VALUE BASED ORTHOPEDIC CARE

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2016 - 2022

HORIZON
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.
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.
Click on the map to view APCD information about each state or use the links below to go directly to the state data.
PRICING TRANSPARENCY
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.
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.
MACRA shifts the traditional Medicare PFS payment to two value-based payment tracts.

- 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.

http://www.aaos.org/Membership/Member_Resources/Practice_Resources/MACRA_MIPS_APMS/?ssopc=1
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.
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**SINGLE ORTHOPEDIC SURGEON**
Average Monthly Collections: $100,000

**12 ORTHOPEDIC SURGEON**
Average Monthly Collections: $1,000,000
“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
- Continue to Focus on The Entire Patient Experience, Patient Outcomes – Demonstrating Value (with Data)

- As patients increasingly become active consumers of healthcare and choose 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, you probably ending up on the menu”
thank you!