

Developing New Physician Payment Models: Comprehensive Care for Joint Replacement Model—A Preview of What’s to Come in Spine

Morgan P. Lorio, MD, FACS, Chair of ISASS Coding & Reimbursement Task Force

In July 2015, the Centers for Medicare and Medicaid Services (CMS) proposed a new payment model called Comprehensive Care for Joint Replacement (“Model”). The Model bundles Medicare payment for lower extremity joint replacements (hip and knee) and holds the hospital in which the joint replacement surgery takes place accountable for the costs and outcomes of the surgery throughout the episode of care. The Model defines the episode of care as the surgery and the 90-day post-surgical period. The Model is set to take effect on January 1, 2016 for a 5-year period in 75 geographic areas throughout the United States; most hospitals, physicians and post-acute providers in these areas are **required** to participate. According to CMS, the Model encourages patient-centered care and greater coordination among hospitals, physicians, home health care agencies and nursing/rehabilitation facilities through incentives and/or penalties to hospitals based on the costs and outcomes during each episode of care.

Under the Model, each entity involved in the episode of care continues to bill Medicare fee-for-service, just as it has always done. After the episode, the actual costs and outcomes are evaluated by CMS and compared to CMS’ target cost of the episode. If the episode comes in less than the target, CMS makes incentive payments to the hospital. If the episode comes in over the target, penalty payments must be made to CMS by the hospital.

This Model may constitute an “alternate payment model” but it certainly does nothing to transform healthcare delivery systems. It represents a mandatory edict from CMS that establishes a 5-year human experiment, billing stakeholders as usual with subsequent reconciliation and financial penalties, and will serve as template for more to come. Rather than patient-centered care, this Model encourages hospital-centered care and represents the beginning of hospital-based reimbursement. If CMS puts the hospital at the center of the episode (i.e. the entity designated and held accountable by CMS), the hospital naturally will attempt to control all aspects of the episode of care (the inpatient surgery and all follow-up care in the 90-day post-surgical period) in order to minimize its costs, maximize its outcomes and ultimately minimize its risks. How will the hospital do this? By acquiring/merging all parts of the care chain (e.g. MDs, nursing facilities, rehab facilities, home health agencies, physical therapy agencies)? By treating only the patients with the lowest risk of surgical and post-surgical complications? By restricting patient choice in surgical and post-surgical care?

There is little to no infrastructure in place to coordinate care within this mandatory Model. As proposed, the Model gives hospitals more leverage than currently exists and physicians become easy targets. We have already started to see consolidation and mergers of hospitals and healthcare systems in order to manage broad geographic

networks¹; this Model incentivizes hospitals to continue down the path of acquiring all parts of the care chain as part of a plan for a united health system. This begs the question of whether the physician, rather than the hospital, should be the accountable entity at the center of the episode of care and be responsible for assembling the “care team” necessary to treat the patient during the episode.

Let's consider the care chain: the patient presents to his/her primary care physician (PCP) with lower extremity joint pain; the PCP evaluates the patient, orders imaging and attempts to manage the pain with physical therapy and/or medication; if the pain cannot be managed, the PCP refers the patient to an orthopedic surgeon; the surgeon evaluates the patient and determines whether joint replacement surgery is necessary; if necessary, the orthopedic surgeon schedules the surgery and develops the surgical and post-surgical care plan; the patient is admitted into the hospital and the surgery is performed by the orthopedic surgeon with involvement from anesthesiologists/anesthetists, radiologists, nurses and other healthcare professionals (the surgery triggers the beginning of the “episode” of care under CMS’ Model); post-surgery, the surgeon, PCP/hospitalist, nurses and other healthcare professionals are involved in the patient’s post-acute care; the patient is discharged from the hospital and either goes home or to a nursing/rehab facility; home services and physical therapy services are utilized in the 90-day post-surgical period; the patient has follow-up appointments with the surgeon and/or PCP in the 90-day post-surgical period.

Based on this care chain, the care team would consist of the PCP, a radiologist, potentially a pain management physician, a physical therapist, a surgeon, an anesthesiologist/anesthetist, nurses, a hospitalist, a nursing/rehab facility, and a home services agency. Which member of the care team and which part of the care chain has the largest impact on patient outcomes and cost of the episode? Cost containment and quality outcomes are dependent on a number of factors that are difficult for any one piece of the care chain and/or care team to control. Does the patient have chronic conditions that must be managed? Are there geographic considerations for discharge planning (e.g. where the patient resides relative to his/her PCP, surgeon, hospital, nursing facility, rehab facility, physical therapy agency, family/friends/support team)?

Accountability requires that one individual/entity controls the care team and how and where services are provided to the patient during the episode. Who should pick the individual members/entities and assemble the care team? The hospital? The surgeon? The patient? Should patients’ options be limited to a predetermined menu of care team members? What happens if the patient deviates from the menu—could a patient choose a nursing or rehab facility that is not a part of the standard care team due to geographic considerations (e.g. distance to home, family, support team, etc.)? We currently have a culture of choice in care for Medicare beneficiaries, but this mandatory Model could restrict the ability of the patient to choose individuals/entities involved in his/her care team.

¹ Rubenfire, Adam. “It takes a village to merge Wellmont and Mountain States Health Alliance.” Modern Healthcare. 06/12/15. <http://www.modernhealthcare.com/article/20150612/NEWS/150619968>.

A physician-led team should have an equivalent voice throughout the episode of care at a minimum and ideally, the episode should be overseen by a physician team leader because he/she bears a substantial amount of risk in containing costs and optimizing patient outcomes. The surgeon should clearly be the team leader during and after surgery. However, the acute total joint episode of care is directly controlled by the surgeon in the hospital for approximately 3.4 days of the 90-day episode; approximately 87 days are managed outside the hospital. This Model makes it difficult for the surgeon (or the hospital) to lead from afar. The PCP becomes very relevant and a constant in the chain of care from the upstream management phase, intra-surgery phase (inpatient phase), and post-surgical recovery phase.

This Model does not make sense for patients or physicians. The accountable entity should only be held accountable for the pieces of the care chain it can control. The best scenario might be a specialty-owned-system, but the financial risks to the physician to implement the Model are substantial and not accounted for within the Model. At a minimum, a functional risk status assessment needs to be developed prior to implementation of the mandatory Model so the surgeon can stay upstream, ahead of the currents.

At this point you may be wondering how this joint replacement model relates to you as a spine surgeon. Keep in mind that CMS developed this Model because joint replacements are the most commonly performed Medicare inpatient surgery with long, resource-intensive recovery periods. Additionally, CMS predicts high utilization going forward. Fee-for-service will soon be a thing of the past as CMS continues to consistently identify high-expenditure, high-utilization procedures and develop bundles and/or alternate payment models. **Spine is next.** Implications for ACDF and TLIF are obvious.

As spine surgeons, we cannot be caught flat-footed and must be ready to respond with our solutions for an alternate payment model that works and makes sense for spine surgeons and patients. In terms of a risk assessment tool, we might think about using something similar to the Society of Thoracic Surgeons' risk calculator (<http://riskcalc.sts.org/stswebriskcalc/#/calculate>). In fact, it is now a SCIP (Surgical Care Improvement Project) requirement to document the risk calculation as well as an attestation to its discussion with the patient as part of the pre-op evaluation. Or we might adopt something like The Euroscore (<http://www.euroscore.org/calc.html>).

I encourage you to read the [proposed rule](#) in addition to the AMA comment letter and the AAOS comment letter to CMS on this Model and think about (1) how does this model work or not work? (2) how should spine surgeons prepare for the day that CMS announces its "Comprehensive Care for Spine Model"? It is my intention to engage ISASS membership to start a dialogue on alternate payment models and develop ways that we spine surgeons can advocate for functional payment and delivery models.

References:

AAOS Comment Letter to CMS. “[CMS-5516-P] Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule”. 09/08/15.

Alternative Payment Model Discussion. “Implications of CMS Bundled Payment Proposals for Joint Surgery and Other Procedures and Conditions”. Hosted by Sandy Marks & Harold Miller, Center for Healthcare Quality & Payment Reform 10/01/15.
www.CHQPR.org

AMA Comment Letter to CMS. “Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule [CMS-5516-P]”. 09/01/15.

CMS Proposed Rule. “Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services”. Federal Register. 07/14/15.
<https://www.federalregister.gov/articles/2015/07/14/2015-17190/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals>

Rubens, Adam. “It takes a village to merge Wellmont and Mountain States Health Alliance.” Modern Healthcare. 06/12/15.
<http://www.modernhealthcare.com/article/20150612/NEWS/150619968>.