

# VALUE BASED ORTHOPEDIC CARE

Becker's 14th Annual Spine, Orthopedic and Pain Management-  
Driven ASC Conference + The Future of Spine  
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2016 - 2022

HORIZON



# SMOOTH SAILING



- orthopedics has enjoyed an extended period of reimbursement stability- elective surgeries, ancillary revenue acquisition; sparing the specialty from the reimbursement declines experienced by other specialties.
- Its been essentially '*smooth sailing*' for orthopedic care delivery.
- Mergers and health system acquisitions continue to hardwire patient referral pathways.
- Flat or shrinking reimbursement levels and new payment models are going to slowly affect orthopedic physician practices.
- Payers are beginning to seek more cost-saving opportunities amid high growth expectations.
- As a result, a dynamic environment is developing in which health systems and orthopedic physicians alike are looking to restructure and optimize the delivery of orthopedic care in the outpatient setting

# DOWNWARD PRICE PRESSURES CONTINUE



- More states have introduced or are introducing all-payer claims databases that track how much patients are actually paying for procedures
- Guroo, Clear Health Costs, Healthcare Blue Book, fairhealth, newchoicehealth, faircaremd, are new websites listing prices
- The movement towards transparency in pricing is entering the patient/consumer healthcare market place
- CMS bundling (capitated) for joint replacement have been introduced

# PRICING TRANSPARENCY

Interactive State Report x +

apcdouncil.org/state/map

APCD All-Payer Claims Database

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SHARE

## State Efforts

- APCD Legislation by State
- Claims Data Release Rules
- Claims Data Collection Rules

## Interactive State Report Map

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Click on the map to view APCD information about each state or use the links below to go directly to the state data.

Existing	In Implementation	Strong Interest
Existing with Voluntary Submission	Existing Voluntary Effort	No Current Activity

Alabama	Hawaii	Massachusetts	New Mexico	South Dakota
Alaska	Idaho	Michigan	New York	Tennessee
Arizona	Illinois	Minnesota	North Carolina	Texas
Arkansas	Indiana	Mississippi	North Dakota	Utah
California	Iowa	Missouri	Ohio	Vermont
Colorado	Kansas	Montana	Oklahoma	Virginia
Connecticut	Kentucky	Nebraska	Oregon	Washington
Delaware	Louisiana	Nebraska	Oregon	Washington
District of Columbia	Maine	New Hampshire	New Jersey	New Mexico
Florida	Massachusetts	New Jersey	New York	North Carolina
Georgia	Michigan	New Mexico	North Carolina	Ohio
Idaho	Minnesota	North Carolina	Ohio	Oklahoma
Illinois	Mississippi	North Dakota	Oklahoma	Oregon
Indiana	Missouri	Ohio	Oklahoma	Oregon
Iowa	Montana	Oklahoma	Oregon	Oregon
Kansas	Nebraska	Oklahoma	Oregon	Oregon
Kentucky	Nebraska	Oklahoma	Oregon	Oregon
Louisiana	Nebraska	Oklahoma	Oregon	Oregon
Maine	Nebraska	Oklahoma	Oregon	Oregon
Massachusetts	Nebraska	Oklahoma	Oregon	Oregon
Michigan	Nebraska	Oklahoma	Oregon	Oregon
Minnesota	Nebraska	Oklahoma	Oregon	Oregon
Mississippi	Nebraska	Oklahoma	Oregon	Oregon
Missouri	Nebraska	Oklahoma	Oregon	Oregon
Montana	Nebraska	Oklahoma	Oregon	Oregon
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Ohio	Nebraska	Oklahoma	Oregon	Oregon
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Pennsylvania	Nebraska	Oklahoma	Oregon	Oregon
Rhode Island	Nebraska	Oklahoma	Oregon	Oregon
South Carolina	Nebraska	Oklahoma	Oregon	Oregon
South Dakota	Nebraska	Oklahoma	Oregon	Oregon
Tennessee	Nebraska	Oklahoma	Oregon	Oregon
Texas	Nebraska	Oklahoma	Oregon	Oregon
Utah	Nebraska	Oklahoma	Oregon	Oregon
Vermont	Nebraska	Oklahoma	Oregon	Oregon
Virginia	Nebraska	Oklahoma	Oregon	Oregon
Washington	Nebraska	Oklahoma	Oregon	Oregon
West Virginia	Nebraska	Oklahoma	Oregon	Oregon
Wisconsin	Nebraska	Oklahoma	Oregon	Oregon
Wyoming	Nebraska	Oklahoma	Oregon	Oregon

# PRICING TRANSPARENCY

Healthcare Bluebook.

Español | Help

Search for a procedure, test or service [Search City or Zip Code](#)

Hospital Physician X-ray Imaging Labs Cosmetic Medicine Hearing Aids Dental Medications

### Anterior Cruciate Ligament Knee Surgery (ACL)

Total Fair Price: **\$11,071**

Fair Price Fee Details

#### Ways To Save

Having this surgery performed at a hospital with an overnight stay will usually be the most expensive option. Discuss with your physician if this surgery can be performed as an outpatient procedure (no overnight stay).

There are two types of outpatient facilities: 1) outpatient surgery performed at a free-standing Ambulatory Surgery Center (ASC), which is usually the best value and 2) hospital-based outpatient surgery, which is typically less expensive than inpatient care.

#### Fair Price Information

The Fair Price is the price that you should reasonably expect a medical service to cost if you shop for care. Even in-network providers can have big cost differences for the exact same service. The most expensive can cost more than five times as much as providers that charge a Fair Price. Providers with the 'green' designation offer pricing at or below the Fair Price.

Fair Prices On The Go

Download on the App Store GET IT ON Google play

SETUP INSTRUCTIONS

Your employees deserve fair pricing. And we can help. [Transparency solutions for employers](#)

Did You Know

The cost of certain in-network procedures can be as much as 4x the Fair Price. The biggest factor driving cost is where the care is provided.

# WHAT IS VALUE BASED CARE?

- An initiative to transform the U.S. health care system from a fee-for-service model to a value-based reimbursement system.
- A new reimbursement model which aims to align physician incentives with quality measures and rewards better outcomes rather than just high volumes and redundant diagnostics.
- The transition from a fee-for-service model towards value-based care will increasingly tie financial reimbursement to a physician's performance.
- Orthopedists are beginning to work more with their colleagues to play a greater role in value-based care by employing evidence-based practices and tracking quality outcomes.

# IT STARTS WITH AN.. M!

Macra, Mips, Meaningful Use



- In Less than 5 Months – Value Based Models will be introduced from the new 962 page Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- **How Might The Orthopedist be Paid under 'MACRA' ?**
  - MACRA creates a new Merit-based Incentive Payment System (MIPS) that will adjust physician payments up or down annually based on performance.
  - CMS will be integrating PQRS and MU into a single payment initiative
  - There will be 4 categories to be measured on
  - There are maximum penalties and bonuses
- MACRA also places new emphasis on alternative payment models (APMs) that will create a pathway for the development of physician-focused APMs. Physicians who provide a certain percent of their patient care in the APMs will be exempt from many MIPS requirements and will be offered additional incentives.



- **Two 'Value-Based' Payment Tracks**  
MACRA shifts the traditional Medicare PFS payment to two value-based payment tracks.
  - The first track, MIPS, consolidates and expands pay-for-performance incentives in the fee-for-service system.
  - The second track, APMs, provides bonus payments for physicians who participate in "alternative payment models" that hold providers financially accountable for healthcare costs.
- MACRA consolidates as well as expands the pay-for-performance incentives of the traditional fee-for-service model. The MIPS program consolidates the Physician Quality Reporting System (PQRS), the Electronic Health Records (EHR) Incentive Program, and the Physician Value-Based Modifier into a single payment adjustment applied to physician payments beginning in 2019.
- MIPS also broadens the definition of quality to include resource use and clinical improvement measures. The range of adjustments based on performance against MIPS measures will grow through 2022. Because the program is designed to be budget neutral, the total negative adjustments across all providers will equal the total positive adjustments for all providers. This is a zero-sum game.
- Providers may opt out of MIPS if they participate in the APMs. Under the APMs, lump-sum bonuses to the PFS are available from 2019 to 2024. Qualifying APMs require providers to take on "more than nominal" financial risk, report quality measures, and use certified EHR technology.

# WHAT IS VALUE BASED CARE?

- **When Might an Orthopedist start to see these reimbursements?**
- The new MIPS payment update and incentives for APM participation will take full effect in **2019**. However, because of the significant lag between performance periods and payment years, physicians are likely to have their payments adjusted in 2019 based on their performance in **2017**.
- it is important to begin preparing NOW for the current changes in reimbursement policies, and the potential for more based on the upcoming government elections.

WAIT A MINUTE...

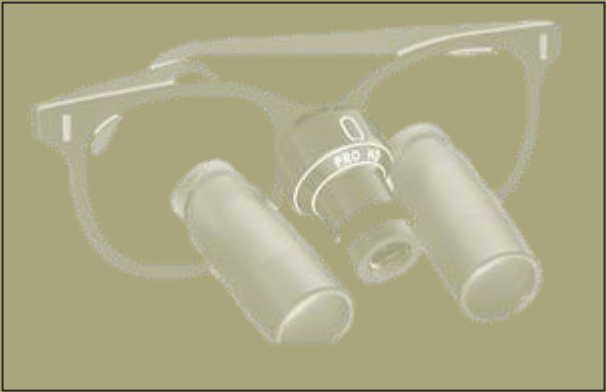
ISNT THIS JUST  
MANAGED CARE?

(not necessarily, there will still be  
fee-for-service)





- **How Can Orthopedists Prepare to Succeed Under MIPS?**
- To provide each physician with a composite score between one and 100, CMS will combine and streamline existing quality programs, discontinuing their associated penalties after **2018**.
- These quality programs include
  - the Physician Quality Reporting System (PQRS)
  - the value-based payment modifier (VM)
  - the Electronic Health Record (EHR) Incentive Program.
  - An additional category referred to as clinical practice improvement activities (CPIA) will be added to provide credit for expanding access to care, using clinical decision support tools, implementing surgical checklists, and participating in APMs and other efforts designed to improve patient care.
- Because the new updates will be based largely on modified versions of existing programs, the best way to ensure success under the new program will be to make certain your practice are successfully participating: PQRS, VM, and EHR Incentive Programs.



**SINGLE ORTHOPEDIC SURGEON**

Average **Monthly** Collections: \$100,000

**INCENTIVES** (annual)

CCM \$4,733

TCM \$683

**PENALTIES** (annual)

PQRS \$5,745

MU \$11,491

VM \$5,745

**12 ORTHOPEDIC SURGEON**

Average **Monthly** Collections: \$1,000,000

**INCENTIVES** (annual)

CCM \$56,803

TCM \$8,202

**PENALTIES** (annual)

PQRS \$ 57,456

MU \$ 114,912

VM \$ 114,912

*“There is no doubt that the government is accelerating its shift to value-based payments, where physicians are rewarded — to an increasing extent — for quality, rather than quantity of care from volume to value”*





- Value Based Care is designed to improve quality, outcomes and costs across a patient's episode of care, and it financially rewards the orthopedist for better outcomes.
- Payers will begin to provide orthopedic practices with more robust data and analytics for managing the care of each patient.
- From the patient perspective, this is expected to deliver a more coordinated care experience and reduced readmission and complication rates.
- (Humana) Ohio program is piloting this now, and plans to expand to other states if the new model generates the expected outcomes improvement, coordinated member experience and cost savings



- Effective in 2017, the Medicare Access & CHIP Reauthorization Act of 2015 will replace the current MU, PQRS, and V-BPM and reward physicians based on their ability to improve quality and lower costs. Medicare payment adjustments associated with MACRA will begin in 2019
- Initially, most orthopedists will operate under MIPS, which is a combined weighted score of quality, resource use, meaningful use and practice improvement scores.
- The exemptions from MIPS include orthopedists who are in their first year of Medicare billing, providers whose volume of Medicare payments or patients fall below a still undefined threshold and providers qualifying for payments under APMs with associated MIPS-exempt bonuses.





- The shift toward value-based payments is driving two key trends among independent orthopedists: practice consolidation and vertical expansion. Larger groups will benefit from:
  - Pooled resources to build a data gathering infrastructure
  - Benchmarking and data-sharing capabilities
  - Improved quality
  - Enhanced ability to manage costs
  - Attractiveness to ACO partners
  
- In 2016:
  - Define your regulatory strategy and make sure partners understand MACRA
  - Evaluate payer mix, paying close attention to Medicare
  - Define your environment — is an ACO available?
  - Define your technology needs — can your current tools support your future goals?
  
- In 2017
  - MACRA will begin and could require workflow changes. Next year plan to:
  - Experiment with alternate payment programs such as PBCI and CCJR
  - Develop clearer outcomes definitions and benchmarks with data analytics
  - Optimize processes with hard data and implement changes to drive quality and efficiency

# ORTHOPEDIC'S HISTORY IN DATA GATHERING



- **Continue to Focus on The Entire Patient Experience, Patient Outcomes – Demonstrating Value (with Data)**
- As patients increasingly become active consumers of healthcare and chose where to receive their elective orthopedic surgeries, competitive programs increasingly win market share through delivering on a more patient-centered experience. As such, it is crucial to prioritize assessing and tracking access, convenience, and other metrics that signal a positive patient experience.



- **1. Allocate staff to data tracking**

Providers can first help allocate staff and other resources to support the necessary data tracking that often occurs across multiple care sites (e.g. outpatient office, inpatient hospital, post-acute setting) and at different points in time (e.g. pre-operative, post-operative 3 months, post-operative 1 year). Hospitals need to incorporate extra time into staff's daily responsibilities as well as into the care pathway and protocols. For example, a nurse navigator is an ideal staff member to conduct patient assessments for joint replacement procedures given their close interaction with the patient across the care episode.

- **2. Enfranchise physicians in outcomes tracking**

Hospitals and health systems can also engage with physicians by becoming a strategic thought partner throughout the outcomes tracking process. Aligning goals and objectives will be beneficial since hospitals are similarly being held accountable for delivering high-quality care.



- **The Outpatient Delivery Arena will Continue to Be Pushed -- Joint and spine surgical procedures will keep shifting to ambulatory surgery centers (ASCs).**
  - The push toward price transparency, enabling patients to shop for low-cost, high-quality care
  - New technological innovations that are allowing a broader array of procedures to be conducted in the outpatient setting.
  - CMS's decision to approve reimbursement for certain surgical spine procedures conducted in ambulatory settings.
  - CMS still does not reimburse for total joint replacements in ASCs, private payors recognize this as a future opportunity.
- This shift in scope is expected to drive more profitable volumes to ASCs, creating new drivers that will affect the outpatient market for orthopedic surgery, including:
  - Increased interest in partnership
  - A need to develop new ASC infrastructure
  - An acute focus on cost efficiencies



- **As value-based reimbursement becomes more prevalent in orthopedics, orthopedists are aiming to create “one-stop shops” for musculoskeletal services.**
- Design of infrastructure designed provide a number of services along the continuum of care. Developing one-stop shops for orthopedic patients is a solution some physicians are considering as a means to control the quality and total cost of care.
- More orthopedic groups are working with health systems to establish these REAL centers of excellence.
- “Tighter integration is a theme common to all of these trends, and emblematic of the transformational change affecting the entire healthcare industry. And while orthopedic care dodged the trend of declining reimbursement for nearly 10 years, the shift toward value-based care delivery won’t be so easy to avoid.”

“If you choose to not sit at the Value-Based table, your probably ending up on the menu”



thank you!

