AAOS Legislative and Regulatory Wins

The American Association of Orthopaedic Surgeons (AAOS) Office of Government Relations monitors a wide variety of issues related to advancing the highest quality musculoskeletal health. Each year, the Council on Advocacy reviews and updates its Unified Advocacy Agenda, which guides the Office of Government Relations’ work in the legislative and regulatory arenas. With the primary objectives of enhancing access to and quality of orthopaedic care for our patients, major legislative and regulatory initiatives include Medicare reimbursement reform, addressing health information technology, increasing research funding, protecting in-office ancillary services, ensuring access to high-quality care, shaping emerging opioid legislation, and increasing congressional awareness of the large and growing prevalence of musculoskeletal diseases.

For an online version of this document, visit www.aaos.org/dc.

Federal Legislative Accomplishments

2017 was a year of important wins for health care policy. With health care reform again at the forefront of political debates on Capitol Hill, the AAOS Office of Government Relations worked hard to continue to ensure physician priorities—including medical liability reform, ownership issues, and IPAB repeal—were heard and advanced. Below is a list of some accomplishments achieved during 2017 and 2018.

Sports Medicine Licensure Clarity Act and the Medical Controlled Substances Transportation Act

The Sports Medicine Licensure Clarity Act, designed to ensure team providers are properly covered by their professional liability insurance when traveling with athletic teams, passed in the House of Representatives by voice vote. Read more online here. A Senate companion bill was introduced in April and has 22 cosponsors.

From high school to college to professional levels, it is important that the men and women who are trained to protect and care for athletes and who best know the players’ medical histories are able to engage in the treatment of injured athletes.

On July 12, 2017, the House of Representatives passed the Medical Controlled Substances Transportation Act of 2017. The bill would update the Drug Enforcement Administration (DEA) registration process for mobile medical practitioners and team physicians to ensure they can administer controlled substances at locations other than their principal place of business while complying with new limitations on timing of transport and related recordkeeping requirements.

For more on these issues, visit: www.aaos.org/advocacy/mlr/

Antitrust Reform

On March 22, 2017, the House easily approved a bill that makes needed reforms to the McCarran-Ferguson Act to reduce health care costs for consumers by ensuring competition. AAOS has raised the issue of the current exemption for health insurers, commenting that the antitrust exemption, “together with the recent health care industry consolidations,” has enabled a select few health plans to dominate the health care market. As a result, physicians are frequently placed in positions of diminished bargaining strength, and health plans can impose unilateral, non-negotiable contracts.
On February 14, 2018, AAOS released a statement related to a House Energy and Commerce Subcommittee hearing on health care consolidation, which urged Congress to secure passage of this legislation as soon as possible. Read the statement online here.

For more on the issue of antitrust, visit: www.aaos.org/advocacy/antitrust/

Medical Liability Reform
The House of Representatives passed the Protecting Access to Care Act. This legislation—which contains important reforms such as a cap on noneconomic damages, limits on attorney fees, and a 3-year statute of limitation—was one of the issues discussed by nearly 400 orthopaedic surgeons who attended the National Orthopaedic Leadership Conference in Washington, D.C., in April. Currently, there is no Senate companion, but the nonpartisan Congressional Budget Office estimates the legislation would save the government approximately $1.5 billion, an important first step in passing legislation into law.

“These reforms will ensure negligently injured patients are compensated promptly and equitably, and they will, importantly, improve our overall health care system even before the filing of a lawsuit, by lowering health care costs, improving patient safety, and preserving the patient-physician relationship.” – AAOS President William J. Maloney, MD

Additionally, AAOS continued to build support for the Good Samaritan Health Professionals Act. On February 14, the House Energy and Commerce Committee approved the legislation, which helps protect health care professionals who volunteer their services when a major emergency arises. Specifically, H.R. 1876 provides clear liability protections to licensed health care professionals who volunteer health care services to victims during a declared national disaster. Notably, the legislation respects existing medical liability laws and does not protect providers in cases of willful or criminal misconduct, gross negligence, or reckless misconduct. Read a Feb. 14, 2018 letter sent by AAOS and the Orthopaedic Trauma Association on this issue online here.

H.R. 1876/S. 781
The Good Samaritan Health Professionals Act of 2017 will ensure that an adequate supply of trained health care professionals are ready, willing and able to volunteer their services during a catastrophe, and that they will not be deterred or turned away due to the threat of lawsuits.

For more on the issue of medical liability reform, visit: www.aaos.org/advocacy/mlr/
CHIP, NIH, and Defense Department Medical Research Funding
On February 9, 2018, Congress passed legislation that includes an additional $2 billion in funding for the National Institutes of Health (NIH) requested by AAOS (read more online here and here), another extension of the Children’s Health Insurance Program (CHIP) funding, and further funding to address the opioid epidemic.

After CHIP authorization expired, AAOS, SRS, and POSNA combined forces in advocating for the nearly 9 million children enrolled in the program. “The POSNA leadership would like to thank its membership for their involvement in the process, particularly the many members who participated in the grassroots effort. We feel that the combined voice of POSNA members had a profound effect on energizing the process, and we are proud of our organization's history of advocating for our patients.”

The Senate on Nov. 16, 2017 approved the final version of the National Defense Authorization Act (NDAA), which removed harmful language that would have impeded vital defense health research. Specifically, the language would have instituted a prohibition on conduct of certain medical research and deployment projects like the Peer Reviewed Orthopaedic Research Program (PRORP). The PRORP, championed by AAOS, works to help military surgeons find new limb-sparing techniques to save injured extremities, avoid amputations, and preserve and restore the function of injured extremities.

AAOS successfully advocated for $30 million in funding for the Peer Reviewed Orthopaedic Research Program through the Department of Defense Congressionally Directed Medical Research Program. Once the FY2018 defense appropriations money is allocated, this program will have received more than $330 million in funding since its inception in 2009.

For more on these issues, visit: www.aaos.org/advocacy/researchappropriations/

The Medicare Access and CHIP Reauthorization Act (MACRA)
Legislation signed into law Feb. 9, 2018 included a number of encouraging updates to MACRA requested by AAOS. For example, the legislation excludes Medicare Part B drug costs from MIPS payment adjustments and from the low-volume threshold determination; eliminates improvement scoring for the cost performance category for the third, fourth, and fifth years of MIPS; allows CMS to reweight the cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS; and allows CMS flexibility in setting the performance threshold for years three through five to ensure a gradual and incremental transition to the performance threshold set at the mean or median for the sixth year. The legislation also permanently repeals the outpatient therapy caps beginning on Jan. 1, 2018 and removes the current mandate that meaningful use standards become more stringent over time. This eases the burden on physicians as they would no longer have to submit and receive a hardship exception from HHS.

For more on the issue of MACRA, visit: www.aaos.org/macra/

Independent Payment Advisory Board (IPAB)
While no members had been appointed to the IPAB yet, repealing this board – which was charged with making recommendations to cut Medicare expenditures if spending growth reaches a certain level – has been a top priority for AAOS over the years. Even without board members, the Secretary would be directed to develop and implement proposals automatically if the IPAB protocol was triggered. Further, not only did the IPAB
limit congressional authority with little accountability and preclude meaningful opportunity for stakeholder input, but AAOS had deep concerns about the specific impact that IPAB-directed cuts would have on patient access to quality musculoskeletal care.

In November 2017 and as a result of AAOS efforts, the U.S. House passed a bipartisan measure introduced by Reps. Phil Roe, M.D. (R-TN) and Raul Ruiz, M.D. (D-CA). In February 2018, IPAB repeal was included in a bipartisan budget deal that was signed into law by President Trump. Read more about the changes online here.

“IPAB repeal has been a topic at the NOLC as well as the subject of the grassroots efforts that many of you supported. Hundreds of orthopaedic surgeons have gone to Capitol Hill and/or talked to their elected representatives about this issue, and we are happy to see our voices heard.” – AAOS President William J. Maloney, MD

Physician-Owned Hospitals
Important progress was also made this year toward lifting the moratorium on new or expanded physician-owned hospitals. The House bill, sponsored by Rep. Sam Johnson (R-Texas), has received 64 cosponsors, more than double what it received in past years. Moreover, for the first time, the legislation has a Senate companion, which was introduced by Sen. James Lankford (R-Okla).

BY THE NUMBERS

Physician-owned hospitals provide high-quality, cost-effective care to a diverse patient population.

According to Dec. 2017 CMS star ratings: 51.1% of physician-owned hospitals received 4 or 5 stars; only 40% of non-physician-owned hospitals received the same.

For more on the issue of physician-owned hospitals, visit: www.aaos.org/advocacy/ioas/

In-Office Ancillary Services and Stark Law Reform
AAOS prevented the in-office ancillary services exception from being used as a pay-for in any legislation, despite legislative threats, and continued work with the IOAS Working Group to pursue an aggressive legislative strategy. Further, AAOS also worked on Stark law reform efforts, including support of the Stark Administrative Simplification Act and the Medicare Care Coordination Improvement Act of 2017. The Stark Administrative Simplification Act, H.R. 3173, would limit the penalties for technical violations of the Stark law and create an expedited process for their resolution. The Medicare Care Coordination Improvement Act,
H.R. 4206, creates new flexibilities, waivers, and exceptions to the Stark law to accommodate alternative payment models. The President’s 2019 budget reinforced the need for these modifications, recommending reform of the Stark self-referral law to better support and align with alternative payment models. Additionally, in the 2018 budget agreement, language was included to modernize application of the Stark law under Medicare, codifying changes made in CMS rulemaking to “streamline and clarify” certain rules for providers.

For more on the issue of in-office ancillary services and Stark law, visit: [www.aaos.org/advocacy/ioas/](http://www.aaos.org/advocacy/ioas/)

**Opioids and FDA**

AAOS has worked with Congress on a number of opioid-related measures, ensuring the primacy of the doctor-patient relationship is protected. Read a Feb. 16, 2018 letter sent to the Senate Finance Committee [online here](http://www.aaos.org/advocacy/ioas/). Additionally, AAOS supported introduction of H.R. 4236, the Monitoring and Obtaining Needed Information to Track Opioids Responsibly Act of 2017, which would aid orthopaedic surgeons in addressing this issue by establishing minimum standards that Prescription Drug Monitoring Programs (PDMPs) must meet in order to receive funding from the Account for State Response to the Opioid Crisis.

On August 18, 2017, President Trump signed H.R. 2430, the FDA Reauthorization Act of 2017, into law. H.R. 2430 reauthorizes the FDA’s critical medical product user fee programs, ensuring the agency has the tools it needs to more efficiently deliver safe and effective drugs, devices, and treatments to patients.

To read more about the issues of opioids and the FDA, visit: [https://www.aaos.org/advocacy/fda/](https://www.aaos.org/advocacy/fda/)
Trauma Care
AAOS worked with Representative Burgess (R-TX) to introduce H.R. 880, the Mission Zero Act, and the legislation was passed by the U.S. House of Representatives on February 26, 2018. This bill will provide grants and allow Department of Defense trauma surgeons to be assigned to civilian trauma centers. The legislation is intended to help fill gaps in care and ensure that advances in military trauma care are brought home for civilian patients. AAOS, working with the Orthopaedic Trauma Association (OTA), participates in the Trauma Coalition, which worked to formulate and advance this legislation.

VA Provider Equity Act
AAOS successfully amended legislation that would have included language elevating podiatrists to the same status as physicians under the Veterans Health Administration (VA). Related, on Tuesday, May 2, 2017, orthopaedic surgeon Col. James Ficke, MD (ret.) testified on behalf of AAOS and the American Orthopaedic Foot and Ankle Society (AOFAS) before the House Veterans’ Affairs Subcommittee on Health on the issue of lower extremity injuries among veteran patients. Read more on this testimony online here.

Emergency Medical Services (EMS)
The Protecting Patient Access to Emergency Medications Act was signed into law on November 17, 2017. Introduced by Reps. Richard Hudson (R-NC) and G.K. Butterfield (D-NC), the AAOS-supported legislation provides a statutory framework to allow EMS agencies, professionals, and medical directors to fulfill their mission to save lives and alleviate pain, while also enabling the DEA to continue with appropriate oversight to prevent drug diversion.

Site Neutral Payments
AAOS provided comments to the House Energy & Commerce Committee on the Medicare site-neutral payments issue and mentioned the issue in a statement following a House Energy and Commerce Subcommittee on Oversight and Investigations hearing on health care consolidation. Read it online here.

Expanding site-neutral payment policy – and in particular, equalizing rates for office visits and in-office procedures as well as ASC procedures – will continue the progress made towards addressing health care choice and consolidation.

Orthopaedic PAC
2017 was an exciting year for the Orthopaedic Political Action Committee (PAC). In addition to the growth of the Advisors’ Circle and record-breaking resident involvement, the Orthopaedic PAC had unprecedented access and representation at more than 600 political events, an increase of more than 30 percent from last election cycle. The strength of the PAC has allowed orthopaedists to have a seat at the table and educate members of Congress about the importance of musculoskeletal care. Visit the PAC website online here.

Federal Regulatory Accomplishments
The AAOS Office of Government Relations’ regulatory efforts ensure that orthopaedic concerns are addressed even after the conclusion of the legislative process and throughout agency rulemaking and implementation stages. To this end, the regulatory staff works closely with Department of Health and Human Services agencies such as the Food and Drug Administration (FDA), Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention.
(CDC). In addition, expertise in coding, reimbursement, and payment policy is shared across the Academy and with our members. The Office of Government Relations also houses the AAOS’ practice management information and educational efforts. Both of these are key services to our fellowship and members.

Scoliosis Screening
On January 9, 2018, the United States Patient Safety Task Force (USPSTF) released updated guidance on screening for adolescent idiopathic scoliosis. The guidance was upgraded from “D”, discouraging screening, to “I”, indicating the data is inconclusive on the effectiveness of screening. POSNA and SRS led a letter in June 2017 signed by 13 other BOS societies as well as AAOS and the American Academy of Pediatrics urging the USPSTF to upgrade their recommendation. Read the USPSTF’s announcement [here](#).

Medicare Access and CHIP Reauthorization Act (MACRA) and the Quality Payment Program
The Quality Payment Program—which replaces the flawed Sustainable Growth Rate (SGR) formula as required by MACRA—includes two tracks: the Merit-based Incentive Payment System (MIPS) track and the Advanced Alternative Payment Models (APMs) track. AAOS has been working closely with CMS to address a number of concerns related to the Quality Payment Program, including the need for additional flexibility and simplification, as well as protection for small, solo, and rural practices.

MACRA/QUALITY PAYMENT PROGRAM (QPP)

- **MIPS**
  - Quality
  - Resource Use
  - Clinical Practice Improvement Activities
  - Advancing Care Information

- **Advanced APMs**
  - Accountable Care Organizations (ACOs)
  - Bundled Payment Models

Most recently, AAOS submitted comments to CMS on its proposed rule that would make changes in the second year of the Quality Payment Program, including participation requirements for 2018. The 2018 Quality Payment Program proposed and final rules took significant steps to respond to AAOS’ concerns for needed flexibility and simplification, as well as protection for small, solo, and rural practices.

Specifically, AAOS applauded a number of provisions in the MIPS track to decrease the burdens on solo and small practices (defined as 15 or fewer eligible clinicians). These provisions included:

- higher low-volume threshold (now $90,000 or 200 Medicare beneficiaries)
- significant hardship exemption from Advancing Care Information
- a 5-point bonus to the MIPS final score
- 3-point scoring for measures that do not meet data completeness.

AAOS also commented on new proposals for virtual groups and the need for provision of clinician/practice data. Finally, AAOS commented that we look forward to working on “redesigning Medicare value-based payment models such that they are voluntary, physician-led, have accurate price setting, and provide access to data for all participants.” Read the entire AAOS comment letter online here.

“The Quality Payment Program remains overly complex and there are continued issues regarding access to data and Advanced APM qualification for specialists, but we are encouraged by proposals that improve the program for providers and ensure quality care for Medicare beneficiaries.” – Wilford K. Gibson, MD, Chair, AAOS Council on Advocacy

VISIT THE AAOS MACRA RESOURCE PAGE FOR ALL MATERIALS AND UPDATES: www.aaos.org/macra
FOR ANY QUESTIONS, CONCERNS, OR COMMENTS, EMAIL macra@aaos.org

**Bundled Payment Models**

In August of 2017, CMS announced changes that address significant concerns raised by AAOS related to mandatory bundled payment programs. First, the changes reduce the number of mandatory geographic areas participating in the CMS’s Comprehensive Care for Joint Replacement (CJR) model from 67 to 34. In addition, the changes would allow CJR participants in the 33 other areas to participate on a voluntary basis. CMS also proposed to make participation in the CJR model voluntary for ALL low volume and rural hospitals in all of the CJR geographic areas. Finally, CMS cancelled the Surgical Hip and Femur Fracture Treatment (SHFFT) payment model and others that were scheduled to begin on January 1, 2018.

“AAOS applauds Secretary Price, Administrator Seema Verma, and others at CMS for clearly hearing concerns of orthopaedic surgeons related to these mandatory payment models.” – AAOS President William J. Maloney, MD

On January 9, 2018, CMS announced a new voluntary bundled payment model that will qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program. This new model, called “Bundled Payments for Care Improvement Advanced” (BPCI Advanced), requires participants to bear financial risk, have payments under the model tied to quality performance, and use Certified Electronic Health Record Technology. The pricing methodology of this new model no longer relies on the National Trend Factor (NTF), as AAOS has consistently argued that the NTF is detrimental to the sustainability of BPCI models. AAOS has some additional concerns – including the model’s interaction with CJR, the semi-annual reconciliations, and benchmark price consideration – but is working to ensure interested orthopaedic surgeons have the tools and resources to participate. This includes a well-attended webinar, which aired on February 21, 2018, and formal communications with CMS.

FOR THE WEBINAR AND TO READ MORE ABOUT THESE ISSUES, VISIT: www.aaos.org/advocacy/medicarepaymentcms/

**Regulatory Relief**

Throughout the year, the Department of Health and Human Services has issued several requests for information, proposed rules, and other documents that indicate their commitment to reducing many of the day-to-day burdens that orthopaedic surgeons face. For example, CMS recently launched the “Patients Over Paperwork” Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a
goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. According to CMS, this effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The recently-released Medicare Physician Fee Schedule final rule includes the following as part of this initiative: (1) reducing reporting requirements and (2) removing downward payment adjustments based on performance for practices that meet minimum quality reporting requirements.

“We recognize and appreciate that CMS has recently released a number of RFIs and has encouraged stakeholder input on new policies to better achieve transparency, flexibility, program simplification, and innovation.” – AAOS President William J. Maloney, MD

Additionally, AAOS responded in July 2017 to a CMS RFI on reducing regulatory burdens. Issues raised by AAOS included MIPS reporting requirements, Medicare claims data, the need for Stark law reform, and issues related to the restrictions on physician-owned hospitals. Read the entire comment letter online here.

As a result, AAOS was pleased with a CMS announcement in January 2018 about the creation of an interagency task force to review the federal Stark law.

**Total Knee and the Inpatient Only List (IPO)**

On November 1, 2017, CMS finalized the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System rule, which includes updates to the 2018 rates and quality provisions, and other policy changes. Importantly, the rule finalizes changes to the Medicare IPO list for CY 2018. AAOS applauded CMS for removing total knee arthroplasty (TKA) from the IPO list and for acknowledging this decision should be “made by the physician based on the beneficiary’s individual clinical needs and preferences.” AAOS further acknowledged CMS for noting that the surgeons, clinical staff, and medical specialty societies who perform outpatient TKA and possess specialized clinical knowledge and experience” are most suited to create guidelines to identify appropriate candidates.

Read the AAOS press release on the announcement online here.

AAOS continues to work with stakeholders as this change is implemented. To that end, AAOS recently released a FAQ document with answers to questions related to this decision. Read the FAQ online here. AAOS also wrote a letter to CMS discussing some concerns with the implementation of this policy change.

FOR THE LETTER AND TO READ MORE ABOUT THESE ISSUES, VISIT: [www.aaos.org/advocacy/medicarepaymentcms/](http://www.aaos.org/advocacy/medicarepaymentcms/)

**Orthotics/Prosthetics**

After AAOS communicated serious concerns to CMS, the agency withdrew a proposed rule that would have added substantially more onerous qualifications needed for practitioners to furnish and fabricate prosthetics and custom-fabricated orthotics than current law requires. AAOS applauded the decision to withdraw it and avoid adding burdensome and unwarranted requirements related to prosthetics and orthotics. Read the AAOS press release on this issue online here.

**Accrediting Organizations**

In early 2017, CMS proposed to revise the application and re-application process for Accrediting Organizations (AOs), specifically related to transparency by requiring AOs to post provider/supplier survey reports and plans of corrections from CMS-approved accreditation programs on their public-facing websites. AOs currently do not make their survey reports and acceptable points of care from their CMS-approved
accreditation programs publicly available. AAOS opposed the publication of quality improvement surveys and plans of correction by AOs in current form. After consideration of the comments received, CMS decided that it would be best if the proposal was not finalized and instead, the proposal was withdrawn.

**Accounting for Social Risk Factors and Risk Stratification**
In comment letters to CMS, AAOS has argued that risk stratification and adjustment are equally significant components of valid quality assessment. Providers should not be financially penalized when caring for patients with greater needs. CMS has recognized the importance of risk stratification and adjustment and has said they will consider the analyses and recommendations from a report that analyzes the effects of certain social risk factors in Medicare beneficiaries on quality measures and measures of resource use used in one or more of nine Medicare value-based purchasing programs, as well as reports that include considerations for strategies to account for social risk factors in these programs. Furthermore, CMS awaits the recommendations of the National Quality Forum (NQF) trial on risk adjustment for quality measures.

**Coding**
After consideration of comments from AAOS and others that CMS received, CMS is reassigning TAR procedure codes from MS DRG 470 to MS DRG 469, even if there is no MCC (Major complication or comorbidity) reported for FY 2018. As the Medicare claims data demonstrated, there is substantial cost difference between TAA and other lower extremity joint replacements. Read more online here.

AAOS continues to work on issues related to coding and reimbursement which include review and comment of new and revised CPT codes, proposed National Correct Coding Edits (NCCI) procedure-to-procedure edits, proposed CMS Medical Unlikely Edits, and issues related to ICD-10CM and ICD-10PCS. In addition, AAOS develops educational material and updates to the Academy’s coding products such as the Global Service Data for Orthopaedic Surgery book and the Code-X program as well as coding courses held throughout the year.

**Registries**
In 2017, AAOS announced plans to create a national family of clinical data registries for a broad range of orthopaedic conditions and procedures. As part of this effort, the American Joint Replacement Registry (AJRR) is integrating into the AAOS. The AJRR, a national hip and knee joint replacement registry with 970 participating U.S. hospitals and 40 ambulatory surgery centers, has captured and analyzed data on more than one million procedures since its creation in 2010.

On June 23, 2017, AAOS and AJRR participated in a meeting with 16 high-level CMS and CMMI staff to successfully resolve the problem the registry has encountered accessing Medicare claims data. AJRR was encouraged to utilize the ResDAC program, and is the first QCDR to do so. After three years of working on this issue, AAOS is anticipating receipt of the first delivery of Medicare claims data to AJRR at any time. AAOS also continues to advocate for full implementation of Section 105(b) of MACRA.

**State Advocacy Accomplishments**
State orthopaedic societies have had a successful year in advocating for patient access to prevention and treatment of musculoskeletal conditions. Since August 2016, state orthopaedic societies secured 16 laws that protect physician ownership of ancillary services, end certain harmful insurer practices, and promote patient-
centered policies. For detailed reports on every win, please email AAOS’ State Government Affairs Manager, Manthan Bhatt, at bhatt@aaos.org.

Protecting Physician Ownership
In a major win for the AAOS, the South Carolina Supreme Court agreed with two orthopaedic surgeons in their decade long fight protecting the integration of physical therapy (PT) and physician services. The AAOS’ Health Policy Action Fund and the South Carolina Orthopaedic Association have invested significant time and resources into this battle and protecting physician ownership of ancillary services like PT.

Similarly, the Massachusetts Orthopaedic Association (MOA) successfully advocated for significant reforms in Massachusetts’s determination of need (DoN) law, a highly restrictive certificate of need law. Existing ASC’s now have the freedom to expand and the door for new ASC’s in Massachusetts is open for the first time in over 20 years. All existing facilities will be allowed to apply for a DoN without affiliation or in a joint venture with an acute care hospital. Multispecialty facilities will be allowed to add a new service line, expand the facility and transfer ownership. Similar pathways will be created for single specialty facilities.

The Maryland Orthopaedic Association successfully advocated for HB 403, a measure that exempts a health care practitioner who has a specified compensation arrangement with a health care entity from the prohibition against self-referral so long as that compensation if from an advanced payment model. Maryland, before this law, had the most restrictive regulatory burdens on physician ownership of imaging services. The project was funded, in part, by the AAOS’ Health Policy Action Fund.

Recognizing Visiting Sports Team Physicians
In Nevada, Georgia, Tennessee, and Missouri, the governor recently signed laws allowing for visiting sports team physicians to practice in a state where they are not licensed so long as they maintain licensure in any other state. The model legislation and campaign was developed through a partnership between AAOS and the American Orthopaedic Society for Sports Medicine (AOSSM) and implemented by state orthopaedic societies and AOSSM members. Texas, Idaho, Wisconsin, Massachusetts, Maine, Oklahoma, Kansas and New York are currently working on recognizing visiting sports team physicians.

Insurance Reforms
The Pennsylvania Orthopaedic Society successfully advocated for HB 2241, a bill that ends the harmful healthcare insurer practice of clawing back paid claims. Sponsored by State Representative Karen Boback (R, Luzerne), HB 2241 prohibits insurer retroactive denial of paid claims beyond a 24-month period. The General Assembly’s actions end a ten-year odyssey that pitted the medical community against the healthcare insurance industry. POS led the healthcare provider coalition that forged the compromise contained in HB 2241. The Society is widely recognized in the General Assembly and medical community as the driving force in securing this vital legislation. The activity was funded, in part, by the AAOS’ Health Policy Action Fund.

In 2016, Sociedad Puertorriqueña de Ortopedia y Traumatologia (SPOT), Puerto Rico’s orthopaedic society, faced a major issue when certain Medicare Advantage health insurers in the state stopped covering disposable materials. Health insurers claimed that since the devices were not implantable, the patient or physician must cover the cost. SPOT applied for a grant from the Health Policy Action Fund and hired a lawyer. The Court sided with SPOT. It was decided that the payment for disposables supplied by orthopaedic device companies for the use of implantation of a device during an orthopaedic procedure must be covered by Medicare Advantage health insurers.
Texas is the first state legislature to pass legislation related to patient-reported outcomes (PROs). SB 55 (Sen. Judith Zaffirini, D-Laredo and Rep. JD Sheffield, DO, R-Gatesville) will direct the Teacher Retirement System of Texas (TRS) and Employees Retirement System of Texas (ERS) to determine whether collecting PROs for musculoskeletal care within the system could enhance the care provided to millions of Texans. SB 55 was signed on June 15th, 2017. TOA educated lawmakers on the concept of how PROs may serve as a better judge of quality, as opposed to the current quality measures that measure hard endpoints, such as complications, clinical processes, and costs. PROs have the ability to measure whether a treatment increased mobility and decreased pain, which are the two goals of musculoskeletal care.

**Texas Orthopaedic Association (TOA) Leads on Childhood Spinal Screening Standards**

Texas lawmakers responded to a 2013 study surrounding bracing for scoliosis. The Legislature passed HB 1076, a bill heavily lobbied for by TOA, physician groups and nursing groups, which will update the state’s scoliosis screening standards in schools to match the latest science, which determined that bracing is effective when scoliosis is found early.

With recent proposed classification changes at the U.S. Preventive Services Task Force on scoliosis screening standards, AAOS will be taking lessons learned from TOA and adopting them in a nationwide campaign to require childhood spinal screenings to identify and treat scoliosis early.