Executive Director
Diane M. Przepiorski
1246 P Street
Sacramento, CA 95814
Phone: (916) 454-9884
Fax: (916) 454-9882
E-Mail: coa1@pacbell.net
Web Page: www.coa.org

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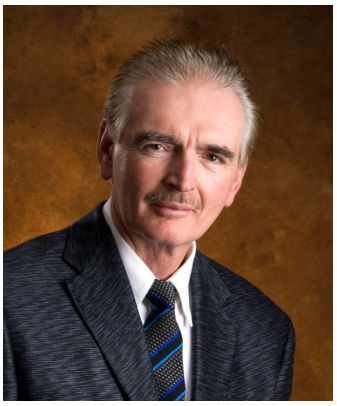
COA Report

A publication of the California Orthopaedic Association

Summer, 2014

PRESIDENT MESSAGE



Robert O'Hollaren, M.D.

Recently, I've become more informed than I might have preferred concerning the concept of "disruptive innovation." According to the pundits and policy-makers, this is what is currently occurring in healthcare delivery.

Now, I don't know about you, but for me, the concept of "disruption" doesn't have a positive connotation. According to the dictionary, disruption is defined as "the forcible separation or division into parts." For those of us that may have spent decades trying to develop integrated, cohesive, high-quality practices, this wouldn't normally be considered a positive concept. However, when combined with the word "innovation" it apparently changes the definition into something that could be considered more palatable. Disruptive innovation is described as "innovation that helps create a new market or value network." Of note is that it does not include a component describing the time, cost, and effort included in achieving such a result.

The "innovation" occurring in medicine revolves around the concept of value-based purchasing. This has been described as requiring a change in practice focus from "volume to value." From my perspective, this seems pejorative, in that it appears to assume that we currently practice medicine primarily to generate volume, without regard to the value provided to our patients or society.

As in any profession, there are undoubtedly those who have volume as their primary motivation. However, I would argue, with some confidence, that the majority of us don't practice orthopedics for that reason. We want to obtain the best outcomes for our patients utilizing our knowledge of the best and most efficient treatments. The problem occurs when the expectations of patients, the available technology, and the financial constraints of the system are out of sync with our ability to provide that care.

(Continued on Page 2)

Save the Date

COA's 2015 Annual Meeting/QME Course

Course for Orthopaedic Practice Managers

April 23-26, 2015

Renaissance Esmeralda Resort—Indian Wells (Palm Springs area)

You can already make your hotel reservations.

Hotel Reservations

President's Column (Continued from Page 1)

There certainly is an argument to be made for improving quality and consistency in healthcare. As physicians, we understand this, and are constantly educating ourselves and looking for ways to improve the care we deliver. However, when it comes to the business of medicine, many physicians don't have the skill set, time, or perhaps the interest, to address the imbalance that has developed. This has resulted in other entities with a significant financial stake in the business of medicine, looking for a different approach to cost containment and access. Thus, we are now experiencing "disruptive innovation" starting to be applied to orthopedic practice. In my opinion, this is about to cause "disruption" using the more singular and classic definition of the term. How we respond will determine the course of our future practice lives.

I recently attended the COA 2014 Annual Meeting, and an AAOS course in Washington D.C. on the transition to value-based healthcare. These have been very helpful in advancing my understanding of the very powerful forces at work to advance this concept. If I had to give advice concerning the bottom line of these presentations it would be: "You ignore this information at your financial and professional peril."

As someone who has been in practice for 32 years, I have learned that the only constant in orthopedics is change. This has been true both with respect to the science of what we do, as well as the business side of medicine. Thirty years ago, the only reason we would have a practice business meeting was to set the date for the annual Christmas party and decide how much we were going to increase our fees. Today, the landscape has changed so significantly that it would be unrecognizable to someone who had not been involved over the ensuing years. My contention would be that the forces pushing toward "value-based healthcare," stand to cause the previous changes to pale in comparison.

The reasons for the coming changes are rooted, as most of us are aware, in a number of factors. Most importantly, is the cost of delivering care. Other factors include the increasing number of insured through the ACA, healthcare needs of the aging baby boom generation, inadequate physician workforce, and a push toward more evidence-based medicine (with associated outcome and patient satisfaction metrics). Although there is very little science behind the current standards for outcome measures, these are being rapidly expanded and enhanced. They are now being used, whether you are aware of it or not, to evaluate physician performance. Ultimately, this will become a primary driver of both physician payment and patient access. Independent of your current practice model, in the near future, these changes will impact the economics, processes, and perhaps the model, in which you practice.

It would be easy for me to simply point out the doom and gloom portents, wring my hands, and deliver platitudes. However, I think COA and its hard-working and dedicated CEO and Board of Directors can do better than that. I've always felt that knowledge is power, and it will be our intent over the coming year to provide you with knowledge helpful in dealing with the coming changes. We will also do our best to direct you to information concerning the people or companies that may be of assistance. Finally, we hope to be able to help you with developing a roadmap to an action plan that results in being able to implement constructive changes in your practice. There isn't a practicing orthopedic surgeon who doesn't feel overwhelmed, at least part of the time, by the demands of practice and family. However, being proactive, developing professional and business partnerships, becoming informed, and developing an action plan, will give each of us the highest chance of success. I know I speak for the entire Board of Directors in pledging to you that we will direct our resources toward assisting you in any way that we can.

Rich Barry, one of our past COA presidents stated, "We must value our intellectual equity." I would suggest an addendum that states, " We must value our intellectual equity, and apply it with focused and cooperative force to achieve the results we have determined to be best for our patients and orthopedic medicine." I look forward to working with you toward that goal in the coming year.

Bob O'Hollaren, M.D., President

People in the News

New COA Officers/Board Members

Congratulations

President:
Robert O'Hollaren, M.D., Ventura
First Vice President:
William Brien, M.D., Los Angeles
Second Vice President:
Jan Henstorf, M.D., Fremont
Secretary-Treasurer
Basil Besh, M.D.

New /Re-Elected Board Members:
Los Angeles District
George Balfour, M.D., Van Nuys
Ronald Navarro, M.D., Harbor City

Orange District
Francois LaLonde, M.D., Orange

Northern California District
Ronald Wyatt, M.D., Walnut Creek

Sacramento Valley
Elspeth Kinnucan, M.D., Fair Oaks
Stephen Weber, M.D., Sacramento

Young Orthopaedists
Raymond Raven, M.D., Burbank
Alexandra Schwartz, M.D., San Diego

New HHS Secretary
Senate confirmed Sylvia Mathews Burwell as the new U.S. Department of Health and Human Services Secretary. There was bipartisan show of support for her appointment.

Montri Wongworawat, M.D. has been elected President of the San Bernardino County Medical Society.

Jay Lieberman, M.D., has been elected First Vice President of the American Association of Hip and Knee Surgeons (AAHKS).

Robert C. Sullivan, M.D. passed away on February 19, 2014. Dr. Sullivan practiced in Indian Wells and was active with the Shriner's Hospital for Crippled Children.

COA Member Benefits That you May Have Missed If you Did Not Attend COA's 2014 Annual Meeting

"Top Orthopedic ICD-10 Reference Cards"

Ten reference cards that cover nearly 500 of the most common orthopaedic conditions in the following areas: Shoulder and Elbow, Hip and Knee, Wrist and Hand, Foot and Ankle, and Spine. These laminated cards, developed by Newport Medical Solutions, Orange, CA, are a quick at a glance reference for orthopaedic practices as they prepare to transition to ICD-10. Available only from COA's website: www.coa.org 30% discount for COA Members.

ODG/ACOEM Treatment/Disability Guidelines

ODG and ACOEM Treatment/Disability Guidelines are routinely cited by payors, particularly Workers' Compensation payors, in their Utilization Review process. COA has established a reduced rate for COA members to be able to access these treatment/disability guidelines online**. Each company has discounted their annual rates for COA members from several hundred dollars each year to just $50 for each guideline.** Take advantage of this offer by contacting the company (Work Loss Data Institute - ODG Treatment Guidelines and/or the Reed Group for the ACOEM Treatment Guidelines - mention that you are a COA member to receive the discount.) For more information:

Work Loss Data Institute—ODG Treatment Guidelines
Reed Group—ACOEM Treatment Guidelines

OKU-10 Flashcards

An effective study tool for orthopaedic surgeons involved in the ABOS MOC process. Over 2,000 flashcards help orthopaedic surgeons nationwide prepare for their MOC. The flashcards can be accessed on-line or downloaded to a smart device. They can only be ordered through COA - www.coa.org. 38% discount for COA members.

Best "Apps" for Orthopaedic Surgeons

Orrin Franko, M.D., founder of www.TopOrthoApps.com, developed a list of the best apps for orthopaedic surgeons - practical apps for improving practice efficiencies and helping to improve patient care. Orthopaedic Apps.

Take advantage of these discounts to save money and improve practice efficiencies.
If you are not a current COA member, you can renew your membership
www.coa.org - click on "Membership."

Winners

COA's 2014 Annual Meeting/QME Course

Resident Award Winners

Lloyd W. Taylor Resident Award

Kent Sheridan, M.D., UC Davis

Orthopaedic Institute for Children Resident Award

Trevor Scott, M.D., UCLA

J. Harold LaBriola, M.D. Resident Award

Alexandra Stavrakis, M.D.
UC San Francisco

OREF Resident Award

Orrin Franko, M.D., UC San Diego

Leslie Kim passing the gavel to Bob O'Hollaren—COA's new President

Office Space Available for sublease/part-time/full-time

- State-of-the-art digital imaging technology, including X-ray and ultrasound
- Fully digitalized office
- Perfect for Orthopedics, Spine PM & R, Pain Management
- A family-like office atmosphere and extremely experienced, multilingual staff, able to speak/translate languages including Spanish and Farsi
- High end office with high-quality furnishings
- Practice located in a Class A building, in a very convenient and accessible location, close to surgery centers, Olympia, and Cedars Hospitals

Contact: Office Manager Nikki 310-855-0751

2014 Exhibit Hall Prizes

NewportMed—iPad	David Graubard, M.D.
Kessenick/Gamma—$100 Gift Card	Alan Kawaguchi, M.D.
Medical Coding- $600 Amazon Gift Card	Peter Salamon, M.D.
Proclaim—$600 Best Buy Card	Raymond Zarins, M.D.
Pharma Pac—iPad 32gb	Daniel Oakes, M.D.
Liberty Mutual—Silver Oak Wine	Jan Henstorf, M.D.
Continuity Care—$100 Gift Catalog	Jack Nichols, M.D.
CAP-MPT—Coffee Maker	Derek Chase, M.D.
Hub International– Surface Computer	Brian Brenner, M.D.
The Doctor's Company-$100 Gift Card	Ernest Miller, M.D.
Honor System—$100 Gift Card	David Wren, M.D.
LWW—$300 Book Certificate	Don Williams, M.D.
	Hugh Bogumill, M.D.
	Ken Ishizue, M.D.
	Jeffrey Smith, M.D.
	Leisure Yu, M.D.
Bactes—$1,000 Gift Card	Lynne Tromble

Grand Prize

Comp Registration
Annual Meeting/QME Course — John Minor, M.D.
Upgrade to a Suite

Stagecoach Festival –2 tickets/transport	Gary Watson, M.D.
2 tickets/transport	John Gainor, M.D.
60 minute Spa Treatment – Esmeralda	Lis Stark, M.D.
2 complimentary nights – Esmeralda	Emmett Cox, M.D.

Poppy Hills Golf Tournament

Closest to the pin	2nd hole—Mark Schrumph—8"
	6th hole—Betsey Tapper—10' 1"
Longest Put	10th hole—Tom Hugack—17'1"
	17th hole—Edward Tapper—16" 2"
	18th hole—Stewart Shanfield—26' - birdie
Longest Drive	13th hole—Michael Klassen
Straightest Drive	12th hole—Basil Besh

Lowest Scramble Team Score—64
Michael Klassen
Basil Besh
Ramon Jimenez
Hansi Hell

5K/Walk

Korina Winter	time 25:40 minutes
Patrick Guerrero	time 22:31 minutes

News of Interest

UnitedHealthcare—Rolling out Premium Designation Program in CA

United Healthcare recently met with COA representatives to announce it will begin implementation of its Premium Designation program in California. This program is expected to be rolled out in August of 2014.

Under the Premium program, physicians will be ranked on both national and specialty-specific measures for quality and various cost-efficiency benchmarks. The program uses clinical information from health care claims and other sources and medical society and national industry standards to evaluate physicians across 25 specialties. Physicians achieving United's criteria for quality and cost thresholds will receive a Premium Designation on their physician profile, marketed to United members through the United online physician directory. UnitedHealthcare's Premium Designation program has been implemented in 41 states.

UnitedHealthcare indicated in our meeting that their goal is to make the administration of this program as easy and efficient as possible for physician offices. UnitedHealthcare's physician and practice administrator website at UnitedHealthcareOnline.com has specific and detailed information about the Premium program.

What you need to know now

Each year, all eligible network physicians in specialties covered by the program are evaluated to determine if they meet the UnitedHealth Premium quality and/or cost efficiency criteria. The assessment summary results will be mailed to you in early June 2014. After you receive the letter, you will have several weeks to review your result and your individual suite of quality and cost efficiency assessment reports. If applicable, you may submit a request for reconsideration of your results. The results will be displayed publicly in UnitedHealthcare's provider directories in August 2014. Refer to the flier called Introducing the UnitedHealth Premium® Designation Program. Go to **UnitedHealthcareOnline.com** to review other important resources for the program (FAQ, methodology, etc.).

Launched in 2005, UnitedHealth Premium Designation is the longest running physician quality and cost efficiency designation program in the industry. It received the National Committee for Quality Assurance (NCQA) Physician Quality (PQ) certification and meets the Consumer Purchaser Disclosure Project's Patient Charter standards. The program consists of both quality and cost efficiency evaluations with quality serving as the primary measurement. This emphasis on quality demonstrates their commitment to evidence-based practice as only those physicians who meet quality standards are evaluated for cost efficiency. The results of these quality and efficiency evaluations are used together to determine a designation result that we display on UnitedHealthcare's public websites. Quality and cost efficiency evaluations each incorporate adjustments for the case mix of the physician and the level of the patient's severity of illness where appropriate.

Quality evaluations compare each physician's observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. The quality standards are based on evidence-based medicine and national industry guidelines. Cost efficiency evaluations compare each physician's health care costs to the risk-adjusted costs of peers in the same specialty and market. The cost efficiency standards are based on local market benchmarks for the efficient use of resources in providing care.

UnitedHealthcare is committed to continually enhancing the UnitedHealth Premium® physician designation program to promote access to quality and affordable health care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality, and with cost efficiency peer groups in the same geographic area. ◆

Physician Recertification Program Focuses on Quality Improvement

Modern Healthcare—June 5, 2014 By: Andis Robeznieks

The American Board of Medical Specialties' Maintenance of Certification program has come under fire from physicians who consider it onerous, irrelevant and expensive. But an ABMS initiative, called the Portfolio Program, aims to answer such criticisms with a streamlined process that allows physicians to use quality-improvement projects conducted within their organizations to satisfy individual MOC requirements.

The Portfolio Program, which began in 2010 as a project between the family medicine, internal medicine and pediatrics boards and the Mayo Clinic, is now active at 18 of the ABMS' 24 specialty boards. Orthopedic surgeons launched their program in April.

Previously, physicians were able to earn certification or recertification by taking an exam every seven to 10 years. But, with MOC, the 24 ABMS specialty boards have turned the recertification process into a continuous professional development program requiring hands-on ongoing learning and assessment.

Not all doctors are pleased with the change from recertification every seven to 10 years. Some 16,000 internists have attached their names to an online petition calling on the American Board of Internal Medicine to replace their MOC program with a simplified process which doctors would have to complete every 10 years.

As of April 17, the ABMS reports that 3,250 physicians have satisfied some MOC requirements through the Portfolio Program and 529 quality-improvement projects have been completed. Eighteen of the 24 ABMS boards are working with 32 healthcare organizations that have gotten involved. This includes the University of Michigan Health System, based in Ann Arbor, whose projects have involved improving diabetic foot exam rates at University of Michigan family medicine clinics, improving its red blood cell transfusion process, and increasing documentation of obesity in patients seen at primary-care clinics.

The ABMS held a forum June 10-11 in the Chicago area. The forum will allow participating organization to share ideas and experiences. ABMS spokeswoman Karen Metropulos said the Mayo Clinic was the first organization to participate in the Portfolio Program, starting in 2010. They presented the results to other providers who then approached the ABMS about News Topics Research Opinion Blog Recognition Videos & Webinars Events Marketplace Jobs Doc recertification program focuses on quality improvement | Modern Healthcare http://www.modernhealthcare.com/article/20140605/NEWS/306059935/[6/19/2014 4:03:55 PM]

About the same time Portfolio Program participants will be sharing their success stories, doctors at the American Medical Association’s House of Delegates meeting in Chicago will be calling for reforms to the ABMS system. The AMA’s MOC debate began at last year’s House of Delegates meeting where the program was criticized for being too expensive, too time consuming and having little value. Metropulos said the ABMS maintains an “evidence library” on its website which shows that MOC and board certification have value.

ABMS spokesman Rich Waters said that, across its 24 member boards, MOC costs average $300 a year per physician and are comparable to what airline pilots, attorneys and other professionals must pay to maintain their credentialed standing. He added that MOC is also measurable and more directed than fulfilling general continuing medical education requirements. ◆

Coding and Billing Tips

ICD-9-CM and ICD-10-CM Comparison
AMA CPT Assistant, April, 2014

Most Common Orthopaedic Procedures
Laminated reference cards of nearly 500 of the most common orthopaedic conditions.
ICD-10-CM Reference Cards

Changes to the Musculoskeletal System Section for 2014—AMA CPT Assistant, March 2014

KarenZupko & Associates
Intraoperative Monitoring
Question: When performing spine surgery and a physician's assistant is assisting, can the PA bill for intraoperative monitoring?

Answer: No, neither the surgeon or an assistant surgeon or even a co-surgeon may bill for intraoperative monitoring.

Medicare News

Physicians Must Submit Hardship Exception Applications by July 1, 2014 to Avoid Meaningful Use Penalties in 2015

Are you a Medicare provider who was unable to successfully demonstrate Meaningful Use in 2013? CMS is accepting applications for a hardship exception to avoid the upcoming Medicare payment reductions for the 2015 reporting year. The adjustments will be implemented as of 1/1/15.

You can avoid the adjustment by completing a hardship exception application before July 1, 2014 and providing supporting documentation that shows that demonstrating meaningful use would be a significant hardship for you. CMS will review applications to determine whether or not you are granted a hardship exception.

The posted hardship exception application can be found on the CMS site: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException_EP_Application.pdf

Medicare News

June 1 is the first day to register at CMS "Sunshine Act" Portal

The "Sunshine Act" provisions of the Affordable Care Act requires that data on payments and gifts made to physicians and teaching hospitals, medical device and pharmaceutical companies be publicly available on a searchable federal database starting in September 2014. Before the data is publicly posted, physicians and representatives of teaching hospitals can review it and dispute any inaccurate or incomplete information– but only if they have registered to do so. On June 1, 2014, physicians and teaching hospital representatives will be able to register on the U.S. Centers for Medicare & Medicaid (CMS) Enterprise Portal for what CMS is calling the "Open Payments Program."

Registration is voluntary and will be conducted in two phases:

- Phase 1 (begins June 1) includes user registration in CMS' Enterprise Portal,
- Phase 2 (begins in July) includes physician and teaching hospital registration in the Open Payments system.

During a 45-day period, registered physicians and teaching representatives will be allowed to review and dispute data submitted by applicable manufacturers and applicable group purchasing organizations. If the dispute is resolved during that time, CMS will publish the corrected information; if resolution cannot be reached, the data will still be published but marked as disputed.

To access the CMS Enterprise Portal:
http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Physicians.html

Workers' Compensation News

DIR Reduces Fees for Independent Medical Review, Independent Bill Review by 25%

The Department of Industrial Relations (DIR) announced a reduction in Independent Medical Review (IMR) and Independent Bill Review (IBR) fees effective April 1, 2014. These new fees represent a 25% reduction. Parties who submitted an IMR or IBR on or after April 1, 2014 will receive a refund in the amount of the fees paid in excess of the new fee schedule.

IMR Fees
Standard IMRs Involving Non-Pharmacy Claims—
Previous Fee $560 per IMR; Fee Effective April 1, 2014—$420 per IMR
Expedited IMRs Involving Non-Pharmacy Claims—
Previous Fee $685 per IMR; Fee Effective April 1, 2014—$515 per IMR
Standard IMRs Involving Pharmacy Only Claims —
Previous Fee not applicable; Fee Effective April 1, 2014—$390 per IMR
IMRs Terminated or Dismissed Not Forwarded to a Medical Professional Reviewer —
Previous Fee $215 per IMR; Fee Effective April 1, 2014—$160 per IMR
IMRs Terminated or Dismissed After Case if Forwarded to a Medical Professional Reviewer:
Previous Fee $560 per IMR; Fee Effective April 1, 2014—$420 per IMR

IBR Fees Any IBR application submitted on or after April 1, 2014 will be subject to the following fee schedule:
Completed IBR—Previous Fee: $335 per IBR Fee effective April 1, 2014—$250 per IBR
Terminated IBR Not Sent to Review—Previous Fee: $65 per IBR Fee effective April 1, 2014 $50 per IBR

DWC IMR and IBR forms are available: http://www.dir.ca.gov/dwc/forms.html

Copy Service Fee Schedule Earns Mixed Reviews

The Division of Workers' Compensation is proposing a fee schedule for copy services. Copy services would be paid $180 for a set of records up to 500 pages long that is obtained from a single custodian of records. The fee would include costs for mileage, postage, pickup and delivery, page numbering, witness fees, check fees, fees for release of information services and subpoena preparation. For copies of more than 500 pages, the copy rate would be 10 cents per page. Reimbursement for additional sets of records in paper form would be $50 if ordered within 30 days from the day the copy service receives the documents.

DWC to Stick with Maximus for IMR and IBR– Decision is Protested

The California Department of Industrial Relations published a notice on May 28, 2014 of its intent to contract with Maximus Federal Services to provide IMR and IBR services for the next three to five years.

CID Management and Peer Review Solutions have protested the propriety of the bidding process. CID claims that DIR evaluators held a "preconceived determination" that it had a conflict of interest, preventing its submission from advancing to the cost-analysis phase. The company proposed the lowest fees for filers. Peer Review Solutions cited that the DIR did not provide any information regarding mandatory oral presentations which they claim significantly prejudiced them in the RFP process. The protests have not yet been resolved.

Genex is Sold to Apax; One Call Care Management continues to grow

With Apax announcing the acquisition of Genex, the pending Coventry transaction, and ongoing consolidation of the Pharmacy Benefit Management space, the Workers' Comp services industry will look much different at the end of 2014.

OneCall Care Management continues to grow in its portfolio (and among its sister companies):

- The largest (in terms of revenue) physical therapy network
- The largest DME/Home Health supplier (MSC)
- The largest imaging network (OCM)
- The largest case management firm (Genex)
- The largest DME/Home Health supplier (MSC)
- Transportation and translation (Stops)
- The dominant dental network (Express Dental)
- IME and peer review

HLB HEALTH LAW E-ALERT
JUNE 9, 2014

HHS Seeks Comments on Reference Pricing

Katrina A. Pagonis and Stephanie A. Gross[1]

In a recent answer to a frequently asked question (FAQ), the Departments of Labor, Treasury and Health & Human Services (the Departments) have temporarily indicated that large group health plans may be able to use reference-based pricing strategies without violating the Affordable Care Act (ACA).[2] Reference pricing is a relatively new benefit design approach to reducing plans' claim expenditures. Because reference-based pricing limits the plan exposure through price-based coverage limitations, this approach threatens to reduce provider reimbursement without the plan engaging in provider negotiations. It is thought by some that reference pricing might implicate the ACA's beneficiary protections, particularly the limit on out-of-pocket spending by beneficiaries. The FAQ, however, indicates that the Departments will not enforce the out-of-pocket limit requirements in a way that precludes health plans from using reference-based pricing for the time being. At the same time, the FAQ acknowledges that the practice may be harmful to patients and announces that the Departments may issue guidance on the issue in the future.[3] To that end, the Departments seek comment on the permissibility of the practice and potential standards that might apply to reference pricing strategies. ***Comments are due to E-OHPSCA-FAQ.ebsa@dol.gov by August 1, 2014.***

What is Reference Pricing?

A plan that uses reference pricing defines the maximum amount it will cover for a particular service (e.g., facility fees for hip replacement surgery or imaging), regardless of the allowed amount it may have negotiated with each provider. This is the "reference price" above which enrollees are responsible for any additional costs. If, for example, a plan imposes a 20 percent coinsurance obligation on enrollees and restricts coverage for hip surgery to a reference price of $30,000, an enrollee would be liable for his or her coinsurance obligation based on the reference price ($6,000), up to the plan's out-of-pocket maximum *in addition to* any amount between the reference price and the hospital's allowed amount. A hospital that has negotiated an allowed amount of $40,000 would thus only receive $24,000 from the plan, and the remaining $16,000 would be the enrollee's responsibility. The health plan's enrollees are thus encouraged to seek treatment from a provider who will accept the reference price, and the provider is in turn pressured to adopt the reference price as its allowed amount.

To date, reference pricing has been primarily explored by large, self-funded plans for drugs, imaging, and certain procedures (e.g., colonoscopies and hip and knee replacements). In 2011, the California Public Employees' Retirement System (CalPERS) adopted reference pricing for hip and knee procedures. CalPERS is the second-largest employer purchaser of health care after the federal government. Over two years, the program reportedly saved $5.5 million dollars, and 85 percent of the savings came from hospitals that cut their prices in order to remain competitive. Safeway Inc., a California-based supermarket chain, has used reference pricing for pharmaceuticals since 2008, and Kroger Co., the nation's largest grocery store chain, uses reference pricing for certain imaging scans. An estimated 12 percent of the nation's largest employers were using reference pricing in 2013. In some instances, plans have asserted that they have taken quality measures into account when developing reference-based pricing strategies. Other plans, however, may exclusively rely on cost data.

Reference Pricing under the Affordable Care Act

The ACA establishes a number of requirements intended to make health insurance affordable and limit patients' cost-sharing obligations. For example, the ACA bans lifetime and annual

(Continued on Page 11)

HLB—HHS Seeks Comments on Reference Pricing
(Continued from Page 10)

limits, imposes actuarial value requirements, and limits out-of pocket spending. Health plans' use of reference pricing may undermine these financial protections in general and raise particular concerns with regard to the ACA's out-of pocket limits. The ACA places dollar limits of $6,350 (individual) and $12,700 (family) on enrollees' out-of-pocket expenses, even for non-grandfathered, large group and self funded ERISA plans. Once an enrollee meets the out-of-pocket maximum, the enrollee receives any further covered services without any cost sharing. The Departments' regulations, however, permit health plans to exclude enrollee spending on out-of-network providers from those limits.

The Departments' recent FAQ acknowledges the practice of reference pricing and notes that the Departments intend to issue guidance on reference-based pricing strategies. In the interim, however, the FAQ states that the Departments will not at this time apply the ACA to broadly prohibit reference-based pricing strategies. For now, the FAQ says that plans can treat "providers that accept the reference price as the only in network providers, provided that the plan uses a reasonable method to ensure that it provides adequate access to quality providers." In other words, if enrollees are responsible for any provider charges above the reference price, those payments need not be counted toward the out-of-pocket limit. The Departments currently do not require that plans limit out-of-pocket spending for care provided by non-network providers. As a result, treating amounts in excess of the reference price as out-of-network costs exposes enrollees to potentially significant cost sharing. Likewise, contracted providers with allowed charges above a reference price face decreased utilization and reimbursement below negotiated amounts.

The FAQ's current approach only applies to large group and self-funded group plans. Non-grandfathered individual and small group health plans, including those offered on the new health insurance exchanges (also known as Marketplaces), are subject to a broader set of consumer financial protections in the ACA. In particular, these non-grandfathered individual and small group plans must cover essential health benefits and cannot impose additional limitations on coverage beyond those set forth in the benchmark plan. Though it appears that these restrictions would preclude the use of reference pricing by these plans, the Departments have not yet addressed this issue, except to note that these plans are subject to additional requirements.

The FAQ acknowledges that this payment strategy may shift significant costs to patients, undermining the law's broad goals of affordability and access and exposing providers to the risk of non-payment. These concerns are heightened if the health plans fails to ensure that an adequate number of high-quality providers will accept the reference price for a particular procedure. The FAQ currently requires a plan employing reference-based pricing strategies to use a "reasonable method to ensure that it provides adequate access to quality providers." But the FAQ does not explain how the Departments would enforce this broad standard. With these risks in mind, the Departments indicate that they will issue future guidance on the application of out-of pocket limits to reference pricing arrangements and seek comment on specific standards to protect patients in these circumstances.

At present, the FAQ provides minimal, interim, sub-regulatory guidance on reference-based pricing strategies. Thus, there is an opportunity for stakeholders, including health care providers, to offer comments reflecting the potential impact that reference-based strategies will have on providers and patients.

Even if the Departments' anticipated guidance ultimately attempts to limit the ACA's protections so as to broadly permit reference pricing, plans that employ such strategies may violate the terms of managed care agreements, depending on the contractual language. Furthermore, the Departments' non-enforcement of the out-of-pocket maximum requirements and any final guidance on this issue may itself be subject to judicial challenge.

We are available to provide advice and counsel concerning the impact of reference-based pricing strategies on clients' managed care relations and to assist clients in supplying comments in response to the FAQ by August 1, 2014. For additional information, please contact John Hellow or Glenn Solomon in Los Angeles at 310.55.8111; Katrina Pagonis or Felicia Sze in San Francisco at 415.875.8500; or Marty Corry or Keith Fontenot in Washington, D.C. at 202.580.7700.

1 Stephanie Gross is a current summer associate at Hooper, Lundy & Bookman and a law student at the University of California, Berkeley, School of Law (Boalt Hall) She is a former program analyst at CMS's Center for Consumer Information and Insurance Oversight (CCIIO). While at CCIIO, Ms. Gross worked on developing CMS's policy surrounding the implementation of the Affordable Care Act (ACA) and the establishment of Health Insurance Exchanges.

2 Center for Consumer Information & Insurance Oversight, Department of Health & Human Services, FAQs About Affordable Care Act Implementation—Part XIX, p.5 (May 2, 2014), at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

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