Optimizing Value in Larger Orthopedic Practices

COA Annual Meeting 2013

Robert M. O’Hollaren M.D.
Ventura Orthopedics and Sportsmedical Group
Ventura, Calif.
“I Feel a Change Comin’ On”
-Bob Dylan

Do not fear change because change is good.

Actually, studies show that any big changes in a person’s life vastly increase the odds of sickness and death.

Are you trying to kill us?

I can’t feel my arm!
Value = Quality/Cost

- How to deliver on the value proposition?

- Kaiser has spent 10 years and $30 Billion on IT infrastructure and care coordination programs

- N.Y. Times article March 21, 2013:

- “Kaiser CEO George C. Halvorson acknowledges that they have yet to deliver care at low enough cost”. He states, “We think the future of health care is going to be rationing or re-engineering”.

The ACA Goal

- Replace the fee for service model with a “value-based” model
- Incentivize physicians and health systems to assume increased risk with reward for cost savings and quality improvements.
- Have physicians assume risk for the 80% of the health care dollar not part of physician fees
Current Value-Based Programs

- CMMI has launched 16 value based initiatives including: Pioneer ACO and bundled care programs
- Physician Value Based Modifier to apply to large groups in 2015 and all physicians in 2017
- Episode of care programs rolled out by large employers and insurers, i.e. Walmart (1.4 million employees)
- Narrow network provider panels, i.e. Blue Distinction and United Health Premium programs
Value-Based System Requirements

- Cost data for each episode of care
- Robust IT system for data acquisition and analysis
- Appropriate personnel and administrative support
- Cultural shift that will allow accommodation to changes in practice processes and physician income distribution
Efficiency = More work with the same or fewer resources. Potential areas of improvement:

- Evaluate each expense category and re-bid services on a regular basis
- Evaluate all personnel and cross-train when able
- Evaluate job descriptions to match job requirements with training and pay levels
- Regularly evaluate patient wait times and impediments to throughput
Changes to Care Processes

- Addition of mid-level providers for additional or satellite clinics
- P.A. ED call coverage
- P.A. or N.P. staffed after hours urgent care clinic
- Pre-screening of new patients for x-ray needs prior to being seen by the physician
- Group pre-op visits
Care Process Changes (cont.)

- Increased on-line information capture prior to office visit, utilizing multiple portals
- Physician or mid-level use of telemedicine to expand practice footprint (especially in underserved areas)
Improving Other Care Processes

- Ancillary services: establishing best practices. Changing from revenue center to cost center.
- Hospital based services: participation in co-management and gain-sharing arrangements
- Development of cooperative culture necessary for bundled payment programs
- Development of integrated MS service line attractive to ACOs, health systems, and payers
The Quality Component of Value

“You Can’t Manage What You Can’t Measure”
CMS
- Starting to look at quality metrics, cost and outcomes:
  - Physician Value-based payment modifier
  - Physician Compare website

Insurers
- Beginning to share cost data for bundled payment initiatives.
- Developing narrow network programs such as Blue Distinction and United Health Premium Designation.
Quality Assessment Resources

- Development of registries i.e. CJRR
- Private companies providing:
  - Tools for evaluation of patient data
  - Software programs for data mining and reporting
  - Assistance with utilization of data to improve re-imbursement.
  - Cost: $2,500-8,000/physician/year
Other Requirements

- Robust IT infrastructure
- Sufficient personnel to assist with data acquisition
- Multiple types of input portals
- Dedicated IT officer
- Program oversight to ensure adequate compliance
“Why Not Let Somebody Else Figure This Out First?”

- Do you have PT or OT services in your practice?

- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act of 2012 requires a claims-based data collection system utilizing G-code and modifier data for outpatient therapy services by July 1, 2013. It requires data collection of beneficiary function during the course of therapy services. The purpose is “to better understand beneficiary conditions, outcomes, and expenditures. This data will be used in developing an improved payment system”.
Conclusion

- Measures of quality and cost are currently being utilized to judge physician performance
- These measures will become increasingly sophisticated as more data is obtained and processes are refined
- Payers are interested in the survival of private practice to promote competition in the market, and to prevent a monopoly by hospitals and health systems.
The Opportunity

- Beginning the process of data acquisition and analysis gets you in the game and shows an understanding of the requirements of the new system.
- Encourage our state and national societies to assist us in developing appropriate quality assessment and benchmarking tools.
- Begin to develop a practice culture that promotes the concept of process re-engineering and new compensation models.
- CMS timeline may be slower. Insurers: 3-5 years.
The Liability

Groman and Rubin: “Neurosurgical Practice and Health Care Reform: Moving Toward Quality-based Health Care Delivery”:

- “Simultaneous implementation of multiple accountability programs will create extraordinary financial and administrative burdens, as well as mass confusion, for health care professionals”.

- “This perfect storm of regulatory and financial burdens threatens the viability of many physician practices and imperils patient access to care”.

The (potential) Asset

- A lean, efficient practice that actually can prove it provides quality care at reasonable cost.
- A physician reimbursement structure that may more appropriately reward you for your efforts.
- A sustainable practice model for yourself and your patients.
Extra! Extra! Hold the Presses!
SGR Repeal and Reform Proposal

- Congressional Committee proposal for SGR Repeal that includes a significant shift in the reimbursement model and “value-based purchasing” initiative including:
  1. Phased in approach for changes allowing a period of “stable payment”
  2. ENGAGING THE PROVIDER COMMUNITY in efforts to reform the reimbursement systems
  3. Empowering providers.......to determine the measures of quality and efficiency that are meaningful
Hold the Presses! (cont.)

- 4. Establishing a more reasonable timeframe for developing measures that promote value
- 5. Prompting CMS to provide timely feedback, enabling providers to make adjustments
- 6. Providing options that enable providers to select the Medicare payment system...that best fits their practice
- 7. Improve the provider practice environment by reducing practice costs and administrative burden
You’ve Got To Be Kidding Me!
Has Someone Seen the Light?
Proposal In A Nutshell

- Phase 1: Stable, Predictable Updates- Predictable fee schedule with adequate time to develop quality and efficiency measures
- Phase 2: Portion of payment Based on Quality through Update Incentive Program (UIP)
- Phase 3: Payment based, in part, on risk-adjusted measures of quality of care and efficient use of health care resources
Yes, Virginia, There Actually May be Sanity in Government!
Thank You!