Private Bundles: Negotiating with Payers

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Disclosures

- Stryker Orthopaedic
  - Consultant
  - Research Support
  - Royalties
- Irrisept
  - Speaking

Why private bundles??? Is FFS dead? Have Government Programs paved the way or simply caused a race to the bottom?

In order to address the issue we have to ask the correct questions.

- **Do we feel there is still an issue with our current payment models or where they are headed?**
- **How do we provided the appropriate amount of care for the appropriate amount of time and the appropriate amount of reimbursement?**
- **Who should drive a patient's episode of care? The patient, the hospital, the post acute agencies or the Provider?**
- **Are we currently providing the highest quality of care, thus exhibiting the best outcomes?**
- **How are we currently handling our patients through their entire continuum of care? (Pre-op/Acute Setting/Post Op)**

To understand negotiating with payers you must first understand bundles vs FFS.

Fee for service:

Little to no coordination of care
All services are independent and bill independently
Patient has to navigate the system alone
Excessive number of bills/ billing issues
Bad Behavior is indirectly rewarded….

Good outcome from surgery = paid once
Bad outcome from surgery = paid multiple times!

Bundles: Medicare vs. Commercial

Medicare / BPCI

- Driven by Surgeon
- Fee for Service still underlying payment with additional risk/reward based on outcomes.
- Challenges post acute service providers to better individual care
- Affects larger patient group due to limited exclusions

Commercial (Private)

- Driven by Surgeon with Insurance contracts
- Very predictable payment model for providers and patients
- Allows for specific patient criteria to be met for participation
- Flexibility for growth to patients with increased risk profile

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Bundles: Prospective / Retrospective

Prospective

- Provides a very predictable model as funds are paid up front.
- Risk mainly falls on Provider group managing the bundle.
- Very clear and concrete order sets and expectations
- Clear exclusion criteria
- Surgeon decision to operate
- Set metrics must be met for full payment

Retrospective

- “All in” approach to bundle
- Set # days is established, usually 90 days from discharge
- Requires more attention from CM group to ensure post acute cost are appropriate
- Provider is at larger risk due to more variables than with Prospective bundle.

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Step 1: Determining the right program

1. Each Provider group must analyze which program fits their needs.
   - Prospective = High Risk, High Reward
   - Retrospective/Shared Savings = Generally lower risk, Low to Moderate Reward
   - Site of Service = High Reward if Physicians are willing to move patients to low cost facilities.
2. What are the Market conditions to support a change to bundle services.
   - How many facilities?
   - Ratio of Hospital to ASC?

Determining the right program continued:

3. What is the best payer and procedure mix for Provider's practice?
    - What payers and procedures will provide the maximum return on your investment. Is it just TJR, or is it worth expanding to other procedures.
4. What are realistic goals for the group?
    - Bundles per year
    - Number of Payer contracts achieved
5. How to commit all Shareholders to change their behavior?
    - Must have Provider Leadership to drive necessary change

Picking Partners: A great surgeon is not enough… but it is essential to lead the initiative!

Hospitals/ASCs:

- Streamlined Pre-op clearances to help ensure optimization
- Consistent message with patients (Pre-op/Floor/Post-op)
- Internal Patient Navigators
- Standardized orders
- Approachable Administration; they are your new partners:
  - Aligned incentives for patient success, not just volume
  - Hold staff accountable – all disciplines

Anesthesia:

- Independent group vs. Hospital staff
- Must be able to adapt – from inpatient to outpatient setting

Optimization

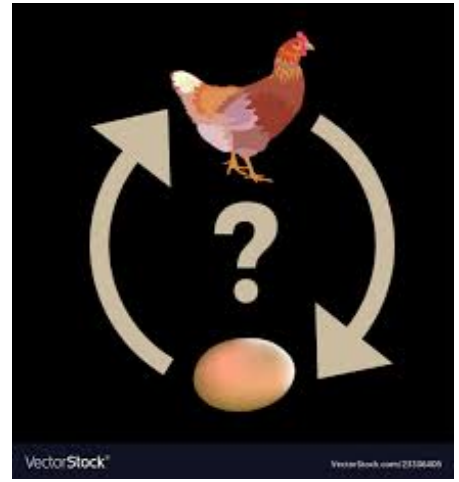
Optimization of bundle patients is more than just Optimizing their medical readiness for surgery. Partnerships must be established between Surgeon/Facility/Payer to ensure all aspects of Optimization are met:

- Payer contracts must address patient inclusion/exclusion criteria
- Surgeons must optimize their practice to use standardized order sets that will produce predictable results
- Hospital/ASC partners must ensure optimization is met pre-op to help reduce patient risk (pre-op screening)

Picking Partners: Understanding what Payers want:

1. Save Money:
   - Payers approach bundles in various ways depending on how sophisticated and advanced they are in Value Care
2. Shared Risk:
   - Payers strategically look at programs with large reimbursement upside and small downside to risk, thus putting risk on Surgeon Group
   - Surgeon Group must look at each type of bundle to determine how much risk they can take.
3. Quality Outcomes:
   - Payers expect quality metrics to be met or shared savings, bundle pricing may be in jeopardy; **you must follow quality metrics**

Picking Partners: Negotiating with Payers:



Chicken or the Egg…..

- Payer agreement first?...suppose you can't align the downstream vendors
- Downstream vendors first?... Suppose the payors will not agree to a bundle price high enough to cover costs?

- Both parties must have realistic goals
  - Payers want lowest price possible
  - Providers want rewards big enough to take the financial risks
- Provider must be willing to explore different agreements
  - There is no cookie cutter bundle for each procedure/payer/facility

How to Pick the right Payers:

1. Must understand what programs the Payer can offer.
   - Many Payers have difficulty operationalizing certain bundles, therefore your options with those payers may be limited
2. Is Payer willing to adjust their program to the needs of your organization?
   - Perhaps the duration of the episode needs to be adjusted to help reduce Provider Group's risk due to low number of bundles.
3. Does the payer program mirror other programs your organization is doing?
   - This allows for less confusion when processing claims and minimizing creation of new internal processes.
4. **Does payer have a robust platform for accurate reconciliation and metric reporting**
   - Samples of reports should be reviewed, adjustments should be requested if additional information is needed
5. **Is the Risk/Reward discussion a burden or does the Payer show a genuine willingness to share in the savings**

OrthoCarolina: What do we expect?

Hospital/ASCs:

- A commitment to increasing Quality and decreasing cost
- The use of standardized Order Sets for all bundle patients
- Staff Training on how to handle bundle patients
  - This is extremely important to reducing billing issues and to maximize patient satisfaction and outcomes
- Accurate data reporting to help OrthoCarolina's reconciliation process

Payers:

- Fair financial compensation due to associated risk and program implementation cost
- Accurate and timely reporting of financial outcomes and quality metrics
- Open communication lines with Payer team to address issues in timely manner
- Dedicated team to assist with program implementation
- Clear program rules without confusing language

Key Considerations: Must Align Incentives!!!

- Payer: wants lower cost and risk shifted to provider
- Provider: wants increased reward for taking risk
- Facility: wants incremental volume – provider to shift bundle patients to contracted bundle facility
- **Most Important - Patient: wants lower cost, higher quality, better experience**

The OrthoCarolina Commercial Experience:

1. **Commercial Products continue to grow** and develop as Payers increasingly adapt to handling difficult payment models.
2. **We have Value Based Agreements with every major payer**
3. Successfully runs bundle TPA (**T**hird **P**arty **A**dministrator) to pay down stream contracted providers
4. Successful partnerships to enhance care coordination and bundle onboarding qualifications for patients
5. Successful management of Commercial Prospective, Retrospective, Site of Service bundles resulting in **Provider distribution ranging from 125% to >200% of Fee for Service.**
6. Increase in patient satisfaction, compliance and overall improved clinical outcomes with all Bundle metrics

Coordinated Care Program Hospital Reported Outcomes			
Mortality	0.0%	Transfusion	0.0%
Related Readmission	1	DVT / PE	0.0%
Unplanned return to OR	0.0%	Discharged to home	100.0%
Surgical Site Infection	0.0%	Average length of stay	1.06 days

The Above chart shows a running 12 month (2018-2019) look at HRO's for OrthoCarolina's Coordinated Care Program. These numbers have been consistent throughout the duration of the program.

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Conclusion:

Transition to commercial bundles is only possible if Provider groups drive the necessary changes with Payers and hospitals to ensure incentives are aligned and standardized processes are established.

By making these changes, we have been able to align programs between the area's largest Payers, largest Healthcare Provider and largest Orthopedic group to provide the highest level care for our patients.

OrthoCarolina

HIP & KNEE CENTER

Thank You