ACE program and the Baptist Hospital System

ACE Program.pdf

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If one is playing blackjack, one loves to receive aces. Hands with aces often win. “ACE” though, has a new meaning on the playing field of health care.

The ACE program, or Acute Care Episode is a, so called, “demonstration” project by Medicare. Hospital systems in a handful of states, including Texas were asked to put forward a proposal for the treatment of certain types of problems as they apply to Medicare beneficiaries. Aggressive advertising for this program recently started. The aim of the program is to save the government money on commonly performed procedures. There are a great many lures and promises, but also a great many caveats and concerns.

The information provided here is based upon my review of the publicly available government documents, my experience in San Antonio, and my direct discussions with the administration of the Baptist system, other physicians, other hospitals, and involved vendors. Again, that which is reported here is either a repetition of information provided to me, or is my interpretation, the latter is subject to change as new information becomes available. I will endeavor to keep this page updated as new information becomes available, so please check back here frequently.

My point in preparing and providing this discourse is to bring to light both the potential benefits, the known problems, and places where you, the Medicare patient should have some concerns. The advertising that has recently started, like all advertising, will try to sell the product. The program is to include considerable “inducements” to you, the patient, to participate. The big question is, do you really want to buy? There are substantial reasons that Medicare patients may not want to participate, regardless of the physician involved.

First is that the Baptist System portrays their selection as some great honor. There is no other hospital in San Antonio, that even applied! It may be that no other hospital in Texas applied. Certainly, none of the big “players” in Houston and Dallas did. Some people are trying to, through various freedom of information acts, to get the list from the government of those who did put forward proposals. The government apparently has not responded to these requests for information. It would be my guess that they are not eager to show how limited was the response.

Initially, the Baptist system made it clear to me that, despite my position as an “opted out” physician, I was encouraged to participate in the program. Specifically, I was told by the Baptist administration that CMS (Center for Medicare and Medicaid services, ie. the government) wanted me in the program. A number of vague e-mail have been sent to me as evidence for the same. Subsequently, the government has made it absolutely clear that under no circumstances could an opted out physician get money from the government directly or indirectly. Thus, my patients will not be able to participate. If my patients want to have their surgery at a Baptist hospital, I have been told that they may, and that neither I nor they would be subject to the restrictions of the ACE program. Unfortunately, despite the fact that I have this statement in an e-mail from one of the key administrators, it is not true.

The Baptist system had made it very clear that they plan to obtain 100% physician participation. They will now have to change this to 100% of eligible physicians or potentially, 100% of remaining physicians. Several physicians either have or are contemplating moving a significant portion of their practice away from Baptist.

In order to participate, a physician must sign a contract indicating willingness to do so, and to abide by a long list of rules. Most, if not all of these contracts were out and back to the Baptist system before Baptist moved some of the goalposts. (More on this below.)

The government also requires of the demonstration site that there be no adverse consequences for the physicians choosing not to participate. Baptist promised at least this physician that they would require that I make no compromises in the manner that I practice. Unfortunately this is also no longer true. Some very recent changes in the contracts that Baptist has with it's vendors, driven by the politics of the ACE program, limit the choices of all surgeons, whether they or their patients participate in the ACE program. It limits the choices available to patients, whether they are insured by Medicare or not.

For those who would like to view the public pages from the government, please click on this link:

www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDid=-99&sortBYDID=3&sortOrder=descending&itemID=CMS1204388&intNumPerPage=10

The name of the project tells a lot about the goals. ACE stands for "Acute Care Episode". The focus is completely upon the cost of the acute care stay for several orthopaedic procedures. There is also a corresponding program for cardiac procedures, but that is not the focus of this discourse. I have no personal information concerning the cardiac program. There is, within orthopaedics, no consideration for the value of the procedure to the patient or to society, nor is there any consideration for the costs associated with rehabilitation after the hospital stay, or the time until the patients returns to work, returns to earning a wage and paying taxes.

Inducements are included in the program, for the hospital, the physician, and for you, the patient. What you may hear when advertising begins, is that you will receive $1,157 to offset your share of the cost of a total hip replacement, or of a total knee replacement, should you have the procedure done at one of the Baptist hospitals. Yes, you may get some money from the government if you have your surgery at Baptist, but there is by no means any promise of the same. Here is the story on patient rebates, please pay attention to the added emphasis:

1) Only straightforward Medicare patients may be part of this program. Those enrolled in Medicare HMOs are not eligible.
2) CMS will share up to 50% of the Medicare savings from the program with the patients.
3) Payments will not exceed one year of your Part B premiums. Some people pay $1,100 per year, some as little as $200.
4) CMS has three contractors involved in determining the definition of "up to" and the payment mechanism (each contractor constitutes an expense)
5) It appears that the definition of "Medicare savings" involves the whole system, not what might be saved on your procedure.

So, it appears that the government has added expenses to the system that do not benefit you, the patient, in any way, and will limit your rebate check, if you get one at all. It turns out that the estimated savings on a joint replacement to the government is on the order of $600, so the amount of "rebate" to the patient will be "up to about $300." This, it seems, is a far cry from the $1,157 heard on the commercials.

There are inducements for the physicians involved as well. These are interesting in many ways. Currently, Medicare pays physicians less than $1,500 for the pre op visit, if any, the hospital care, and 90 days of post operative care. Out of this, the physician then pays his staff, his rent, and all other expenses before taking a portion of this home. This program would pay the physician exactly $1,500 per surgery for the same. The surgeon then must pay the assistant out of this sum. Then, there is the "opportunity" to "earn" up to 25% additional ($375) if cost savings are maximized and quality is maintained.

What is the physician encouraged to do to earn this sum? Please keep in mind that the government explicitly states "Incentive payment must not induce a physician to reduce/limit services that are medically necessary to a patient entitled to Medicare benefits." (www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACEProviGainsRules.pdf) The

physician's reimbursement is tied to the cost savings of the whole project, not of their own patients. One of the physicians on the steering committee commented that if another physician chooses to use an expensive prosthesis, there will be pressure placed upon him by his colleagues to use something less expensive.

Certainly, less expensive does not always mean lower quality. However, several implant options that I believe are higher quality are currently prohibited from use in the Baptist system. Some on the basis that the steering committee does not believe that they are any better and some on some other political basis, as they are in fact less expensive. Thus, to do a joint replacement in the Baptist system, I'd have to use implants that I would not want for my family.

All of this for the potential for $375! Not the way that I want my family treated.

There is, fortunately, or unfortunately, an appeals process. Should a surgeon want to use an implant that is not on the approved list, he or she can appeal to a three member panel. If two of the three agree, the exception would be allowed. Two of the three doctors on this panel have already explicitly stated that they would change the prosthesis that they use on the basis of cost to the system. This includes the doctor who would lead the peer pressure on other doctors to use less expensive implants. I don't know anything about the politics of the third doctor involved. I also don't know how far in advance this appeal would have to be made.

Implants, like cars, come in many varieties. While none of the currently marketed implants are lemons, one cannot expect the safety features of a 2009 automobile from a 1982 vehicle, even if it were "new". At the same time, the Hyundai and a Porsche will both get you from the house to the corner store. The average American budget does not allow for a Porsche in every garage. Still, there are considerable advances that have been made in the last few years that have admittedly increased cost, but they also have greatly improved performance. One specific example is the interface between the ball of the hip joint and the socket. The traditional interface is a metal ball on a plastic socket. This interface wears out in 10-15 years, faster for more active patients, a bit more slowly for older patients. A new way to process the plastic was developed about a decade ago. This greatly improved the longevity of hip replacements. Changing the metal ball to ceramic or a hybrid material called oxynium further reduces wear. Ceramics introduced 10-15 years ago were not, in my opinion, safe to use. Those introduced in the last 2-3 years are much much better. Oxynium has been specifically excluded from Baptist hospitals. Some ceramics are allowed, but I do not yet know about modern plastics.

While the difference between the Cadillac or Mercedes knee replacement and the middle of the line is considerably smaller than the difference between the Hyundai and the Porsche, the one to two thousand dollars per implant that the newer technology costs when compared to the older designs does cost the government is a lot of money. Now there is a philosophical problem. Medicare, like Social Security, was first designed as a safety net for the oldest and most debilitated in our society. At their inception, the 65 year old was expected, if I'm allowed slight exaggeration to prove the point, to walk to the corner store and spend much of the day on the porch. Now there are baseball leagues and triathlon brackets for the over 70. Sixty five is no longer considered "old". I have routinely offered my patients the Cadillac, Mercedes, or Porsche of implants. I save the system a much larger sum of money than I spend on implants, after the discharge from the hospital. This savings is not considered a part of the ACE program.

Baptist has reneged (after getting physician contracts signed) on it's promise to allow all prostheses into the ACE program. Physicians who insist on using the modern technology will be labeled as "expensive" and therefore "bad". Those doctors who compromise care in line with the doctors on the steering committee will not be sanctioned by the government for this compromise. At present, the hospital has set up considerable barriers to the physician attempting to provide state of the art care. I doubt that they will take responsibility for the same.

Another major area for cost savings is the length of the hospital stay. Here is a bit of history. One of the local Medicare HMO programs put together a joint replacement program whereby patients would be discharged from the hospital on the first post operative day, and transferred to a skilled nursing facility (a fancy name for nursing home), under the care of the primary care physician, and away from the orthopaedic surgeon. Some doctors in town bought into this program. I had a contract with this HMO at the time, but I refused to have my patients transferred before I thought that

they were stable, and would not need urgent or emergent orthopaedic care.

I don't see that it is possible or practical for any skilled nursing facility to provide the level of care routinely found in a hospital. The HMO therefore directed their patients to the other doctor(s) who allowed and condoned the transfer. In all likelihood, the total expense for my patients in terms of diminished rehab needs, faster return to ordinary activities etc, was less, but the HMO, at the time, did not recognize that. Similarly, this government program pays no attention to the expense after the hospital stay. The steering committee has recognized that it cannot control or monitor this expense, so they've removed both length of stay and disposition (where the patient goes after the hospital stay) from the list of quality markers. I believe that higher quality care will result in a higher percentage of discharge to home compared to discharge to nursing homes. No credit will go to the doctor achieving this goal.

The length of stay has now been officially been removed from the list of "quality markers". However, the expense of the hospital stay is based upon length of stay. The doctor whose patients stay an extra day therefore costs more. This doctor is therefore "expensive" and it follows that he/she is "bad".

What then determines quality? By my way of thinking, quality is a high rate of patient satisfaction with a low rate of complications. It appears that the surgeon is in a catch-22. If the hospital does not allow the state of the art prostheses, then the surgeon cannot provide the same quality as he provides non-ACE patients, or patients at other hospitals. Therefore, the physician is in violation of the contract. If he uses the state of the art (and more expensive) prostheses and techniques anyway, he is labeled as expensive, inefficient, and therefore "bad" or "low quality".

Thus, the participating physician and patient are both caught. If they stick to the limits imposed by either by the Baptist system or the physicians of the steering committee, then they will implant technology from the last decade. This to me is compromised care. The government insists that the physicians don't compromise care. This is a "no win" situation for both patient and physician, if either participate. Fortunately, neither has to participate. Both can choose hospitals not participating in the ACE program. Again, at least in San Antonio, and in large parts of Texas, only Baptist even applied.

I personally have been working with one of the companies to develop instruments that allow their "Porsche" total knee to be implanted in a true tissue sparing manner. The instruments and technique are unique to the implant, and do not apply to other implants, even by the same company. (By the way, I have no active consulting agreements with any company, I get no reimbursement or compensation for this effort from the company.) This type of personal advance will not be available to patients whose surgeons participate in ACE program.

There are still many other unanswered questions. For example, there are some physicians in this community who routinely implant total joints in under half an hour. The tissue sparing techniques that I use take an hour and a half to two hours. I take the extra care and extra time because it is what I'd want for my family. The ACE program will penalize those who take this type of time. The government pages suggest that the physician can opt in or opt out of the program. The Baptist system has communicated to me that every Medicare patient who has their joint replacement surgery at Baptist will be part of the program, whether they or their surgeon want to or not. These two are mutually exclusive. The government states that there should be no penalty for a physician who chooses to not participate. If the government is to be believed, the physicians not participating can make use of Baptist facilities without they or their patients being subject to any of the constraints and limitations of the ACE program. If Baptist is to be believed, the only choice that a non participating physician and his or her patients have is to select a different hospital. In the latter case, Baptist would be in violation of the government's directive.

Please don't get me wrong, I have no problem with the quality of care provided at St. Luke's Baptist Hospital, and I would have my family there in a heartbeat. I am frustrated by the newly acquired Baptist philosophy that hospital administrators are best suited to make health care decisions, the limits that are being placed upon my ability to care for patients, and the extremely short time interval afforded me and my patients to gather information and make reasonable decisions.

In conclusion, health care is not a card game. In Las Vegas, even with an ace in your hand, the odds are still stacked against you. I personally would not suggest that you sit and play. In this game, only the government holds the aces.

As new information becomes available, I will update this page. My opinion will continue to reflect the most current data available. Please check back every few days.