A Sea Change in Medicine:
Current Shifts in the Delivery and Payment of Medical Care

Richard Bruch

The Patient Protection and Affordable Care Act and the Triple Aim are driving a shift toward value-based care. Significant financial risk is being transferred from commercial insurers and government payers to hospital systems and independent physician groups. Medicare has developed bundled payment programs, but legislative barriers still impede the implementation of value-based health care.

In today's health care environment, the Patient Protection and Affordable Care Act and the Triple Aim are driving a shift from fee-for-service medical care to value-based care. The Triple Aim has become a national goal: to provide patient-friendly medical care with good outcomes, to treat populations of patients, and to provide this care at a lower per-capita cost. Simultaneously, significant financial risk is being transferred from commercial insurers and government payers to those who provide medical care. Commercial and governmental payers are attempting to find the correct incentives for hospitals and physicians to accelerate the switch to value-based care.

New Payment Models: ACOs and Bundled Payments

Two models of American medical care delivery have evolved over the past 5 years to meet the Triple Aim mandate: the accountable care organization (ACO) and the bundled payment program. In the ACO model, initiated by the Center for Medicare and Medicaid Innovation (the Innovation Center), ACOs are responsible for the health care of an assigned patient population. These ACOs are led by either independent primary care physicians or by health systems. In the second model—the bundled payment program—a group of health care providers agree to a set fee for providing an episode of care. For example, the bundle for knee replacement surgery includes the hospital episode and all appropriate post-procedure rehabilitation and physician care for a contracted number of months. The bundled payment program is more suited to specialist physicians.

Most ACOs and bundled payment programs are retrospective. Initial payment is received on a fee-for-service basis. Several months to a year later, quality of care and expenses are evaluated and a reconciliation occurs, with the provider of care either receiving or returning monies.

A Prospective Bundled Payment Plan

In 2012, Triangle Orthopaedic Associates, P.A. (TOA) entered into a contract with Blue Cross and Blue Shield of North Carolina (BCBSNC) to provide total knee replacements for BCBSNC's adult commercial patient population under a prospective bundled payment program. Soon after surgery, the bundled payment is made to TOA. TOA then pays the hospital for inpatient medical and surgical care, pays the anesthesiology expenses, and is responsible for all postoperative care expenses for the contracted number of months. In this program, a TOA care coordinator guides patients through the surgical and recovery process, and outpatient physical therapy visits do not require separate patient copayments. After 1 year, BCBSNC reported 97% patient satisfaction and 22% lower medical costs compared to the marketplace [1]. Throughout the entire episode of care, a patient receives only 1 bill, and patients greatly appreciate the increased attention to their needs.

Given this success, the BCBSNC prospective bundled payment program with TOA has been expanded to include total hip replacements. TOA, OrthoCarolina, and Novant all currently have orthopedic bundled payment programs with BCBSNC. In 2015, the North Carolina Department of Insurance expanded commercial bundled payment programs. Currently, prospective bundled programs require substantial administrative efforts by both the insurer and the physician practice.

Medicare and Bundled Payments

The Innovation Center has developed voluntary programs for Medicare patients known as the Bundled Payments for Care Improvement (BPCI) initiative. The most popular BPCI program has been the Model 2 program, a retrospective program in which each participant manages patients through acute and postacute episodes of care and which offers options regarding financial risk. Currently, TOA, Blue Ridge Bone and Joint, Greensboro Orthopaedics, OrthoCarolina,

Electronically published July 6, 2016.

Address correspondence to Dr. Richard Bruch, 207 Pineview Rd, Durham, NC 27707 (rich.bruch@gmail.com).

N C Med J. 2016;77(4):261-264.
0029-2559/2016/77406

OrthoWilmington, Southeastern Orthopaedic Specialists, and Sports Medicine and Joint Replacement of Greensboro are all BPCI participants via Signature Medical Group (SMG), an independent physician practice in St. Louis, MO. SMG is the only physician group practice selected as an awardee/convener in the Innovation Center Model 2 program. This program lumps medical care by diagnosis-related group (DRG) codes. If high-quality care is delivered at a reduced cost, the Centers for Medicare & Medicaid Services (CMS) will financially reward the participating physicians. Through SMG acting as an agent, 55 independent orthopedic practices in 26 states participate in the Model 2 program. All practices are striving to achieve best-practice patterns.

The Model 2 program is unique in that it permits certain patient benefits that—were they outside the program—would be termed "inducements" and would violate federal law. For example, in an attempt to decrease the utilization of more expensive skilled nursing home and home health agency care, physicians enrolled in the Model 2 program are allowed to pay transportation expenses to enable post-operative patients to come for office-based physical therapy. Another unique aspect of the program is the expanded role of gainsharing, now a 3-year program. Surgeons and hospitals can work together to achieve total joint-implant monetary savings; if quality criteria are met, hospitals are allowed to share savings with participating surgeons. The Innovation Center is also able to change program design quickly without having to proceed via the federal rule-making process.

Through this program, an amazing medical experiment is occurring: medical care provided by independent physicians can be compared to hospital system–provided care. BPCI is currently closed to additional hospital or physician group enrollment. I believe the Model 2 BPCI program will demonstrate that care provided by independent physicians is superior to hospital system–provided care both in terms of patient satisfaction and cost savings.

Comprehensive Care for Joint Replacements

Through regulation, CMS has expanded the bundled payment approach in an attempt to hasten the transition to value-based care [2]. The Comprehensive Care for Joint Replacement (CJR) model is a 5-year mandatory national program targeting hip and knee replacement surgeries in 67 metropolitan statistical areas. Beginning April 2016, Asheville, Durham-Chapel Hill, and Greenville hospitals were included in this mandatory program.

When compared to the Model 2 BPCI program, the CJR program is limited in important ways. The CJR model pales in comparison to the BPCI waivers supporting hospital and physician collaboration. For simplicity, the CJR model interacts with and rewards hospitals, not physicians. The majority of patient care provided in the CJR program does not occur in hospitals. Also, the amount of reconciliation monies at stake in the CJR program is smaller.

Obstacles to Achieving Pay-for-Value

I believe there will be more growth in the ACO model of physician care and reimbursement than in the bundled payment model. It is administratively easier to set a target price for an ACO population of patients than to have monitoring and interaction with many practices providing care via bundled payment programs.

The past 2 decades have seen a major shift in American physician employment, such that currently about 30% of physicians are employed by hospitals [3], and additional physician groups are affiliated with hospital systems. The Bipartisan Budget Act of 2015 placed a freeze on the ability of hospitals to reclassify these physician offices as Hospital Outpatient Department (HOPD) sites of service [4]. This federal law will slow the acquisition of physician practices by health systems, although all HOPD reclassifications prior to the freeze are grandfathered.

The remaining independent physicians should not be overlooked by those who develop health care policy. Small independent physician practices will have difficulties complying with continuously changing computerized reporting requirements and new payment models; these physician practices will survive, but they likely will not convert to the value-based system. To meet reporting and best-practice requirements, larger physician practices will be required. These large physician practices will have more capital than smaller practices yet will be more nimble in changing health care delivery than are large hospital systems.

Independently practicing physicians fear the narrowed network concept of health care delivery reminiscent of health maintenance organizations. Hospital system networks routinely favor internal referrals rather than referrals to independent physicians regardless of quality or cost. This referral restriction and subsequent HOPD charges increase the cost of physician office visits, laboratory, imaging, and surgeries. In other words, HOPD charges increase the cost of health care every step of the way from the preoperative evaluation, the surgical procedure itself, through rehabilitation services and follow-up physician visits [5]. Identical health care provided by hospital systems is more expensive than that provided by independent physicians. To save money and preserve patient choice, state and federal legislation is needed that will allow any independent physician to participate in a narrow network if the physician complies with the network's quality and financial terms.

Both hospital system–led medicine and independent physicians are attempting to meet our nation's goals of achieving high-quality, patient-friendly health care at reduced per-capita costs. Since both care delivery models involve accepting significant financial risk, both must have equal access to currently regulated medical assets—the tools to

deliver care—such as ambulatory surgery centers (ASCs), magnetic resonance imaging (MRI) and computed tomography (CT) scanners, home health agencies, and hospital ownership.

Currently, North Carolina's Certificate of Need (CON) rules prevent independent physicians from having the tools to meet the goals of the Triple Aim, despite significant potential cost savings. Nationally, 77% of all Medicare advanced imaging (MRI and CT scans) occur in the HOPD setting [6], yet commercial insurance pays 52% more when an MRI is performed at a HOPD site [7]. North Carolina CON rules control MRI scanner "need." If an ACO or a physician does not already own an MRI scanner, they are not likely to be able to obtain one due to North Carolina CON restrictions. Similarly, for CT scanners, North Carolina law has a diagnostic center clause that is only applicable to physicians (hospitals are exempt) [8]. The total allowable amount for all imaging equipment ever owned by the physician practice, including design and construction costs, is $500,000. Since the law does not recognize depreciation of imaging equipment over time, many North Carolina physicians who own CT scanners are prevented from upgrading them. Reforming North Carolina's CON rules to allow for additional ownership of MRI and CT scanners will allow physicians to offer patients the same services as hospitals but at a lower cost.

Similarly, CON rules limit the availability of high-quality, lower-cost surgery provided in ASCs. CMS pays 82% more for HOPD surgeries compared to ASCs [9]. In North Carolina, 75% of ambulatory surgeries are performed in the HOPD setting [10]. In the years 2010–2014, North Carolina ranked 5th nationally in population growth, but during the years 2011–2015, North Carolina's CON rules allowed for only 2 additional operating rooms: 1 in Dare County and 1 in Catawba County [11, 12]. I believe this amounts to restraint of trade. During 2015, the North Carolina General Assembly considered legislation that would increase ASC availability [13], but this bill was not passed during the 2015-2016 session.

According to a 2015 study, if approximately 126,000 patients annually moved their site of surgery from an HOPD to an ASC, then the state would reach the national average for ASC utilization (unpublished data). The North Carolina State Health Plan pays on average $2,000 more for each surgery performed in the HOPD setting than it pays for surgery performed in an ASC [14]. By my calculation, this results in more than $250 million wasted annually on ambulatory surgery in North Carolina.

Both commercial insurers and governmental payers will continue to modify financial reimbursement, seeking to accelerate the shift to value-based care delivery by incentivizing both hospital systems and independent physicians. An important point to bear in mind is that it is physicians who prescribe medical care; thus, the closer a program interacts with and rewards individual physicians, the more likely it is to succeed.

As our nation shifts from fee-for-service medical care to value-based care and as our rules change to facilitate the shift to value-based care, independent physicians will continue to provide great patient care, and patients will continue to be well served by patient-friendly health care models. North Carolina patients will be best served, however, if they continue to have a choice between the following 3 options: hospital system medicine, independent physicians participating in value-based programs, or independent physicians who do not convert to a value-based model. If choice is preserved, our patients will likely access all 3 of these options for health care. NCMJ

Richard Bruch, MD consultant, Triangle Orthopaedic Associates, P.A.; board chair, North Carolina Specialty Hospital; executive committee member, North Carolina Orthopaedic Association; board of councilors member, American Academy of Orthopaedic Surgery; advocacy committee member, The Ortho Forum. R.B. lives in Durham, North Carolina.

Acknowledgments

Potential conflicts of interest. R.B. is a consultant to Triangle Orthopaedic Associates, P.A., a lobbyist for Triangle Orthopaedic Associates, P.A., and a minority investor in the North Carolina Specialty Hospital. R.B. also serves as board chair for the North Carolina Specialty Hospital, and he serves on the executive committee of the North Carolina Orthopaedic Association, the board of councilors of the American Academy of Orthopaedic Surgery, and the advocacy committee of The Ortho Forum.

References

1. Expanded collaboration provides BCBSNC customers with 10–20 percent savings on hip replacement surgeries. Blue Cross and Blue Shield of North Carolina website. http://mediacenter.bcbsnc.com/news/expanded-collaboration-provides-bcbsnc-customers-with-10-20-percent-savings-on-hip-replacement-surgeries. Published February 6, 2014. Accessed February 28, 2016.
2. Centers for Medicare & Medicaid Services. Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services. Published November 24, 2015. Federal Register website. https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals. Accessed June 19, 2016.
3. The Physicians Foundation. 2014 Survey of America's Physicians. Washington, DC: The Physicians Foundation; 2014. http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf. Accessed February 28, 2016.
4. Bipartisan Budget Act of 2015. Pub L No. 114-74 §603. https://www.congress.gov/bill/114th-congress/house-bill/1314/text. Accessed June 19, 2016.
5. Avalere Health. Medicare Payment Differentials Across Outpatient Settings of Care. Washington, DC: Avalere Health; 2016. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/doc/Payment-Differentials-Across-Settings.pdf. Accessed February 28, 2016.
6. United States Government Accountability Office. Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions. Washington, DC: Government Accountability Office; 2012. http://www.gao.gov/assets/650/648988.pdf. Accessed February 28, 2016.
7. Reschovsky J, White C. Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services. Washington, DC: National Institute for Health Care Reform; 2014. http://www.nihcr.org/Hospital-Outpatient-Prices. Accessed February 28, 2016.
8. General Assembly of North Carolina. Certificate of Need. NCGS § 131E-176. Clause (7a). http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_131E/Article_9.html. Accessed June 22, 2016.

9. The Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Washington, DC: Medicare Payment Advisory Commission; 2015: 115-116. http://www.medpac.gov/documents/reports/chapter-5-ambulatory-surgical-center-services-(march-2015-report).pdf. Accessed June 22, 2016.
10. State Health Coordinating Council. 2016 State Medical Facilities Plan. Raleigh, NC: North Carolina Department of Health and Human Services; 2015: 77-88. https://www2.ncdhhs.gov/dhsr/ncsmfp/2016/2016smfp.pdf. Accessed February 28, 2016.
11. Tippett R. Population growth in the Carolinas: projected vs. observed trends. University of North Carolina at Chapel Hill website. http://demography.cpc.unc.edu/2015/12/08/population-growth-in-the-carolinas-projected-vs-observed-trends/. Published December 8, 2015. Accessed February 27, 2016.
12. North Carolina Division of Health Service Regulation. North Carolina State Medical Facilities Plan. North Carolina Department of Health and Human Services website. https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html. Updated January 13, 2015. Accessed February 27, 2016.
13. General Assembly of North Carolina. Amend Certificate of Need Laws. H.B. 200. http://www.ncleg.net/Sessions/2015/Bills/House/PDF/H200v0.pdf. Accessed June 21, 2016.
14. French DJ. Cost savings and justification for changes to CON law. Presented to: North Carolina Legislative Joint Study Committee: Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care; Raleigh, NC; March 18, 2014. http://www.ncleg.net/documentsites/committees/BCCI-6610/March%2018,%202014/Single%20Specialty%20ASC%20Powerpoint%203-18-2014%20final.pdf. Accessed February 29, 2016.