# Bundled Payments in Action

## How to Make Value-Based Surgical Care Work for You

ValueHealth

# Daniel R. Tasset

## Chairman, Nueterra Capital





# Macro Economics Refresher

## Healthcare Industry

## $3T = 17% of GDP

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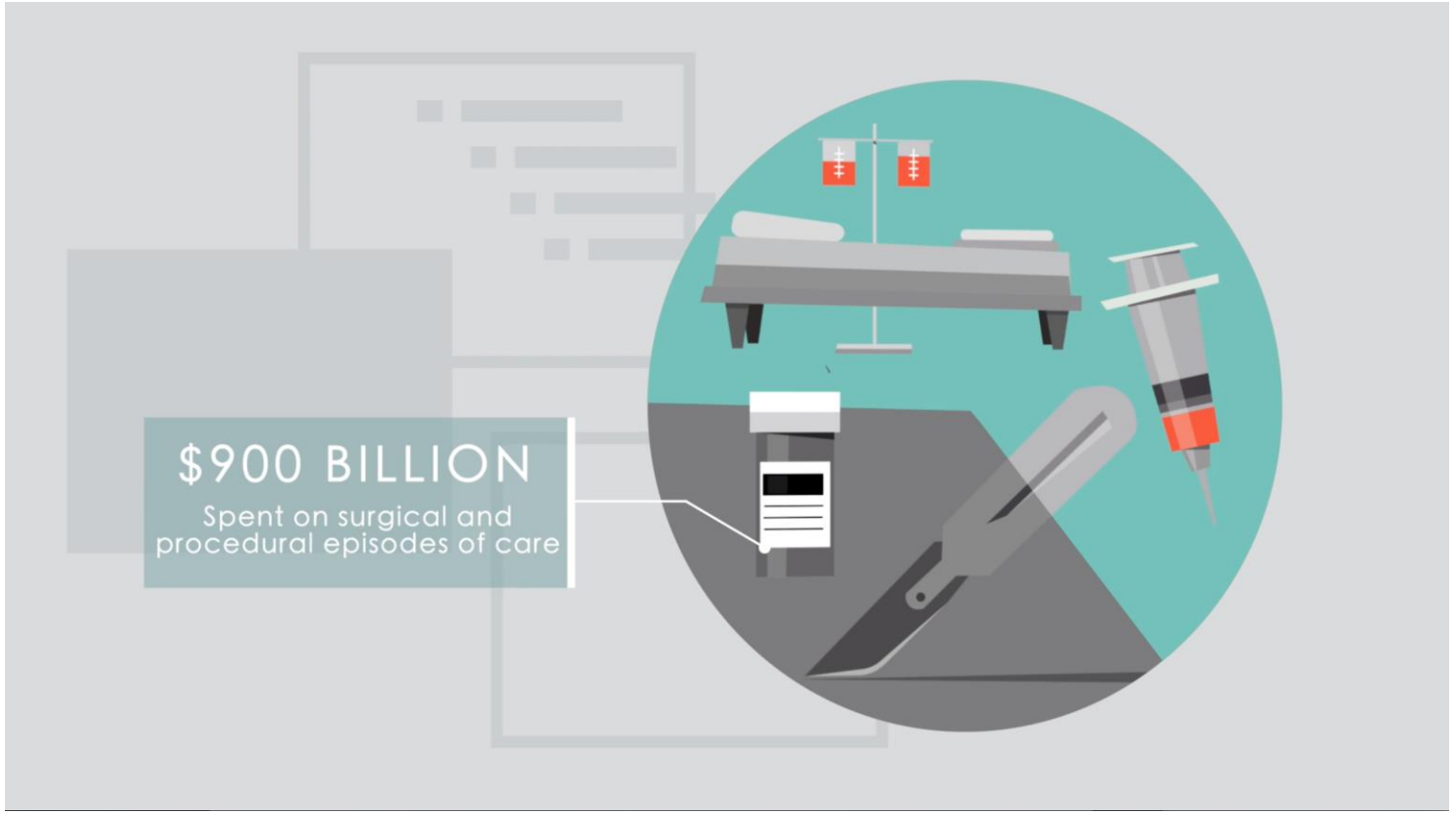
Of that $3 trillion, approximately 1/3 is spent on surgical and procedural episodes of care.



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In the transition of the healthcare industry from fee-for-service to value-based care **Orthopedics** is clearly emerging as the specialty to lead the way for these reasons:

1. Orthopedic surgery is the largest segment (1/3 or $900B) of the U.S. healthcare market

2. Easiest to impact/low hanging fruit

3. It is a growing segment

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# Orthopedic Growth

**Because of population growth /shift and disease prevalence orthopedic service line is expected to grow by over 40% by 2027. Almost all of that (35%) will be outpatient growth.**

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# Total Hip & Knee Replacement

## Facts & Figures

### 1 Million

Total hip & knee replacements performed annually in the U.S.[1]

### 673% Growth

By 2030 demand for TKAs will grow annually to 3.4M[2]

### 174% Growth

By 2030 THA will grow to 0.5M[2]

## Medicare Expenditure on TJA

Greater than $7B per year

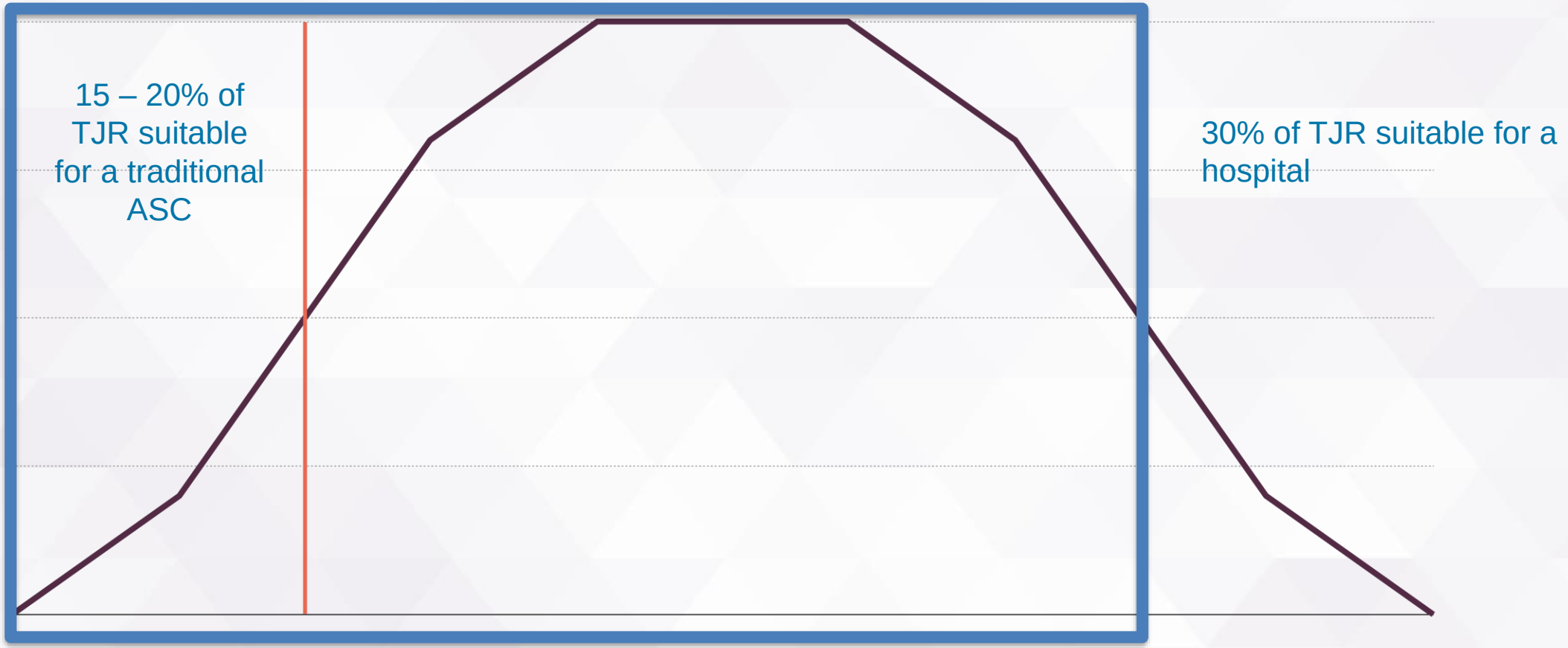
## 5,519 Ambulatory Surgery Centers

3.3% are preforming total joint replacements[3]

[1]CDC/NCHS National Hospital Discharge Survey
[2]Kurtz et al, The Journal of Bone and Joint Surgery
[3]Beckers ASC Review

# The Muve Program enables ambulatory care to a broader population on TJA patients through integrated processes and enhanced recovery in our Muve Stay Suites

70% of TJR Suitable for new emerging and proven delivery models






Muve Health: Better Care by Design

# The Value Equation

$$\text{VALUE} = \frac{\text{Clinical Quality + Patient Experience}}{\text{Cost}}$$

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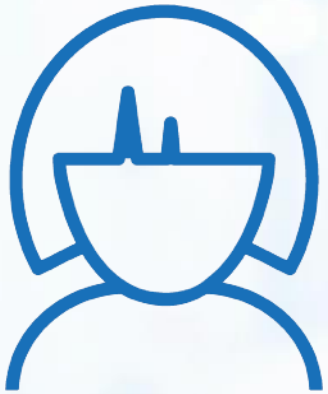
# Two Major Market Forces Driving the Transition to Value



Consumerism

Payment Reform

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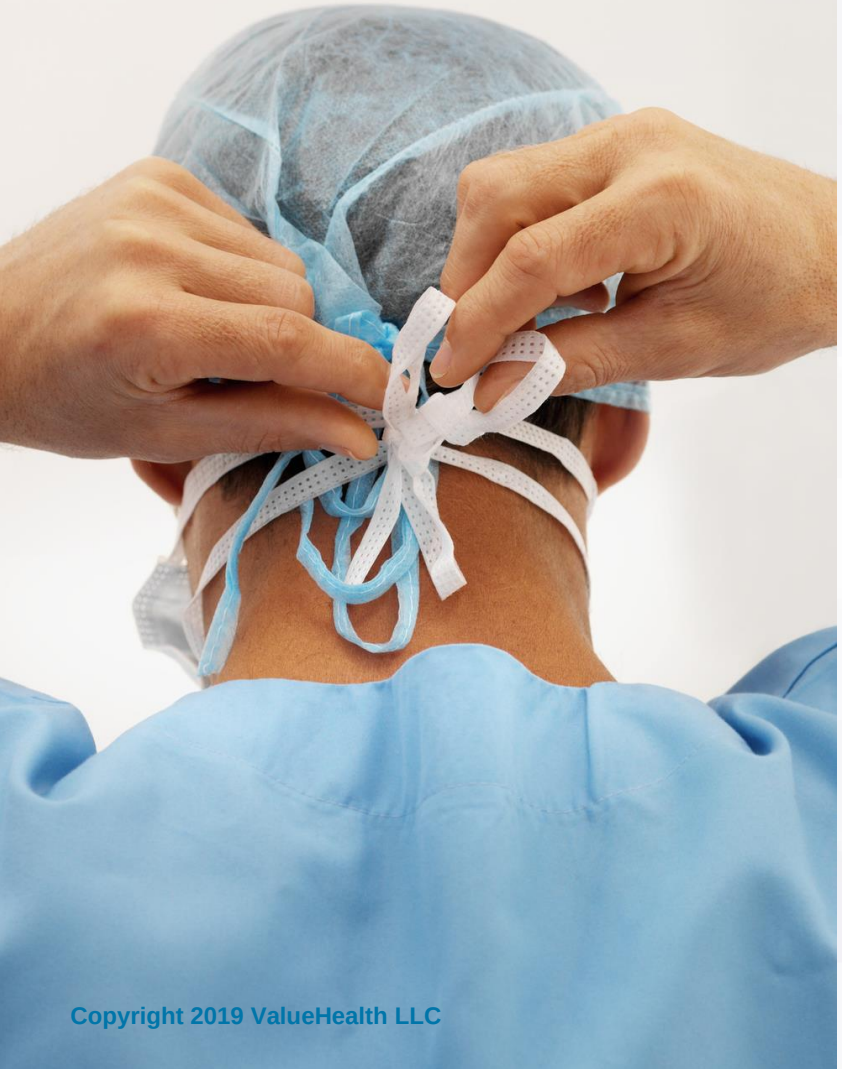
# Provider/Consumer Relationship

# Does The Value Equation Still Apply?

$$\text{VALUE} = \frac{\text{Clinical Quality + Patient Experience}}{\text{Cost}}$$



# Payors do care about Quality

# Six Things Providers Must Be Able To Do

1. Bundle Their Services

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# Must Meet The Needs of Bundled Payment Models

## A Progressive Spectrum of Payor Contracts

**Least Advanced – Case Rate**

**Most Advanced – Full Bundle at Risk With Warranty**


- Modified FFS
  - Excl. Surgeon fees
- Pre-surgical consult to 48 hours post-op
- No post-acute care risk

- Modified Prospective Bundle
  - Excl. Surgeon fees
- Pre-surgical consult to 48 hours post-op
- No post-acute care risk

- Full Prospective Bundle
- Pre-surgical consult to 48 hours post-op
- No post-acute care risk

- Full Prospective Bundle
- Pre-surgical consult to 48 hours post-op
- 45-day follow-up

- Full Prospective Bundle
- Pre-surgical consult to 90 days post-op
- 90-day follow-up

# Six Things Providers Must Be Able To Do

1. Bundle Their Services
2. Provide A Warranty

# Six Things Providers Must Be Able To Do

1. Bundle Their Services
2. Provide A Warranty
3. Financially Back The Warranty

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# Six Things Providers Must Be Able To Do

1. Bundle Their Services
2. Provide A Warranty
3. Financially Back The Warranty
4. Purchase Warranty Reinsurance

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# Six Things Providers Must Be Able To Do

1. Bundle Your Services
2. Provide A Warranty
3. Financially Back The Warranty
4. Purchase Warranty Reinsurance
5. Provide Data To The Underwriter

# Patient Population THA Assessment

- CPT code for Total Hip Replacement (27130)
- Must have active enrolment allowing a minimal follow-up of at least 30 days post index date
- Having patient claim with at least one Total Hip Code

**Analytical expediency, patient claim records with two Total Hip codes were excluded**

**Approximately 400 Cases were excluded (a single patient with two trigger codes for HIP TJR)**

| Code Group | Code Number | Code Description | Role 1 | Role 2 |
|---|---|---|---|---|
| CPT | 27130 | Replacement Hip Total Simple | Procedure | Trigger |

| Code Group | Frequency | Frequencies (first Hip Repl. event only) |
|---|---|---|
| 27130 | 1065 | 657 |

13 ASC Patients
644 Hospital Patients

# Patient Population THA Assessment

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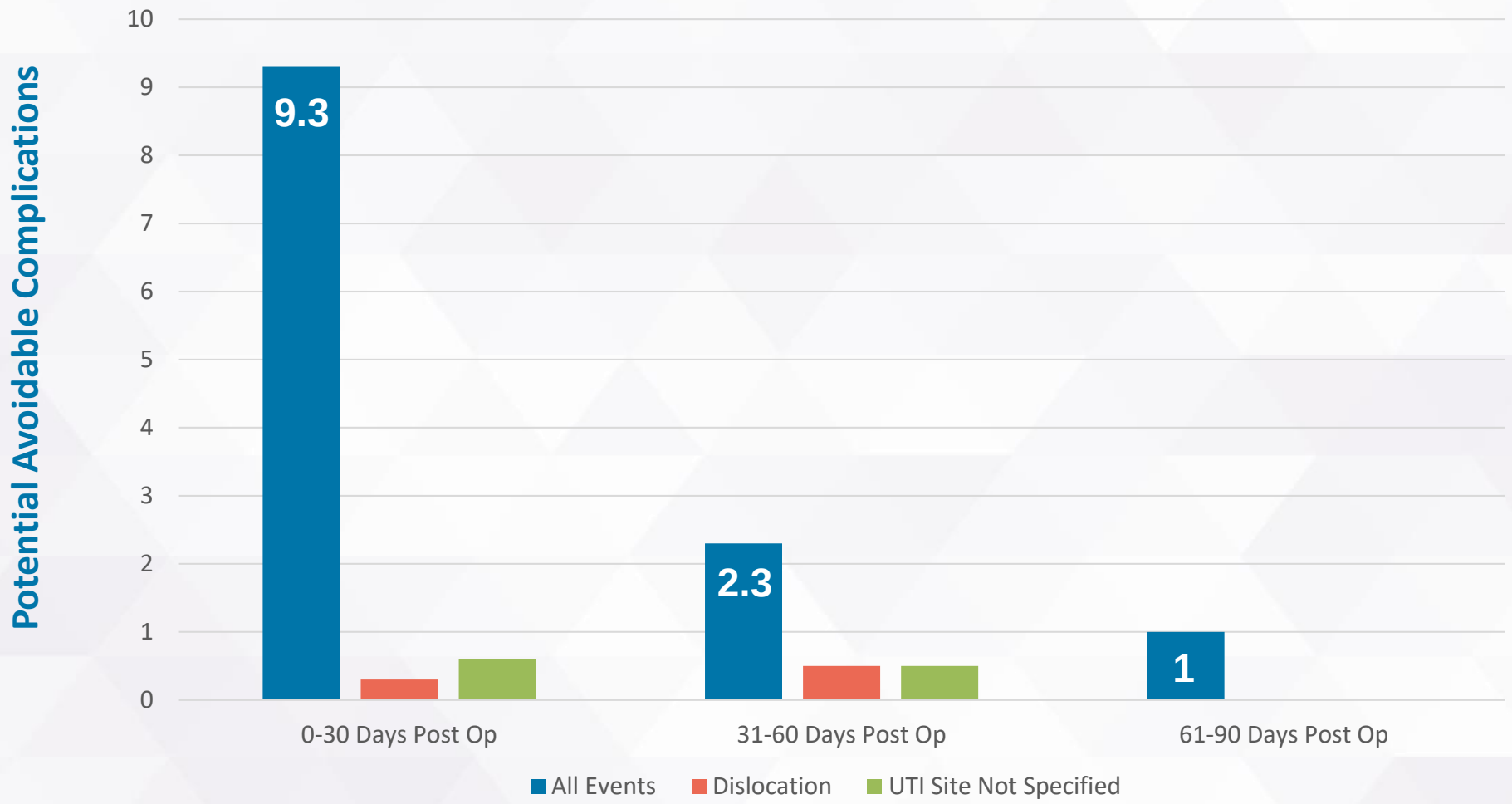
## Fig. 1 PAC Incidence Rates Following Total Hip Replacement Procedure in 10-60-90 Days Windows



# Patient Population THA Assessment

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## Total Amount Billed Charges (All Claims)

| | N (Cumulative) | Amount Billed | Difference | Ratio |
|---|---|---|---|---|
| **30 days following day procedure (9.3% of Patients Claim a PACs by 30 Days)** | | | | |
| No PAC | 596 | $50,521 | | |
| PAC | 61 | $57,813 | +$7,292 | 1.14 |
| **60 days following day procedure (11.6 % of Patients Claim a PACs by 60 Days)** | | | | |
| No PAC | 581 | $52,581 | | |
| PAC | 76 | $62,925 | +$10,344 | 1.20 |
| **90 days following day procedure (12.8 % of Patients Claim a PACs by 90 Days)** | | | | |
| No PAC | 573 | $54,436 | | |
| PAC | 84 | $67,303 | +$12,867 | 1.24 |

# Patient Population THA Assessment

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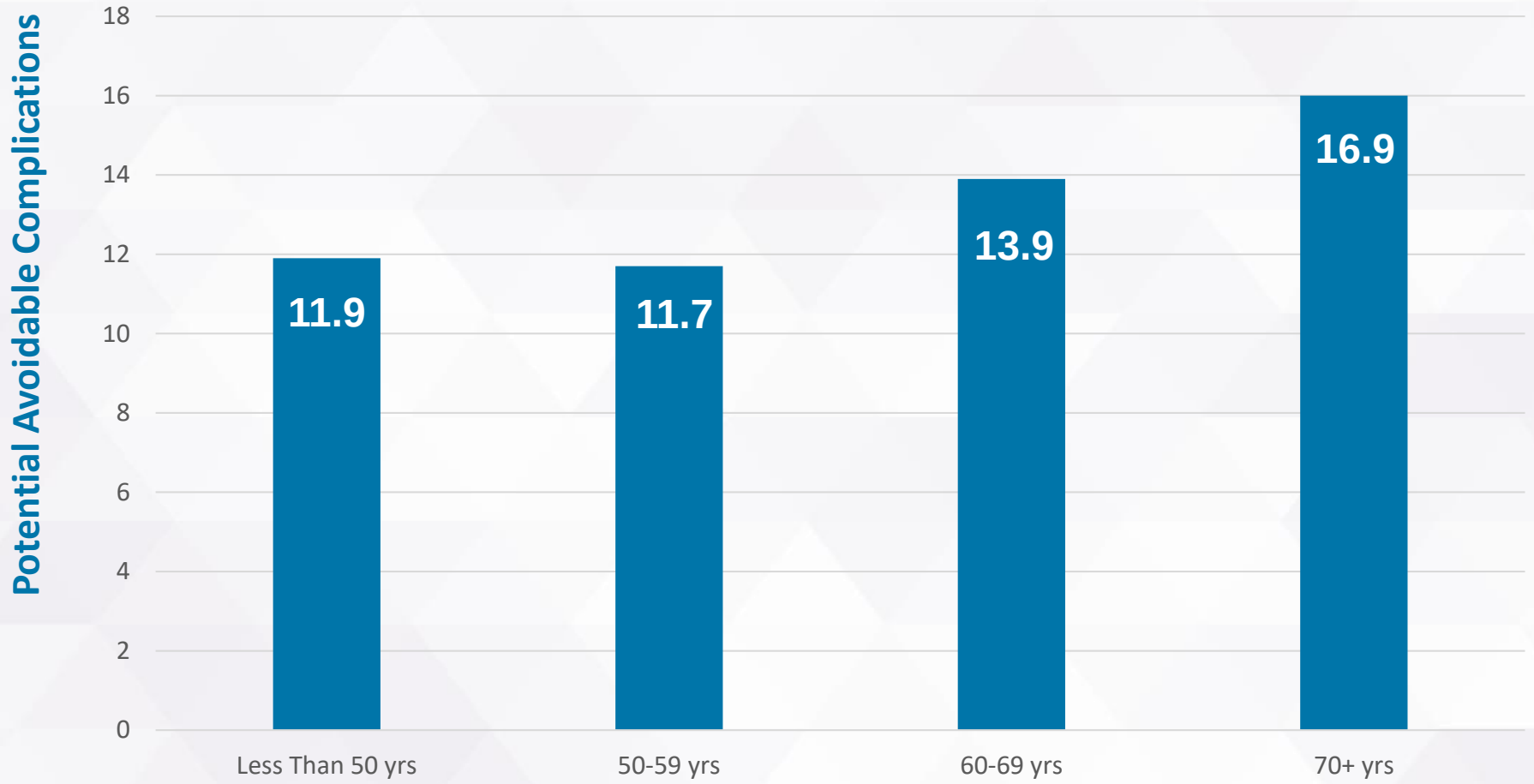
## PAC: Incidence Rates 90 Days Post Op
## Total Hip Replacement Procedures Stratified by Age Group (years) of Day Surgery



# Data on Completed THA/TKA Joints

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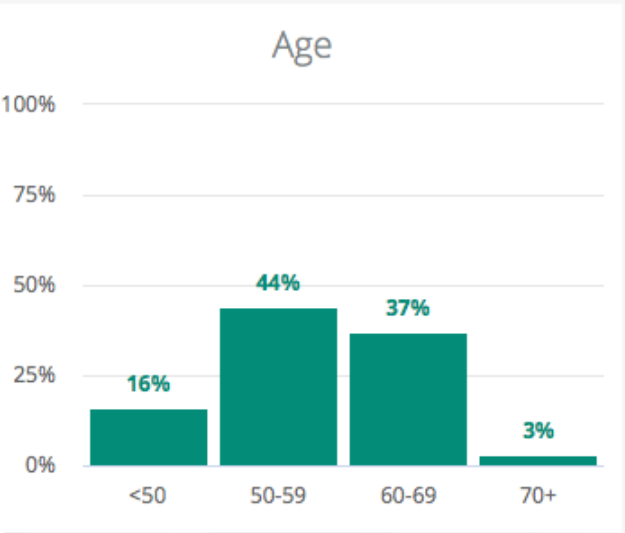
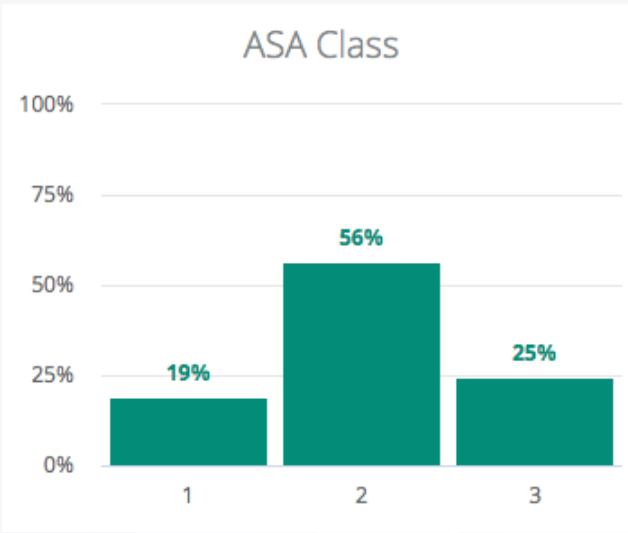
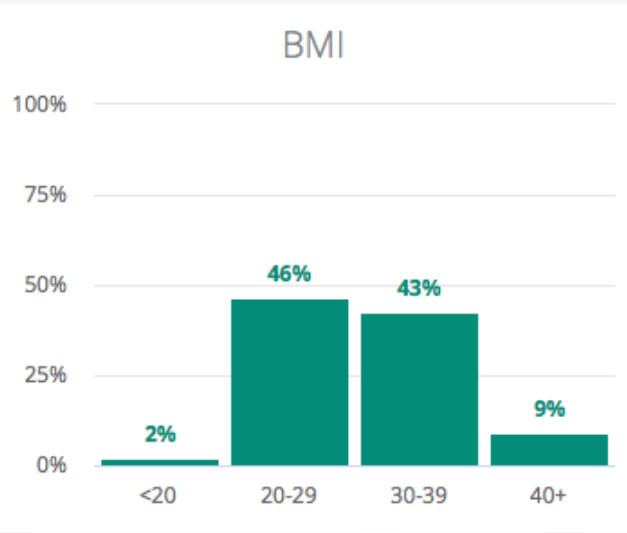
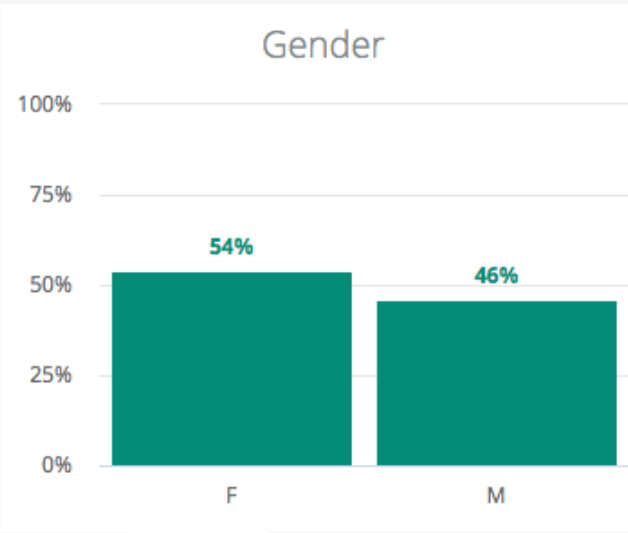
## Patient Demographics

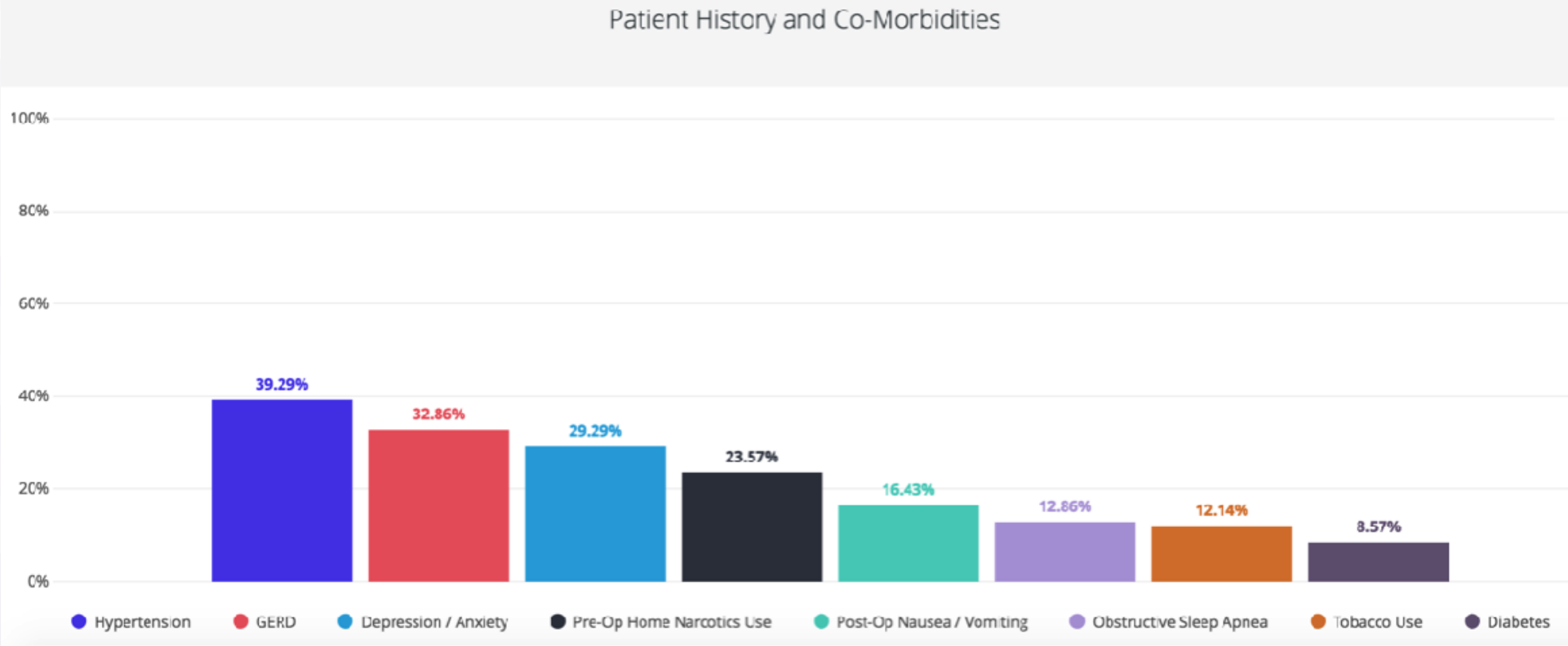


# Data on Completed THA/TKA Joints



# Data on Completed THA/TKA Joints

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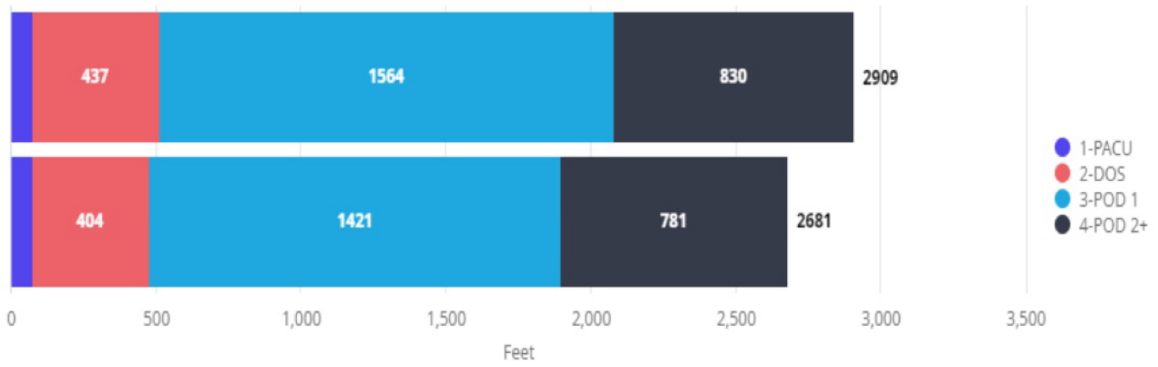
Ambulation

100%
Patients Walked in PACU

Average Distance Walked




PACU - First Ambulation

147.1
THA

151.7
TKA

Suites - First Ambulation

40.1
THA

53.7
TKA

# Data on Completed THA/TKA Joints

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Patient Experience

| Net Promoter Score (Average) | 90 Day Procedure Satisfaction (Average) |
| --- | --- |
| How likely are you to recommend Muve to your family and friends? (-100 to +100) | How satisfied are you with your procedure? (5 Point Scale) |
| 99 | 4.5 |

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# New Emerging Delivery Models

## Clinical Outcomes are Surpassing Industry Benchmarks

| Industry Norms | | Muve Health Innovation |
|---|---|---|
| 01 9.4% THA, 5.6% TKA* | % Patients Ambulating Day of Surgery | 01 100% THA and TKA Patients |
| 02 137 ft. ** | Distance Walked Before Discharge | 02 2,652 ft. |
| 03 1.7% All Patients | Surgical Site Infection Requiring Re-Operation | 03 0% All Patients |
| 04 10.5% THA, 8.6% TKA*** | Pulmonary Embolism Instance Rate | 04 0% All Patients |
| 05 0.55% | Hospital Readmission Within 90 Days | 05 0% All Patients |

I. Chua, M. J., Hart, A. J., Mittal, R., Harris, I. A., Xuan, W., & Naylor, J. M. (2017). Early mobilisation after total hip or knee arthroplasty: A multicentre prospective observational study.
II. ACCP Database - TKA/THA combined
III. 3. Magee Women's Hospital of UPMC Averages. MacGee is a a Top Ranked U.S. News and World Report Best Orthopedic Hospital
IV. 4. Kurtz1 - S.M. Kurtz et al. / The Journal of Arthroplasty 31 (2016) 2099e2107 Kurtz2 - S.M. Kurtz et al. / The Journal of Arthroplasty 31 (2016) 2130e2138
V. Becker's 2017 Study

# Provider data people can't be IT jocks and they need to be part of the multi-disciplinary team

They'll need to understand….

- Comorbidity and Risk Stratification
- Orthopedic-specific Risk Factors
- Independent Risk Factors
- Sensitivity Analysis on PAC
- Related Care Utilization

….so Providers can begin the process of pricing the bundle, providing a warranty and underwriting the reinsurance.

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# Six Things Providers Must Be Able To Do

1. Bundle Their Services
2. Provide A Warranty
3. Financially Back The Warranty
4. Purchase Warranty Reinsurance
5. Provide Data To The Underwriter
6. Have Technology to Capture the Data

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# Provider Technology Capabilities Must Include but are Not Limited To:

Patient Assessment Data
Care Pathway Digital Platform
Real Time Collection of Current Patient Outcomes
Direct to Consumer
Accommodate Payor Steerage
Accommodate Employer Steerage
Digital Platform for Patient Navigation
Value Based Claims Adjudication (if the employer or Payor does not have this capability)

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# Care Pathway Digital Platform

# New Provider Delivery Models

1. Have superior clinical outcomes
2. Have higher patient satisfaction scores
3. Significantly reduce costs to the payor

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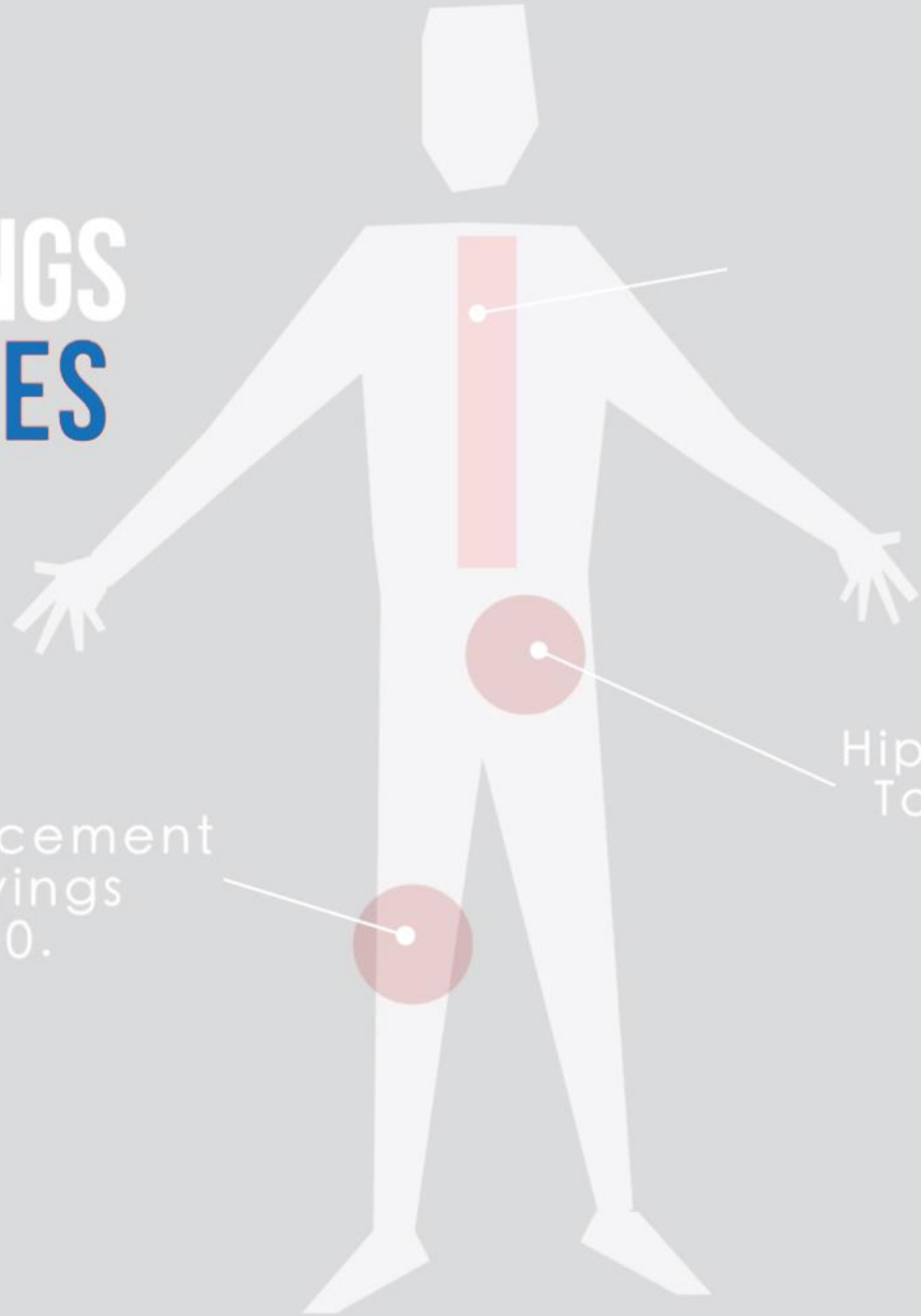
# PAYOR AVERAGE SAVINGS ON PROCEDURES



Knee Replacement
Total Savings
$21,000.

Hip Replacement
Total Savings
$22,000.

# AVERAGE SAVINGS ON A TOTAL JOINT REPLACEMENT

| Traditional Hospital Fee for Service arrangement with no warranty | ACE Network Bundle Payment with 90 day warranty | Total Savings |
|---|---|---|
| $54,000. | $33,000. | $21,000. |

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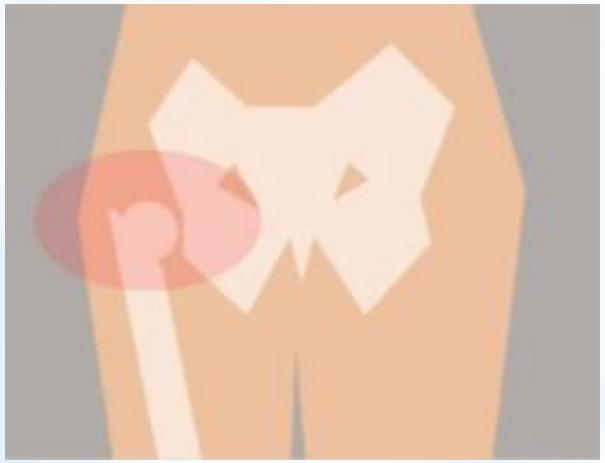
# Patient Savings

## Employee Out-of-Pocket Savings



**Total Joint Replacement $2,500**

# New Provider Delivery Models

1. Have superior clinical outcomes
2. Have higher patient satisfaction scores
3. Significantly reduce costs to the payor
4. Accommodate 70% of Market Need
5. Result in Better Physician Economics

# New Provider Delivery Models

1. Have superior clinical outcomes
2. Have higher patient experience scores
3. Significantly reduce costs to the payor
4. Accommodate 70% of Market Need
5. Result in Better Physician Economics
6. Are beginning to be the Recipients of Significant Payor/Employer Steerage

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# 5 Things Payors Should Be Able To Do:

1. Administer Value Based Models Including Bundles

# Value Based Payment (VBP) Models

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## Flexibility – Administer Any Combination

### Capitation:

- PCP – Enrollment Based/PMPM
- Service Based (ex: Radiology)
- PCMH – Care Coordination Fees
- PCSP – Care Coordination Fees
- Full Capitation – Percent of Premium Dollar – or PCP/SCP Capitation
- Support PCP Member Attribution
  - Member Selected
  - Claims Based

### Quality/P4P:

- PCP's
- Specialist
- Hospital
- ASC's
- Facilities
- Post Acute Care Providers

### Shared Savings:

- Health Systems
- IPA/Clinically Integrated Networks
- ACO's
- Large Multi-Specialty Groups
- Independent Providers/Facilities

### Bundled Payment:

- Prospective
- Retrospective
- Invoicing
- Fee-for-service with Retrospective Reconciliation
- Distribution of Payments

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# 5 Things Payors Should Be Able To Do:

1. Administer Value Based Models Including Bundles
2. Define the Bundle

# Prospective Bundles

## Definition Example

| Component | Clinical/Payment |
|---|---|
| Summary Description | Episode includes all covered services provided to a covered bundled individual during the 7-day episode period for:<br>• Prescreening assessment and evaluation before knee arthroscopy, such as physician/staff consultation, lab work, chest-x-ray, and instructions.<br>• Outpatient knee arthroscopy procedure (including anesthesia etc.) and primary or secondary diagnosis indicating conditions that require a knee arthroscopy.<br>• Post procedure physical therapy evaluation and therapeutic visits.<br>• Treatment of any complications that arise related to the index procedure (regardless of treatment setting) within the defined episode period. |
| Care Setting | Outpatient |
| Episode Period | Episode Begin: Day 0-3 (Pre-Operative Services Date) \| Trigger Event Begin: Day 0 (Procedure Date) \| Episode End: Day 7 (Post-Procedure Date) |
| Standard Services | All facility and professional services between the admission date and the discharge date.<br>Services included and expected to occur within the episode period:<br>• OP Facility Charges – in the ambulatory surgery center or outpatient hospital department<br>• OP Professional Charges - including physicians and assistants<br>• Anesthesia Charges<br>• Ancillary Charges<br>Services included if they occur within the episode period:<br>• Facility charges for treatment of complications during episode period<br>• Professional fees for treatment of complications during episode period<br>o Repeat arthroscopy due to incomplete procedure<br>Services excluded from the bundle during the Outpatient phase:<br>• Outpatient pharmacy medications not related to the procedure |
| Identification of Principal Accountable Provider | • Orthopedic surgeon performing the procedure<br>• Other physician specialty performing the procedure |
| Age Criteria | Age >=18 and <65 on date of procedure (day 0) |
| Patient Qualification Inclusion Criteria | • Coverage under primary plan from episode begin date through episode end date<br>• Procedure performed by an orthopedic surgeon participating in the program |
| Coverage Exclusions | • Inconsistent coverage during episode begin date through episode end date<br>• Death during episode<br>• Patient with status of "left against medical advice" during the episode |
| **Standard Exclusions** | • ASA >=IV<br>• Pregnant<br>• BMI <=35<br>• Readmissions to the hospital not directly associated with the primary surgery |
| **Clinical Exclusions** | • Chronic pulmonary disease and/or chronic smoker<br>• Current treatment of chemotherapy or radiation<br>• End stage renal disease<br>• End stage liver disease or history of coagulopathy<br>• Hepatitis A-C<br>• Multiple diagnostics performed on the knee considered for surgery<br>• Drug or ETOH abuse and/or non compliant psychological issues<br>• Transplants<br>• Persistent angina |
| **Risk Stratification Methodology** | ASA scoring methodology |
| **Patient Reported Outcomes Instruments** | Oxford Knee Scoring Methodology questionnaire before and after surgery combined with the WOMAC demographic profile components |
| **Pre-Admission Testing** | See pre-admission testing protocols document |
| **Supplies and Hardware** | *Best practice supply chain formulary approach to be customized and standardized based on current Nueterra/facility practice and purchasing arrangements* |
| **Surgical Tray Components** | Healthcare Common Procedure Coding System code A4550 (surgical tray). *Review current Nueterra/facility practice and purchasing arrangements* |

# Prospective Bundles

## Code Set Example

| CODE TYPE | CODE | DESCRIPTION | ROLE 1 | ROLE 2 | ROLE 3 |
|---|---|---|---|---|---|
| CPT | 29873 | ARTHROSCOPY KNEE SURGICAL WITH LATERAL RELEASE | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29874 | ARTHROSCOPY KNEE SURGICAL FOR REMOVAL OF LOOSE BODY OR FOREIGN BODY (OSTEOCHONDRITIS DISSECANS FRAGMENTATION CHONDRAL FRAGMENTATION) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29875 | ARTHROSCOPY KNEE SURGICAL SYNOVECTOMY LIMITED (PLICA OR SHELF RESECTION) (SEPARATE PROCEDURE) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29876 | ARTHROSCOPY KNEE SURGICAL SYNOVECTOMY MAJOR TWO OR MORE COMPARTMENTS (MEDIAL OR LATERAL) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29877 | ARTHROSCOPY KNEE SURGICAL DEBRIDEMENT SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29879 | ARTHROSCOPY KNEE SURGICAL ABRASION ARTHROPLASTY (INCLUDES CHONDROPLASTY WHERE NECESSARY) OR MULTIPLE DRILLING OR MICROFRACTURE | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29880 | ARTHROSCOPY KNEE SURGICAL WITH MENISCECTOMY (MEDIAL AND LATERAL INCLUDING ANY MENISCAL SHAVING) INCLUDING DEBRIDEMENT SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY) SAME OR SEPARATE COMPARTMENT(S) WHEN PERFORMED | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29881 | ARTHROSCOPY KNEE SURGICAL WITH MENISCECTOMY (MEDIAL OR LATERAL INCLUDING ANY MENISCAL SHAVING) INCLUDING DEBRIDEMENT SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY) SAME OR SEPARATE COMPARTMENT(S) WHEN PERFORMED | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29882 | ARTHROSCOPY KNEE SURGICAL WITH MENISCUS REPAIR (MEDIAL OR LATERAL) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29883 | ARTHROSCOPY KNEE SURGICAL WITH MENISCUS REPAIR (MEDIAL AND LATERAL) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29885 | ARTHROSCOPY KNEE SURGICAL DRILLING FOR OSTEOCHONDRITIS DISSECANS WITH BONE GRAFTING WITH OR WITHOUT INTERNAL FIXATION (INCLUDING DEBRIDEMENT OF BASE OF LESION) | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29886 | ARTHROSCOPY KNEE SURGICAL DRILLING FOR INTACT OSTEOCHONDRITIS DISSECANS LESION | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29887 | ARTHROSCOPY KNEE SURGICAL DRILLING FOR INTACT OSTEOCHONDRITIS DISSECANS LESION WITH INTERNAL FIXATION | PROCEDURE | INCLUSION | TRIGGER |
| CPT | 29999 | UNLISTED PROCEDURE ARTHROSCOPY | PROCEDURE | INCLUSION | TRIGGER |

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# 5 Things Payors Should Be Able To Do:

1. Administer Value Based Models Including Bundles
2. Define the Bundle
3. Enter Into Provider Agreements

# Bundle Provider Agreements

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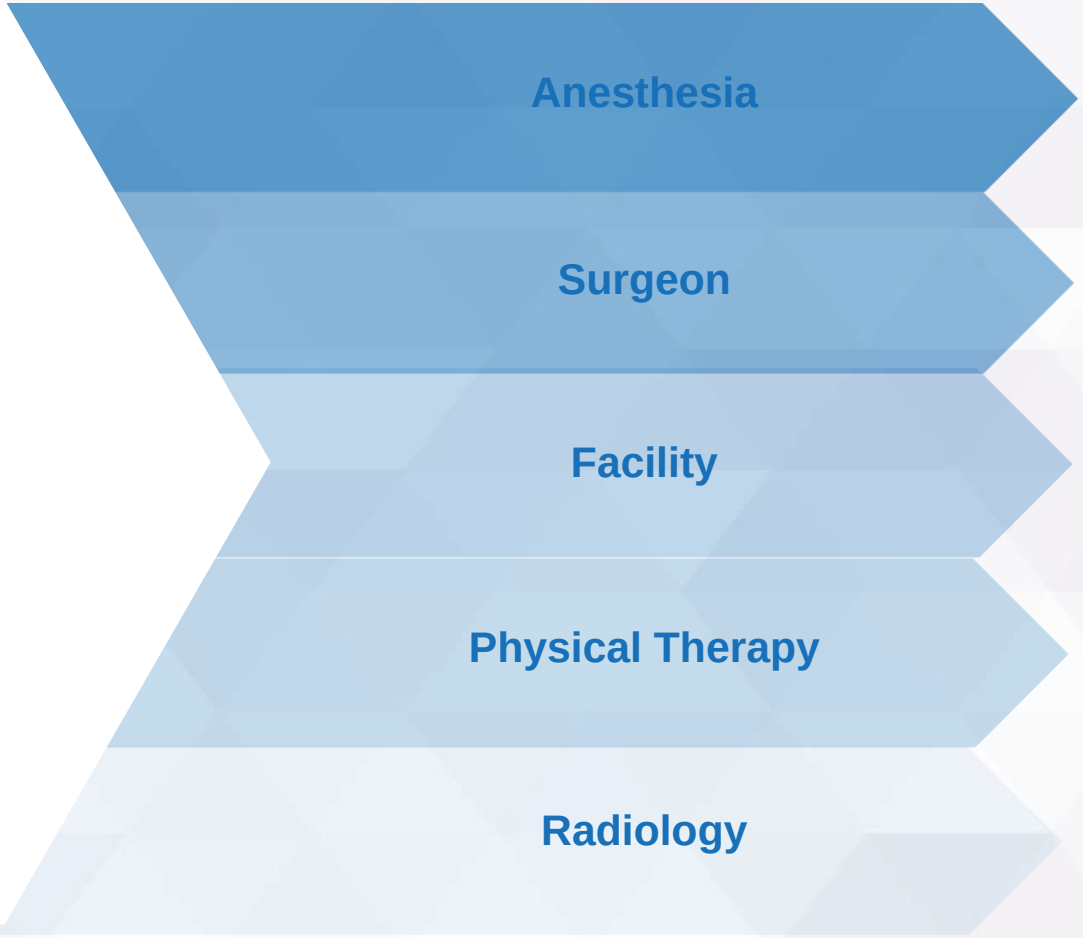
## Final Product

**Bundle Payment Provider Contract Cover Sheet**

**Payor Bundle Procedure:**
**Payor-TJR-K-123**
**Total Bundle Rate = $28,000**

**Provider Participants:**

1. NPI A – $2,000 allowable
2. NPI S – $4,500
3. NPI F – $19,000
4. NPI PT – $1,500
5. NPI R – $1,000



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# 5 Things Payors Should Be Able To Do:

1. Administer Value Based Models Including Bundles
2. Define the Bundle
3. Enter Into Provider Agreements
4. Adjudicate the Bundle

# Value Based Administration

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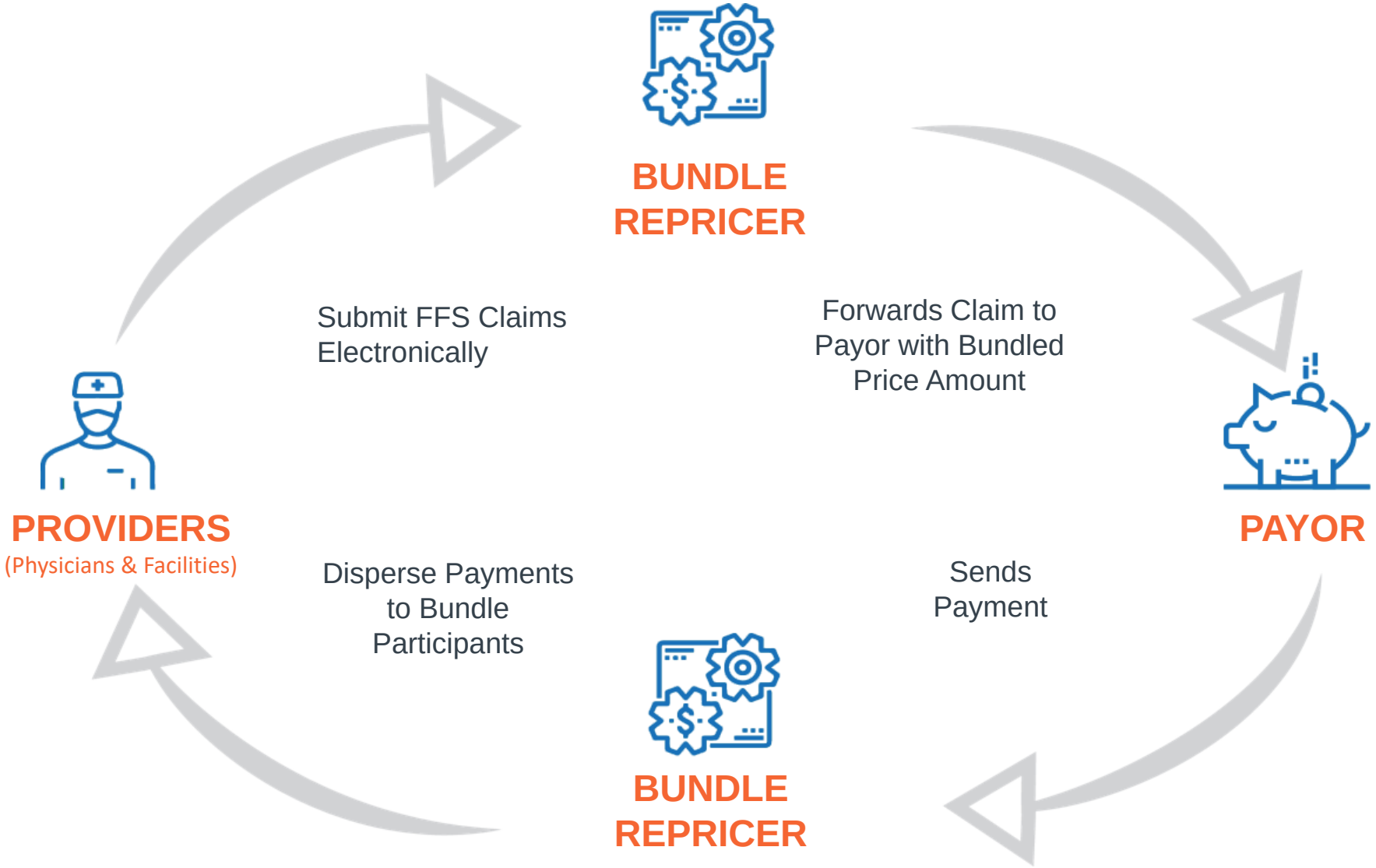
## Automate Administration of Bundles




**Key Takeaway:** No change in the way providers submit claims or the way a payor adjudicates claims

# Value Based Administration

## Direct to Payor w/Payor Payment Distribution

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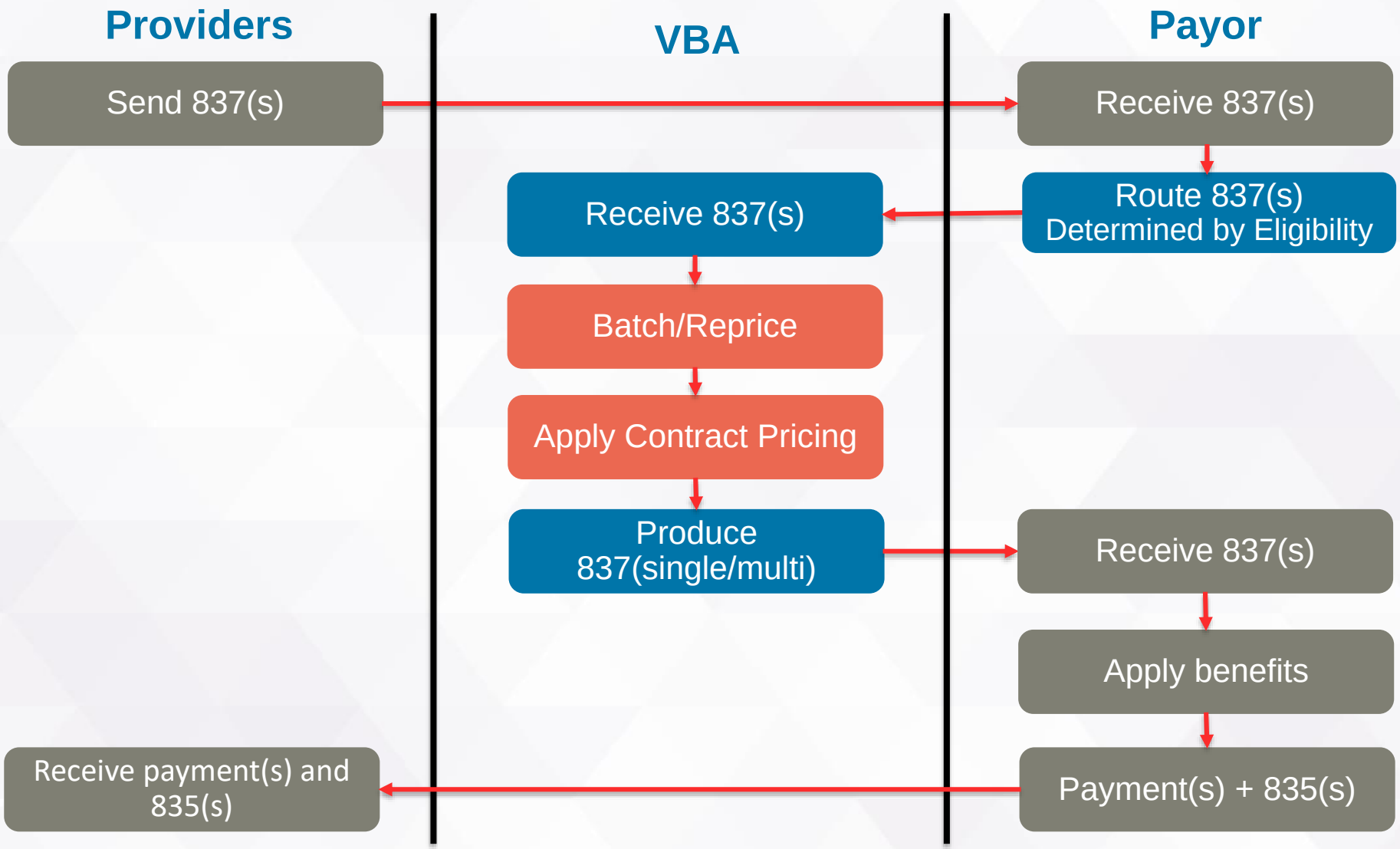

# Value Based Administration

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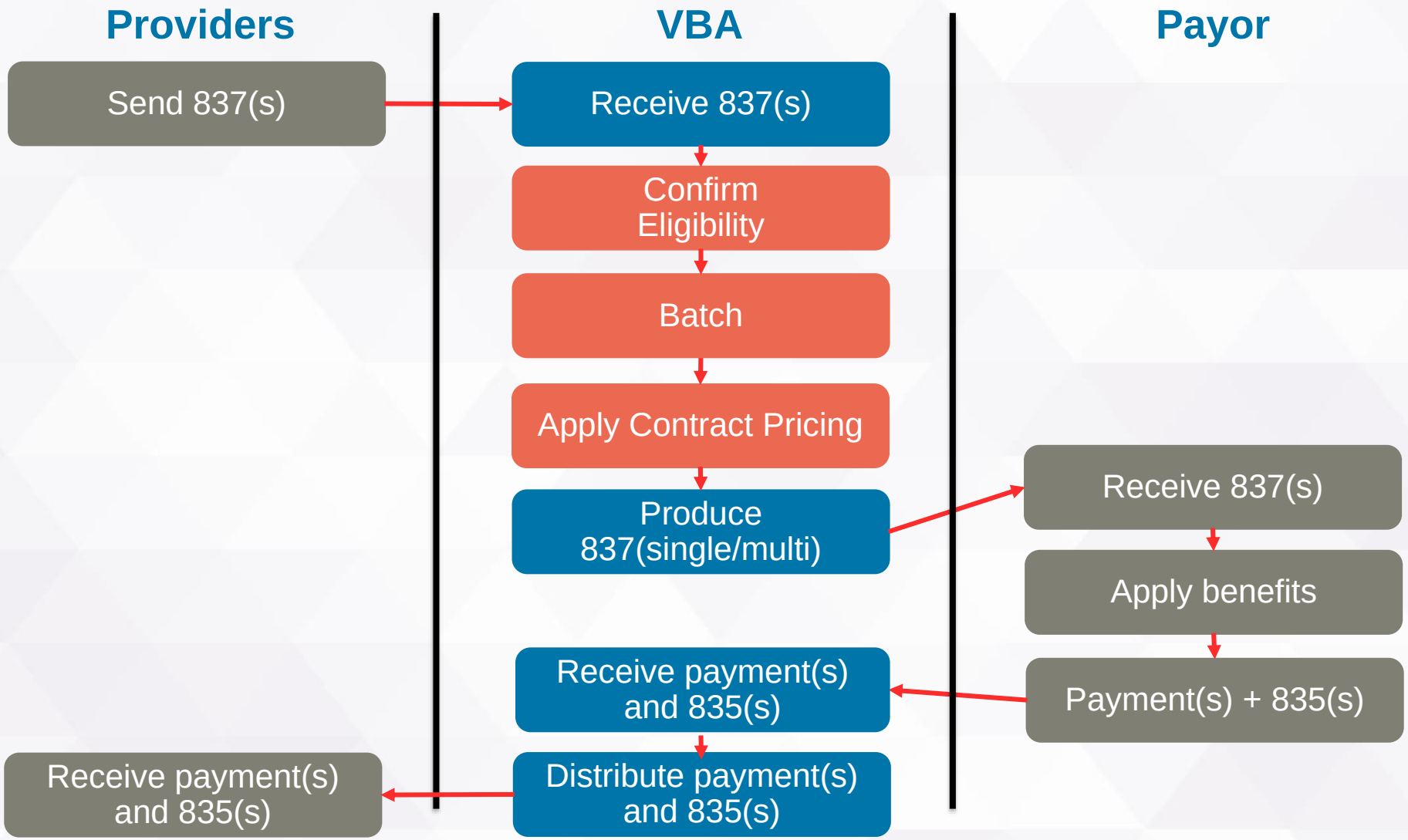
## Direct to VBA w/VBA Payment Distribution



# Value Based Administration Example

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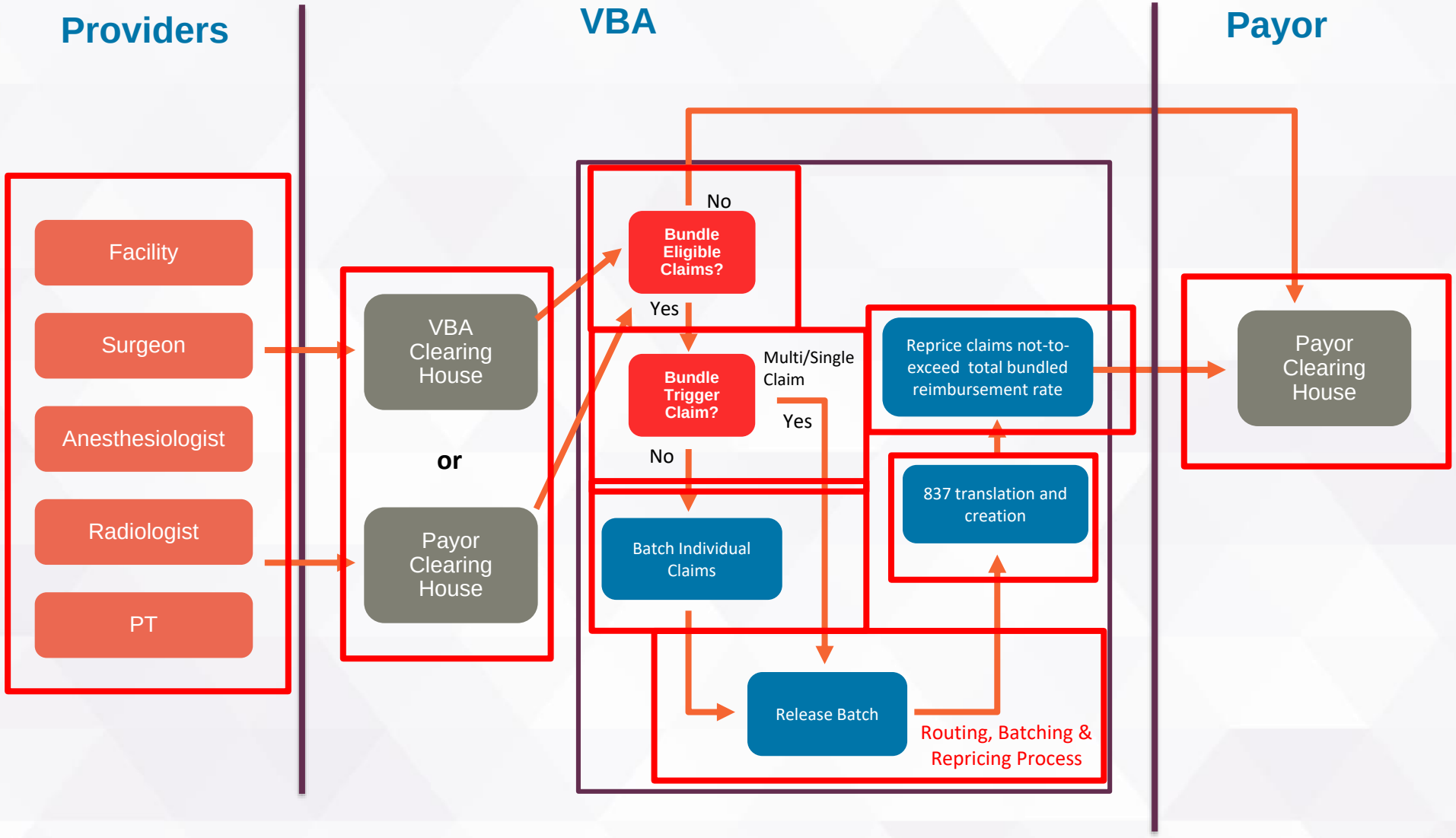
## Prospective Bundle Administration



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# 5 Things Payors Should Be Able To Do:

1. Administer Value Based Models Including Bundles
2. Define the Bundle
3. Enter Into Provider Agreements
4. Adjudicate the Bundle
5. Member Steerage to Maximize Savings Opportunities

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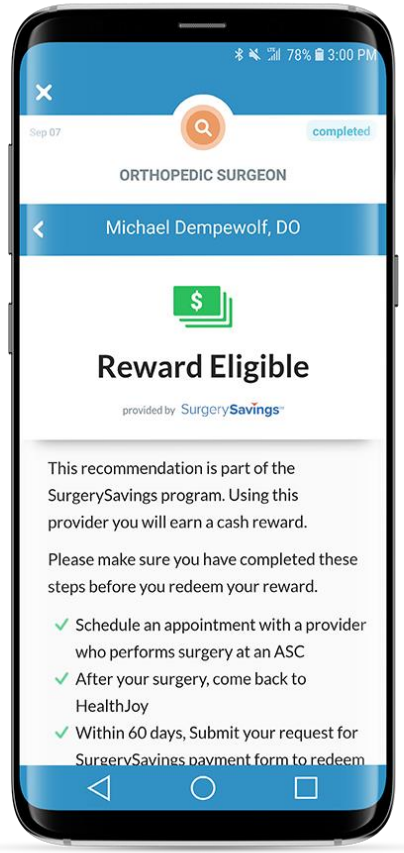
# Surgery Savings

- Surgery Savings is a consumer driven steerage program to reduce the cost of surgeries.
- ValueHealth will customize a Tier 1 Network of low-cost, high quality facilities that participate with Payor.
- When an member needs surgery, they simply access the app with a few simple steps.
- Member takes control of their health decisions and receives a cash and/or benefit incentive.
- Participant incentive payments are set by Payor or Employer.
  - We recommend cash incentives and no deductibles and coinsurance.
- Covers most orthopedic and bariatric surgeries.
- Cost is $2 PEPM



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# Summary

- Surgery is leading value-based care transformation
- Orthopedics is the “spear” in value-based care transformation
- TJR is the “tip of the spear”
- Other Orthopedic procedures to follow
- Other specialties will follow orthopedics
- We can dramatically improve the value delivered to the payor
- Providers must be technology enabled, data driven and payor focused
- Administer Value Based Models Including Bundles
- Define the Bundle
- Enter Into Provider Agreements
- Adjudicate the Bundle
- Member Steerage to Maximize Savings Opportunities

# Thank You

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