Health Care Reform
Impact on Total Joint Replacement

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KEYWORDS

• Health care reform • ACA • Quality care • TJA • MIPS • MACRA • CMS

KEY POINTS

- The implementation of the Affordable Care Act changed the traditional approaches to payment reform and delivery of care, with an emphasis on integrated delivery systems.
- Quality care and reimbursements that drive efficiency, when implemented properly, can be a motivating factor toward improving the health of the nation.
- Understanding health reform and policy will empower arthroplasty providers to effectively advocate for the field of orthopedics as a whole, and the patients we serve.

INTRODUCTION

The US health care system has existed in a fragmented nature for more than 40 years. In his book "The Healing of America," T.J. Reid clearly outlines the 4 models of care in his search for a health care system that would provide the highest quality of care in the most cost-efficient way.[1] Under the Bismarck system, private insurers pay private physicians; the system is funded through the employer and payroll deductions, but the profits that private insurance companies are allowed to make are highly regulated.[1] In the United States, this system is applied to most workers under the age of 65 years.[2] In contrast, the universal care Beveridge model is reflected in the care provided for groups such as the US military, veterans, and Native Americans.[1] These more recognized models, such as the Bismarck system of Germany or the Beveridge model of the United Kingdoms, have been morphed into a complex array of systems that separate access to health care services based on socioeconomic factors. Many politicians, insurance companies, and providers have resisted policies that reflect the type of "socialized" medicine that is provided in models like Canada's National Health Insurance. Nonetheless, this model that uses private sector providers who are paid by government insurance agencies is seen in the 50-year-old American Medicare/Medicaid programs.[2] Ultimately, the American model has included all 3 of these models, and for the 17% of Americans who do not neatly fall into one of these categories, they are forced to pay out of pocket for medical services like the citizens of India.[1] This structure has created vast disparities in access and quality of health care provided to different social classes based on the payment that health professionals accept for medical services provided.

The disjointed model of medical access and payment created a great need for modification in the US health care system. The combination of increasing health care costs with inconsistent

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and suboptimal quality of care that fared poorly in comparison with other nations meant that wide-scale structural changes were warranted.[3] The inconsistency of care has been observed in the approach providers take to manage back pain, osteoarthritis, and other musculoskeletal conditions.[4] The geographic region in the United States has been correlated with determining the options of intervention, whether it is more likely to be surgical or conservative medical treatment with physical therapy, in orthopedic surgery.[5] Additionally, the geographic location has been shown to be an independent variable affecting cost of delivered care. The recent increase in the proportion of Americans covered by Medicare and Medicaid has been governed by the increase in the elderly population, the low-income population, and greater patient complexity. This change will shift a greater proportion of health care expenditures and costs toward the federal and state governments. In an attempt to provide more sustainable methods for health care coverage, the development of a system that increased access, improved quality, and curtailed costs was presumed to be the best option for the American population.

There have been several unsuccessful attempts to revamp the America health care system. The unique combination of sociopoliticomedical system-related factors led to the passage of the Affordable Care Act (ACA) and a complete restructure of health care provision and delivery. Socially, the recession just before the 2008 election led to the highest unemployment rate in several decades and to an increased awareness of the magnitude of health care costs and their impact on the unemployed population. Several constituents were now denied access to care that was provided through their relationship with an employer. The topic of health care reform quickly became a national focal point of the 2008 presidential debates and the newly elected administration of President Obama had become very familiar with the process of remodeling the system. Politically, it was the first time in several years that the party of the executive branch also held the majority in the legislative branch. This meant there were fewer barriers needed to successfully align political goals and pass a bill through Congress that would also be supported by the president. Finally, the new health care model was shaped largely after ideas developed and implemented in Massachusetts, a progressive state in all health care advances. These factors greatly increased the chances of passage and success for revitalizing the health care system.

The 2010 implementation of the ACA changed the traditional approaches to payment reform and delivery of care, with an emphasis on integrated delivery systems.[6] One of the first areas in medicine, and the first area of orthopedics to be impacted by these alterations, were in total joint arthroplasty (TJA). These changes include payment reform through value-based purchasing or bundled payments, and a shift toward multidisciplinary care provided by accountable care organizations and patient-centered medical homes.[7,8] A closer look at the legislative provisions of the ACA allow the orthopedic provider to better understand how these changes can impact their practice, and subsequently the care and outcomes of patients undergoing TJA.

The Three Prongs of the Affordable Care Act: Increase Access, Reduce Cost, Improve Quality

The prongs of the ACA were implemented to increase access to "affordable care" of the highest possible quality under cost-effective measures (Fig. 1). However, most policy provisions have addressed primarily access to care. Currently, there are 14 million more patients insured through Medicaid than there were 3 years ago, with more than 4.2 million insured through the health care marketplace insurance exchanges.[9] It is projected that the number of total hip arthroplasty procedures will increase to 520,000 and the number of total knee arthroplasty (TKA) will be approximately 3.48 million by 2030.[10] Growth rates of upper extremity arthroplasty have been shown to be comparable with or greater than rates of total knee or hip procedures.[11] Procedure volume of shoulder arthroplasty increased at annual rates of up to 13% between 1993 to 2007, with an estimated total increase of 322% since 2007.[11] The Medicaid expansion means even more of the population will qualify for elective procedures, such as TJA, because these projections do not account for the increased access to care brought about through the ACA.

Assessing Quality in Care Delivery

The other 2 prongs have become the focus of reimbursement models in which payments are linked to the assessment of quality of care provided. There have been several regulatory responses to help improve quality in arthroplasty care. Approaches to standardize optimal medical practice that would decrease the rate of medical errors and complications have become more commonplace. Organizations, such as the American Academy of Orthopaedic Surgeons