Creating Physician Owned Bundled Payments

Case Study by Dan B. Murray, Chief Medical Officer for Specialty Practices at OptumCare, former CEO of OrthoCarolina

At OrthoCarolina, a multi-site independent orthopedic physician group in the Charlotte area, we lowered cost by 10-30% and dramatically improved outcomes for hip and knee replacement surgery. We did this by creating a standardized coordinated care program and pairing it with commercial bundled payment contracts in which the surgeons took primary financial risk.

Key Takeaways

- Bundled payments can improve clinical outcomes, reduce variation in care pathways, and substantially lower the cost of joint replacement surgery.
- Consensus-driven pathways, patient and family empowerment, and care navigation are key elements of success.
- Private practice physicians can effectively manage performance-based episode-of-care risk.
- It is possible to scale such a program and reproduce similar results at multiple sites.

The Challenge

The cost of hip and knee replacement in our large local health systems was high enough that local employers began incentivizing patients to choose narrow networks for surgery outside the state. The large local systems were not ready to enter into risk-bearing contracts or to lower their prices until a larger tipping point in the market was reached. Given that orthopedics is the specialty in which much new payment model experimentation is occurring, we knew that our practice would feel the impact of this pricing pressure long before our hospitals did. In addition, the rise of high deductible plans was causing patients to be more price sensitive and demand lower cost options from us as their surgeons.

The Goal

We sought to provide a competitively priced, high-quality local option for joint replacement, with predictably positive outcomes, while reducing the cost to patients and their employers.

The Execution

98% patient satisfaction

Creating a Quality Data Platform

No one wants low-cost, low-quality joint replacement, so we first needed a way to validate that results would be as good as, or better than, our current outcomes. We invested in technology that would allow us to collect patient-reported outcome measures (PROMs) electronically from patients, both pre- and post-op, at regular intervals. Our Quality Improvement (QI) Committee determined which measures to collect, and the QI staff coordinated collection of hospital-based data in addition to the patient-reported data from our new practice platform.

Reducing Variation through Consensus Protocols

All 26 surgeons who do a significant number of total joint replacements in our practice were invited to participate in a consensus process to create an evidence-based common care pathway and order set for knee and hip replacement. The group, working within our physician practice governance, was charged with eliminating anything that didn't add value to the patient's outcome or experience. The process produced a much simpler care pathway for patients, eliminating many commonly used items that could not be proven to add value (continuous passive motion machines and urinary catheters, for example). At the conclusion, surgeons who desired to care for bundled payment patients were required to stipulate that they would use the consensus protocol and order set unless a specific clinical condition required deviation.

Negotiating the Contracts

Without a willing hospital partner at the outset, we needed assistance to obtain cost data. We contracted with a consulting firm to determine the typical cost of joint replacement. We then compared it to the Explanation of Benefits from our employees who had joint replacements in each local system. The comparison revealed a significant opportunity for cost savings.

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First one payer (Blue Cross and Blue Shield of North Carolina), and then a large regional employer, agreed to negotiate a rate for the entire 90-day prospective bundle directly with us, including stop-loss protections and exclusions to limit us to performance risk rather than actuarial risk. We would be responsible for negotiating a facility fee with the hospitals and a professional fee with physicians (including anesthesiologists and radiologists), physical therapists, and any other providers. We would function as the third-party administrator (TPA), responsible for payment to all participants. Patients operated on in a facility where we had an agreement would be paid under the bundle; patients operated on elsewhere (or excluded for certain co-morbidities) would remain fee for service.

A 123-bed suburban community hospital, attracted by the ability to retain patients locally or even gain market share, agreed to participate contingent upon surgeon participation in cost reduction efforts within the service line. After achieving significant success at that institution (see metrics below), we created a new management company that replicated the program at three additional facilities.

Creating the Care Coordination Program

Based on the clinical pathway, we produced a Joint Journal for bundled patients and their families that explained every step, from initial visit to the end of their care episode. This engaged the family and patient, reduced any anxiety or uncertainty about the procedure or the process, and assured them that everything the surgeons agreed should happen actually did. Patients were assigned a navigator to accompany them through all phases of care, to be a first responder to direct quick resolution of any problems, and to ensure timely completion of all outcome measures.

Our business services, accounts payable, and value-based services teams collaborated to create the third-party administrator (TPA) function. Patients — who knew that they would be paying a single price for care within the 90-day episode — were given an OrthoCarolina Bundled Payment "insurance card" to use instead of their regular insurance card for any care during the bundled period, thus limiting inappropriate claim submission.

Partnering with the Hospital

Our four hospital partners to date each designated a team that includes nursing, quality, and administrative departments. This team collaborates with our Coordinated Care team to ensure all who interact with the patient or family are fully trained in the care pathways and expectations so that all care and communications are consistent. Weekly "huddles" ensure that issues are dealt with quickly and patient care processes are regularly updated and improved. Because the clinical process changes applied to all OrthoCarolina patients at that facility, the hospitals enjoyed the "halo effect" of savings and synergies for nonbundled patients.

Timeline

Approximately four years from initial research to our first broad commercial contract.

Metrics

Of the first 200 patients who underwent hip or knee replacement surgery in our commercial bundled payment program in four hospitals, we had 0% readmissions, 0% reoperations, 0.5% deep vein thrombosis, 100% discharged to home, 100% pain controlled. Length of stay dropped from 2.4 days to 1.5 days (compared to our prior patients in the same hospitals). Patient satisfaction, using our own survey, was 98%.

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PROMs, including VR-12 for quality of life and short-form HOOS for hips and KOOS for knees (measuring pain and physical function), all showed substantial improvement compared to pre-op. These improvements were comparable or better than their historical comparison groups. Because we used metrics of the National Orthopedic and Spine Alliance, we were able to compare our PROM results to NOSA's four other major joint replacement centers and found them to be statistically similar.

Payers report that their cost per patient has been 10-30% lower than before. The broad range may reflect differences in payments to facilities previously used by the payers.

In total, we've now negotiated shared savings contracts with two commercial payers, and prospective bundled payment contracts with 6 commercial payers or employers, in addition to participating in the CMS BPCI in 15 episode groups.

Where to Start

Seek a commitment to quality improvement first through systems-based change, and then use incentive-based contracts to drive individual behavior change. Reduce variation in care through consensus-building, collect meaningful outcome metrics, and create a governance process to review them collectively in a nonjudgmental learning environment.