AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

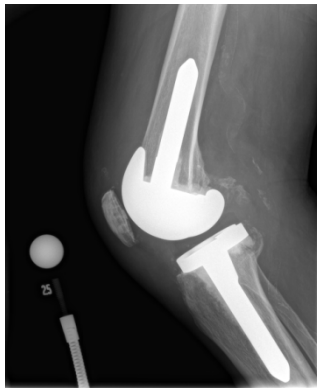
BPCI, CJR – Where We've Been and Where We're Going

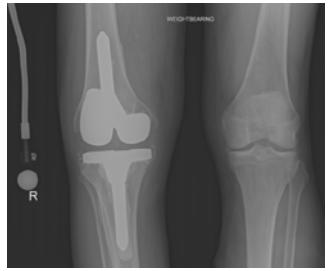
Richard Iorio, MD

Chief of Adult Reconstruction and TJA Service
Vice Chairman of Clinical Effectiveness
Richard D. Scott, MD Distinguished Chair in Orthopaedic Surgery
Brigham and Women's Hospital
Member of the Faculty Harvard Medical School

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Disclosures





- Co-founder Labrador Healthcare Consulting Services
- Co-founder MyArthritisRx.com
- Co-founder Responsive Risk Solutions
- Co-founder Value Based Healthcare Consortium
- Consultant for Recro Pharma
- Consultant for Zimmer/Biomet
- Consultant for Medtronic
- Consultant for Covina
- Product liability consultant for DePuy Orthopedics
- Advisory board for Wellbe, Pacira, MedTel, MuveHealth, Force Therapeutics
- AAHKS, Knee and Hip Society Board Member
- Consultant reviewer for JBJS, CORR, JOA, JAAOS
- Editorial Board JBJS Reviews, Adult Reconstruction Section Editor

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Advocacy Wins

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015

- MACRA created the Quality Payment Program that:
  - Repeals the Sustainable Growth Rate formula
  - Changes the way that Medicare rewards clinicians for value over volume
  - Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
  - Gives bonus payments for participation in eligible alternative payment models (APMs)

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Advocacy Wins

We got rid of the SGR.

BE CAREFUL WHAT YOU WISH FOR…….

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Advocacy Wins

MACRA gives us more Alphabet Soup

- MIPS, merit-based incentive payment system
- AAPM's, Advanced alternative payment models
- IPO, in patient only rule
- 2 Midnight Rule
- CJR, Comprehensive Care for Joint Replacement
- BPCI, Bundle Payment Care Initiative
- BPCI A, the new BPCI Advanced
- ACO, Accountable Care Organization
- Medicare Advantage
- CMMI

It's a Brave New World

ACA without the fake news

- In 2010, the Affordable Care Act was signed into law
- There were 45 million people uninsured which was roughly 16 percent of the population
- After 2017 with a full year of Trump and Republican efforts to eliminate the ACA, there were 26 million uninsured or 9.1% of the population
- There was no change in coverage from 2016 to 2017
- Trump says that Obamacare is imploding and the Democrats say that Trump has sabotaged coverage programs
- What this CDC survey shows is that Americans will cling strongly to their health insurance
- 2 groups affected the most, the healthy working middle class and the poor in states which did not take on Medicaid expansion, these groups have increased their uninsured rate in 2018
- 2018, ACA struck down by Texas Appellate Judge and the Trump administration has chosen to defend this position
- In 2018, 1 million more patients opted out of exchange plans and were willing to forego their coverage, they are the healthy working poor to lower middle class group
- Are we headed for Medicare for all? $2 to 3 trillion in expense

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

ACA without the fake news: Executive Order October 2019

- Sec. 2. Policy. It is the policy of the United States to protect and improve the Medicare program by enhancing its fiscal sustainability through alternative payment methodologies that link payment to value, increase choice, and lower regulatory burdens imposed upon providers.
- Sec. 3. Providing More Plan Choices to Seniors. (a) Within 1 year of the date of this order, the Secretary shall propose a regulation and implement other administrative actions to enable the Medicare program to provide beneficiaries with more diverse and affordable plan choices. The proposed actions shall:
- (i) encourage innovative Medicare Advantage benefit structures and plan designs, including through changes in regulations and guidance that reduce barriers to obtaining Medicare Medical Savings Accounts and that promote innovations in supplemental benefits and telehealth services;
- (ii) include a payment model that adjusts supplemental MA benefits to allow Medicare beneficiaries to share more directly in the savings from the program, including through cash or monetary rebates, thus creating more incentives to seek high-value care; and
- (iii) ensure that, to the extent permitted by law, FFS Medicare is not advantaged or promoted over MA with respect to its administration.

Medicare Advantage Executive Order

- Sec. 5. Enabling Providers to Spend More Time with Patients. Within 1 year of the date of this order, the Secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients by:
- (a) proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession;
- (b) proposing a regulation that would ensure appropriate reimbursement by Medicare for time spent with patients by both primary and specialist health providers practicing in all types of health professions; and
- (c) conducting a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and proposing a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician's occupation.

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

CMS Bundles: Where are we?

CJR

- The study analyzed results from 731 CJR participant hospitals and 841 hospitals not in the experiment, which lasted from April 1 to Dec. 31, 2016.
- In 2017, CMS scaled back the CJR program citing the burden of the program and the belief that models should be largely voluntary. The CJR model is now only mandatory in 34 geographic areas compared to 67 geographic areas when it first launched.
- The agency estimates that 465 hospitals are participating in the effort. That figure is down from 800 acute-care hospitals that were expected to participate in the program.
- NYU entered CJR after leaving BPCI and now has a target price of $23,000

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

CMS Bundles: Where are we?

CJR

- Under the Comprehensive Care for Joint Replacement program, average total payments decreased by 3.9% or $1,127 compared to hospitals not participating in the model
- no statistically significant changes in the quality of care as measured by readmission rates, emergency department visits, and deaths

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

- Data from Medicare and the AHA Annual Survey and found BPCI hospitals had higher mean patient volume and were larger and more teaching-intensive than those in the mandatory Comprehensive Care for Joint Replacement model (CJR).

- However, the two groups had similar risk exposure and baseline-episode quality and cost. BPCI hospitals also had higher costs attributable to institutional post-acute care, largely driven by inpatient rehabilitation facility costs.

- "These findings suggest that while both voluntary and mandatory approaches can play a role in engaging hospitals in bundled payment, mandatory programs can produce more robust, generalizable evidence," the authors wrote. "Either mandatory or additional targeted voluntary programs may be required to engage more hospitals in bundled payment programs."

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

Value Based Health Care

- AAHKS/AAOS are supportive of multiple APM options to speed the transition to value-based care, and we are developing an APM to complement CJR and BPCI.

- AAHKS/AAOS also supports the ability for the physician to choose the APM in which they participate.

- CJR was the first mandatory bundled payment model to be implemented by CMMI; forcing many of our members to participate in an APM that 1) had no physician control of the bundle, 2) suffered from inadequate risk adjustment, and 3) created perverse incentives for cherry picking and lemon dropping due to regional benchmarking.

It's a Brave New World

- **Update on the Number of Participants in BPCI Advanced for Model Year 2**
- After the March 1, 2019 deadline for Participants in the BPCI Advanced Model to terminate their participation completely or withdraw some of their Episode Initiators and/or Clinical Episodes, without any financial risk, we can report that the number of Participants for Model Year 2 remains robust at 1,086.
- The Model Episode Initiators include 715 Acute Care Hospitals and 580 Physician Group Practices – a total of 1,295 Medicare providers. An updated list of Participants for Model Year 2, and the file that identifies the Episode Initiators and their Clinical Episode selections are now posted in the BPCI Advanced website.
- Episode Initiators (EI) list (XLS)
- Participants list (XLS)
- BPCI Advanced qualifies as an Advanced Alternative Payment Model (Advanced APM) under MACRA, so participating providers can be exempted from the reporting requirements associated with the Merit-Based Incentive Payment System (MIPS) and potentially qualifying them for incentive payments.
- The BPCI Advanced Model which is designed to improve quality and reduce costs for inpatient & outpatient care was publicly announced in January 2018, and runs from October 1, 2018 through December 31, 2023.

It's a Brave New World

- Target Pricing for BPCI A:

  CMS outlined the intricacies of the updated target pricing methodology, which will no longer be based solely on a provider's historical costs. New adjustments will incorporate:

- Patient comorbidities through the use of HCC risk factors
- Peer group characteristics based on the 9 US Census Regions
- Peer Adjusted Trend (PAT) Factor to replace the BPCI Trend Factor
- Regression model for added risk adjustments
- Adjusted for BPCI A 2

  CMS also announced it will adjust Major Joint Replacement of the Lower Extremity (MJRLE) target prices for fracture status, and will soon release more detail on how Total Knee Arthroplasty in the hospital outpatient setting will impact target prices for the inpatient MJRLE bundle

- CMS reiterated that CJR takes precedence over BPCI Advanced for the assignment of MJRLE bundles.
- **Outpatient bundle anchor setting**. CMS confirmed that OP bundles can only be triggered in the hospital outpatient department setting. New pricing for OP bundles in 2020.
- Participants in CJR should be able to participate in BPCI.
- Removing TKAs from the IPO list pushes some of the least complicated procedures, healthiest patients and shortest hospital stays out of the bundle, creating a mismatch between historic and future costs.
- AAHKS/AAOS urged CMMI to work with stakeholders prior to the release of BPCI to address issues like these. An opt out provision was extended to April 2019.
- Participation has been less than expected, a new model will need to be developed (1300 Hospitals initially enrolled)

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

- On October 1, 2018, the first cohort of Participants in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model started participation in the CMS Innovation Center's Advanced Alternative Payment model.
- ***CMS opened the application period for Model Year 3 in April 2019.*** The second cohort of Participants will start on January 1, 2020, which is Model Year 3. At this time, CMS does not intend to have additional enrollment periods for Model Year 4 (2021) or Model Year 5 (2022). All new applications must be submitted via the BPCI Advanced Application Portal.
- Organizations interested in applying to participate as a Non-Convener Participant, must be an Acute Care Hospital (ACHs) or a Physician Group Practice (PGPs) that could initiate clinical episodes under the Model. A Convener Participant maybe a non-Medicare provider or supplier, a Post-Acute Care provider, an Accountable Care Organization (ACOs), ACH or PGP.
- Currently, BPCI Advanced consists of 32 bundled clinical episodes - 29 inpatient and 3 outpatient. CMS is finalizing the selection of new clinical episodes for Model Year 3, which will include outpatient Total Knee Arthroplasty (TKA).
- CMS has pledged to improve target pricing, competing value-based episodes (ACO's), risk stratification, and the convener issues usurping surgeon co-management and shared savings arrangements

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Inpatient Only List (IPO):

- **For several years, CMS has utilized a rule called the "Two-Midnight Rule" to define outpatient status for all procedures not on the IPO list.**
- CMS made TKA subject to the "Two-Midnight Rule" in conjunction with the decision to move TKA off the IPO list.
- According to the "Two-Midnight Rule," a hospital admission should be expected to span at least two midnights in order to be covered as an inpatient procedure.
- If it can be reliably expected that the patient will not require at least two midnights in the hospital, the "Two-Midnight Rule" suggests that the patient is considered an outpatient and is therefore subject to outpatient payment policies.

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

CMS – 2017

"We continue to believe that the decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgment ***made by the physician based on the beneficiary's individual clinical needs and preferences*** and on the general coverage rules requiring that any procedure be reasonable and necessary."

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

It's a Brave New World

TJA: The Inpatient Only (IPO) List and the 2 Midnight Rule

- TKA is no longer on the Inpatient only list
- THA was not changed, but may be changed in 2020
- $10,123 payment to the hospital outpatient facility (includes implant, other supplies, ancillary staff, etc) but does NOT include the physician payment , Average reimbursement in the inpatient setting is $12,380, Proposed ASC reimbursement for SDD TKA is $8,639.97!
- Physician payments are the same in both settings (avg $1,403)
- SDD TKA is not eligible for the bundle any longer, THA is still in, but a new bundle for SDD TKA may be available in 2020 and THA may come off of the IPO list
- 2 midnight rule implications are being evaluated, unintended consequence (CMS is not doing RAC audits on TKA LOS, TKA is not UKA), QIO audits have been minimized
- There can be increased deductibles for Hospital Outpatient Surgery, there may be multiple services each with $1364 deductibles, as well as outpatient medication costs

It's a Brave New World

If all checked then OBSERVATION on admission:

( ) ASA ≤ 2

( ) Home Social Support

( ) Unilateral Surgery

( ) Hgb > 12

( ) No comorbidities which would preclude early home discharge

( ) No Chronic Anticoagulation

( ) No preoperative chronic opioid use

( ) No Chronic or Severe Apnea (OSA)

( ) No active CAD or arrhythmia

It's a Brave New World

Letter to CMS patients who do not qualify for inpatient admission

Based on your health, baseline activity level, and good social supports – we expect you to have a quicker than average in hospital recovery after your total knee replacement and hope that you will to be able to go home the day after your surgery. This will be determined by your post-operative progress, particularly your ability to mobilize with physical therapy and do the things you will need to do at home.

Medicare's rule in cases like this (hospital stay of less than 2 midnights) is that your surgery will be considered an "outpatient surgery" which may have implications for your out of pocket costs. This means that your surgery and hospital care will be covered by Medicare Part B. Patients may have an annual Medicare Part B Deductible ($185) and a 20% copay depending on your particular insurance situation. If your recovery is such that a second midnight in the hospital is medically necessary, your state may change to inpatient.

In planning for your surgery, you should understand the following:

Physical Therapy:

* It is important to attend the Pre-Operative Patient Education Class for patients awaiting Total Joint Surgery. Speak with the Surgical Scheduler to get signed up for class.
* Your recovery milestones will include adequate pain control, the ability to walk with an assistive device (crutches, or walker), and perform stairs if needed.
* You are not required to have someone with you at home 24 hours a day but it will be useful to have a friend or family member able to check in on you daily
* You may have home PT services for a week or two after surgery depending on your progress while in the hospital. You will likely be ready to go to outpatient PT 2-3 weeks after your surgery. We recommend you book outpatient PT in advance. You should arrange to go to a clinic that is convenient for you.

Costs Associated with your stay

* Outpatients will typically have an annual Medicare Part B Deductible ($185) and a 20% copay.
* Self-administered medications are not covered by Medicare Part B (so consider bringing your home medications in their original bottles)

If you have questions about your Medicare Coverage – you may contact Medicare at 800-633-4227

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Conclusions:

- There are many unintended consequences to the IPO rule application to TKA
- THA is under consideration to be removed from the IPO list in 2020
- There are clinical, financial, social, and administrative implications for all stakeholders involved in this process
- Many hospitals have defaulted CMS beneficiaries to outpatient status to avoid audit without consideration of need for inpatient admission services

2020 CMS HOPPS Final Rule

- Final rule released November 1
- CMS removing THA from the Inpatient Only (IPO) list
  - Will establish a 2-year exemption period rather than proposed 1-year
    - During the 2-year period, CMS will educate providers and practitioners regarding compliance with the 2-midnight rule
    - Claims will not be denied based on patient status (i.e., site of service) alone during this period.
    - Procedures will not be eligible for referral to Recovery Audit Contractor ("RAC") for noncompliance with the 2-midnight rule for the 2-year period

2020 CMS HOPPS Final Rule

- TKA was removed from the IPO for CY 2018
  - We do not believe CMS took adequate action to address issues that arose from the TKA IPO removal to support the removal of THA
- For CY 2020, CMS is adding a new CPT code for Total Knee Arthroplasty (TKA) to the ASC Covered Procedures List
  - AAHKS did not oppose this proposal but stated the imperative that standard procedures such as admitting arrangements with hospitals be developed before this happens, to ensure patient safety remains of paramount concern

Outpatient shift having greatest impact on demand

Patient consumerism, conservative care secondary, though strong forces

Three trends impacting demand for orthopedic care

Outpatient shift

Technology adoption

Improved clinical protocols enable outpatient surgical volume growth

Outpatient procedure coverage

Payer coverage of outpatient TKAs[1] pushes volumes out of hospital setting

Patient consumerism

Growing consumer activation

Active patient shopping replaces physician recommendations

Defined patient preferences

Selection criteria helps patient consumers independently choose care

Conservative care

Pre-authorization requirements

Pre-authorization of inpatient care pressures providers to offer more conservative options

Patient demand

Patient preference for non-surgical care leads to less use of surgery

1) Total knee arthroplasty

Source: Service Line Strategy Advisor research and analysis.

BPCI Advanced furthers CMS' value-based initiatives

Significant presence of orthopedics and spine episodes

Participants

1,299 Total participants

Eligible convener participants

- Eligible Medicare-enrolled providers or suppliers
- Acute care hospitals
- Physician group practices

Eligible non-convener participants

- Acute care hospitals
- Physician group practices

Clinical episodes

11 Orthopedics and spine related clinical episodes

Orthopedics

- Bilateral lower extremity TJR[1]
- Femur, hip, pelvis fracture
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major TJR – upper & lower extremity

Spine

- Back and neck except spinal fusion (IP & OP)
- Spinal fusion (cervical, non-cervical)

Quality measures

7 Total quality measures

Quality measures

- All-cause hospital readmission measure
- Hospital-level complication rate
- Hospital 30-day, all-cause, mortality rate

Process measures

- Advanced care plan
- Perioperative care: selection of prophylactic antibiotic
- Excess days in acute care
- CMS patient safety indicators

1) Joint replacement

Source: Bundled Payments for Care Improvement Initiative Advanced (BPCI) Fact Sheet", Centers for Medicare Services Service Line Strategy Advisor research and analysis.

Bundled payment still the dominant payer trend

CMS, private payers continue exploring alternative payment models

Three trends shaping the financial outlook for orthopedics providers

BPCI Advanced

Episode prevalence

Orthopedics and spine comprise 11 of 32 clinical episodes included

Focus on quality

Performance measured against a comprehensive set of quality measures

Commercial bundles

Private payer expansion

Large payers expanding alternative payment models with hip and knee bundles

Focus on cost variation

Payers involving major hospitals to reduce significant cost variation

Outpatient bundles

Explore OP opportunity

Private payers and physician groups exploring opportunities to compete in the fast-growing, low-cost outpatient setting

Source: Service Line Strategy Advisor research and analysis

Private payers continue expanding payment bundles

Provider-payer partnerships increase patient capture for both parties

Case in Brief: Blue Cross Blue Shield Michigan

- BCBS[1] Michigan created one of the state's first bundle for non-complex knee and hip surgeries
- Participating hospitals are responsible for 90 days after treatment, including PT, rehabilitation, home health or nursing home care
- BCBS' goal with this bundle is to reduce the significant geographic cost variation it was experiencing- $28K to $55K, as well as to incentivize providers to move cases to lower cost, outpatient settings

To learn more about orthopedic bundled payment programs being developed by private payers, please visit Advisory.com

BCBS bundle details

Participants - two medical groups, five hospitals and 65 surgeons

Bundle rates differ by region, with southeast providers receiving a single fee of **$28,700**

10% savings target off average cost of joint replacement

1) Blue Cross Blue Shield

Source: "Blue Cross Blue Shield of Michigan Launches Bundled Payment Program to Manage Cost, Improve Outcomes for Hip and Knee Replacement Surgeries", MI Blues Perspectives; Service Line Strategy Advisor research and analysis

Private payers exploring outpatient bundles

Physicians are using bundles to compete for outpatient volumes

Delta Joint Management's strategies for success under outpatient bundles

Select top-performing physicians

Emphasize high quality outcomes and low cost variation

Extend comprehensive case management

Employ case managers to streamline transitions at each stage of bundle

Involve post-acute providers in risk

Standardize treatment protocols to decrease patient recovery time and reduce complications

Case in brief: Delta Joint Management

- Physician-owned case management company specializing in operating outpatient joint replacement bundles
- Launched 90-day joint replacement bundles for knees, hips, and shoulders in partnership with **Blue Cross and Blue Shield of North Carolina.**

Impact of bundle

200%	Increase in program volumes under bundle since 2017
15%-20%	Average cost savings over fee-for-service OP joint replacements

Source: "Physician driven bundles — How Drs. Steve Lucey, Frank Aluisio, Matt Olin and Frank Rowan took control of the bundle", Becker's ASC review; Service Line Strategy Advisor research and analysis

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

CMS' Innovation Center is launching an initiative that provides primary care practices with five new payment options, including three direct contracting models.

- 1. The CMS Primary Cares Initiative will provide the new payment model options under two paths: Primary Care First and Direct Contracting.
- 2. The two payment models offered under the PCF track are aimed at individual primary care practices, while the DC model options are aimed at larger practices, health systems and other organizations that have experience with risk-based contracts.
- 3. All of the new model options link performance to payments to varying degrees. CMS said the PCF options seek to reduce hospital use and total cost of care through performance-based adjustments. The DCF payment options provide participants with a range of financial risk arrangements and focus on care for patients with complex, chronic needs and serious illness.
- 4. The PCF models will be tested for five years and are slated to begin in January 2020. Two of the DC options will begin in January 2020 with an initial alignment year, and a third option, the geographic model, is expected to launch in January 2021 and run for five years.
- 5. CMS expects 25 percent of primary care providers to join one of the five models.
- 6. The American Medical Association is pleased with the new payment options.

"Providing adequate financial support for high quality primary care must be an essential element of any strategy to improve the quality and affordability of our country's healthcare system," Gerald E. Harmon, MD, immediate past chair of the AMA board of trustees, said in a press release. "Many primary care physicians have been struggling to deliver the care their patients need and to financially sustain their practices under current Medicare payments. The new primary care payment models announced today will provide practices with more resources and more flexibility to deliver the highest-quality care to their patients."

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Bundles: Where are we?

Now what? A race to the bottom…..

- Original NYULMC BPCI target price for 90 days- $35,000 in 2013
- Lowest average episode price we got to was $24,000 in 2018
- Target price was reduced in BPCI to $31,000
- New target price in CJR mandatory is $23,850
- What happens to the safety net hospitals???
- BPCI-A target prices are even lower, in the 16,000 to 22,000 range. Reportedly increased in BPCI A 2.
- Outpatient TKA reimbursement proposal $8,639.97!
- Is this sustainable?

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Bundles: Where are we?

Now what? A race to the bottom…..

- So what happens when a DRG for TJA (470) approaches $14,000 per hospital stay and the 90 day episode cost for TJA approaches $16,000???
- 90-day DRG's for all TJA, public and private, at a set price
- Once we master that…..
- They will roll TJA into an ACO model for arthritis care and we will have to fight with the internists for our share of the musculoskeletal management dollars

It's a Brave New World

Accountable Care Oganizations (ACO)

- Modern Healthcare (8/27, Dickson, Subscription Publication) Next Generation ACOs require "physicians to take on substantial financial risk."
- The program saved Medicare more than $100 million during its first year.
- "After paying out shared savings to providers, Next Generation ACOs generated $62 million in net savings for Medicare." These figures are based on data from "the 18 ACOs that launched in 2016 under the new model.
- They collectively cared for 477,197 Medicare beneficiaries.

It's a Brave New World

Accountable Care Organizations (ACO)

- Congressional Quarterly (8/27, Clason, Subscription Publication) reports the Next Generation ACO program, a pilot which seeks "to reduce costs and improve care coordination for Medicare patients, saved more than $62 million in its first year, a 1.1 percent reduction in spending
- On the whole, the program had "savings of $11.20 per Medicare beneficiary per month and reduced acute care hospitalizations by 1.3 percent in 2016, according to the Centers for Medicare and Medicaid Services."
- However, only "four out of the 18 participating accountable care organizations accounted for roughly 57 percent of the savings."
- CMS Administrator Seema Verma stated, "ACOs in the Next Generation Model are being held accountable with strong financial incentives and are provided with substantial flexibility and regulatory relief. ... They are delivering value and providing quality care to patients and taxpayers even in their first performance year, and we believe that these results are achievable for other ACOs under similar incentives."

It’s a Brave New World

Bundling Drives Value

- Incentivizing the surgeon to find better value is the lynchpin to driving prices down. Alignment of payer, surgeon and hospital in order to deliver the right operation, at the right price in the proper setting is the key to success
- While in their infancy, true bundled payment programs are proving to be fruitful for provider, facility and most importantly, patients, in the pursuit of better value. These bundled payment programs reimburse facility and surgeon with one, predetermined payment. The result is that physician and facility are aligned and driven to find the best value for the best delivery of care.
- A separate reimbursement for facility and surgeon is a large impediment to lower healthcare costs. The movement is considered to be one where healthcare migrates from “fee-for-service” to “pay-for-performance.” Under fee-for-service, incentives are all volume driven and do not reward value. Pay-for-performance awards best practices and highest value.
- The incentives for surgeons are not in their reimbursement per se, but rather the quality of medicine they practice. Large, academic hospitals are proving to be the most progressive in moving to generic devices. Gainsharing is a key to driving this change.
- While methodologies vary, large, academic hospitals provide service-line reinvestment when doctors create better value. Whether it’s for research, expanding the fellowship program, or adding supporting clinical staff, all of which allow doctors to practice better medicine and further its science
- What about the RUC????
- The next battle ground will be specialist reimbursement within an ACO

Thank You

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

1:05 – 2:30 p.m. Session V

Alternate Payment Models: What's Next?, Richard Iorio, MD

1:05 – 1:20 p.m. BPCI, CJR – Where We've Been and Where We're Going, Richard Iorio, MD
1:20 – 1:35 p.m. Private Bundles – Negotiating with Payers Walter B. Beaver, MD
1:35 – 1:50 p.m. Musculoskeletal Capitation William A. Jiranek, MD, FACS
1:50 – 2:05 p.m. Cash Only, Please Richard F. Santore, MD
2:05 – 2:30 p.m. Discussion Richard Iorio, MD and Panel
2:30 p.m. Adjourn

AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

Discussion

2020 CMS HOPPS Final Rule

- Final rule released November 1
- CMS removing THA from the Inpatient Only (IPO) list
  - Will establish a 2-year exemption period rather than proposed 1-year
    - During the 2-year period, CMS will educate providers and practitioners regarding compliance with the 2-midnight rule
    - Claims will not be denied based on patient status (i.e., site of service) alone during this period.
    - Procedures will not be eligible for referral to Recovery Audit Contractor ("RAC") for noncompliance with the 2-midnight rule for the 2-year period

2020 CMS HOPPS Final Rule

- TKA was removed from the IPO for CY 2018
  - We do not believe CMS took adequate action to address issues that arose from the TKA IPO removal to support the removal of THA
- For CY 2020, CMS is adding a new CPT code for Total Knee Arthroplasty (TKA) to the ASC Covered Procedures List
  - AAHKS did not oppose this proposal but stated the imperative that standard procedures such as admitting arrangements with hospitals be developed before this happens, to ensure patient safety remains of paramount concern