Outpatient Bundled Payments

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No Disclosures

Outline

- Why bundled payments?
  - Where is the disconnect and how to address it
- What procedures are amenable to outpatient bundles?
- What are the challenges?
- What are the opportunities?
- Actionable steps

Why Bundle?

- Healthcare delivery and payment reform
- Post- SGR value-based payment models (MACRA)
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
- Proposed models driven by overall trend towards ***value-based care*** : Quality/Cost

Why Bundle?

- For orthopaedic surgeons → Advantaged position in understanding which components in care cycle of procedure are critical vs expendable.
- For orthopaedic surgeons in outpatient setting→ greater control over decision making.
- Outpatient bundles simpler than inpatient bundles (less complex cases, fewer providers, less post-acute care, lower readmissions).
- With mandatory bundling for total joint replacement in place, need to prepare to participate more widely in the model.

What Does This Mean for Orthopaedic Surgeons?

- Who currently defines value?
- Who currently controls value?
- Where is the disconnect?
- How do we identify it and bridge it?

Value

- Value = Quality / Cost
  - Quality set by metrics we must report
    - *Measurable use* rather than "Meaningful Use"
  - Cost set by CMS/insurance providers we must adhere to

- Currently excluded from process of defining "value"

Value

- Where is the disconnect?
  - Our patients cannot quantify quality
  - Our patients are shielded from costs
  - Payers utilize non-specific proxies for quality
  - Payers are in the business of transferring/shifting costs
  - Surgeons lack data on individual performance/outcomes
  - Surgeons have not previously been able to influence cost

Value

- What can we control?
  - Our indications
  - Choice of procedures
  - Post acute care utilization
- How do we seize more control?
  - Define and standardize our indications
  - Create/Adhere to evidence base for our procedures
    - Data and the culture of measuring ourselves
  - Become active in directing post-acute care

Outpatient Bundles

- Require much work, but provide an opportunity
- Inpatient model has been reviewed
  - Single payment for bundle → pre-op eval, hospitalization, physician services, post-acute care and readmissions
- How does outpatient model differ?
  - Single payment for bundle that includes pre-op evaluation, procedure/physician services, outpatient care

What Procedures Are Amenable to Outpatient Bundling?

- High-volume procedures with a definable cycle of care for which there is variability across physicians
  - Procedures with opportunity to improve outcomes + standardize treatment around best processes as defined by provider*
  - Procedures with cost saving opportunities (implants used, outpatient services, imaging)
    - *e.g.* Distal Radius Fracture Fixation/Rotator Cuff Repairs

***SCAMPS:** **S**tandardized clinical assessment and management plan

Developing Outpatient Bundles

- Define cycle of care that corresponds with condition

- Select care cycle that starts with initial pre-op appointment → concludes 1 year from day of surgery
  - Allows short-term surgical complications to emerge and be addressed within bundle.
  - Allows Recovery time sufficient to meaningfully measure patient outcomes.

Developing Outpatient Bundles

- Procedures and resources in bundle would include:
  - Pre-op appointment and testing
  - OR and facility services on day of surgery
  - Surgeon, anesthesiologist and support staff
  - Clinic visits
  - In-hospital drug and laboratory tests
  - Post-surgical PT/OT
  - Defined forseeable complications within specified period

Developing Outpatient Bundles

- Selecting Population:
  - Inclusive in specifying patient population for bundle while incorporating appropriate risk adjustments

Developing Outpatient Bundles

- Specify outcomes and guarantees:
  - Provide data (clinical literature/research) to select with insurer outcomes most pertinent to patient care
    - Objective measurable outcomes → strength, ROM and rates of complications
    - Subjective patient-reported outcomes → pain, ability to perform activities of daily living, and satisfaction w/ outcomes.

Developing Outpatient Bundles

- Identify anticipated procedure specific complications → have mechanism in place for acute management (ER *vs*. Clinic) → control unnecessary costs

- Create position for provider to help navigate patients → Receive calls to guide to clinic *vs*. ER as needed

Developing Outpatient Bundles

- Incorporate Metrics into Bundle:
  - Payments made to physicians/ hospital only if patients achieve specified minimal performance.
  - If outcomes exceed expected performance level, insurer would make incremental bonus payments.

Developing Outpatient Bundles

- Transparency:
  - Insurer communicates to patients price for treatment cycle + expected outcomes
  - Physicians provide outcomes data to insurer throughout care cycle.
  - Insurer transparent with progress on bundle throughout care cycle
  - Revisit bundle and re-negotiate at 1 year cycle

Developing Outpatient Bundles

- Engage patients and external professionals involved in cycle of care
- Identify downstream PT/OTs to train, certify, and compensate → # of visits necessary in the outpatient setting should be physician driven and communicated
- Conduct patient pre-op education on narcotics, discharge, PT, provide 24-hour turnaround for phone calls, same-day office visits for urgent care, call from physician's office POD#1.

Estimating Cost

- Time-Driven Activity-Based Costing (TDABC) to measure costs across full cycle of care
  - Take inventory of resource needs/ use for each process in cycle.
  - Identify personnel + equipment required and measure time consumed by each resource in performing step.
  - Estimate "capacity cost rate," the cost/min of each person + piece of equipment in care cycle.
  - Calculate cost of space used by each resource / process.
  - Combine time + cost estimates to obtain total cost per episode

Financial Goal

- Aim is to achieve better patient outcomes and thereby earn margin over actual costs incurred
  - Utilize surgeon-defined patient outcomes
  - Review surgical indications + choice of implants
  - Identify forseeable complications for each procedure → agree on time period for which to include complications in bundle

- Achieve bonus payments for consistently producing superior outcomes → more business driven to provider by the insurer (*i.e.* referral network) → higher volume of patients → more cost-efficient processes

What are the challenges?

- Current contracts negotiated at payer-administrator level in zero-sum cost-shifting process.

- Contracts currently use artificially short time horizons→ not a complete cycle of care → similar to traditional FFS model.

What are the challenges?

- Insurers strive to lower prices while hospital's contract administrators attempt to preserve top-line revenues.

- Physicians not involved in new contracts forged → further distanced from new model due to lack of data in measuring performance and patient outcomes → not involved in costing

What are the challenges?

- Hurdles establishing agreement among physicians on protocols and achieving uniformity/standardization
- Financial structure/Accounting methodology
- Ownership of bundle → physician *vs*. hospital
  - Orthopaedic Group negotiates individually with insurance providers vs. via institution

What are the challenges?

- Standardization of implants/vendor negotiations → cost $$
- Preoperative stratification and optimization of patients to decrease complications and readmissions, determine therapy needs and duration of

What are the opportunities?

- Surgeons best positioned to understand which components in care cycle of an orthopaedic procedure are critical and which can be removed.

- Culture of measurement → To routinely measure and trend our performance / outcomes

- In ASC setting → surgeons generally have greater control in decision making → Partnership allows for increased ability to influence care delivered.

Actionable steps

- Bundling becomes feasible when providers can control the services included in a bundle
  - Need to get involved
- Successful bundling requires data
  - Need to measure → surgeon performance and patient outcomes
- Effective protocols and standards require teamwork
  - Need to work together towards agreement based on evidence

Thank You

Questions?