AAOS Resident Issue Guide

Payment Reform

MACRA

The Issue: Signed into law on April 16, 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) repeals the flawed Sustainable Growth Rate (SGR) formula. The SGR formula is a cap on aggregate spending on physicians’ services where exceeding the cap resulted in punitive recoupments in subsequent years. The formula was passed into law in the Balanced Budget Act of 1997 to control physician spending, but has failed to work. Since 2003, Congress has spent nearly $17 billion in short-term patches to avoid unsustainable cure imposed by the SGR. The new system introduced in the legislation moves away from a volume-based system towards one that rewards value, improving quality of care for patients.

AAOS Supports: The AAOS, along with over 750 other national and state-based physician and specialty organizations, supported this bill as it went through Congress. The MACRA bill:

- Permanently repeals the sustainable growth rate (SGR), effective immediately;
- Provides for positive payments of 0.5 percent through 2019;
- Provides a 5 percent bonus, from 2019 to 2024, to physicians in alternative payment models (APMs);
- Retains the fee-for-service payment model, and maintains that physician participation in APMs in entirely voluntary;
- Provides bonuses from 4 to 9 percent for physicians who score well in the Merit-based Incentive Payment System (MIPS), a new pay-for program under the current fee-for-service payment system;
- Provides technical support for smaller practices, funded at $20 million per year from 2016 to 2020, to assist in participation in APMs or the MIPS program;
- Provides funding for quality measure development, at $15 million per year from 2016 to 2019;
- Streamlines Medicare’s existing quality programs into one value-based performance program, which will remove many of the reporting burdens faced by physicians;
- Expands availability of Medicare data by allowing qualified clinical data registries to purchase claims data for purposes of quality improvement and patient safety; and
- Clarifies that the development of quality guidelines in Medicare or through other laws cannot be construed to establish a standard or duty of care, protecting doctors from lawsuits based on federal quality measures.
- Requires the HHS Office of Human Research Protections (OHRP) to issue guidance on applicability of the Common Rule to clinical data registries.
- Directs CMS to provide access to Medicare claims data by July 2016 for Qualified Clinical Data Registries (QDDRs).
- Directs CMS to expand the Qualified Entity Program to give medical specialty societies access to Medicare claims data for quality measure development activities.
Bundled Payments/Value Based Payments

The Issue: The rising cost of healthcare has prompted federal policymakers, payers, and other stakeholders to investigate and implement various types of payment incentive programs designed to control the costs of delivering healthcare goods and services. In January of 2016, US Department of Health and Human Services (HHS) Secretary Burwell announced that HHS has set a goal of tying 30 percent of traditional fee-for-service Medicare payments to quality or value thought alternative payment models, or bundled payments by the end of 2016. The term 'bundled payments', or 'episode payments', normally refers a payment system in which a single entity (typically a hospital) receives a single reimbursement for all care related to a clinical episode and is responsible for disbursing the payment to the associated providers. Value-based payments, on the other hand, are tied to quality metrics and other outcomes measures. In the recent MACRA legislation, the Alternative Payment Models (APMs) are based on bundled payments, and the Merit-based Incentive Payments are value-based payments.

AAOS Supports: The AAOS supports efforts of all stakeholders to develop and evaluate payment methodologies that will incentivize coordination of care among providers (including physicians and hospitals) and help curb healthcare inflation. The AAOS supports maintaining the fee-for-service payment system as an option for physicians whose patients are best served by this model. The AAOS believes risk adjustment is an indispensable component of a successful episode of care or bundles payment initiative and policy. AAOS also believes:

- The patient must be the primary focus of all initiatives and should be empowered to be a fully participating stakeholder in the healthcare process;
- The patient’s access to quality care must always be a priority over cost savings;
- The physician must be the patient’s primary advocate for his or her medical needs;
- All stakeholders must disclose potential conflicts of interest when providing patient care;
- All stakeholders must not be incentivized to limit care or provide unnecessary care;
- Patients must maintain access to a variety of necessary providers and facilities;
- Payment must be agreed upon prior to delivering care;
- Payment must be risk-adjusted for patient- and procedure-specific characteristics;
- One provider must not have control over another provider;
- Competition must be maintained in the healthcare system; and
- A physician must have the autonomy to provide care that addresses each patient’s unique medical needs.

Independent Payment Advisory Board (IPAB)

The issue: In an effort to lower Medicare's health care costs, the Independent Payment Advisory Board (IPAB), created by the Patient Protection and Affordable Care Act (PPACA), threatens the ability of elected representatives in Congress to ensure access to the health care they need, when they need it.

Specifically, problems with the IPAB include the following:

- The IPAB will consist of 15 unelected, unaccountable members.
- Fewer than half of the IPAB members can be health care providers, and no member can be a practicing physician or otherwise employed.
• Requiring IPAB to achieve savings in a one-year time period is not conducive to generating savings through long-term delivery reforms.

• IPAB recommendations are “fast-tracked” and automatically go into effect starting in fiscal year 2015 unless Congress passes an alternative proposal that achieves similar savings or votes to reject the proposal (with a 60 vote majority needed in the Senate).

• Providers representing roughly 37 percent of all Medicare payments, including hospitals and hospice care, are exempt from IPAB cuts until 2020; thus IPAB directed cuts will disproportionately fall on all other providers and suppliers, including orthopaedic surgeons.

• Finally, not only does the creation of the IPAB severely limit congressional authority, it essentially eliminates the transparency of hearings, debate and the meaningful opportunity of stakeholder input.

**AAOS Supports:** The AAOS recommends the full repeal of the IPAB. Unless the IPAB is fully repealed, the Department of Health and Human Services (HHS) is still required to make cuts based on spending targets mandated in the ACA. Access to orthopaedic care will be threatened unless IPAB is permanently repealed.

**Action:** AAOS has helped secure over 275 bipartisan, bicameral cosponsors to H.R. 1190 and S. 141, Protecting Seniors’ Access to Medicare Act of 2015, a bill that fully repeals the IPAB.

**Medical Liability Reform**

**The issue:** According to the Congressional Budget Office, medical liability reform would save the government $62 billion over 10 years. Some estimates put the total costs associated with the professional liability system at as much as $850 billion per year. For many specialties, including orthopaedics, annual professional liability insurance (PLI) premiums have continually risen, at times by an average of 15 percent a year. These dramatic increases make premiums prohibitively expensive for many physicians and reduce patient access to musculoskeletal care.

**AAOS Supports:** AAOS supports responsibly reducing costs through patient safety, cultural competency, and providing high-quality health care. The AAOS currently develops clinical practice guidelines; it initiated and is a partner in the American Joint Replacement Registry (AJRR) and has published a primer to help educate orthopaedic surgeons on issues related to Accountable Care Organizations.

Additionally, AAOS supports:

• Placing time-tested, reasonable limits on non-economic damages, such as the successful reforms in California and Texas.

• Protecting physicians volunteering services in a disaster or local or national emergency.

• Applying the Federal Tort Claims Act to cases involving EMTALA-mandated services.

• Exploring alternatives, including health courts and early disclosure and compensation offers.
• Ensuring that nothing in the Affordable Care Act creates a new cause of legal action.
• Funding the $50 million liability grant program and amending the law to prevent plaintiffs from opting out of the program once enrolled.

Read the full AAOS Position Statement on Medical Liability Reform here.

Integration of Clinical Services

The issue: The ability to quickly diagnose a musculoskeletal condition and initiate a treatment plan is integral to restoring patient mobility and preventing future injury. The in-office ancillary services (IOAS) exception to the Stark Law is essential to efficiently diagnosing and treating musculoskeletal conditions by allowing orthopaedic surgeons to provide imaging and physical therapy services in their offices.

Physician ownership of ancillary services enables:
• Better physician oversight of the quality of care being delivered.
• Improved care coordination among providers through shared knowledge of patient and case information.
• Greater patient adherence to treatment plans by eliminating scheduling delays, prolonged waits, and the need to travel to other offices, which is critically important for orthopaedic patients with mobility issues, especially those who are elderly.
• An integrated care model that combines health care providers of various fields to promote a team-based approach to musculoskeletal care delivery.

A change to the IOAS exception would be detrimental to orthopaedic patients as they would no longer be able to receive the continuum of care necessary to properly treat musculoskeletal conditions.

AAOS Supports: Congress should create incentives for high quality clinical services. The AAOS and other medical organizations are invested in quality initiatives to ensure the highest quality services are performed on their patients.

These initiatives include:
• The development and implementation of training guidance
• Clinical practice guidelines
• Appropriate use criteria
• Decision support tools, which support physicians in delivering the most appropriate care

Action: AAOS prevented the in-office ancillary services exception (IOASE) from being used as a pay-for in any legislation, despite legislative threats like H.R. 2914 and the President’s Budget. AAOS also established an IOASE Working Group to pursue aggressive legislative strategy, which resulted in a Congressional Doctors Caucus letter, meetings with targeted Hill staff, and a physician fly-in in February. Further, the AAOS successfully rolled-out an IOASE study, which has armed AAOS with positive data for
efforts to preserve the IOASE exception. The AAOS also worked with the Government Accountability Office on its physical therapy self-referral report, recruiting physicians to review the document prior to publication and offer comments.

Value of Orthopaedic Care

The Issue: Bone and joint health problems are the leading cause of disability in the United States. Orthopaedic surgeons deliver high quality care that improves mobility, restores independence, returns Americans to work, alleviates pain and saves lives. With an aging population, the need for orthopaedic care is increasing significantly and will continue for years to come.

- More than 1 in 4 Americans has a musculoskeletal condition.
- Musculoskeletal diseases and conditions are the greatest cause of total lost work days and medical bed days in the United States.
- The majority of injuries sustained during war and following natural and man-made disasters affect the extremities.
- In 2008, an estimated 99.3 million individuals annually reported musculoskeletal disease as their primary health concern.
- The demand for orthopaedic care is scheduled to outpace the number of available physicians in 2020.
- Annual direct costs related to bone and joint health exceeded $705 billion, or 4.9 percent of the gross domestic product in 2008.

AAOS Supports: Bone and joint health problems are among the most prevalent and debilitating health challenges that Americans face, both in human and economic terms. Unencumbered access to orthopaedic care is the key to ensuring that our communities, workers, and economy remain healthy and strong.

Action: AAOS continues to educate lawmakers on the importance of promoting musculoskeletal health and preserving patient access to orthopaedic care.

GME Funding

The Issue: Without residency training, medical school graduates cannot obtain licenses to practice medicine. Therefore, if an adequate number of residency slots are not available after graduation, some new physicians will be unable to practice their profession in the U.S. Continuing calls to cut health care costs have made GME funding a prime target. Since 1997, the number of federally funded GME spots have been capped to control costs, forcing hospitals and states to find creative ways to fund their needed compliment of residents. Financing of GME should not be used as a means to implement national
physician workforce policies. It is also critical to show that funds paid toward indirect costs of GME are appropriately disbursed.

**AAOS Supports:**
--At a minimum, keep GME level funded
--Ensure primary care and specialty care slots are distributed evening
--Provide greater transparency of funds

**Action:**
Congress should work to pass legislation that reforms the current GME system by including, at a minimum, the three issues stated above. Any legislation must address potential shortages of both specialty and primary care residency slots, as well as ensure that current levels of funding are not reduced.

Working along with the with AAMC and Congresswoman Kathy Castor (FL) to secure a Ways and Means Republican to introduce “Training Tomorrow’s Doctors Today” legislation which would address the shortfall of GME slots by increasing the number nationally by 3,000 each year (up to 15,000) and ensures that at least half of the available new slots must be used for a shortage specialty residency program.

**Anti-Trust Reform**

**The Issue:** Private health insurers engaged in contractual negotiations with healthcare providers are protected from antitrust prosecution under the McCarran-Ferguson Act. This antitrust exemption, together with recent healthcare industry consolidations, has enabled a few select health care plans to dominate the market. In contrast, health care providers in private practice are subject to antitrust prosecution if they attempt to come together to negotiate reimbursement with private insurers. As a result, physicians are frequently placed in positions of diminished bargaining power, and health plans are able to impose unilateral, non-negotiable contracts which give insurers the power to deny patients access to optimal care, and impose costly administrative burdens on physicians that further limit their ability to provide care.

**AAOS Supports:** AAOS supports allowing physicians to negotiate with dominant insurers on a level playing field which ensures heightened quality standards for patient care, removes administrative burdens, and allows physicians to engage in care coordination endeavors. Additionally, AAOS supports:

- Providing protection from federal antitrust prosecution to health care professionals who are engaged in contractual negotiations with a health plan;
- Increasing physicians’ ability to negotiate meaningful contracts that deliver high quality health services and protect patient safety;
- Removing administrative barriers to high-quality care; and
Promoting the coordination of health care by allowing health care providers to engage in care coordination endeavors, such as Accountable Care Organizations (ACOs), without fear of antitrust prosecution.

**Action:** H.R.105, the Quality Health Care Coalition Act of 2015. This legislation exempts health care professionals, including individuals and entities, from federal and state antitrust laws in connection with negotiations with a health plan regarding contract terms under which the professionals provide health care items or services for which plan benefits are provided. This Act applies only to health care professionals excluded from the National Labor Relations Act; and does not apply to negotiations relating to Medicare or Medicaid programs, the Children's Health Insurance Program, medical and dental care for members of the uniformed services, veterans' medical care, the federal employees health benefits program, or the Indian Health Care Improvement Act.

**ICD-10**

**The Issue:**
Physicians must comply with the newly mandated system by October 2015 which increases the number of codes from 13,000 in ICD-9 to 68,000 in ICD-10 and is particularly relevant to orthopaedics as the number of codes used by orthopaedic surgeons outnumbers all other specialties. Thus, the transition to ICD-10 will have a more negative impact on orthopaedics than on any other physician group. The U.S. is the only country in which the ICD system is tied to reimbursement. Concerns include the cost of implementation, the added cost of denied claims, the substantial administrative burdens (verifying patient eligibility, obtaining pre-authorization for services, documentation of the patient’s visit, public health reporting and quality reporting) and decreased productivity. Adding to administrative burdens is the fact that orthopaedic surgeons will be using ICD-9 for worker’s compensation claims all the while using ICD-10 for Medicare patients.

**AAOS Supports:**
AAOS supports prohibiting implementation of ICD-10. However, should ICD-10 be implemented, there must be more end-to-end testing conducted to ensure the system is fully functional. AAOS also supports an 18 month “safe-harbor” transitional period should minor sub-code mistakes be made.

**Action:**
- Support letter sent regarding Congressman Ted Poe’s legislation (H.R. 2126), which would prohibit implementation of ICD-10. [View letter here](#)
- Support letter sent regarding Congresswoman Diane Black’s legislation (H.R. 2247) which would conduct full end-to-end testing and allow for an 18 month “safe-harbor” period. [View letter here](#)
- Support letter sent regarding Congressman Gary Palmer’s legislation (H.R. 2652) which would provide a two-year grace period for physicians and other health care providers in transitioning from ICD-9 to ICD-10. [View letter here](#)