

Reimbursement for Total Joint Replacement in an Outpatient Site of Care

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Introduction

While the benefits of performing total joint replacement in an outpatient setting can be significant, the challenges of developing this option are also large. To do so requires the development of a number of relationships, protocols and contingency plans. Some of the key considerations when developing an outpatient total joint replacement plan include patient education, pain management protocols, and reimbursement. This white paper will focus on the challenges exclusive to reimbursement for the total joint replacement in an outpatient setting.

Trends in Market

From 2006 until 2013, the US saw a decline in national health expenditure growth, from 6.5% to 3.6% annually. Interestingly, that trend changed in 2014, when the annual growth in spending surged back upwards to 5.0%.¹ Conventional wisdom would assume that US hospitals realized a price increase as a result; however, annualized price growth for hospitals remained flat, if not declined, during that time period. The growth in spending lies elsewhere.

Two of the sites of care that are expanding quickly for surgical procedures include hospital outpatient departments and ambulatory surgery centers. From 2006 to 2013, Medicare inpatient discharges decreased 17%, while outpatient services grew 33%.² Projections across both private and public payors assume double digit growth in outpatient procedures across the most lucrative inpatient procedures for hospitals, including cardiac services, neurosurgery and orthopedics. Specific to orthopedics, projections assume that **half** of all elective hip and knee replacements will shift to the outpatient setting over the next decade (2016-2026).³

There are a number of factors driving this trend and enabling the transition of traditionally hospital-only based procedures to migrate to a less acute site of care. Two prominent factors are cost and patient satisfaction. Payors are eager to improve quality, lower costs and increase patient satisfaction. The ambulatory surgery center setting represents an attractive option for payors

(including employers) to realize the Triple Aim for patients. For a healthy patient with no comorbidities, particularly those who are anxious to return to work and normal activity as quickly as possible post-surgery, the ambulatory surgery center (ASC) offers an alternative to treatment at the hospital. In an era of high deductibles and co-pays for patients, outpatient surgery is often financially desirable as well for patients.

Another factor driving this trend is HHS's commitment to payment reform. Specifically, Health and Human Services (HHS) expects to have 50% of Medicare provider payments shifted to an alternative payment model by 2018.⁴ One of the vehicles that the Centers for Medicare and Medicaid Services (CMS) has accelerated to achieve this goal includes bundled payments. The implementation of the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016 has required that nearly 800 hospitals in the US manage spending for Medicare joint replacement patients during a 90 day episode of care.⁵ Surgeons and hospitals have had to revisit the entire treatment pathway for these patients to ensure that the highest quality care is provided within a pre-established price, particularly in the post-acute setting. This increased scrutiny on post-acute care has challenged conventional assumptions regarding discharge patterns for patients, particularly the healthier Medicare beneficiary. This trend will continue to accelerate as new payment models proliferate, including the currently proposed Surgical Hip/Femur Fracture Treatment (SHFFT), as well as the Bundled Payments for Care Improvement (BPCI) program, which includes joint replacement procedures.

While joint replacement procedures remain on CMS's Inpatient Only list, it is likely that the agency will revisit this decision in forthcoming rulemaking. In August 2016, the Hospital Outpatient Panel, which provides recommendations to CMS, approved a recommendation to remove total knee arthroplasty (TKA) from the Inpatient Only list and reimburse it in the hospital outpatient setting.⁶ Additionally, CMS included language in the 2017 Proposed Hospital Outpatient rule to seek feedback from stakeholders on removal of TKA from the Inpatient Only list.⁷ While TKA remains on the list for

2019, CMS indicated that future rulemaking will include more specific discussion on this topic based on robust feedback from the proposed rulemaking process.

In the meantime, private payors and employers are increasingly interested in the savings that might be available by transitioning these procedures to the outpatient setting.

Payor Relationship

As trends continue to shift care from inpatient to ambulatory settings, physicians and facilities are eager to be part of this evolution. Aside from offering possibilities for increased reimbursement and a competitive advantage over other providers, patients/consumers are increasingly interested in receiving care in less costly and complex environments. They are more aware of the choices available and are willing to seek them out. Further, as consumer responsibility for medical costs continues to grow, consumers are motivated to select facilities and physicians who can deliver high quality care in a more cost effective setting.

For physicians, one of their biggest challenges will be to demonstrate to payors the value they deliver. Value is the interplay between cost and outcome; both elements are necessary to validate that a service has value. This will require identifying and collecting some key metrics, to be discussed below. The goal should be a mutually beneficial performance-based arrangement that rewards high quality of care with appropriate reimbursement. This linkage of dollars to outcome offers significant opportunities for providers, well beyond the reimbursement traditionally available with a standard fee for service contract. But before that discussion can lead to a successful contract with a payor, the relationship with that payor must be developed.

Building a Strong Payor Relationship

A medical group may or may not have devoted time or attention to the cultivation of their payor relationships. Viewed from a purely transactional perspective, this is understandable. However, in the world of value-based contracting, relationships will be key to achieving the kind of contract that will both reflect the work the group does as well as appropriately reward it. How to differentiate a medical practice to avoid being seen as a commodity in the marketplace is essential. Where and how does an organization begin this process?

Insurers view medical groups as marquee customers. What better endorsement of the health plan can there

be than having the doctors who deliver care to its members as customers of the plan? Positive word of mouth about a plan from a physician to his/her patient has always been a tremendous boost. As such, every medical group has a built-in advantage with the health plan it has selected as its carrier. Starting the discussion with that plan around potential contracting is a natural place to begin.

It is important that the payor knows your practice. While the plan may certainly consider the medical group a valued customer, the plan medical director may not have personal knowledge or experience of the group. Reaching out to that individual is a critical first step. A meeting to familiarize him/her with the medical team, the facilities, the capabilities, etc, is an excellent way to put the group on the radar. Touring sites can provide firsthand experience for the care being provided to members and to keep abreast of new technologies. If the group encounters difficulties contacting the medical director, it should work through the provider representative from the health plan who is dedicated to servicing the account and working with the HR staff. The provider rep can usually pass an invitation directly to the medical director and make sure the message is received.

The goal for that first meeting, especially if on-site, is to present an accurate and detailed picture of the care being delivered by the group. Ideally the physician leaders will be present as well as the lead administrator(s). It can demonstrate commitment to building the new relationship and can help answer questions that the medical director may have. Sharing data on processes and outcomes is advisable to show the effectiveness of the care, and hopefully differentiate the group from others. Despite the heavy emphasis on outcomes and tracking in the industry, it is still not routine to see health care organizations prepared to communicate this data routinely. The philosophy of the group should also be on display. Is this an organization comfortable with change? Does it see health reform and new models of delivery and reimbursement as opportunities or barriers? Is this approach shared across the group, or is it only top-down? Is the group ready for the hard work, both structurally and culturally, to embrace alternative payment models?

Going forward, the group needs to demonstrate its differentiation from competitors and why it deserves premium or value-based pricing. This approach has to be built on two foundations: data documenting the group's performance, and a contract that puts the group at risk for achieving certain mutually-agreed upon goals. Those

will include both clinical and financial endpoints. Any quality metric that reflects improved clinical outcomes will help define the group. These should also lead to a better cost profile, since better results typically translate into reduced utilization of resources. Collecting and analyzing internal data is critical. This need not be a complex process, since many of the elements are basic and should be easy to track.

Ultimately, the ability of the group to prove its potential to help payors achieve quality and cost benchmarks will support its value proposition in the market place. This will best position the group to take advantage of the shift to performance-based arrangements, and to maximize its potential for growth.

Collecting Data

When starting a program to provide total joint replacements in the outpatient setting, the following data should be considered to help evaluate both the safe and effective delivery of care but also as a starting point for discussions with payors. Coupling these data with the cost of care during the entire episode of care should provide a basis for payor negotiations. If available, comparing these data with a similar practice at an inpatient setting can help to form the best case for enabling additional procedures at the outpatient site.

- Patient information: Age, gender, primary diagnosis, ASA classification
- Clinical performance:
 - Harris Hip Score (HHS)
 - Knee Society Score (KSS),
- Patient reported outcomes:
 - Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)
 - Hip disability and Osteoarthritis Score (HOOS) and HOOS Jr ,
 - Knee disability and Osteoarthritis Score (KOOS) and KOOS Jr
- Patient satisfaction
- Complication rates
- Post-Acute Care utilization
- Return to work rates

Conclusions

Reimbursement for total joint replacement in the outpatient setting must be an area of focus for providers when considering migration of procedures to the outpatient setting. As part of a plan that also addresses patient education, pain management and other clinical protocols, the guidance above can help enable health care professionals and payors to work together to offer an additional setting of care for their patients.

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