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- This document was written and produced by:
  American Academy of Orthopaedic Surgeons
  9400 West Higgins Road
  Rosemont, Illinois 60018-4976
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Introduction

Value-Based Care Origins

Health care payment in the United States originally looked very different than it does today. Like many other industries that offer up goods and services, historically the provision of health services involved a direct relationship between the supplier (i.e. health care provider) and the purchaser (i.e. consumer). In the early 1900s patients would often negotiate directly with providers based on their ability to pay (Moriates, Arora, & Shah, 2015). Fast forward and today’s payment landscape looks much different.

Health insurance for medical care is now commonplace, serving as an intermediary between the supplier and purchaser of health services. Originally contemplated for catastrophic care coverage, modern health insurance provides coverage for virtually all care including routine services with payers negotiating rates with physicians, facilities and other providers of care on behalf of their members. The Kaiser Family Foundation (KFF) estimates a proportional breakdown of insurance type as follows:

- **Employer-Based**
  - 49%
  - Individuals with insurance through their current or former employer.

- **Medicaid**
  - 20%
  - Individuals covered by Medicaid, Medical Assistance, Children’s Health Insurance Plan (CHIP), dual-eligibles (both Medicaid and Medicare), and other government plans focused on low-income and/or those with disabilities.

- **Medicare**
  - 14%
  - Individuals covered by Traditional Medicare (Parts A, B and/or D) and Medicare Advantage (Part C); focus area is older Americans, individuals with end stage renal disease (ESRD), and individuals with specified disabilities.

- **Uninsured**
  - 9%
  - Individuals without health care insurance, and those covered by the Indian Health Service.

- **Non-Group (Individual)**
  - 6%
  - Individuals who are covered directly by a health insurance company.

- **Military**
  - 1%
  - Individuals covered by the military or the Veterans Administration (VA).

(Kaiser Family Foundation, 2018)
Defining Cost, Quality and Value
This complicated patchwork of health insurance coverage has made it challenging to longitudinally assess, organize and deliver health interventions for patients across their lifetime, and in a holistic way. As a result, payment models did not take quality of service or outcomes into account and only reimbursed based on utilization, thus incentivizing doing more rather than improving health. As multiple factors have driven healthcare costs up faster than the rest of the economy, employers and the federal government have recognized that the current system of payment is unsustainable and must be redirected to produce “high-value” health interventions.

Greater demand for lower costs and more significant improvements to quality continues to evolve and mature, making it critical to define cost, quality and value and their relation to one another. Appropriate measurement of these elements is needed to achieve the desired future state of “value-based care”. In an effort to guide Members throughout this process, the American Academy of Orthopaedic Surgeons (AAOS) has defined cost, quality and value as follows: (Adapted from Quinn & Murray, 2020)

Cost, Quality, and Value as Defined by The American Academy of Orthopaedic Surgeons

**Quality**
- is the successful delivery of appropriate, evidence-based musculoskeletal health care in an effort to achieve sustained patient-centered improvements in health outcomes and quality of life
- is exemplified by a physician-led musculoskeletal team focused on the individual patient’s preference in the delivery of care that is safe, accessible, equitable, and timely
- fosters evidence-based innovations essential for the advancement of professional and scientific knowledge

**Value**
- is defined as the relationship of a patient-centered health outcome to the total cost required to reach that outcome, given that:
  - care is:
    - evidence-based
    - appropriate
    - timely
    - sustainable
    - occurs throughout a full cycle of musculoskeletal care for a patient’s condition
  - cost is:
    - of musculoskeletal care is an investment and includes consideration of greater lifestyle and economic impacts
The Cost, Quality and Value definitions serve as a universal framework for defining musculoskeletal (MSK) care aimed at achieving greater value. While critically important, this is only the beginning. Providers will have to take these elements and translate them into new care delivery models that perform effectively in alternative payment models (APMs) being developed by payers. **Understanding how various APM models are constructed and what it means for clinical practice is needed to improve patient outcomes, lower costs, maintain financial stability, and achieve long-term success.**

### 2 Purpose

The purpose of this document is to take the existing — often opaque — value-based care landscape and make it more digestible and understandable. To accomplish this, the American Academy of Orthopaedic Surgeons (AAOS) has developed a value-based care continuum (VBCC) to help practices navigate the various APMs created to achieve value-based care. This includes identifying where a practice’s existing payment arrangements fall along the VBCC, understanding the transition sought by purchasers/payers to value-based care, and planning for continued changes in APM payer contracting arrangements.

### 3 Scope

The VBCC focuses on categorizing various APMs in terms of how aggressively they set cost and quality metrics to achieve greater value. The typical assessment of an APM along the continuum is the level of risk and opportunity that is involved for providers. The greater the opportunity for both financial gains and losses, typically the further along the continuum a given APM is found. **The scope of this document is to provide a comprehensive outline of APMs in the existing value-based landscape of specific relevance to MSK care.** Since this is a fluid environment, this document may be updated in the future to reflect new changes. Additionally, future documents may utilize this framework and focus more directly on specific APMs, or other value-based care topics.
Defining Risk in Alternative Payment Models

APM Risk Categories

Prior to engaging in an APM it is critical to determine the level of risk presented by the new model. Purchasers directly (or indirectly through payers) are increasingly seeking out providers who can lower costs and increase quality for health services. In order to align business incentives towards reductions in cost and increases in quality, payers reward and penalize providers in APMs through financial arrangements. By accepting an arrangement that has associated rewards and penalties a provider is putting a certain amount of current reimbursement “at risk” for the opportunity to obtain a greater financial reward. If a provider is able to lower cost of care while improving quality of care, they receive a portion of the savings created. There are many types of risk associated with achieving a positive financial outcome.

For the purposes of this VBCC framework, the AAOS has adopted the Society of Actuaries (SOA) categorization of risks inherent in APMs.

<table>
<thead>
<tr>
<th>Society of Actuaries APM Risk Categorization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Risk..........................</td>
<td>The risk of changes in utilization (volumes) and payment changes, relative to operating cost changes (variable costs).</td>
</tr>
<tr>
<td>Technical Risk............................</td>
<td>The risk of appropriately structuring technical elements of a contract to match the population and circumstances.</td>
</tr>
<tr>
<td>Insurance Risk............................</td>
<td>The risk related to the normal variation in demand for medical services over time, and differences in utilization within segments of insured populations.</td>
</tr>
<tr>
<td>Performance Risk..........................</td>
<td>The risk related to inefficiency, suboptimal quality, and high cost of care.</td>
</tr>
</tbody>
</table>

(Society of Actuaries, 2015)

Essentially, if you are able to lower cost of care while improving quality of care, you receive a portion of the savings created.
APM Risk Controls
Knowing what risks are controllable can enhance the likelihood of success before undertaking an APM. Based on the size and scope of a provider’s practice, certain types of risk are more controllable than others. The AAOS strongly recommends that providers focus on performance risk where they can have the most control and greatest impact. If a provider is responsible for the financing of their organization, they may want to understand the technical and utilization risk associated with an APM contract. Insurance risk should be avoided unless there is significant integration of services and a large enough risk pool to offset expected and unexpected variation.

### APM Type of Risk and Control

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Level of Control</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Risk</td>
<td><strong>High Level of Control</strong></td>
<td>The most controllable aspect for providers because it directly applies to the provision of care delivery and health outcomes associated with that care. Applicable to all front-line providers.</td>
</tr>
<tr>
<td>Technical Risk</td>
<td><strong>Medium Level of Control</strong></td>
<td>Less controllable because it involves risk related to appropriate financing (technical, utilization risk) of a practice. For example, are APM model payments able to cover overhead, needed care redesign, and other necessary expenses? Does the contractual agreement factor in exclusion criteria that are outside the control of the provider? Applicable to the financing arm of a provider entity.</td>
</tr>
<tr>
<td>Utilization Risk</td>
<td><strong>Medium Level of Control</strong></td>
<td></td>
</tr>
<tr>
<td>Insurance Risk</td>
<td><strong>Low Level of Control</strong></td>
<td>Least controllable aspect for providers because it relates to the normal and unexpected variation of population-level demand for health services. Applicable to those willing to take on insuring a population.</td>
</tr>
</tbody>
</table>

The AAOS strongly encourages providers to focus on areas that have high controllability.
5 Health Care Payment Learning & Action Network

In 2015, a multi-stakeholder collaborative called the Health Care Payment Learning & Action Network (HCP-LAN) was formed to align payment activities among public and private health care purchasers. Funded by the Centers for Medicare and Medicaid Services (CMS), HCP-LANs’ stated goal is to “accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models” and has set specific targets related to this end. (HCP-LAN, 2020)

The significance of these aims is bolstered by the wide range of public and private payers within the U.S. health care system that support these goals. The HCP-LAN has developed several resources to aid stakeholders in the adoption of these targets. Most notably, they put together a nationally recognized framework for categorizing various APM arrangements. (HCP-LAN, 2020)

The HCP-LAN framework delineates categories based on the underlying payment structure. As you move from Category 1 to Category 4, there is an increasing shift away from retrospective fee-for-service based payment models to more prospective capitated payment models, along with increasing levels of risk for model participants. The HCP-LAN framework emphasizes that any payment model without corresponding quality metrics will not be considered a “true” APM.

While the AAOS has not taken a position endorsing this framework, it is useful to know for two reasons:

1. It is the most widely adopted framework, to date, categorizing the transition from fee-for-service to value-based care.
2. It provides a payer perspective of progressively moving towards value-based care.
6 Value-Based Care Continuum

There is no question that the existing value-based care landscape can at times be confusing and daunting, with many incentives and structures. Various stakeholders have different definitions for the same terms that are used in a clinical setting, which only adds to the complexity.

We encourage reviewing the Definitions section to understand how various terms are used in the context of this document, and can be used uniformly moving forward.

The AAOS VBCC serves to view the existing APMs from the vantage point of MSK providers and how best to enter into and perform well on value-based care models. The AAOS will continue to stay current as more is learned and new models are developed. (Note: This document does not endorse one area of the continuum over another, nor a particular APM over another)

Value-Based Care Continuum Framework

Category 1: Fee-for-service Incentive-based Payment

Alternative payment model constructs use incentive payments for sharing quality information and/or meeting specified quality metrics. Actual payment may or may not be based on meeting specified quality metrics.

Purchasers: Traditional Medicare

PAYMENT ARRANGEMENTS:

Model Type 1: Pay for Reporting
Model Type 2: Pay for Performance

Examples:

- Merit-Based Incentive Payment System (MIPS)
- MIPS Value Pathway (MVP)

Purchasers: Commercial (Employer-Based and Non-Group Individual)

PAYMENT ARRANGEMENTS:

Model Type 1: Pay for Reporting
Model Type 2: Pay for Performance

Examples:

- Provider receives referral based on value performance (e.g. premium designation or centers of excellence (COE status))
- Provider receives incentive payment for shifting to low cost site of care (Professional Fee Payment)

Purchasers: Medicare Advantage

PAYMENT ARRANGEMENTS:

Model Type 1: Pay for Reporting
Model Type 2: Pay for Performance

Purchasers: Medicaid

PAYMENT ARRANGEMENTS:

Model Type 1: Pay for Reporting
Model Type 2: Pay for Performance

(chart continued on next page)
Value-Based Care Continuum Framework (cont.)

Category 2: Fee-for-service Benchmark-based Payment
Alternative payment model constructs that use benchmark methodologies to assess cost and determine participant profit/loss. **Actual payment is based on meeting specified quality and cost metrics.**

**Purchasers: Traditional Medicare**

**PAYMENT ARRANGEMENTS:**

**Model Type 1:** Retrospective Procedural Bundle (Acute Care)
- **Examples:**
  - Bundled Payment for Care Improvement (BPCI) Model 1*

**Model Type 2:** Retrospective Procedural Bundle (Acute Care & Post-Acute Care)
- **Examples:**
  - Comprehensive Joint Replacement (CJR) Model
  - Bundled Payment for Care Improvement (BPCI) Model 2*
  - Bundled Payment for Care Improvement (BPCI) Advanced Model

**Model Type 3:** Prospective Procedural Bundle (Acute Care)
- **Examples:**
  - Bundled Payment for Care Improvement (BPCI) Model 4*

**Model Type 4:** Prospective Procedural Bundle (Acute Care & Post-Acute Care)

**Model Type 5:** Prospective Condition-based Bundle

**Model Type 6:** Sub-agreement With Risk-Bearing Entity
- **Examples:**
  - Medicare Shared Savings Program (MSSP)**
  - Next Generation ACO Model **

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**Purchasers: Commercial (Employer-Based and Non-Group Individual)**

Commercial purchasers and payers are implementing various types of these models.

**PAYMENT ARRANGEMENTS:**

**Model Type 1:** Retrospective Procedural Bundle (Acute Care)
**Model Type 2:** Retrospective Procedural Bundle (Acute Care & Post-Acute Care)
**Model Type 3:** Prospective Procedural Bundle (Acute Care)
**Model Type 4:** Prospective Procedural Bundle (Acute Care & Post-Acute Care)
**Model Type 5:** Prospective Condition-based Bundle

Examples for all Medicare Advantage Model Types:
- **Sub-agreement with risk bearing entity (i.e. Commercial Payer, Independent Practice Association, Clinically Integrated Network)**

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(Chart continued on next page)
Value-Based Care Continuum Framework (cont.)

Category 2 (cont.)

**Purchasers: Medicaid**

- **PAYMENT ARRANGEMENTS:**
  - Model Type 1: Retrospective Procedural Bundle (Acute Care)
  - Model Type 2: Retrospective Procedural Bundle (Acute Care & Post-Acute Care)
  - Model Type 3: Prospective Procedural Bundle (Acute Care)
  - Model Type 4: Prospective Procedural Bundle (Acute Care & Post-Acute Care)
  - Model Type 5: Prospective Condition-based Bundle

Category 3: Capitated/Sub-capitated Payment

Alternative payment model constructs that use capitated and/or sub-capitated payments to enforce cost restraints and determine participant profit/loss. **Actual payment is based on meeting specified quality and cost metrics.**

**Purchasers: Traditional Medicare**

- **PAYMENT ARRANGEMENTS:**
  - Model Type 1: Capitation/Sub-capitation for condition-specific MSK care
  - Model Type 2: Capitation/Sub-capitation for full range of MSK care

**Purchasers: Commercial (Employer-Based and Non-Group Individual)**

- **PAYMENT ARRANGEMENTS:**
  - Model Type 1: Capitation/Sub-capitation for condition-specific MSK care
  - Model Type 2: Capitation/Sub-capitation for full range of MSK care

**Purchasers: Medicare Advantage**

- **PAYMENT ARRANGEMENTS:**
  - Model Type 1: Capitation/Sub-capitation for condition-specific MSK care
  - Model Type 2: Capitation/Sub-capitation for full range of MSK care

Examples for all Medicare Advantage Model Types:

- Sub-agreement with risk bearing entity (i.e. Commercial Payer, Independent Practice Association, Clinically Integrated Network)

**Purchasers: Medicaid**

- **PAYMENT ARRANGEMENTS:**
  - Model Type 1: Capitation/Sub-capitation for condition-specific MSK care
  - Model Type 2: Capitation/Sub-capitation for full range of MSK care

* No Longer Active

** Indirect = Not a Direct Participant in the Program. Enter Into Sub-agreements with Participants in the Program
Future Trends Related to Health Care Delivery

In 2020, the world experienced the emergence of a novel coronavirus, causing the infectious syndrome known as COVID-19. As COVID-19 reached pandemic proportions, many countries instituted various “social distancing” and “stay-at-home orders” to contain the transmission. Since its emergence, COVID-19 accelerated several existing health care delivery trends in the United States.

**Retrospective vs. Prospective Payment**

There is a greater drive to achieve value-based care, which includes a greater emphasis on taking on risk and prospectively managing payment. COVID-19 accelerates this trend as health services are curtailed to prevent disease transmission. Providers who rely on fee-for-service and other retrospective payments are experiencing significant financial strain, since payment is made following the delivery of a specific service, vs. upfront management of a patient population. A mix of prospective and retrospective payment sources buffers a practice against the risk of a sudden rise or drop in utilization and creates more stability for practice finances.

**Virtual Care Delivery**

The federal government has made several changes to federal payer programs, like Medicare, to enhance virtual care delivery during the COVID-19 pandemic. This includes increasing telemedicine reimbursement (paying the same as in-person services), and expanding virtual care service reimbursement in areas like remote virtual monitoring. As in-person services are curtailed to prevent disease transmission, virtual care delivery becomes an essential component of effective care delivery.
8 Document Definitions

Note: Definitions have been constructed for the purpose of this document and may not represent uniform consensus of a given term in existing nomenclature. Additionally, uniform consensus for many of these terms remains elusive. Please use these definitions to guide your understanding of this document.

**Quality:** Is the successful delivery of appropriate, evidence-based musculoskeletal health care in an effort to achieve sustained patient-centered improvements in health outcomes and quality of life; is exemplified by a physician-led musculoskeletal team focused on the individual’s patient preferences in the delivery of care that is safe, accessible, equitable, and timely.

**Value:** Is defined as the relationship of a patient-centered health outcome to the total cost required to reach that outcome, given that:

- Care is evidence-based; appropriate; timely; sustainable; occurs throughout the full cycle of musculoskeletal care for a patient’s condition.
- Cost of musculoskeletal care is an investment and includes consideration of greater lifestyle and economic impacts.

**Alternative Payment Model (APM):** An alternative financial arrangement to traditional fee-for-service that aims to either reduce costs, increase quality, or reduce costs and increase quality.

**Value-Based Care:** An optimal state of health services that achieves value for patients through effective valuation and improvements in quality and cost metrics.

**Value-Based Care Continuum (VBCC):** An AAOS framework for evaluating existing alternative payment models that have been constructed to achieve value-based care.

**Health Care Payment & Learning Action Network (HCP-LAN):** A public-private consortium of individuals committed to accelerating the U.S. health care system’s adoption of alternative payment models.
9 Value-Based Care Continuum Definitions

Note: These definitions have been constructed for the purpose of the VBCC and may not represent uniform consensus of a given term in existing nomenclature. Please use these definitions to guide your understanding of the VBCC.

9.1 Health Care Payer Definitions

**Purchaser:** Entities/individuals that purchase health services.

**Payer:** Entities that have responsibility for paying a claim and may provide other third-party administrative services. Purchasers and payers may be interchangeable.

**Traditional Medicare (Parts A, B, and D):** A type of insurance administered by the federal government to purchase health care services for older Americans (65 or older). Individuals are enrolled automatically in Part A (inpatient) and Part B (outpatient); both purchaser and payer are the federal government. Individuals may elect to enroll in Part D (prescription drugs); purchaser is the government and the payer is a private health insurer plan.

**Medicare Advantage (Part C):** A type of insurance overseen by the federal government and administered by private health insurer plans to purchase health services for older Americans (65 or older). Individuals select private health insurer plans based on marketplace offerings; purchaser is the government and the payer is a private health insurer plan.

**Commercial:** A type of insurance administered by private health insurer plans to purchase health care services for individuals. Employers, employees, and individuals purchase health services through a private health insurer plan and may pay a portion of those overall costs in the form of a premium (monthly payment to an insurer).

**Medicaid:** A type of insurance overseen by the federal government and administered by state governments to purchase health services for low-income individuals, individuals with disability, and others that meet federal and/or state-specific criteria. A state government may purchase health services through private health insurer plan offerings.
9.2 Alternative Payment Model (APM) Definitions

**Benchmark**: An agreed upon cost target between a purchaser/payer and provider for the provision of health services.

**Episode of Care**: The life cycle of a specified health intervention to achieve a given outcome.

**Risk-adjustment**: A financial calculation to account for health conditions and adjust expected costs based of a patient's risk profile.

**Global Payment**: An agreed upon lump sum payment between a purchaser/payer and provider for the provision of health services.

**Per Member Per Month (PMPM)**: An agreed upon monthly payment per patient between a purchaser/payer and provider for the provision of health services.

**Pay for Reporting**: APM financial arrangement where the purchaser/payer rewards the provider for reporting cost and/or quality-specific information.

**Pay for Performance**: APM financial arrangement where the purchaser/payer rewards and/or penalizes the provider for achieving specified quality targets.

**Shared Savings**: APM financial arrangement where the purchaser/payer rewards (upside) and penalizes (downside) providers for costs under/over a pre-determined benchmark. APM financial arrangements can be upside only, or upside and downside.

**Retrospective Procedural Bundle**: APM financial arrangement where the purchaser/payer retrospectively (after an event has already occurred) pays a provider for managing the full episode of care for a given procedure (e.g. total knee arthroplasty) based off a pre-determined benchmark.

**Prospective Procedural Bundle**: APM financial arrangement where the purchaser/payer prospectively (before an event has occurred) pays a provider for managing the full episode of care for a given procedure (e.g. total knee arthroplasty) based off a pre-determined benchmark.

**Condition-Based Bundled Payment**: APM financial arrangement where the purchaser/payer prospectively (before an event has occurred) pays a provider for managing the full episode of care for a given health condition (e.g. osteoarthritis) based off a pre-determined benchmark.

**Capitation**: APM financial arrangement where the purchaser/payer pays a provider a global payment, or per member per month (PMPM) payment for providing a comprehensive set of services for a patient. Payment is typically risk-adjusted to account for differences in patient profiles.

**Sub-Capitation**: APM financial arrangement where the provider of a capitation contract pays another provider a global payment, or per member per month (PMPM) payment for providing a comprehensive set of services for a patient. Payment may or may not be risk-adjusted to account for differences in patient profiles.
9.3 Centers for Medicare and Medicaid Services (CMS) Model Definitions

**Merit-Based Incentive Payment System (MIPS):** A pay-for-performance program in Traditional Medicare aimed at improving value. The MIPS program comprises four performance categories that include Quality; Promoting Interoperability (PI); Improvement Activities (IA); and Cost measures.

**MIPS Value Pathway (MVP):** A pay-for-performance program in Traditional Medicare that aims to expand the existing MIPS program into episodes of care for specified measures.

**Episode of Care:** The life cycle of a specified health intervention to achieve a given outcome.

**Medicare Shared Savings Program (MSSP):** A voluntary shared savings program in Traditional Medicare that utilizes accountable care organizations to improve population health outcomes.

**Next Generation ACO Model:** A voluntary, advanced (increased risk and reward) shared savings program in Traditional Medicare that utilizes accountable care organizations to improve population health outcomes.

**Bundled Payment for Care Improvement (BPCI) Model:** A voluntary procedural bundle program in Traditional Medicare that focused on improving value for clinical episodes set by specified procedures. BPCI included both retrospective and prospective models.

**Bundled Payment for Care Improvement Advanced (BPCI-A) Model:** A voluntary, advanced procedural bundle program in Traditional Medicare that focuses on improving value for clinical episodes set by specified procedures.

**Comprehensive Joint Replacement (CJR) Model:** A mandatory procedural bundle program in Traditional Medicare that focuses on improving value for clinical episodes for lower extremity joint replacement (LEJR) procedures.

**Direct Contracting (DC) Model:** A voluntary program in Traditional Medicare that allows providers to contract with other providers to improve value and population health outcomes.

**Longitudinal Surgical Care (LSC) Models:** (Note: These models are currently still in develop by CMS).

10 **Right to Modify Policy**

The American Academy of Orthopaedic Surgeons reserves the right to modify this Navigating Value-Based Care Arrangements: An Orthopaedic Guide at any time. Changes and modifications will be effective when approved and posted.

11 **Bibliography**


