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THE UNIVERSITY HOSPITAL



Medicare Free Fridays: Insurance and how far are we getting pushed?

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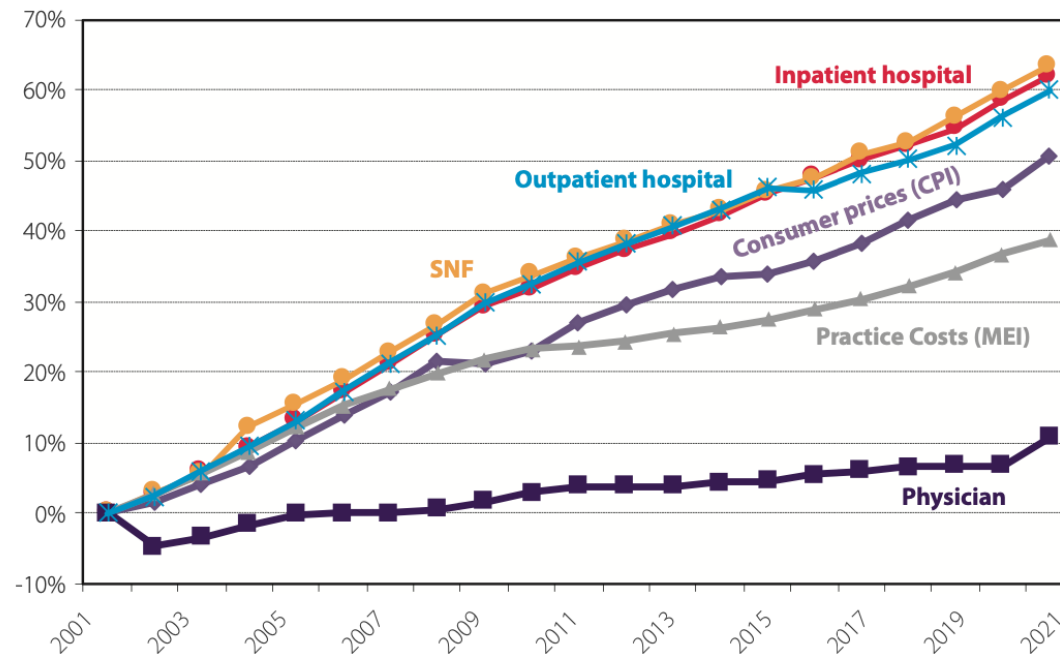
I have nothing to disclose.

Detailed disclosure information is available via:

AAOS Disclosure Program on the AAOS website at

Medicare physician payment is **not** keeping up with inflation. Why is treating patients taking a backseat?

Medicare pay updates compared to inflation (2001–2021)



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Reimbursement for Orthopaedic Surgeries in Commercial and Public Payors: A Race to the Bottom

Table 1. Decreasing Medicare and Commercial Surgeon Payments for TKA, THA, TSA, ACDF, and PLF

Year	TKA		THA	
	Medicare	Commercial	Medicare	Commercial
2010	\$1,704.04	\$2,634.66	\$1,593.47	\$2,508.32
2011	\$1,732.72	\$2,650.46	\$1,621.05	\$2,507.16
2012	\$1,688.82	\$2,580.39	\$1,580.87	\$2,461.69
2013	\$1,671.40	\$2,557.53	\$1,565.56	\$2,443.92
2014	\$1,477.37	\$2,453.15	\$1,478.14	\$2,383.38
2015	\$1,489.08	\$2,435.77	\$1,489.46	\$2,386.04
2016	\$1,465.04	\$2,390.03	\$1,465.40	\$2,364.45
2017	\$1,431.94	\$2,366.47	\$1,432.67	\$2,368.53
2018	\$1,408.30	\$2,405.20	\$1,409.74	\$2,399.91
Annual change	\$(45.25)	\$(39.86)	\$(26.78)	\$(19.35)
CAGR	-2.10%	-1.01%	-1.35%	-0.49%
Trend significance	<0.001	<0.001	<0.001	<0.001



Welcome to Medicare

Get Started with Medicare

CRS Medicare Primer
<https://sgp.fas.org/crs/misc/R40425.pdf>

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Medicare



- Provides insurance ages 65+
- Expanded to include permanently disabled
- Covers hospitalizations, physician services, prescriptions drugs, skilled nursing, home health visits, hospice care
- Administered by the Centers for Medicare and Medicaid (CMS) within the Department of Health and Human Services (HHS)
- 1965 law also established Medicaid, the federal/state health insurance program for the poor

Medicare



- Part A: Inpatient hospital services
 - Funded by payroll tax of 2.9% of earnings between employers and employees
 - Since 2013, additional 0.9% for workers with income greater than \$200,000
- Part B: Physician services
 - Beneficiary premiums (25%) government revenue (75%)
- Part C: Medicare Advantage
 - Private plan option covering Part A&B
- Part D: Prescription drugs
 - Beneficiary premiums and government revenue

In 2021, Medicare Spending Accounted for 10% of the Federal Budget

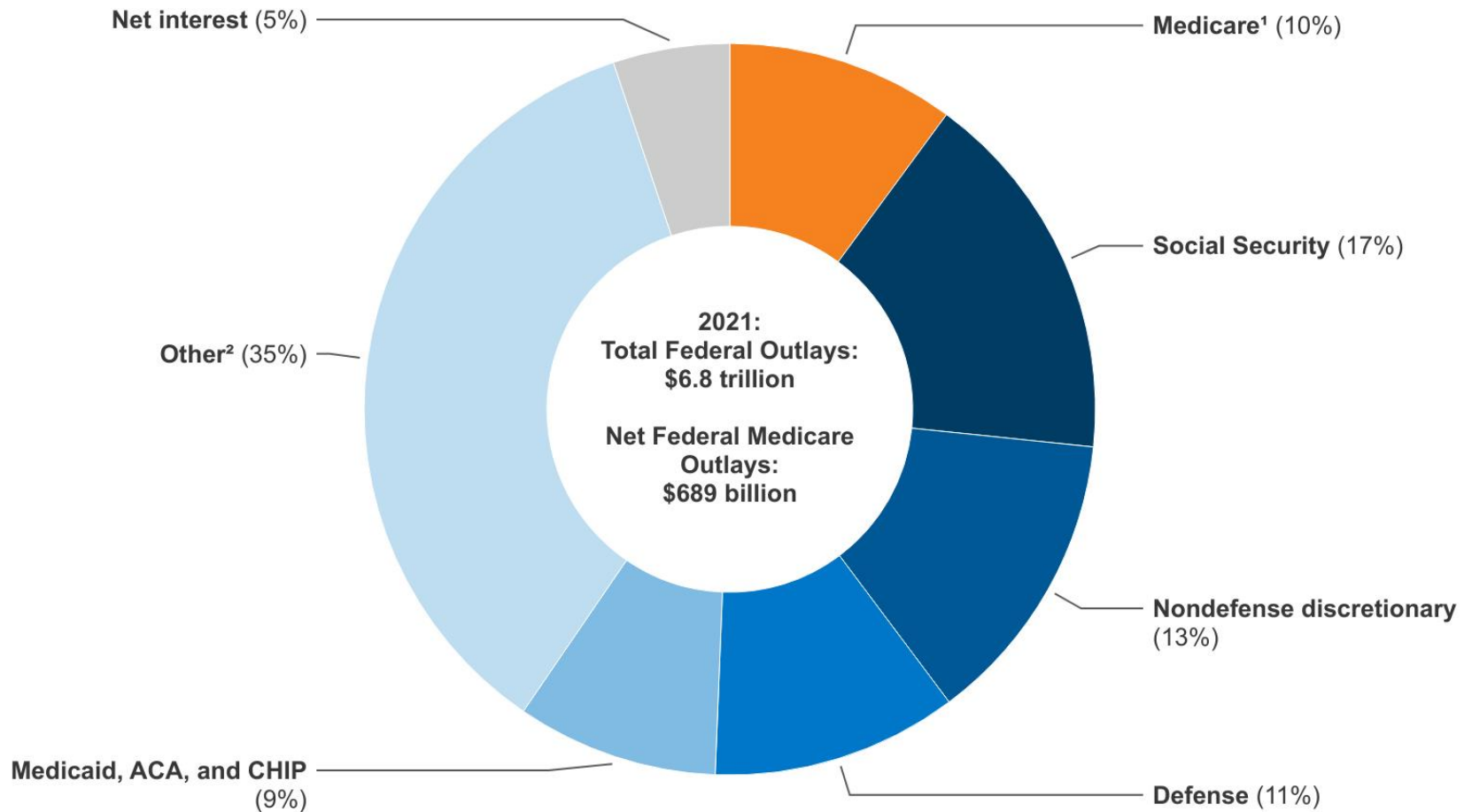


Figure 3

Medicare Benefits Spending Is Projected to Increase from \$829 Billion in 2021 to \$1.8 Trillion in 2031, Due to Growth in the Medicare Population and Increases in Health Care Costs

Actual Projected

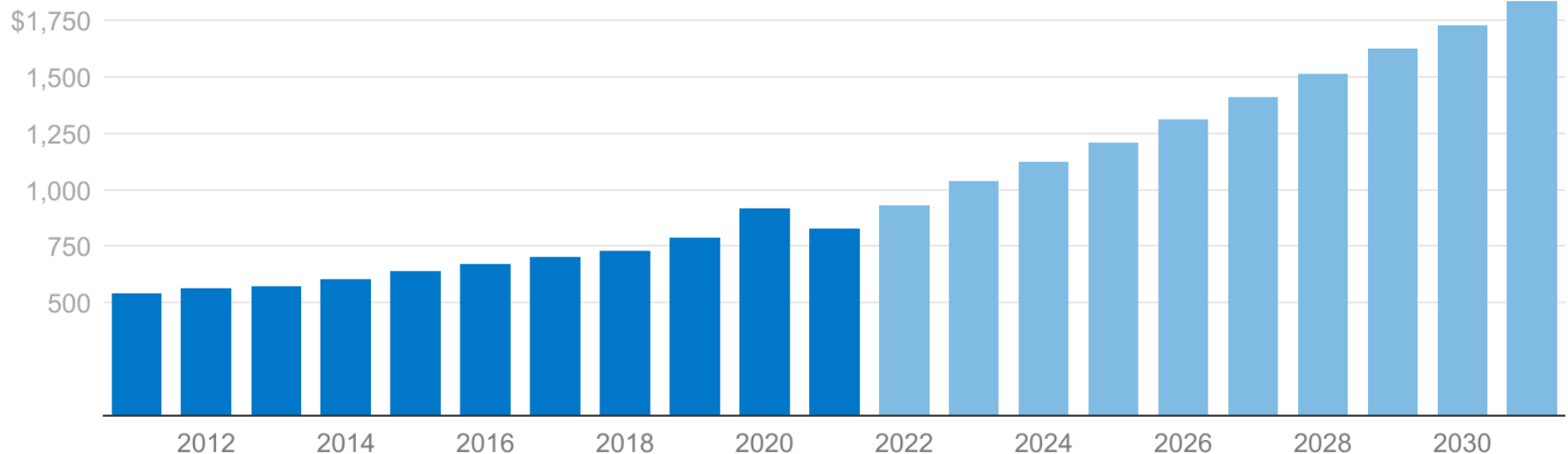
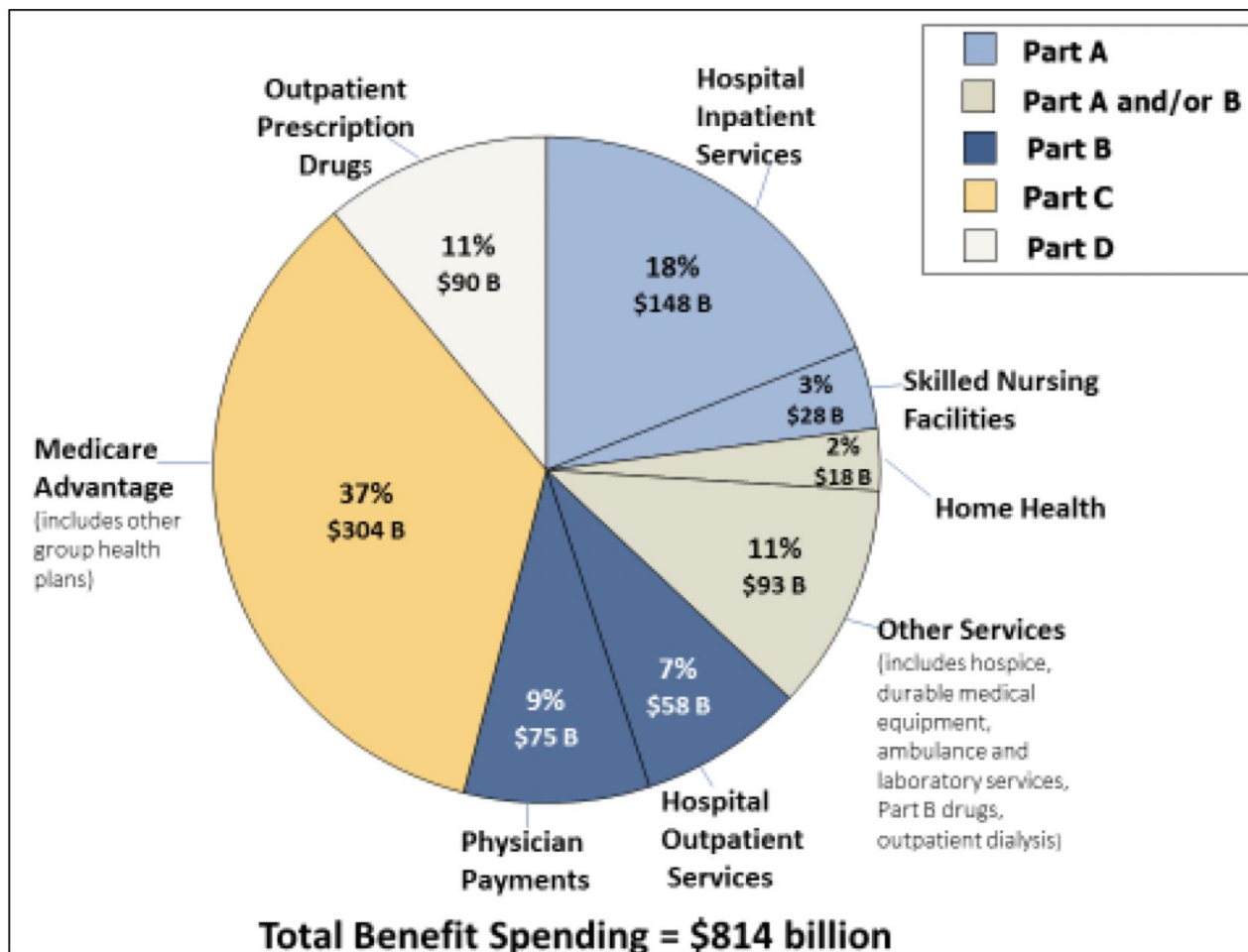


Figure I. Projected Medicare Benefit Spending by Category, FY2020



Sources: Figure by the Congressional Research Service (CRS) based on data from the Congressional Budget Office, "March 2020 Medicare Baseline," March 19, 2020.

Note: Dollar amounts in billions. Totals may not add up to 100% due to rounding.

Medicare Payment History



- Payments was originally based on:
 - “Reasonable costs” for hospital services
 - “usual, customary and reasonable charges for physician services”
- 1972 the program introduced managed care by allowing private insurance companies to provide benefits in exchange for a monthly capitated payment

Hospital Payments



- Formula for hospital reimbursement:
 - “cost + 2% basis”
- Between 1966 and 1976:
 - Consumer Price Index: 89%
 - Hospital costs: 345%

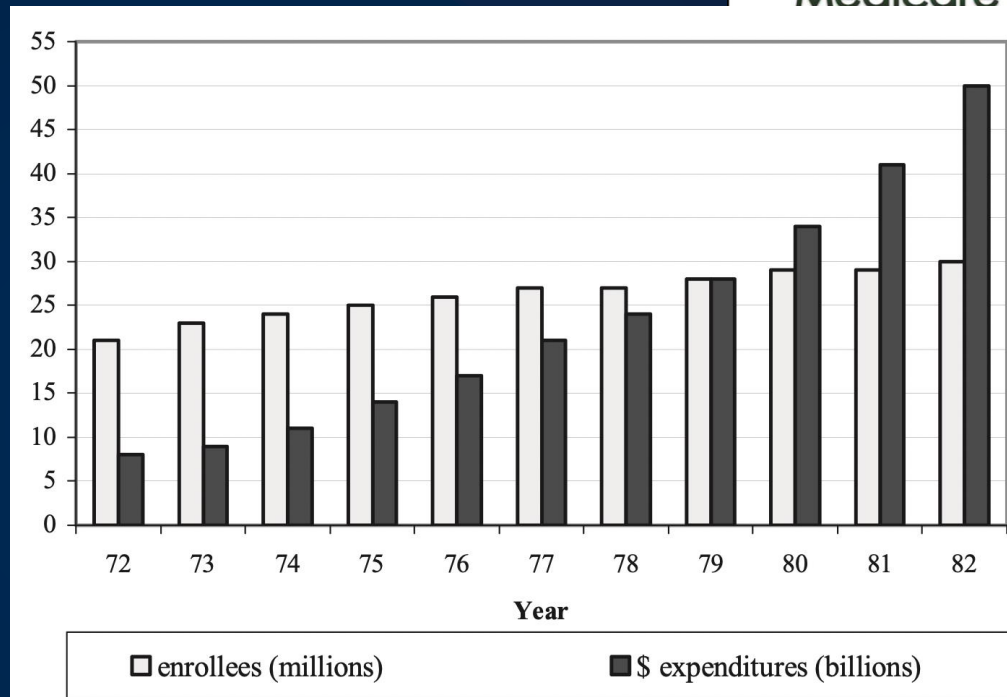


Fig. 1. Medicare Enrollees and Expenditures, 1972–1982.

Source: Data from Centers for Medicare & Medicaid Services, Tables 3.5 and 3.6; also found in Rick Mayes, *Universal Coverage* (Ann Arbor, Mich.: University of Michigan Press, 2005), 113.

Hospital Payments



- Tax Equity and Fiscal Responsibility Act of 1982 established a prospective payment system to slow the growth of expenditures
- Pay a single flat rate per type of discharge, as determined by the classification of each case into a diagnosis-related group (DRG)
- From 1980 to 1990, 20% savings from prior projections

Health Care Financ Rev. 1986 Spring; 7(3): 97–114.
N Engl J Med 1989; 320:439-444

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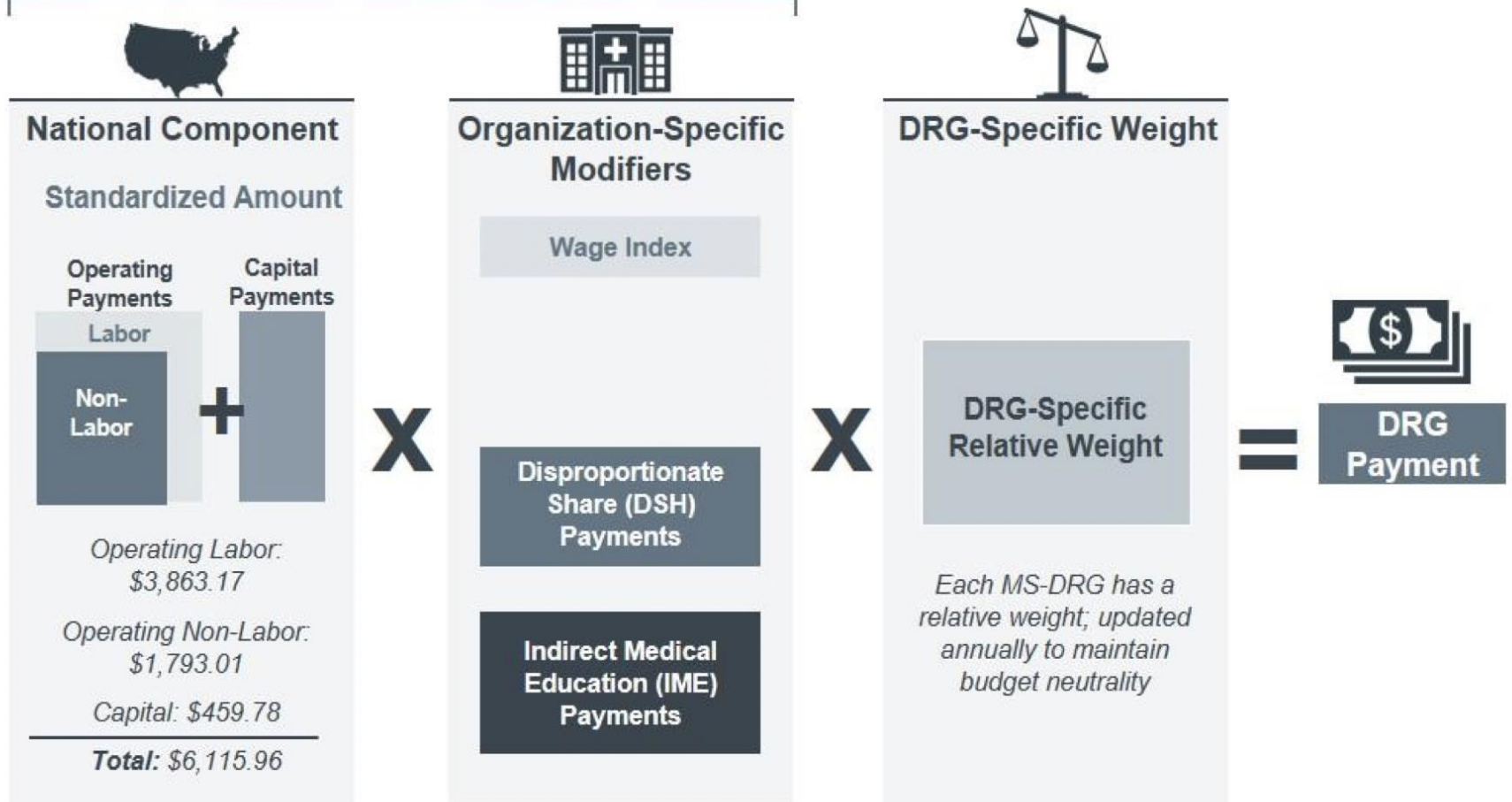
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DRG Payments

- DRGs “bundle” services (labor and non-labor resources) that are needed to treat a patient with a particular disease
- DRG payment rates cover most routine costs attributable to patient care
- Approximately 500 DRGs
- CMS assigns a unique weight to each DRG
- More costly conditions are assigned higher DRG weights.

Hospital Payments

Hospital Base Rate (uses sample historical standardized amount)



<https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>

<https://www.advisory.com/content/dam/advisory/en/public/Advisory/Topics/Medicare/Cheat-sheets/Medicare-payment-programs/D20/IPPS-Onepage.pdf>

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The Regulatory Formula Leads To Automatic Increases in Facility Fees

- 2024 OPPS rates:

CPT	2023	2024 (proposed)
27130 & 27447	\$13,048.08	\$13,269.40

- 2024 ASC rates:

CPT	2023	2024 (proposed)
27130	\$9,508.60	\$9,646.38
27447	\$9,322.62	\$9,436.56

Physician Payments

Resource-Based Relative Values

An Overview

William C. Hsiao, PhD; Peter Braun, MD; Daniel Dunn, PhD; Edmund R. Becker, PhD

- Estimated the relative amounts of “work” physicians contribute to the services they render
- The study was published in 1988, and was the basis for the Relative Value Unit (RVU) system
- 1989, The Omnibus Budget Reconciliation Act implemented the RVU fee schedule effective from January 1992 to help control Medicare part B costs

JAMA. 1988;260(16):2347-2353.

Curr Probl Diagn Radiol 2016 Mar-Apr;45(2):128-32.

RVU Components

Components of practice expense



Clinical staff

(nurse, X-ray technician, etc)



Medical supplies

(gloves, syringes, etc)

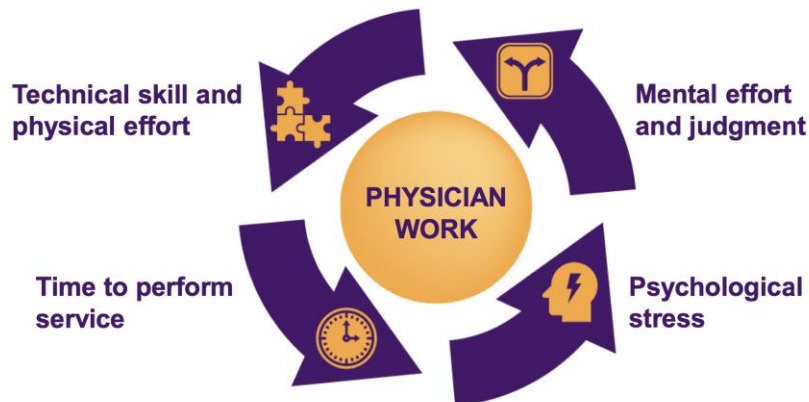


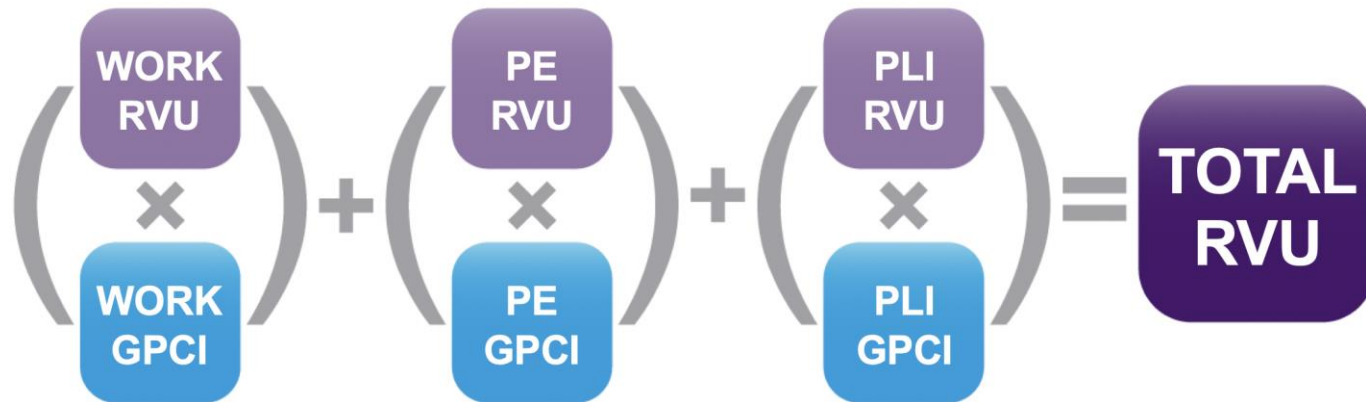
Medical equipment

(exam table, CT scanner, etc)

Professional liability

Components of physician work





Conversion factor (CF) is a monetary payment determined by Medicare each year.
The CF for 2023 = \$33.8872



The RVS Update Committee (RUC)

Composition of the AMA/Specialty Society RVS Update Committee

Chair

American Medical Association

CPT Editorial Panel

Health Care Professionals Advisory Committee

Practice Expense Subcommittee:

Anesthesiology

Cardiology

Cardiothoracic surgery

Dermatology

Emergency medicine

Family medicine

General surgery

Geriatric medicine

Internal medicine

Nephrology*

Neurology

Neurosurgery

Obstetrics/gynecology

Ophthalmology

Orthopaedic surgery

Osteopathic medicine

Otolaryngology

Pathology

Pediatrics

Physical medicine
and rehabilitation

Plastic surgery

Primary care*

Psychiatry

Pulmonary medicine*

Radiology

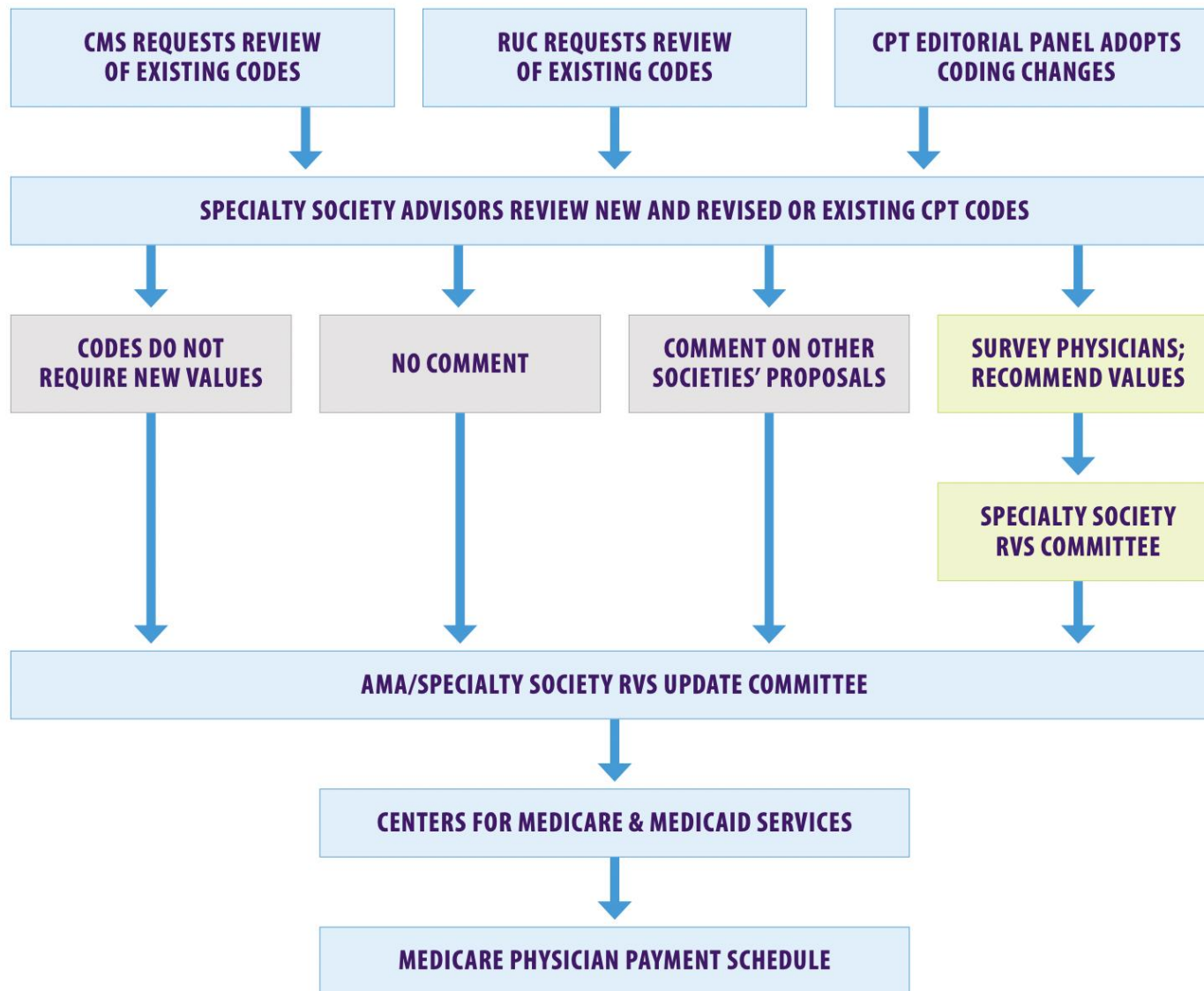
Urology

Vascular surgery*

** Indicates rotating seat*

<https://www.ama-assn.org/system/files/ruc-update-booklet.pdf>

THE RUC PROCESS



<https://www.ama-assn.org/system/files/ruc-update-booklet.pdf>

RUC Outcomes

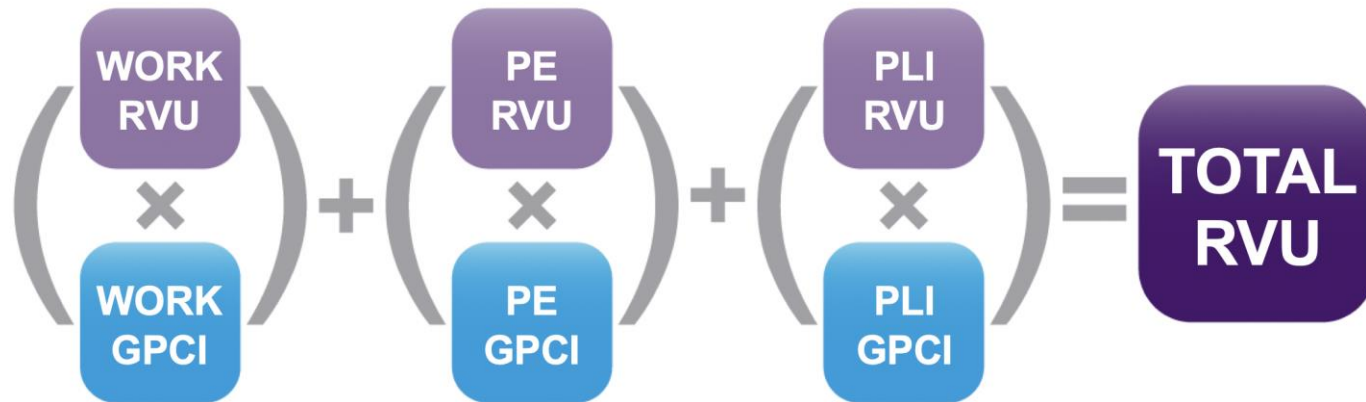
Year	TKA	THA
	wRVU	wRVU
2010	23.25	21.79
2011	23.25	21.79
2012	23.25	21.79
2013	23.25	21.79
2014	20.72	20.72
2015	20.72	20.72
2016	20.72	20.72
2017	20.72	20.72
2018	20.72	20.72

AAHKS Leadership Addressing Potentially Misvalued Codes

Dec 13, 2018 | CMS

"ANONYMOUS" TRIGGERS NEW BATTLE OVER PHYSICIAN PAY

WILLIAM DONOVAN • TUE, NOVEMBER 20TH, 2018

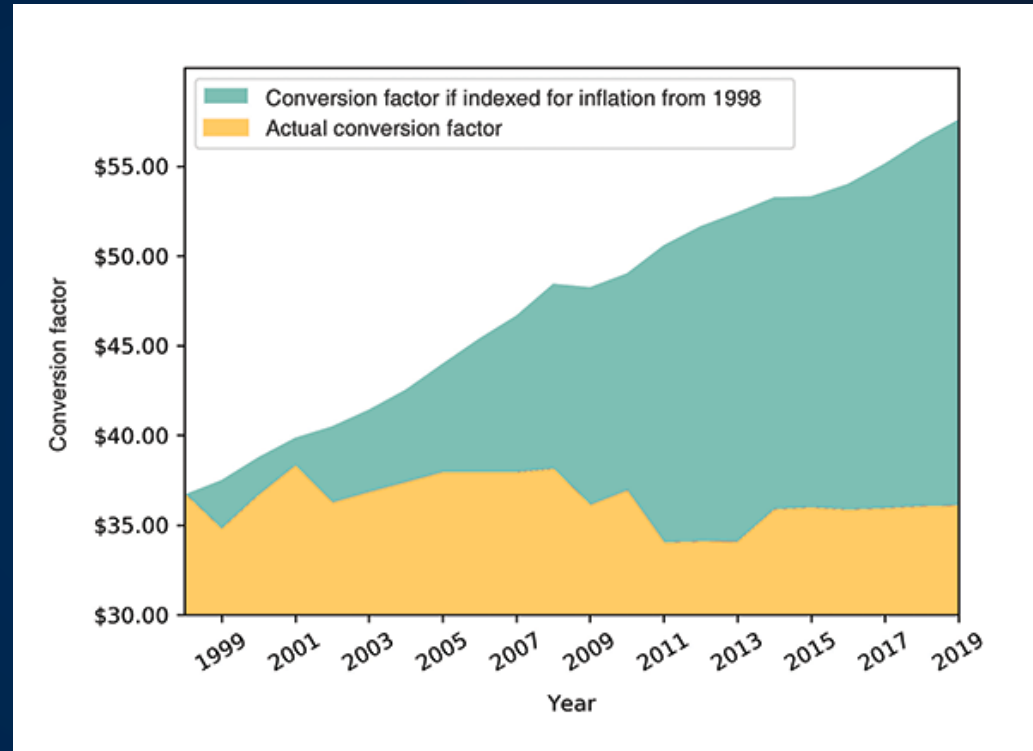


Conversion factor (CF) is a monetary payment determined by Medicare each year.
The CF for 2023 = \$33.8872



Conversion Factor

- Congress has authority to set CF since 1989
- Overall CF has not kept up with inflation
- The initial Medicare CF was set at \$31.001 in 1992
- 2023 CF is \$33.8872



<https://www.ama-assn.org/system/files/2021-01/cf-history.pdf>

<https://bulletin.facs.org/2019/09/medicare-physician-payment-on-the-decline-its-not-your-imagination/>

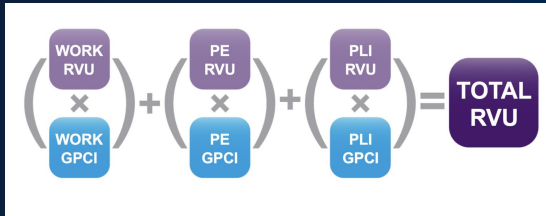
<https://www.ama-assn.org/system/files/history-of-medicare-conversion-factor-under-the-sgr.pdf>

2024 Updates

- CMS proposed a 2024 conversion factor of \$32.7426, representing a reduction of 3.3% from 2023 levels

CPT	2022	2023	2024 (proposed)
27130	\$1,277.40	\$1,300.92	\$1,264.71
27447	\$1,276.06	\$1,299.57	\$1,263.07

Legislative Vs Regulatory



Components of practice expense



Clinical staff

(nurse, X-ray technician, etc)



Medical supplies

(gloves, syringes, etc)



Medical equipment

(exam table, CT scanner, etc)

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Components of physician work

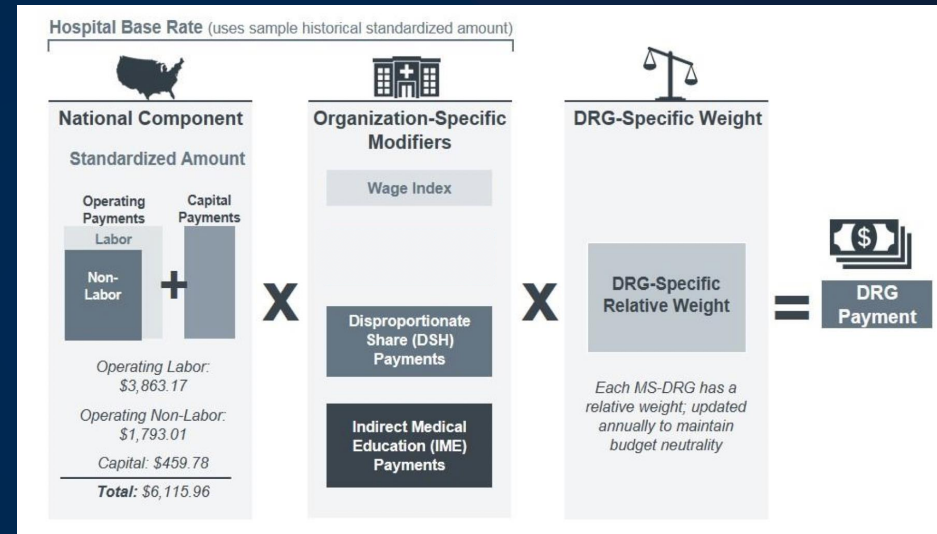
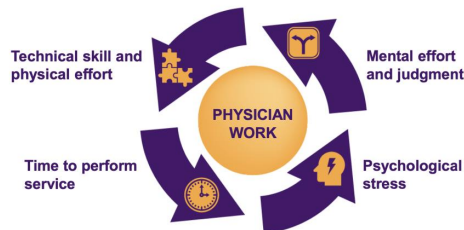
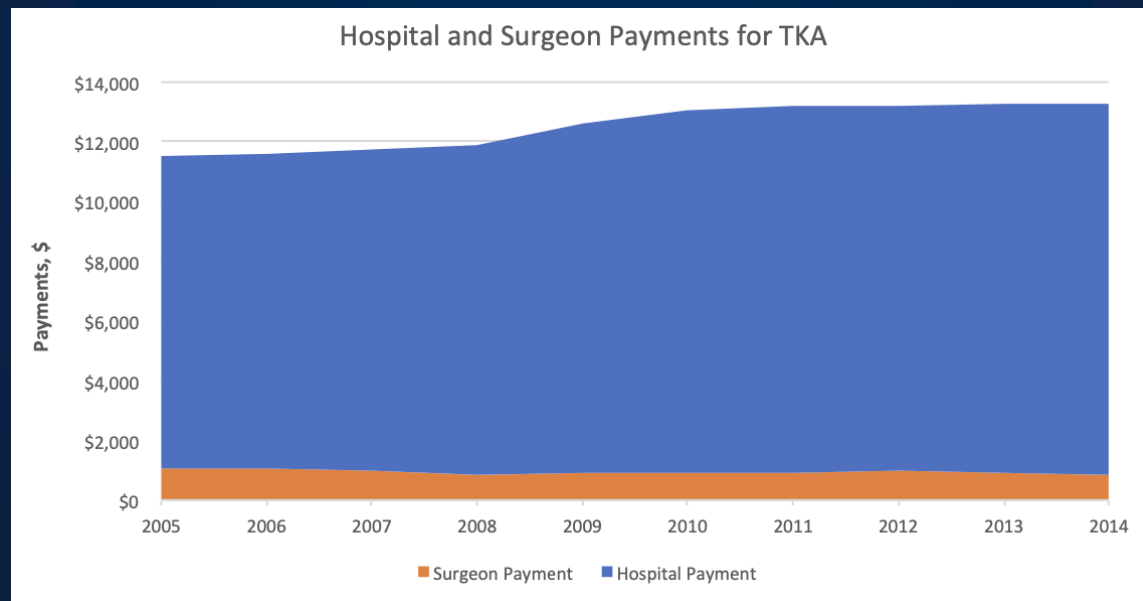
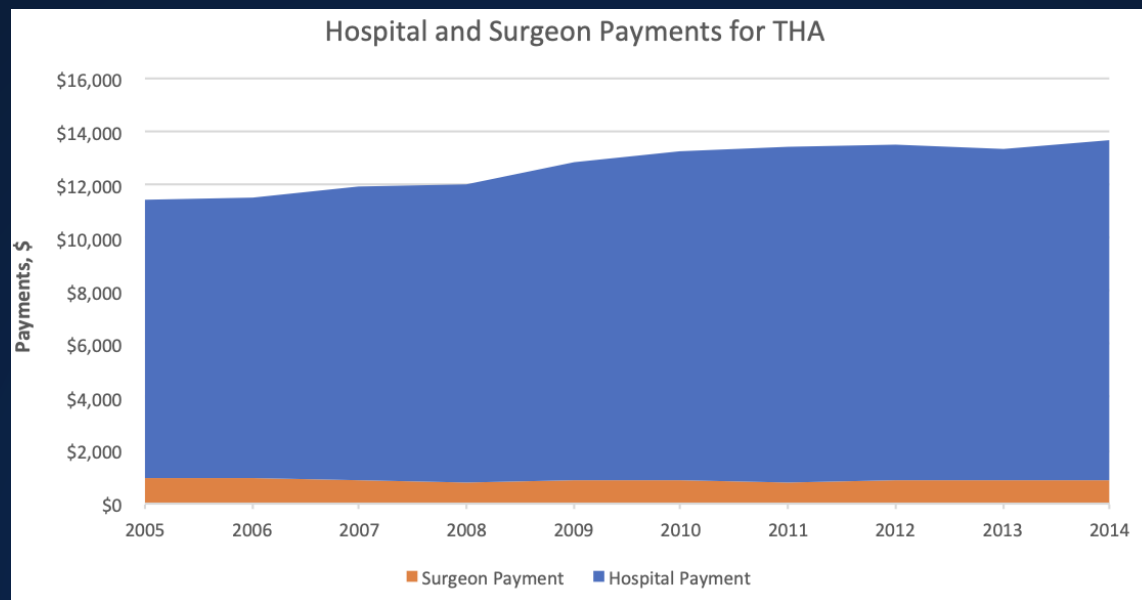


Table 1. Top 20 Reimbursed DRG Families in 2016^a

Rank	DRG Family	Type	NIS unweighted case volume	NIS weighted case volume	Estimated payment, billions USD (% of top 20 total)
1	870-872: Sepsis	M	323 165	1 615 824	15.59 (13.5)
2	469-470: LE joint replacement	P	246 924	1 234 621	14.34 (12.4)
3	774-775: Vaginal delivery	M	485 836	2 429 178	8.11 (7.0)
4	3-4: ECMO or tracheostomy	P	19 143	95 715	7.86 (6.8)
5	853-855: Infectious diseases	P	56 197	280 985	6.77 (5.9)
6	765-766: Cesarean delivery	P	244 010	1 220 049	6.21 (5.4)
7	291-293: Heart failure	M	183 894	919 470	6.02 (5.2)
8	329-331: Bowel procedure	P	71 120	355 600	5.64 (4.9)
9	459-460: Spinal fusion	P	46 876	234 380	5.29 (4.6)
10	246-247: PCI with DES	P	71 732	358 660	4.73 (4.1)
11	193-195: Pneumonia	M	147 953	739 764	4.38 (3.8)
12	682-684: Renal failure	M	120 706	603 530	3.73 (3.2)
13	791-792: Prematurity	M	50 589	252 945	3.67 (3.2)
14	981-983: Extensive OR procedure	P	34 869	174 345	3.58 (3.1)
15	64-66: ICH or stroke	M	104 550	522 750	3.45 (3.0)
16	190-192: COPD	M	123 294	616 470	3.38 (2.9)
17	219-221: Valve surgery without cardiac catheterization	P	20 152	100 760	3.35 (2.9)
18	207-208: Respiratory disease	M	38 583	192 915	3.33 (2.9)
19	391-392: Esophageal and GI disorders	M	140 033	700 164	3.07 (2.7)
20	480-482: Hip and femur procedure except major joints	P	51 267	256 335	2.92 (2.5)
Total	NA	NA	2 580 893	12 904 460	115.39

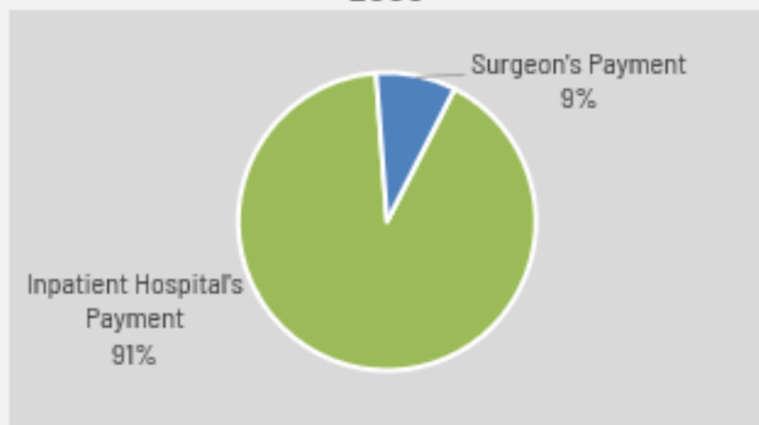
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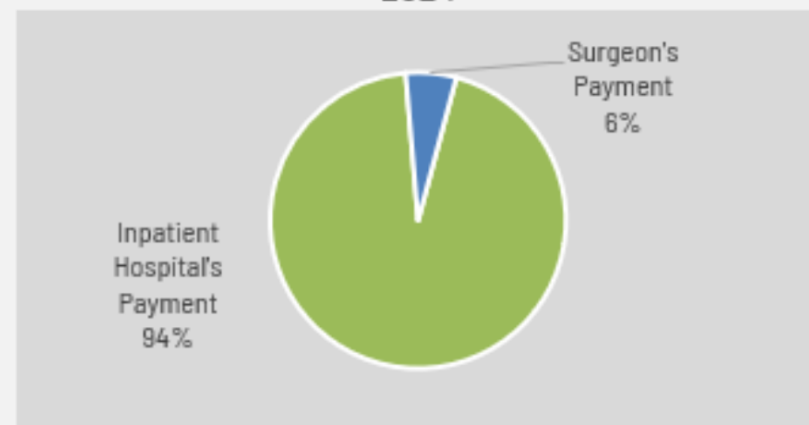
	2008	2024
Surgeon's Payment	8.68 %	5.80 %
Inpatient Hospital's Payment	91.32 %	94.2 %

2008



Surgeon's Payment

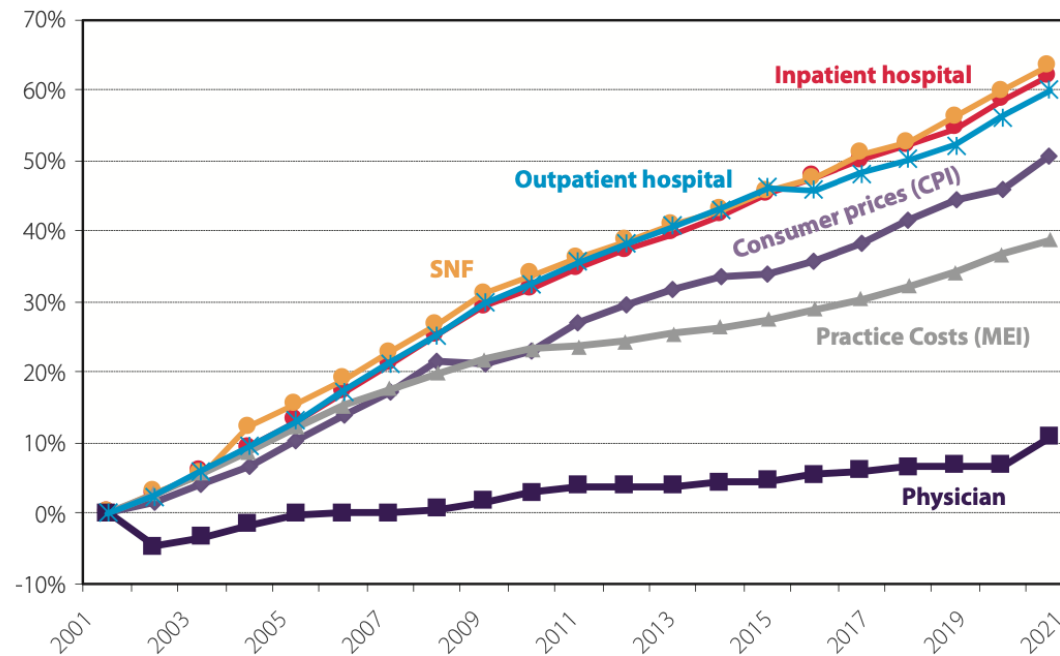
2024



Inpatient Hospital's Payment

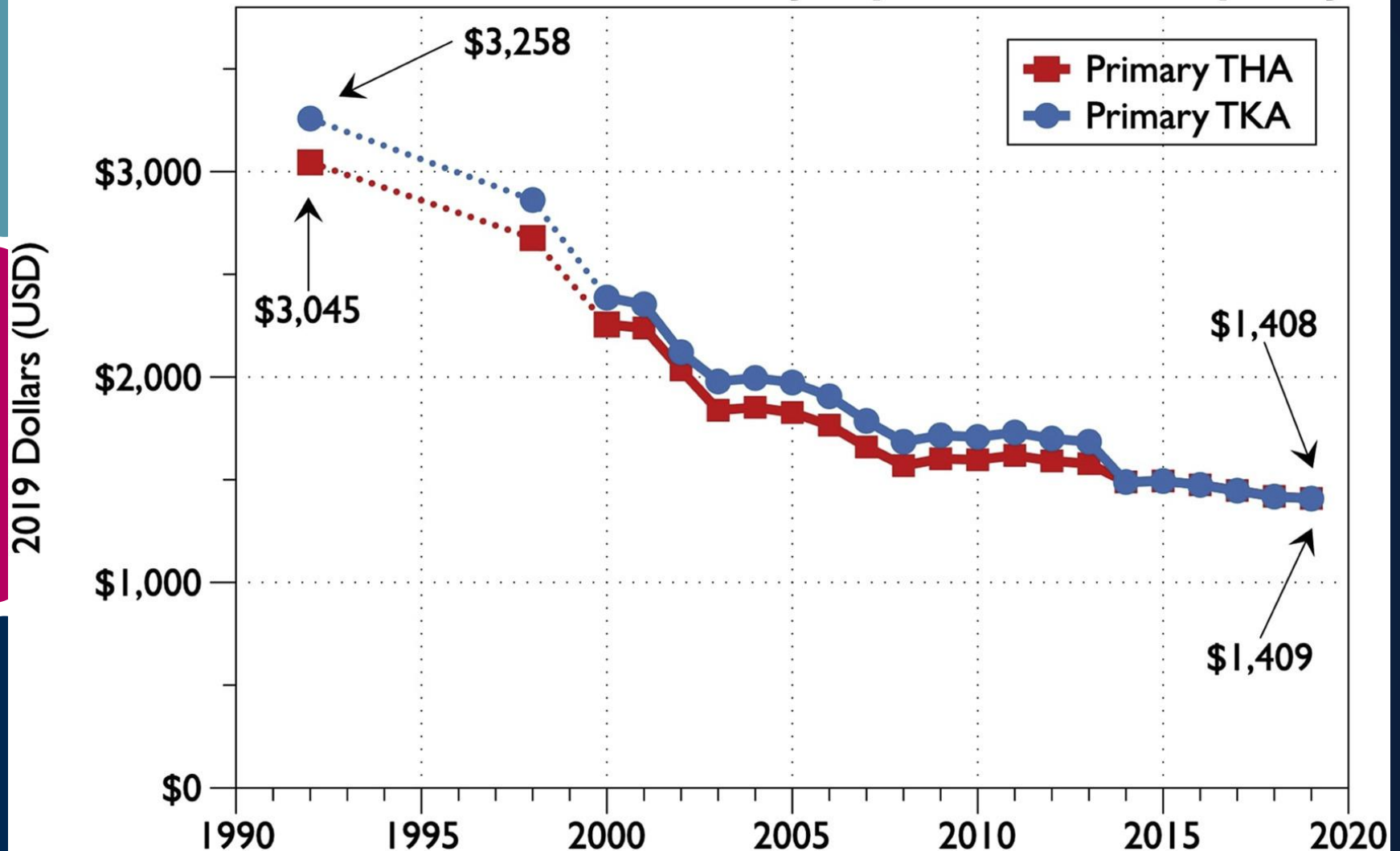
Medicare physician payment is **not** keeping up with inflation. Why is treating patients taking a backseat?

Medicare pay updates compared to inflation (2001–2021)



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Medicare Fee Schedule for Primary Hip & Knee Arthroplasty



J Arthroplasty 2020 May;35(5):1174-1178.

Can a Hip and Knee Adult Reconstruction Orthopaedic Surgeon Sustain a Practice Comprised Entirely of Medicare Patients?

Joseph D. Zuckerman, MD , Emmanuel N. Koli, MD, Ifeoma Inneh, MPH, Richard Iorio, MD

Department of Orthopaedic Surgery, Division of Adult Reconstructive Surgery, NYU Langone Medical Center, Hospital for Joint Diseases, New York, NY

Table 3

Physician Salary Calculations for an AROS in a Medicare-Only Collections Model Utilizing Different Practice Expense Models.

Expense model	United States
Model I	\$287,453
Model II	\$72,502
MGMA survey	\$863,104

Salary is compared with the mean MGMA salary for a Hip and Knee AROS (excludes fringe benefit).

Model I: assumes 50% overhead.

Model II: utilizes MGMA practice expense data for an AROS.

Medicare Enrollment for May 2023

MA: 32.0M
(49% of
total)

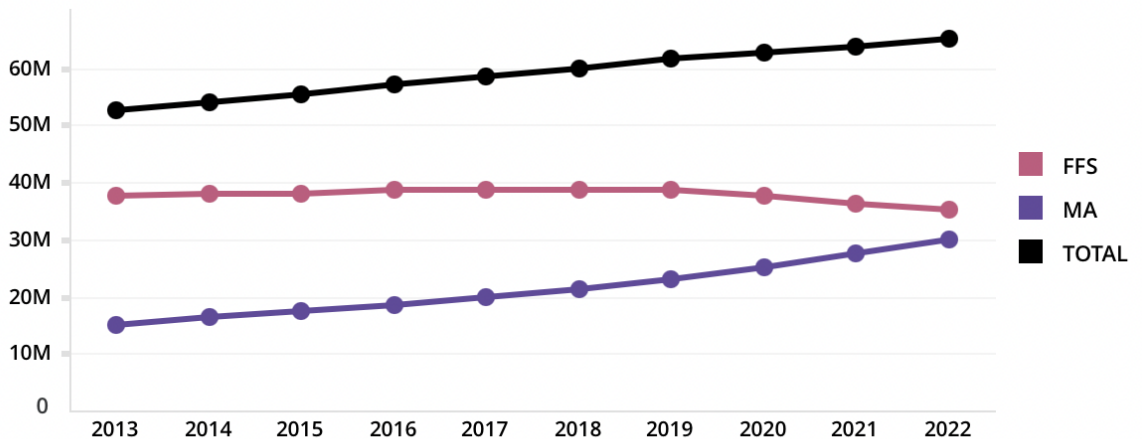


FFS: 33.9M
(51% of
total)

Yearly Trend

12-Month Trend

Enrollment Count Yearly Trend: All Areas



Payment Reform

- U.S. Representatives Raul Ruiz, M.D. (D-CA-25), Larry Bucshon, M.D. (R-IN-08), Ami Bera, M.D. (D-CA-06), and Mariannette Miller-Meeke, M.D. (R-IA-01), introduced H.R. 2474, the **“Strengthening Medicare for Patients and Providers Act”**
- The bipartisan legislation would change the physician payment rate above the current law by providing an **annual Medicare physician payment update tied to inflation**, as measured by the Medicare Economic Index (MEI).

January 23, 2023

Dear Senator/Representative,

On behalf of the undersigned physician and non-physician organizations, representing more than one million clinicians and the patients they serve, welcome to the 118th Congress. Our combined memberships represent a *significant* portion of the clinicians in this nation, and we remain committed to ensuring America’s seniors have access to high-quality care. Reforming the Medicare payment system is a crucial step in maintaining the clinician workforce that is necessary to serve America’s seniors. We urge this Congress to hold Congressional hearings and work with all stakeholders to explore long-term payment solutions.

Unfortunately, we face an increasingly challenging environment providing Medicare beneficiaries with access to timely and quality care, which is particularly important for underserved and rural areas. The medical community continues to contend with the residual impacts of the COVID-19 pandemic, a new triple-demic in many regions of the country, reduced levels of burnout, workforce shortages, and ongoing reductions to Medicare Part B payments for private payer reimbursements.

- Association of Diabetes Care & Education Specialists
- Association of Freestanding Radiation Oncology Centers
- CardioVascular Coalition
- Clinical Social Work Association
- Coalition of State Rheumatology Organizations
- College of American Pathologists
- Congress of Neurological Surgeons
- Dialysis Vascular Access Coalition
- Digestive Health Physicians Association
- Emergency Department Practice Management Association
- Heart Failure Society of America
- Heart Rhythm Society
- Infectious Diseases Society of America
- Infusion Providers Alliance

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- Heart Rhythm Society
- Infectious Diseases Society of America
- Infusion Providers Alliance



Medicare Payment
Advisory Commission

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

RECOMMENDATION 4-1

For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

Future Challenges

- Transition from fee for service to value based models

How to get involved?

- Email campaigns
- Society memberships
- Political Action Committee
- Member of Congress
- Society committees

AAHKS Action Alert - Write Congress Regarding Scope of Practice

Green category X

i Retention: MMC2YR (2 years) Expires: Thu 6/6/2024 6:01 PM

A AAHKS
To: Eli Kamara



links may compromise our secure environment. Do not open suspicious emails. Please click on the "Phish Alert" button on the Outlook dashboard to report any suspicious emails.

American Association of Hip and Knee Surgeons | Click [here](#) if you are having trouble with this message.



AAHKS
AMERICAN ASSOCIATION
HIP AND KNEE SURGEONS

Dear AAHKS Members,

You may have already received an AAOS Action Alert, requesting writing Congress to strongly oppose H.R. 6087, a bill that would recklessly expand scope of practice at the federal level.

It is imperative that Members of Congress hear directly from

AAHKS Action Alert - Write Congress Regarding Scope of Practice

Green category X

i Retention: MMC2YR (2 years) Expires: Thu 6/6/2024 6:01 PM

A AAHKS
To: Eli Kamara



Tue 6/7/2022 6:01 PM

from physicians, who have the proper education, training, and expertise to make these evaluations, is unacceptable and a threat to the practice of medicine.

- Threaten patients' health and safety. Its dangerous approach has also been shown to lead to increased health care costs while doing little to expand access, particularly in rural and underserved areas.

Use the button below to send an urgent message to your legislators before it's too late: **VOTE NO on H.R. 6087**. It is critical that physicians stand together in sending a powerful message to Congress: don't support legislation that prevents physicians from being at the center of critical health care decisions.

Take Action Now



AAOS Office of Government Relations

To: Eli Kamara



Sun 9/11/2022 4:01 PM

CAUTION: This email comes from an external source; the attachments and/or links may compromise our secure environment. Do not open or click on suspicious emails. Please click on the "Phish Alert" button on the top right of the Outlook dashboard to report any suspicious emails.

To view this email as a web page, [click here](#)

AAOS AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

Action Alert

Remove barriers to
timely access to care



TAKE ACTION NOW

Urge Congress to Vote YES on Prior

This Wednesday, Sept. 14, the U.S. House of Representatives will vote on the AAOS-endorsed Improving Seniors' Time



AAOS Office of Government Relations

To: Eli Kamara

The bill would...

- Establish an electronic prior authorization process.
- Require the Department of Health and Human Services to establish a process for real-time decision making for items and services that are routinely approved.
- Require MA plans to report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals or denials.
- Encourage plans to adopt prior authorization programs that adhere to evidence-based medical guidelines in consultation with physicians.

Please urge your congressional representatives to vote YES by taking a few minutes and sending them a pre-written letter via the AAOS Advocacy Center!

TAKE ACTION NOW



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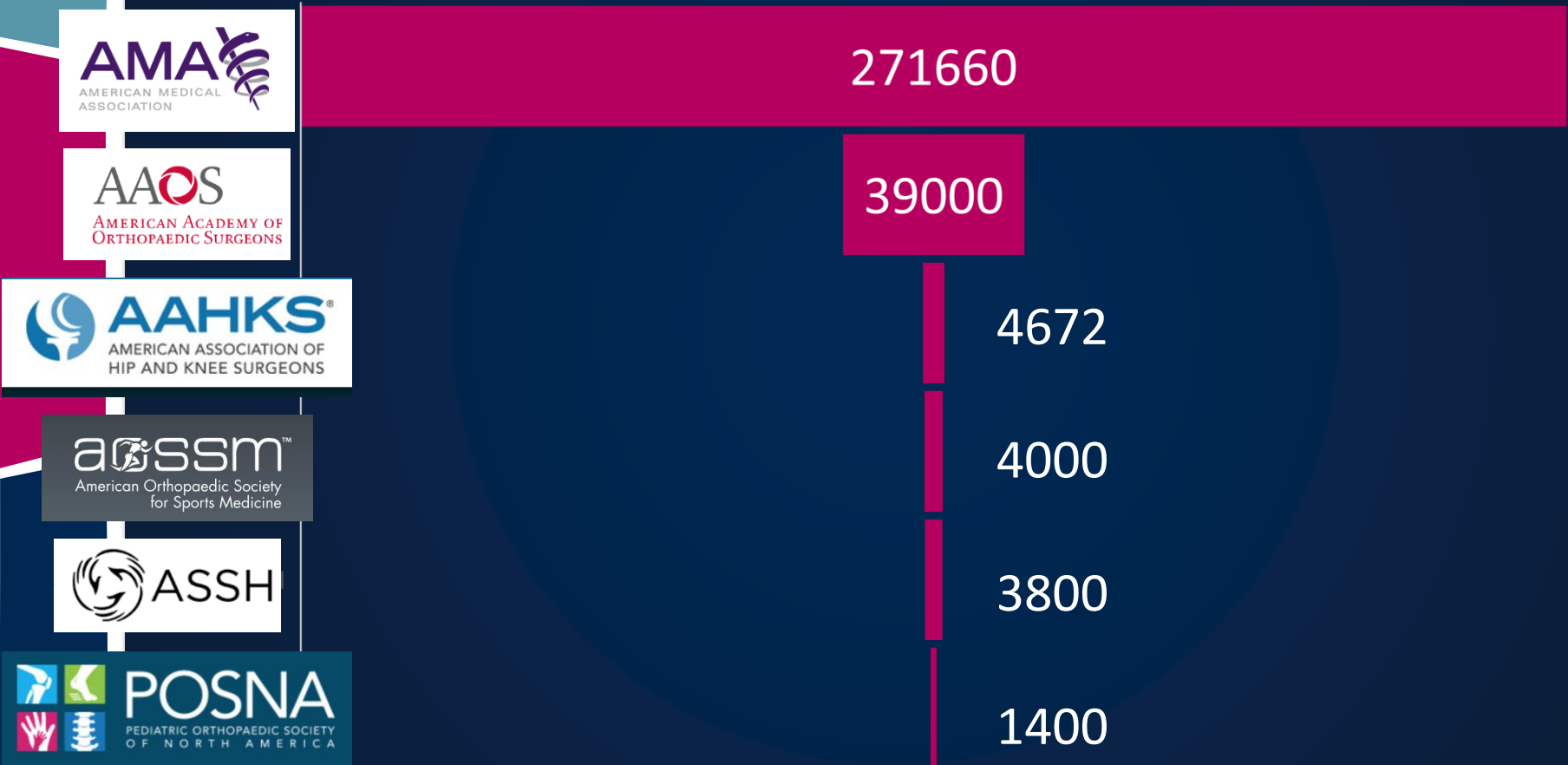
Thanks to the actions of advocates just like you - the House of Representatives passed the Improving Seniors' Access to Timely Care Act by a voice vote!

[Now it's time for the Senate to act](#)

Physicians complete an average of 41 prior authorizations per week. This unnecessary burden amounts to roughly 13 hours weekly that physicians and their staff must spend on administrative work instead of seeing and treating patients. If an insurance plan covers a treatment that would benefit a patient, physicians should not have to waste time ensuring access to it.

This flawed system must be fixed and now it's the Senate's turn to hold the big insurance companies accountable for the undue burden these excessive and

Society Membership



Orthopedic Political Action Committee

Orthopaedic PAC 2021 Financial Highlights



THE ORTHOPAEDIC PAC CLOSED OUT 2021 STRONG DESPITE ONGOING PANDEMIC AND POLITICAL TURMOIL

Hard	Dollars In	Participation	Soft	Dollars In	Participation
2021	\$1.05M	2,225	2021	\$640,000	582
2020	\$1.15M	2,546	2020	\$667,000	787

OVER \$900K

Disbursed to
members of
congress and
candidates



52%
Republicans

48%

Democrats



Orthopedic Political Action Committee

ORTHOPAC SUPPORTER LEVELS

\$100 - SUPPORTER (\$10 RESIDENTS)

- Recognition in all online and printed reports
- Quarterly PAC Newsletter
- Donor Appreciation Event at Annual Meeting
- Opportunity to request OrthoPAC support for federal candidates



\$1,000 - CAPITOL CLUB MEMBERS

(\$100 RESIDENTS/FUTURE CAPITOL CLUB)
(ALL DONOR BENEFITS ABOVE, PLUS):

- Invitations to exclusive Capitol Club events during AAOS meetings
- Opportunities to attend local/state congressional fundraising trips and events
- Opportunities to deliver PAC checks locally to candidates and officeholders
- Lapel pin with Capitol Club recognition



MAX-OUT MEMBERS (\$5,000)

(ALL DONOR AND CAPITOL CLUB BENEFITS ABOVE, PLUS):

- Invitation to NOLC
- Black Car service to and from the airport at Annual Meeting/NOLC
- Lapel pin with Max-Out Member recognition

Congressional Meeting

- House committee
 - Energy and Commerce
 - Health Subcommittee
 - Medicare Part B, Medicaid
 - Ways and Means
 - Taxes
 - Health Subcommittee
- Senate committee
 - Finance
 - Medicare, Medicaid
 - Health, Education, Labor, and Pensions
 - Public health

Society Committees

- AAOOS Orthopedic Advocacy Week
- AAOOS Resident Assembly
- AAOOS Congressional Ambassador
- AAHKS Advocacy Council

Health Policy Fellowship

AAHKS believes in the importance of engaging young, future leaders to assure they remain involved throughout their careers.

- AAHKS members in first four years of practice
- Two year program
- Provides exposure to regulatory and legislative bodies that impact the delivery of hip and knee arthroplasty


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Advocacy


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Guided by the Health Policy Committee, AAHKS provides physicians and their patients comprehensive and timely analysis pertaining to hip and knee surgery. Each year, there are changes in regulations affecting patient care reimbursement for hip and knee surgery. AAHKS develops strategies to keep up with changes and to influence the law-making process. Advocacy is necessary to maintain appropriate reimbursement for services performed by hip and knee surgeons, as well as to ensure the quality of patient care.

Advocacy Supporting Studies and Opinion Pieces

[What Happens When Your Doctor And Insurance Plan Disagree?](#) (Forbes.com, November 14, 2021 by Prem Ramkumar, MD, MBA)

[If Patients Knew: Surgeon Stewardship Versus Balance Sheet Bureaucracy In Orthopaedic Surgery](#) (Forbes.com, October 1, 2021 by Prem Ramkumar, MD, MBA)


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[ADVOCACY / ADVOCACY ACTION CENTER](#)

Advocacy Action Center

House committee passes legislation that would streamline prior-authorization processes in Medicare Advantage plans.


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HEALTH CARE ADVOCACY

The AMA is advocating at the federal and state levels on key health care issues impacting patients and physicians. As a health care organization made up of dedicated and engaged physicians, the AMA works to inform lawmakers, guide decision-making and generate solutions to improve the health care system.

[Advocating for Public Health](#) | [Access to Care](#) | [Administrative Burdens](#) | [Payment Reform](#) | [Advocacy Update](#) | [Federal Advocacy](#) | [State Advocacy](#) | [Judicial Advocacy](#)







Conclusion

- Importance of physician advocacy for **our patients and our profession**
- We can all **make a difference**



Montefiore
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Medicare Free Fridays: Insurance and how far are we getting pushed?

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