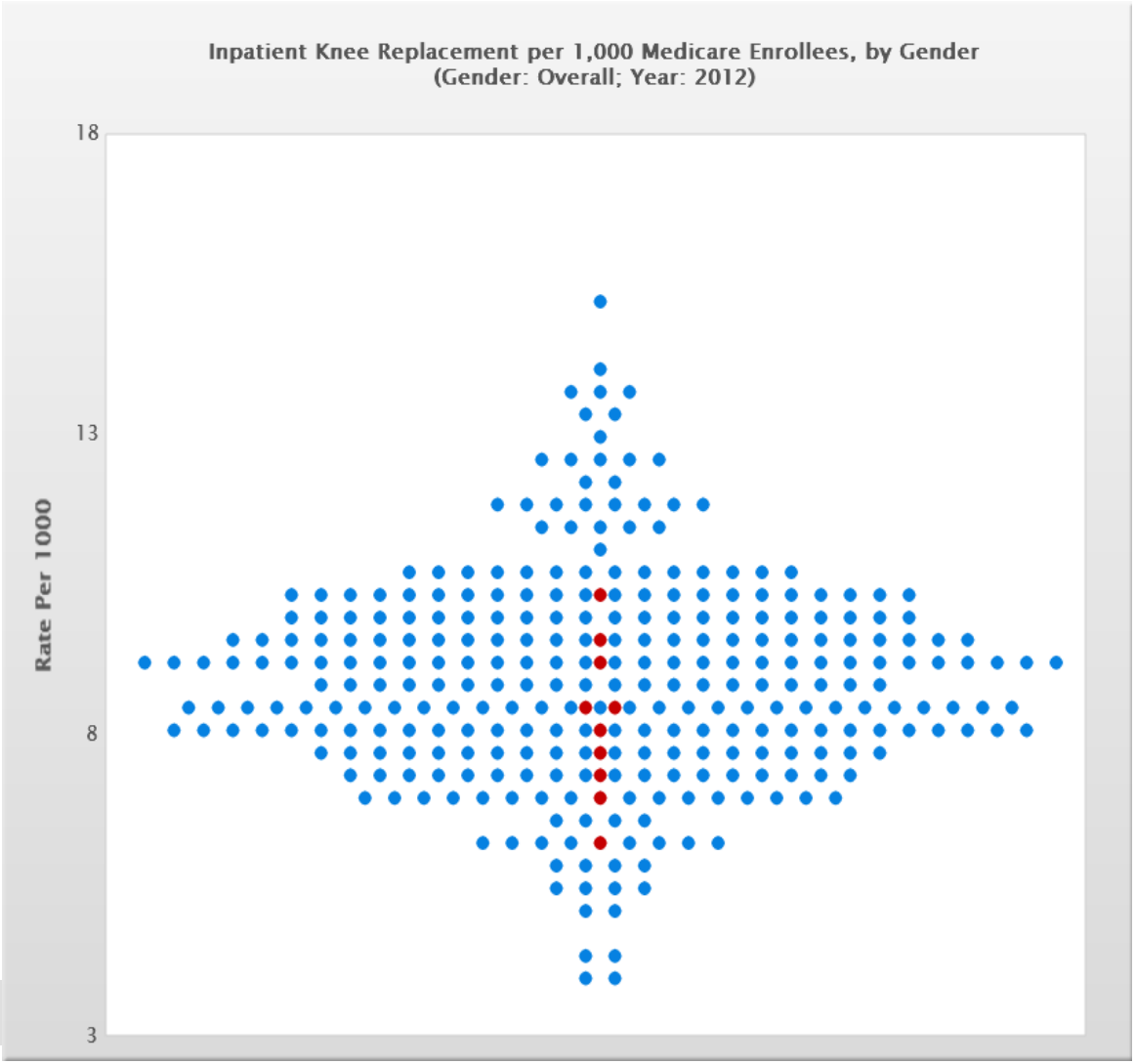
2017 LEGISLATURE PATIENT REPORTED OUTCOMES

SB 55 Was Signed into Law

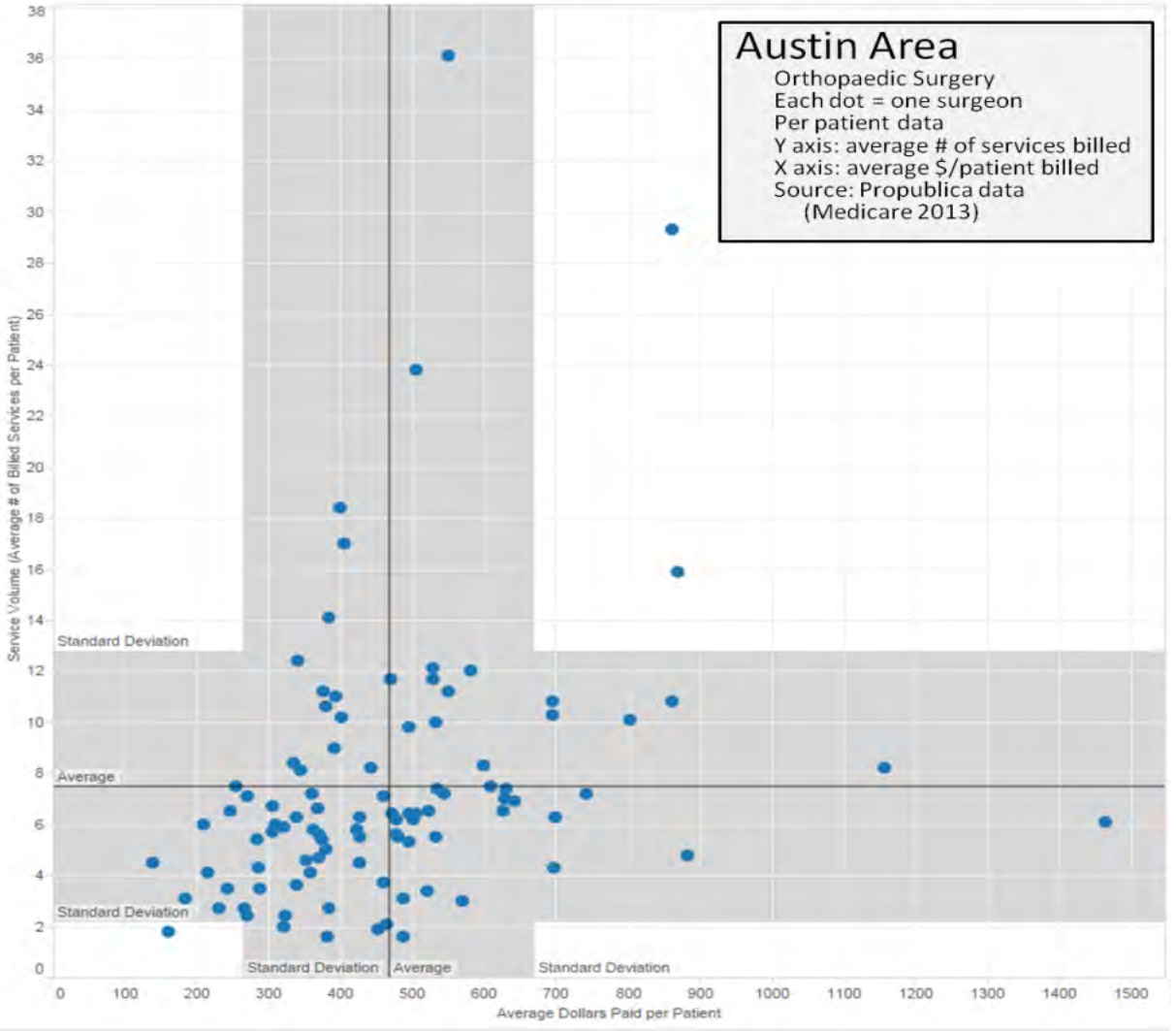
Rep. JD Sheffield, DO (R-Gatesville) and Sen. Judith Zaffirini (D-Laredo) introduced bills that would direct the state's employee health plans – ERS and TRS – to study the potential use of patient-reported outcome measures for musculoskeletal care.

SB 55 was signed into law.

Courtesy: Marc M. DeHart, MD. The Dartmouth Atlas graph representing the health care service areas in the US showing the number of total knee replacements done per 1,000 Medicare enrollees in that area. Labels for the major areas represented in the state of Texas. www.dartmouthatlas.org



Courtesy: Marc M. DeHart, MD. Propublica data reported on 2013 fee for service Medicare data for orthopaedic surgeons in the Austin Market. Average dollars paid by Medicare per patient to an orthopaedic surgeon plotted by the average number of services ordered per patient for the same surgeon. Each dot represents an individual surgeon in the Austin Texas market. Grey zone represents one standard of deviation for each metric.



2017 LEGISLATURE NEW PAYMENT MODELS?

Appropriations Bill Instructed the Employees Retirement System of Texas (ERS) Health Plan

Health Related Institutions Savings. It is the intent of the legislature that the HealthSelect of Texas network administered under the Employees Retirement System of Texas Group Benefits Program shall save $35,000,000 in All Funds and $21,875,000 in General Revenue-Related Funds in the biennium in its contractual provider relationships with Health Related Institutions receiving appropriations under this Act. In order to obtain the specified savings, the Employees Retirement System shall reduce contracted provider rates and may initiate innovative value-based plan design models with Health Related Institutions.

2017 LEGISLATURE TWO PATIENT DEBT BILLS

TOA Testified Against SB 2127

HB 4011 (Rep. Dustin Burrows, R-Lubbock) would have required physicians to provide an itemized statement to patients prior to a non-emergency service. If the patient did not sign the disclosure, the physician would not be able to report the bad debt to consumer credit bureaus.

HB 4011 was voted down on the House floor.

SB 2127 (Sen. Larry Taylor, R-Friendswood and Rep. Larry Phillips, R-Sherman) would have prevented the reporting of bad debt to consumer credit bureaus for for emergency-related care.

TOA testified against SB 2127 in a House committee. After being voted out of the Senate, it stalled in the House committee.

MEDICAID LPPF VS. STATEWIDE

The Issue of “Bed Taxes” Within Regions or Statewide

Local Provider Participation Fund Hospitals have focused on LPPFs as the strategy for utilizing regions to leverage matching federal funds.

Statewide “Bed Tax” HB 2766 and SB 1130 would have created a statewide bed tax on nursing homes to leverage matching funds (“granny tax”). Nursing homes that support private-pay patients opposed the legislation.

WORKERS COMP & PERSONAL INJURY AUSTIN

HB 2300 & HB 2301

2011 Texas Sunset Changes to Designated Doctors

OIEC Narratives

PAs & Form 73

PERSONAL INJURY 2017 LEGISLATURE

HB 2300 and HB 2301 by Rep. Mike Schofield (R-Katy)

The Issue

Stakeholders representing the trucking industry and defense attorneys have questioned the legal process regarding health care services provided by physicians in personal injury cases.

Texas Legislature

HB 2300 would have limited physician payments to 125 percent of Medicare.

HB 2301 was the major push. TOA expressed concerns in the hearing due to the fact that the original version could have required a physician to defend his/her fees or services at any point in the process. Ultimately, orthopaedic surgeons may have fled the system.

DESIGNATED DOCTORS 2017 LEGISLATURE

The Issue

We have witnessed a 67 percent decrease in the number of physicians participating in the Designated Doctor program since the 2011 Texas Legislature implemented changes.

TOA's Action in March 2016

Stephen Norwood, MD testified on behalf of TOA and made the following recommendations to increase physician participation:

- **Bundles.** Allow physicians to see multiple patients at once instead of only one patient at a time.
- **Decrease costs and time.**
- **Regional physicians.** Instead of a "functioning lottery" in which each provider may have 50 counties, TOA recommended that the Legislature make changes so that it becomes more regional.
- **Increased payments.** Increase payments for more complicated services.

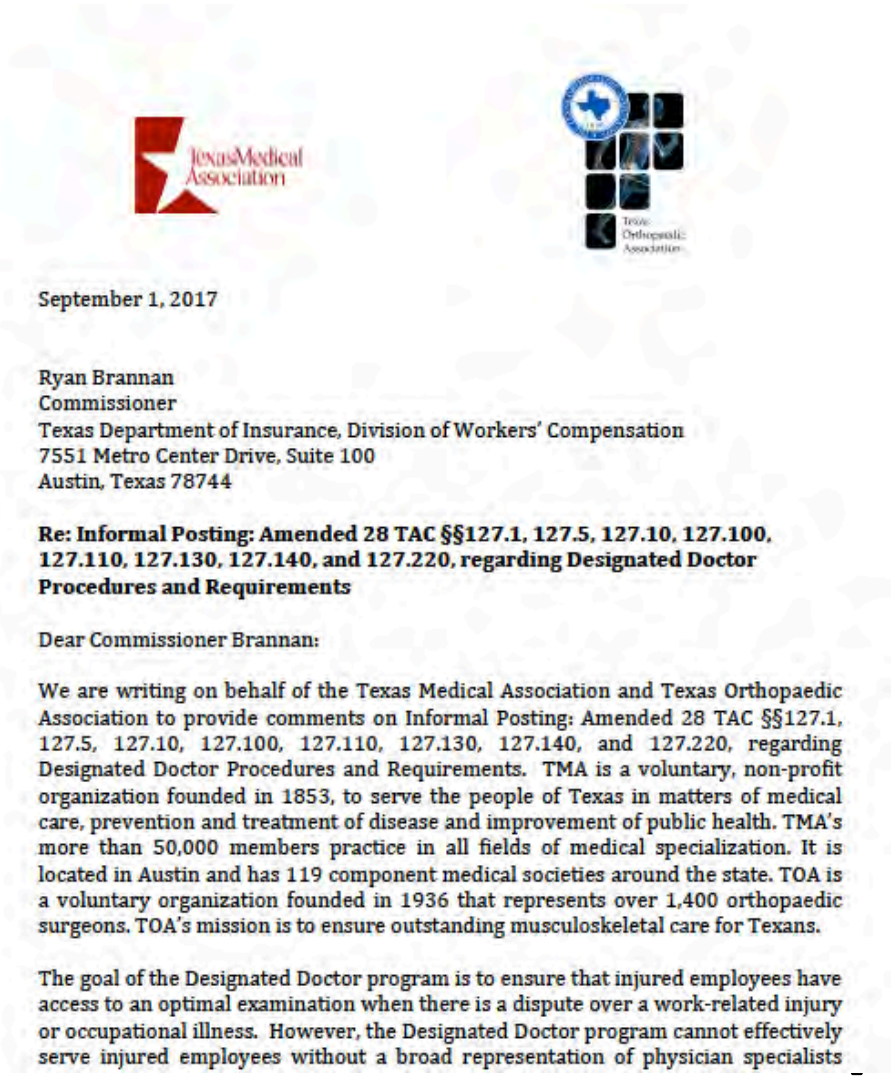
SEPTEMBER 2017 RECOMMENDATIONS

TOA/TMA Letter

Bundles. Assign up to four patients per assignment.

Priority for regions. Instead of a "functioning lottery" in which each provider may have 50 counties, TOA recommended that it should become more regional.

Support for increased qualifications. The letter supported TDI-DWC's proposal to add more qualifications for concussions, tendons, torso, multiple fractures, and other injuries.



September 1, 2017

Ryan Brannan
Commissioner
Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

Re: Informal Posting: Amended 28 TAC §§127.1, 127.5, 127.10, 127.100, 127.110, 127.130, 127.140, and 127.220, regarding Designated Doctor Procedures and Requirements

Dear Commissioner Brannan:

We are writing on behalf of the Texas Medical Association and Texas Orthopaedic Association to provide comments on Informal Posting: Amended 28 TAC §§127.1, 127.5, 127.10, 127.100, 127.110, 127.130, 127.140, and 127.220, regarding Designated Doctor Procedures and Requirements. TMA is a voluntary, non-profit organization founded in 1853, to serve the people of Texas in matters of medical care, prevention and treatment of disease and improvement of public health. TMA's more than 50,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component medical societies around the state. TOA is a voluntary organization founded in 1936 that represents over 1,400 orthopaedic surgeons. TOA's mission is to ensure outstanding musculoskeletal care for Texans.

The goal of the Designated Doctor program is to ensure that injured employees have access to an optimal examination when there is a dispute over a work-related injury or occupational illness. However, the Designated Doctor program cannot effectively serve injured employees without a broad representation of physician specialists

OIEC NARRATIVES 2017 LEGISLATURE

HB 2326 by Rep. Nicole Collier (D-Fort Worth) & Sen. Charles Perry (R-Lubbock)

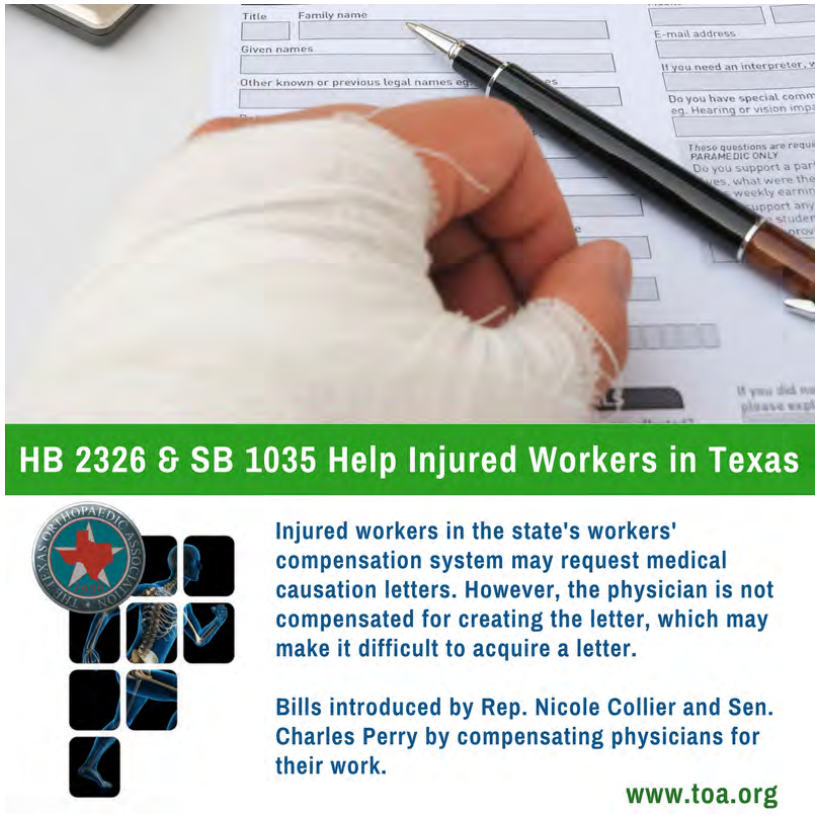
The Issue

Physicians are not being paid for certain OIEC narratives. The number of unpaid narratives is growing.

85th Legislature

The legislation has been viewed as a “compromise” between Texas Mutual and TOA. It would pay for a limited number of medical narratives if the physician would like to be paid.

HB 2326 passed out of the House on 04.27.17. The Senate failed to take up the House bill.



WORKERS' COMP 2017 LEGISLATURE

Physician Assistants & Work Status Reports

HB 2546 (Rep. John Zerwas, MD, R-Richmond). Passed out of the House on 04.27.17.

Argentina Vendor – Claims Processing Program

SB 2211 (Sen. Kelly Hancock, R-North Richland Hills) would require Workers' Comp to create a demonstration that implements a real-time payment processing system for state employees.

Designated Doctor Scheduling Companies – Fee Transparency

HB 2056 (Rep. Rene Oliveira, D-Brownsville) and SB 1495 (Sen. Judith Zaffirini, D-Laredo) would require DD scheduling companies to disclose their fees paid to DDs.

Specialty Pharmacy – Closed Formulary

HB 2830 (Rep. Oliveira) would prevent compound drugs from being utilized in the closed formulary. This bill was introduced to serve as a discussion piece in the Legislature. It will be addressed in the regulatory process.

TEXAS MEDICAL BOARD LICENSING

Fluoroscopy Training

Texas Medical Board Sunset

PDMP Mandate

Medical Liability Issues

FLUOROSCOPY MANDATORY TEXAS TRAINING

- TOA was instrumental in removing the mandate for nine hours of radiation safety awareness training in January 2015.
- The AAOS Patient Safety Committee, led by David Ring, MD of Austin, is examining the issue and will lead an AAOS recommendation for states to follow.

TEXAS MEDICAL BOARD 2017

January 2017 Sunset Decisions:

- Preserved LMRTs.
- Eliminated mandatory licensing for surgical assistants.
- Relief for non-disciplinary actions. A remedial plan once every five years.
- Mandatory PDMP checks.

TMB INFORMAL DISCIPLINARY HEARINGS

July 1, 2016 Proposed Rule

Resembles a "formal hearing." "An 'informal' meeting would not have opening and closing arguments, prescriptive lists of what parties can and cannot do, and may not even have oral witness testimony," Texas Medical Association's response to the TMB's proposed rule. The proposal was withdrawn due to the upcoming Legislature.

Vacant TMB executive director position. The governor has yet to fill the TMB executive director position.

TELEMEDICINE TEXAS LEGISLATURE

SB 1107 Was Signed Into Law

- **HB 2697 & SB 1107**. Rep. Four Price (R-Amarillo) and Sen. Charles Schwertner, MD (R-Georgetown).
- **"Face-to-face" consult.** SB 1107 removes the initial "face-to-face" consult as a pre-requisite for telemedicine services.
- **Payment for consults.** Health plans were concerned that the legislation would require them to pay for a telehealth service provided by only synchronous or asynchronous audio interaction, including an e-mail, fax, or telephone call.
- **Rulemaking Process.** The Texas Medical Board is creating the rule. Workers' Comp and other agencies are likely to follow suit.

MOC TEXAS LEGISLATURE

SB 1148 Was Signed into Law

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

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

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

Viewpoint FREE

August 22/29, 2017

Maintenance of Certification and Texas SB 1148

A Threat to Professional Self-regulation

David H. Johnson, MD[1]

Author Affiliations | Article Information

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

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

PHYSICIAN EMPLOYMENT TEXAS LEGISLATURE

501(a) Arrangements

- **HB 752 and SB 8333**. Rep. Morgan Meyer (R-Dallas) and Sen. Bryan Hughes (R-Mineola.
- **"Employed" Physicians.** The bill would require certain individuals to report violations regarding interference with a physician's independent judgment to TMB and to the Attorney General.

CONTROLLED SUBSTANCES FROM DPS TO TSBP

September 1, 2016 Transition

- **September 1, 2016**. The 2015 Legislature transferred the state's controlled substance program to the Texas State Board of Pharmacy.
- **Controlled substances registration.** No longer required for DPS (federal DEA still required).
- **Prescription Drug Monitoring Program Database.** State lawmakers may require physicians and pharmacists to check the database before every prescription is both written and filled.

DOCTOR SHOPPING NEW MANDATE – 09.01.19

HB 2561 Became Law; September 1, 2019 Effective Date for Physicians

"Beginning September 1, 2018, require physicians and physician assistants to search the Prescription Monitoring Program and review a patient's prescription history before prescribing **opioids, benzodiazepines, barbiturates, or carisoprodol**. A physician who does not check the program before prescribing these drugs would be subject to disciplinary action by the Texas Medical Board. A physician assistant who does not check the program before prescribing these drugs would be subject to disciplinary action by the Texas Physician Assistant Board."

-Senator Chuy Hinojosa, D-McAllen

September 1, 2019 effective date for physicians to check the PDMP:

- Earlier proposal would have required 09.01.18 date for Schedule II.
- Attempts to limit prescriptions were defeated.

RX RESTRICTIONS NORTH CAROLINA

More States Are Restricting What Physicians Can Prescribe

Limitation on Prescriptions Upon Initial Consultation for Acute Pain. **– A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation** and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. **A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure**. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility, as defined in G.S. 14-32.2(c1).

CONTROLLED SUBSTANCES TX LEGISLATURE

Other Bills

- **Electronic Methods.** HB 2711 (Rep. Bill Zedler, R-Arlington) would require physicians to use electronic prescribing for all Schedule II controlled substances. *The bill did not move.*

- **PAs & APRNs.** HB 1846 (Rep. Garnet Coleman, D-Houston) and SB 433 (Sen. Jose Rodriguez, D-El Paso) would allow allow PAs and APRNs to prescribe Schedule II controlled substances beyond their current limitations.

- **PAs.** HB 2548 (Rep. John Zerwas, MD, R-Richmond) would allow PAs to prescribe Schedule II controlled substances at a practice site. *The bill failed in the Senate.*

MEDICAL LIABILITY INSURANCE TEXAS

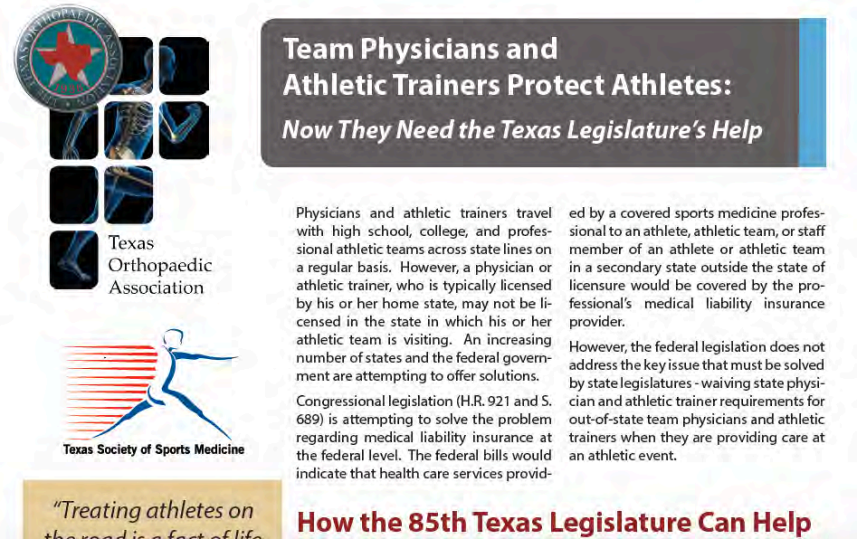
- **New Mexico Court Case.** Issue involving Lubbock physician.
- **Non-economic Damages in Austin.** 2017 legislation introduced to increase non-economic damages cap.
- **Illinois vs. Texas.** Texas' 2003 medical liability reform has worked. The average annual premium for orthopaedics (no spine) in Illinois is $73,943. *Source: Arthur J. Gallagher & Co.*

SPORTS MEDICINE AUSTIN & WASHINGTON

Austin – Licensing Across State Lines

Washington – Liability Insurance Carries Across State Lines

SPORTS MEDICINE IN AUSTIN HB 986 & SB 859



SPORTS MEDICINE LIABILITY INSURANCE IN DC

- H.R. 921 passed out of the House in September. Time ran out in the old Congress.
- Legislation would require liability insurance for team physicians and athletic trainers to carry across state lines when they are covering an event.

SPORTS MEDICINE CARDIOLOGY & CONCUSSIONS

Mandatory Cardiac Screenings for Student Athletes. HB 3476 (Rep. Dan Huberty, R-Kingwood) would require Texas student athletes to undergo an electrocardiogram or echocardiogram prior to participation in both the 9th and 11th grades.

Chiropractors and Concussions. HB 3024 (Rep. Four Price (R-Amarillo) would add chiropractors to the list of individuals who may remove athletes due to suspected concussions.

This would not add a chiropractor to a school's concussion management team.

LICENSING ISSUES ALLIED HEALTH PROVIDERS

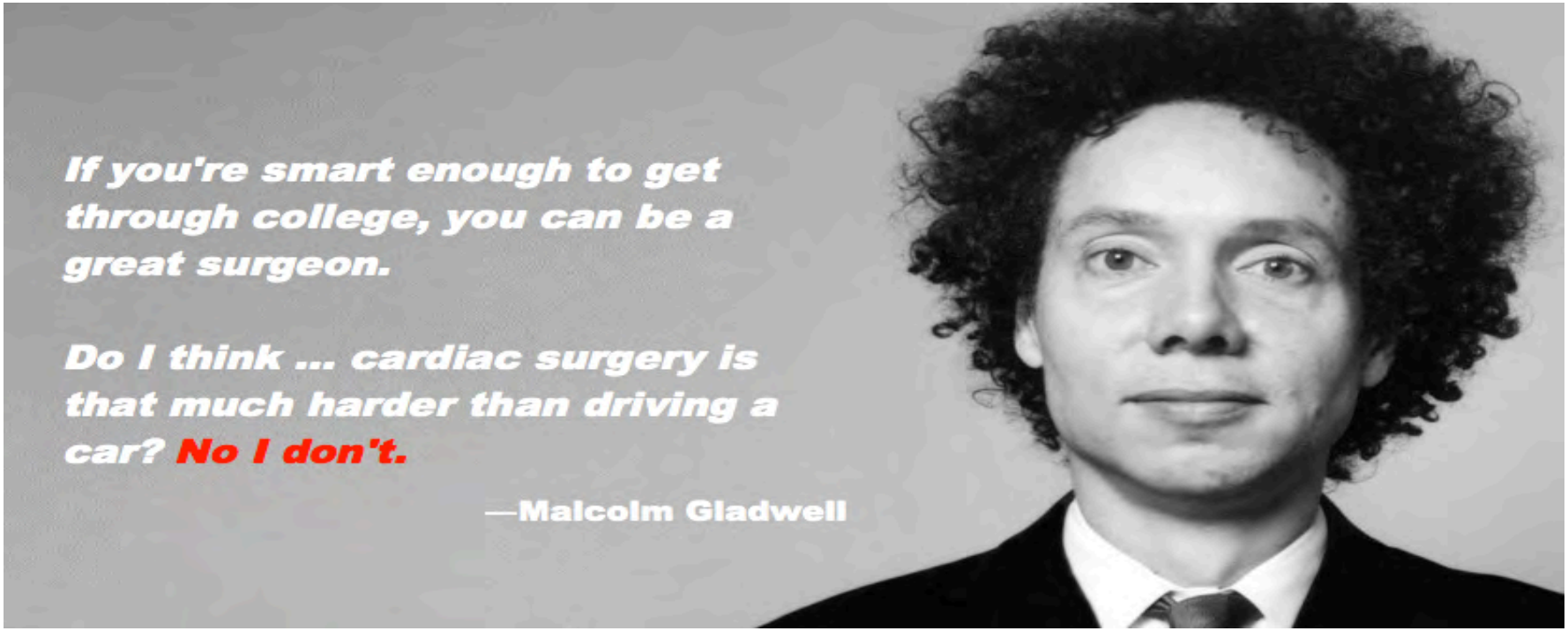
Texas Medical Board

Texas Physical Therapy Board

Texas Podiatric Board

Texas Dental Board

Texas Chiropractor Board


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

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

THE TEXAS TRIBUNE

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

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

AAOS in the States

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

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

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

VA & INDEPENDENT APRNS NURSE ANESTHETISTS

The proposal would have required all advanced practice registered nurses (APRNs) to practice independently in all VA facilities, in all states, regardless of their licensure.

On December 14, 2016, the VA issued the final rule that includes a specific exclusion of nurse anesthetists from the full practice authority model of care.

H.R 1783, which contains the independent practice provision, was introduced in April 2017. No Texans have co-sponsored the legislation.

MID-LEVEL SUNSET 2017 LEGISLATURE

Texas Medical Board also Reviewed

The Issue

Texas agencies are reviewed by the Texas Sunset Commission from time to time. This year, the mid-level boards and the Texas Medical Board are up for review. The Sunset Board wanted all of the mid-level boards to move to the Texas Division of Licensing and Regulation (TDLR). However, the PTs and chiropractors were successful in blocking the challenge.

Physical Therapy Board

This is the first Sunset review in over 20 years for the physical therapists. The PTs will remain independent.

Podiatry Board

The podiatrists agreed to be moved to TDLR.

Chiropractor Board

The chiropractors will remain independent.

TEXAS CHIROPRACTIC BOARD 2017 SUNSET

Legal Battle over Neurology. TMA won the fall 2016 district court case. A state senator introduced language to end the lawsuit.

Fall 2016 Court Decision (According to TMA):

"By voiding the rules, Texas chiropractors can't perform vestibular-ocular-nystagmus (VON) testing. The court also specified to include 'nerves,' 'subluxation complex' as a 'neuromusculoskeletal condition,' and use of the term 'diagnosis' by TBCE in its rules all exceed the scope of practice as defined by the Texas Occupations Code."

Senator Van Taylor (R-Plano) Sunset Amendment:

Attempted to define "diagnosis" for chiropractors and give chiropractors clear authority to handle the "musculoskeletal system."

Do Not Support the Texas Chiropractic Association in their Battle with the TMA

Monday, January 30, 2017 - 20:26

NEWS STAFF

TCA & TBCE Caused all the Problems They Want Your Money to Fix

Similar to what has been going on in numerous states, the Texas Chiropractic Association and the Texas Board of Chiropractic have been attempting to expand the scope of chiropractic practice over the past several years. Their scope expansion attempts have included Manipulation Under Anesthesia (MUA), needle electromyography, Physician Status, Bus Driver Physicals, Concussion Rights and a litany of other procedures they have tried to sneak into the scope.

The Texas Chiropractic Association has even formally adopted a legislative agenda that **would force all chiropractors** to practice to the fullest extent of their education:

"Support legislation which **requires** Chiropractors to practice up to the level of their education. Texas currently limits substantially the practice of Chiropractors to a small subset of what a Chiropractor is taught and trained to do."

All chiropractic programs in the United States are accredited by the Council on Chiropractic Education (CCE) and as such must train chiropractors as primary care providers in order to be accredited. The CCE is part of the so called "Chiropractic Cartel" and the Chiropractic Summit Group which are made up of various schools, trade organizations and regulatory bodies seeking the expansion of chiropractic scope of practice to include the practice of primary care and in some cases drug prescriptive rights.

CHIROPRACTORS PHYSICIAN PARTNERSHIPS

SB 679 and HB 3820. Sen. Kelly Hancock (R-North Richland Hills) and Tony Dale (R-Cedar Park).

Partnerships with Physicians. The bill passed and allows chiropractors to enter into partnerships with physicians and podiatrists.

PHYSICAL THERAPY DIRECT ACCESS 2017

SB 728 & HB 2118. Senator Van Taylor (R-Plano) and Rep. Stephanie Klick (R-North Richland Hills) introduced legislation that would give physical therapists direct access to patients for a period of 30 days without a referral.

Senator Taylor almost amended SB 728 to a germane bill on the final weekend of the Legislature.

FULL PRACTICE AUTHORITY TX LEGISLATURE

Full Practice Authority for Nurse Practitioners. SB 681 (Sen. Kelly Hancock, R-North Richland Hills) and HB 1415 (Stephanie Klick, R-Arlington) would give nurse practitioners full practice authority (including prescription authority).

Rural Counties. Rep. Four Price (R-Amarillo) introduced legislation that would grant full practice authority to nurse practitioners in counties that do not have a primary care physician.

TribTalk

A publication of The Texas Tribune

HEALTH

Nurses are not physicians

By Don Read, May 2, 2017

Advanced practice registered nurses

AUSTIN PUBLIC HEALTH

Scoliosis Screening

SCOLIOSIS UPDATING THE STATE'S STANDARDS

HB 1076 (Rep. Tom Oliverson, MD, R-Houston) & Sen. Don Huffines (R-Dallas)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APRIL 13-14, 2018