

AAOS 2011 Fall Meeting - Symposia Summaries

Symposium 1: Reimbursement Trends vs. General Economic Trends and the Impact on Healthcare Delivery

Moderator **Michael Connair, MD**, Councilor from Idaho, introduced the session by reviewing the current situation, in particular the issues surrounding the Medicare Physician Fee for Service schedule and antitrust legislation. Medicare's shift from paying "usual and customary" fees to the Sustainable Growth Rate formula set the stage for the insurance industry to match lower government payments, leaving physicians as the ones whose fees are cut. In addition, the antitrust relief bill (HR 1409) still does not allow physicians to negotiate Medicare rates. Medicare's under reimbursement for care has led to cost shifting to private insurers. Several questions were raised including 1. How should we restore Medicare solvency? 2. How should we ration care ethically? 3. How much free care should each physician provide?

John Nordt III, MD, of Florida, reviewed trends in payment using select orthopaedic procedures and the consumer price index and based on data prepared by Matt Twetten, AAOS Senior Manager of Regulatory, Quality, and Medical Affairs. While 97 percent of orthopaedic surgeons treat Medicare patients, and Medicare payments make up a significant portion of income for orthopaedic practices, real dollar changes during the period 1992–2010 have meant that orthopaedic surgeons are receiving considerable less today than in 1992. For example, although the consumer price index rose 53.21 percent during that period, the average real dollars received by orthopaedic surgeons for select procedures fell by 57.51 percent. The SGR, which was started in 1998, is a zero sum game and continues to drive down reimbursement. Incomes for orthopaedic surgeons have continued to increase, however, in part because they have expanded their services and changed their payer mix.

According to **Barbara Cataletto, MBA, CPC**, and CEO of The Business of Spine, LLC, physicians should reclaim their rightful place in health care—as physicians, not "providers." She recognized there is fear in the community. She pointed to the impact of for-profit insurers, which continues to experience significant growth in earning and net income, while physicians are barely breaking even. "This is corporate medicine," she said, "responsible to shareholders first and everyone else—including patients—second." She reviewed the shift toward high-deductible health plans, which may in fact, keep patients from going for care they need. She also addressed the cost of doing business, which have increased substantially over the years, even as reimbursements have fallen. She encouraged the audience to use fairhealthus.org, a website that provides healthcare reimbursement data for consumers, insurers, healthcare providers, researchers, analysts, and policymakers to determine payments per procedure. She concluded that our most basic obstacle is the domination of the marketplace by for profit insurance companies.

Symposium 2: Payment and Delivery Systems: Engaging Orthopaedists in Innovation

According to moderator **David Halsey, MD**, of Vermont, the Centers for Medicare & Medicaid Services (CMS) reported that healthcare costs reached an estimated 17.3 percent of the gross domestic product (GDP) in 2009. Left unchecked, costs will rise to 19.3 percent by 2019, almost one-fifth of the nation's GDP. At the same time, research and anecdotal reports continue to identify gaps and inequities in the quality of healthcare delivered in the United States.

The Patient Protection and Affordable Care Act (PPACA) was the greatest change to U.S. health policy since the passage of Medicare and Medicaid in the mid-1960s. Now the challenge is to transform the national infrastructure from a volume-based to a value-based model that better aligns the incentives and needs of all stakeholders. CMS has proposed both delivery (accountable care organizations or ACOs) and payment reforms (bundled payments). He reviewed the demonstration projects and the "Bundled Payments for Care Initiative" (BCPI) and the timeline for applications.

CMS has developed a center for Medicare and Medicaid innovation, which is in charge of these projects. Payment reform for primary care physicians may include a combination of fee for service and a per patient per month payment. Bundled payment would be based on the demonstration projects and would be scheduled to start in 2013. Phase I would probably include total hip and knee and would allow gainsharing with the potential for up to 150% increase in reimbursement. Groups could consider either prospective or retrospective payment plans. To be involved groups would need to submit a letter of intent and then would receive DRG data.

Courtland Lewis, MD, Director, Research & Quality at the Connecticut Joint Replacement Institute, discussed the development and implementation of a bundled payment plan for primary total hip and total knee arthroplasty. Some may consider this a growth strategy. He noted that the five essentials for developing such a plan include the following: a CEO that “gets it”; surgeons willing to “get it”; trust and transparency; savvy legal counsel and clean data. Other considerations include a mature service line, adequate case volume, medical leadership and robust quality and cost systems. He discussed development of a “fair market value” and the division of shared risk. He offered a caution that bundled payments not lead to a “race to the bottom” and pointed out that despite considerable efforts, only 5 patients have been treated using this model. You would definitely need good data on all of your costs including direct, readmission, and complications. You must know your fair market value and have stop loss coverage.

Kate Eresian Chenok, of the Pacific Business Group on Health and the California Joint Replacement Registry, presented the purchaser’s view, pointing out that employers are orthopaedists’ biggest customers. Purchasers are implementing a variety of programs that affect benefit design, often including caps, payment reform including bundling projects, consumer engagement with third party evaluations, and outcomes measurement to improve value. They want improved health outcomes at sustainable costs (accountability and transparency), an infrastructure that supports continuous improvement (registries, electronic health records, and , evidence-based medicine) and a system that engages patients (shared decision making and patient-reported outcome measures).

Symposium 3: MOC is your Key to your MOL and How the PIM Option will be Incorporated into MOC

Moderator **Fred Redfern, MD**, introduced the panel members—**David Martin, MD**, current president of the American Board of Orthopaedic Surgeons (ABOS), and **Thomas P. Vail, MD**, also a member of the ABOS board of directors.

Dr. Martin covered the history of the ABOS and the establishment of the Maintenance of Certification (MOC) process. He noted that directors of the ABOS are nominated by three organizations—the AAOS, the American Orthopaedic Association, and the American Medical Association—and that each of them must also complete the MOC process. He emphasized that the basic MOC process was developed in 2005 and will not change through 2017.

MOC covers four competencies: professional standing, lifelong learning, cognitive expertise, and performance in practice. The lifelong-learning component is address within a 10-year cycle by requiring two 3-year cycles of 120 CME credits (including 20 CME credits from scored-and-recorded self-assessment exams), and three opportunities to pass the exam. The cognitive expertise component is addressed by either a written or an oral exam. The written exam pathway requires a case list (not to exceed 75 cases) for 3 months, and will be modified to provide feedback to those taking the exam. The oral exam pathway requires a 6-month case list. The performance in practice component simply means that one reviews one’s practices, educates oneself on changes, implements improvements, and conducts a second practice review.

Performance Improvement Modules (PIMs) are an optional way to meet the performance in practice measure. During the question-and-answer period, Dr. Martin noted that the ABOS is seeking a way to address the issue of office-based orthopaedists.

Dr. Vail addressed the differences between MOC, a professional program, and maintenance of licensure (MOL), which is a government/state-run function. He pointed out that medical licensure is undifferentiated and the same for all physicians regardless of practice or specialty. Medical licensing boards are looking for proof of competence and professional development, which MOC provides. In addition, hospitals and The Joint Commission are also requiring participation in MOC. He noted that the ABOS website is being upgraded and that the ABOS hopes to push information to diplomates, as well as to provide credit for participation in quality improvement programs such as joint registries.

PIMs are basically closed feedback loops and are being developed by specialty societies. Some currently under development include nonsurgical management of osteoarthritis of the knee, treatment of distal radius fractures, and treatment of bunions and hammertoes.

Symposium 4: Orthopaedic Physician Manpower: What is the Right Approach?

Moderator **Kevin Black, MD**, began the session with a review of some of the controversy surrounding the analysis of orthopaedic physician manpower. The issues include not only whether there will be enough physicians to meet the demand, but also whether residents are overpopulating one subspecialty and how to address the demand of a diverse patient population.

Joshua J. Jacobs, MD, AAOS second vice-president, reviewed the steps the AAOS has taken in this area. A RAND study commissioned in 1995 found a surplus of FTEs, based on hours worked. He reviewed several indicators of a physician surplus, ranging from economic and access to care issues to physician productivity and practice behaviors. An AAOS Project Team in 2005 and a symposium in 2006 both identified possible workforce shortages, in part based on an analysis of current numbers of physicians and growing numbers of patients as "baby boomers" reach an age where orthopaedic care is more likely to be needed. A Dartmouth study in 2006 concluded that the focus should not be on how many physicians, but on what they do. Based on AAOS census data, changes can be seen in state-level data, identifying states with potential shortages and surpluses.

David Teuscher, BOC chair, presented some "workforce alternatives," including the establishment of a "musculoskeletal home" that would enable orthopaedic surgeons to spend more time in the operating room while other medical professionals handled nonsurgical treatment, chronic condition treatment, imaging, referral decisions, and rehabilitation. He also presented the idea of an orthopaedic physician with specific musculoskeletal training supported by nonphysician providers, such as physician assistants, advanced practice nurses, physical therapists, and athletic trainers.

Returning to the podium, Dr. Black reviewed other considerations, including the competency of nonorthopaedic providers, education funding, degree of and growth in specialization within orthopaedics, health disparities, hospital hiring, and curriculum issues. Despite the increasing role seen for nonphysician providers, he concluded, "*The orthopaedist must be the leader, not only in direct patient care but in the orchestration and design of care delivery*" and "*We must accelerate our efforts to increase diversity in our workforce.*"

Symposium 5: How to Optimize your Organizational Talent to Prepare for Healthcare Reform

In the first of two symposia organized by the American Association of Orthopaedic Executives (AAOE), Moderator **Patricia Brewster, MHA, FACMPE**, CEO/Partner at IntraHealth Group in Atlanta, Ga., noted that approximately 20 percent of a physician's time is spent coordinating care for patients not in the office, and about 55 percent of the physician's time is spent in patient care.

George Trantow, FACHE, CMP, executive director, Aspen Orthopaedic Associates, Aspen, Colo., reviewed the importance of selecting and developing qualified staff. Although physician time is the most valuable, staff compensation accounts for about one quarter of overhead in most practices, so their time should be optimized as well.

Jim Kidd, CMPE, executive director, St. Peters Bone & Joint Surgery, St. Louis, defined delegation as assigning and authorizing another person to do something, but the leader remains responsible. He urged orthopaedic surgeons to establish standards within their practices and to push every task down to the lowest level. Giving people appropriate responsibility and authority will result in a high-performance team. "The most important role of staff is to support the billable provider," he said.

He encouraged the use of a practice executive who shares the physician's vision, manages new staff, is a skilled, data-driven negotiator, and participates actively in advocacy. He reviewed possible roles for staff such as physician assistants, nurse practitioners, and athletic trainers. He suggested that offices be designed with efficiency in mind and recommended using financial metrics to measure costs per procedure, practice operating costs per patient, and total costs per episode of care.

Automation is also key to maximizing time, and he encouraged the use of software that checks reimbursements against contracts to ensure proper payments. Automation also helps ensure regulatory compliance, and he outlined the elements of a compliance plan.

Symposium 6: The Spread of State Healthcare Initiatives: Coming to a Town Near You

Moderator **George Trantow, FACHE, CMPE**, introduced **David Schlactus, MBA**, president of the AAOE and CEO of Hope Orthopedics of Oregon. Mr. Schlactus covered both federal and state initiatives on healthcare reform. On the federal level, he covered Accountable Care Organizations (ACOs), bundled payments, and the health insurance exchanges mandated by the Patient Protection and Affordable Care Act. He also noted the challenge facing the Deficit Reduction (Super) Committee, the potential 29.5 percent cut in Medicare reimbursement required under the Sustainable Growth Rate (SGR) formula, and the MedPAC recommendations to cut specialists' payments by 5 percent per year for 3 years and then freeze them for 7 years.

Despite these challenges, Mr. Schlactus expressed more concern over issues at the state level, due to their individual budget deficits and increasing numbers of uninsured. He discussed the Oregon situation, where the state—through Medicaid and its Health Leadership Task Force—controls coverage for 53 percent of the population. He is concerned that regulations applied to high-risk pools of patients might be extended to the entire population. He also discussed reforms in Massachusetts, Oklahoma, Vermont, and Washington that have resulted in higher deductibles for some orthopaedic procedures, limited emergency room visits, and reduced fees for workers compensation cases.

He encouraged orthopaedists to get involved at the state level—"If you are not at the table, you are on the menu!" He advised working together with other physicians and hospitals, to be seen not as an adversary but as a solution. Finally, he recommended a review of practice policies and procedures to develop ways to deliver care at a lower cost.

Symposium 7: PODs for Orthopods?

Moderator **David Teuscher, MD**, introduced the panelists. **Robert H. Haralson III, MD**, medical director for DeRoyal Industries, who reviewed the history of physician-owned distribution of durable medical equipment (DME) and the Congressional interest in physician-owned distributorships (PODs), which he attributed to lobbying by manufacturers who disliked the fact that their sales reps were being bypassed by the PODs. However, by buying directly from manufacturers, physicians could save money for patients and hospitals while providing ancillary incomes for themselves.

Dr. Haralson noted that fraudulent purchases and billing under Medicare for DME is an issue. He urged the audience to record data to support ancillary activities, such as imaging services. He noted that the Office of the Inspector General (OIG) has developed safe harbors for PODs, but that physicians who participate in PODs will have to document, use multiple vendors, avoid using physician-owned manufacturers, distribute profit equally (not based on usage), and disclose their ownership to colleagues, patients, and hospitals. He pointed out that PODs for DME are primarily stock-and-bill operations, but that PODs for spine and/or trauma equipment use different models.

John Steinmann, DO, a California orthopaedic surgeon who has ownership interest in a POD as well as in device companies, discussed his experiences. In his view, PODs provide a system that encourages volume pricing, controls costs, and fosters competition. Where PODs have been introduced, he noted, substantial cost savings have resulted. He reviewed the legal and ethical considerations, including STARK and antikickback regulations, and pointed out that OIG opinions on the legality of PODs depends on their legal, operational, and conduct considerations.

Dr. Steinmann noted that the political landscape is influenced by a strong industry-led initiative to eliminate PODs, despite the benefits they can provide in controlling costs. He discussed the recently established American Association of Surgeon Distributors, which has established standards and criteria for members, and expressed his hope that regulations and standards would be established, recognizing the significance of PODs.

Sara Levin, who is lead staff member of Sen. Herb Kohl's (D-Wisc.) on the Senate Aging Committee, noted that several Congressional inquiries into PODs have been launched, although no official position has been taken. She expressed concern about the impact of PODs on medical decision-making and the potential for financial inducements in making medical decisions. Transparency and overutilization are other concerns. She was interested in the fact that PODs may result in cost savings, but concerned about utilization and legal concerns and investment issues. So far, Congress has heard only about bad models, although she admitted that today's speakers sounded like "good guys."

Bill Kotler, corporate vice-president, government affairs, public affairs, and corporate communication, for Biomet, saw significant potential pitfalls with the POD model, and reported that his company has turned down offers to work with PODs. He understood surgeons' concerns but expressed his belief that PODs are "antikickback traps," which rely on usage and changes in purchasing and prescribing. He saw the model of industry, sales reps, physicians, and hospitals much differently than Dr. Steinmann and pointed to several "myths." For example, he said that implant costs are flat, not increasing and that hospital profits are not declining, with orthopaedics being the most profitable service line. He called PODs a controversial business model.

Symposium 8: PPACA and Alternatives to Traditional Medical Liability Reforms

Douglas W. Lundy, MD, FACS, chair of the AAOS Medical Liability Committee, moderated the session, which primarily focused on alternatives to caps on noneconomic damages. He opened the discussion by reviewing the MICRA legislation in California, which first established the principle of caps on noneconomic damages, and reviewed the situation in Georgia, where caps were overturned by the state supreme court.

David Teuscher, MD, BOC chair and a member of the Claims Review Committee for the Texas Medical Liability Trust, reviewed the situation in Texas. He noted that noneconomic damages, as a percentage of awards, doubled in the 1990s, which threatened access to care as medical liability insurers pulled out of the state and hospitals and physicians were hit with high premiums. A multiyear, bipartisan campaign eventually resulted in a constitutional amendment that permitted caps on noneconomic damages.

Dr. Teuscher also reviewed the results of the campaign: a reduction in the number of lawsuits, an increase in the number of medical liability insurers in the state, a reduction in professional liability premiums, a return of high-risk specialists to the state, and improved access to care.

Graham Newson, associate director of the AAOS office of government relations, reviewed the provisions in the healthcare reform act (PPACA) relating to medical liability. Both PPACA and the president's budget for fiscal year 2012 include funding for medical liability reform demonstration. He noted that if tort reform were part of the Deficit Reduction Committee's (Super Committee) recommendations, it would be an up-or-down vote. He also pointed out that several groups have recommended including tort reform in the deficit reductions because it could save \$62 billion over the next 10 years. He also discussed other medical liability measures before Congress, including the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, the Health Care Safety Net Enhancement Act, and the Medical Liability Procedural Reform Act

According to **James Wootton, JD**, of the Health Information Technology Liability Coalition, one proposed measure—the Patient Safety and Compensation Act—includes “everything except caps” and would hopefully generate enough bipartisan support for passage. He noted that tort reform would improve patient access to care, quality of care, and safety, while lowering costs. He discussed the University of Michigan experience after passage of the State Medical Liability Reform and Transparency Act, which includes a requirement that plaintiffs file a “notice of intent” to sue, giving providers an opportunity to negotiate before the case goes to trial.

Although audience members wondered whether the lack of a cap on noneconomic damages might lower total savings, the other measures within the bill could result in a lower number of lawsuits being filed.