

**Table 1 Summary of major provisions of HR 6331**

Issue	Pros	Cons	AAOS Position
Physician Reimbursement	<p>Extends 0.5% payment increase through 2008 and provides 1.1% increase in 2009.</p> <p>Future budget neutrality adjustments will be made on the conversion factor, not on work relative value units.</p> <p>Extends rural physician payment increases through Dec. 31, 2009.</p>	<p>21% payment cut in 2010 because of how this provision is financed.</p> <p>Temporary “fix” only; bill does not replace the SGR in the Medicare physician payment formula.</p> <p>With a 21% cut in 2010, physicians will be more likely to agree to legislation that will temporarily prevent that cut. Short-term fixes usually contain other detrimental provisions.</p>	<p>The AAOS is concerned that these short-term fixes borrow against the future.</p> <p>Short-term fixes exacerbate the problem, making it harder to solve in each succeeding year.</p>
Quality Initiatives	<p>Extends Physician Quality Reporting Initiative (PQRI) bonus payments through 2010. Physicians who successfully participate may earn a 2% bonus on all Medicare allowed charges (up from current 1.5%).</p> <p>Allows bonus payments to group practices.</p> <p>Requires Centers for Medicare and Medicaid Services (CMS) to contract with Institute of Medicine to identify methodological standards for clinical guidelines and systematic reviews of effectiveness.</p>	<p>Does not require a review of the current PQRI program.</p> <p>Moves PQRI forward without meaningful quality measures for all eligible professionals. PQRI includes “process” measures and does not measure clinical outcomes.</p> <p>Requires public reporting of physicians who satisfactorily submit data on quality measures but does not consider physicians who participate in other quality initiatives or those who did not report for reasons out of their control.</p> <p>Requires establishment of a “Physician Feedback Program.” Although these reports to physicians are confidential, concern exists about how this program will proceed in the future.</p> <p>Requires development of a plan to transition to a value-based purchasing program.</p>	<p>AAOS supports quality initiatives that improve quality. Pay for reporting and pay for performance should not be mandated, however, until measures are proven to improve care.</p> <p>AAOS believes CMS should be cautious when moving forward with inequitable and unstable quality initiatives.</p> <p>CMS should provide meaningful payments that account for the practice costs incurred with reporting.</p> <p>These legislative provisions accelerate the establishment of an untested quality reporting payment system adding one flawed payment system upon another (the SGR).</p>
Electronic Prescribing (e-prescribing)	<p>Provides bonus payments to physicians who e-prescribe: 2% in 2009 and 2010; 1% in 2011 and 2012; 0.5% in 2013.</p>	<p>Mandatory e-prescribing starting in 2012. Physicians who do not e-prescribe (subject to a few exceptions) will have their payments cut by 1% in 2012, 1.5% in 2013, and 2% in 2014 and each subsequent year.</p>	<p>The AAOS has not taken a position on electronic prescriptions. However, some concern exists that the cost of implementing e-prescribing on the physician’s practice may be much more than the bonus payments received.</p>
Primary Care Enhancements		<p>Expands the Medicare Medical Home Demonstration Project (provides additional \$100 million).</p>	<p>The AAOS Council on Advocacy is concerned that this primary care medical home is similar to previous “gatekeeper” models. Expanding the medical home concept may be an attempt to steer Medicare dollars to primary care to the detriment of surgical care.</p>
Mandatory Imaging Accreditation	<p>Allows for the designation of multiple accreditation organizations, which will allow groups such as the Intersocietal Commission for the Accreditation of Magnetic Resonance (a multispecialty organization) to qualify.</p>	<p>Mandatory accreditation for advanced diagnostic imaging services (including MRI and CT) by 2012. Because accreditation entities must be selected by 2010, only the American College of Radiology (ACR) may qualify.</p> <p>Accreditation standards require medical director or supervising physician (including nonradiologists) to complete CME courses relating to imaging services. (Not clear whether typical orthopaedic CME would qualify.)</p>	<p>AAOS strongly opposes efforts by the ACR to restrict and eliminate the ability of orthopaedic surgeons to provide imaging services to patients in their own offices.</p>
Imaging Appropriateness Criteria Demonstration	<p>Voluntary participation in the demonstration program.</p> <p>Criteria must be developed in consultation with medical specialty societies and developed or endorsed by a medical specialty society.</p> <p>Prohibits Health and Human Services (HHS) Secretary from using “prior authorization” as a model for any of the demonstration projects.</p>	<p>HHS Secretary must conduct a demonstration project testing models to collect data regarding physician compliance with imaging appropriateness criteria.</p> <p>Criteria must be developed in adherence to appropriateness principles developed by a consensus organization, such as the Ambulatory Quality Alliance.</p>	<p>AAOS is concerned that the ACR will be in a better position to promote its own appropriateness criteria. Each specialty society should develop its own criteria.</p>
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provisions	<p>Imposes an 18-month delay to Round 1 of the DMEPOS Competitive Acquisition Program (CAP), with a corresponding 18- to 24-month delay of Round 2 and subsequent applications.</p> <p>Excludes negative pressure wound therapy from the CAP.</p> <p>Exempts physicians from having to submit bids under the CAP for off-the-shelf orthotics.</p> <p>Mandates the creation of physician-specific quality standards and grants authority to exempt physicians from the accreditation requirement.</p>		<p>AAOS supports provisions that add more flexibility to the DMEPOS CAP, quality standards, and accreditation processes, recognizing that orthopaedic surgeons who provide DMEPOS to their patients do so in the course of care and not as traditional DMEPOS suppliers.</p>