UNDERSTANDING NEW REIMBURSMENT MODELS AND HOW THEY IMPACT YOUR HOSPITAL OR

Hospitals receive a significant portion of their revenue and profit from operating room procedures, but evolving healthcare trends put more pressure than ever on the financial contributions of the OR. One of the most prominent factors threatening traditional ORs is the healthcare industry's transition from a fee-for-service (FFS) reimbursement model to a value-based care (VBC) model, also known as a fee-for-value model or a valuebased purchasing model. The primary theme across all VBC models is that hospitals are expected to find opportunities to reduce costs while delivering quality care and improved patient outcomes; however, many hospitals are experiencing significant challenges in implementing a VBC model.

The traditional FFS model creates a revenue stream in which incentives are based on volume. Revenue increases when volume increases, such as admitting more patients, ordering more tests, and conducting more medical procedures. The quality of the provided care is not considered as part of the reimbursement process.

Additional issues with the FFS model include a complex reimbursement system where each participant bills for their own services separately, a high degree of cost variability exists for the same procedures, and care quality from one facility to the next can significantly vary. Due to its volume-based nature, the FFS model is one of the primary reasons for escalating healthcare costs. Additionally, it contributes to the United States having the highest costs for healthcare among other industrialized countries while achieving the lowest performance.

In response to the issues created by the FFS model, one of the goals of the Affordable Care Act (ACA) is to shift from a volumebased reimbursement model to a VBC model. This type of model incentivizes facilities and clinicians based on cost savings and care quality, not volume. Several types of VBC models exist, with the **primary models being:**

1. BUNDLED PAYMENTS:

Bundled payments, also known as episode-based care, is the establishment of an overall cost for a procedure as opposed to the current reimbursement process that pays each facility and clinician separately for their rendered services. The single billed amount includes all of the required services and supplies, as well as any downstream costs, such as readmissions. Some risk exists with this model since hospitals and providers must work together to ensure the cost of the episode of care does not exceed the approved amount of the bundled payment. Preferably, the cost is lower than the paid amount, allowing participants to share in the remaining balance.

2. FULL RISK CAPITATION:

A full risk capitation model is when an organization, such as a managed care plan, accepts a per member per month (PMPM) fee from a payer in exchange for managing the healthcare costs for a patient population. If the managed care organization can manage the patient population at a lower cost than the PMPM fee, they retain the remaining balance; however, if the care costs exceed the agreed upon PMPM, the organization is responsible for the additional costs. This method allows a payer, such as Medicare or a Medicaid organization, to budget for the entire year based on the agreed upon PMPM, while the managed care plan gains profits from any cost savings they achieve.

3. SHARED RISK:

A shared risk model is similar to a full risk capitation model in that medical services are expected to be below a negotiated fee for a patient population; however, this agreement is between a payer and a provider group, such as an accountable care organization (ACO). As a financial incentive, the provider group retains the difference between the negotiated fee and the amount actually spent delivering healthcare services; however, they are also responsible for paying a penalty if they spend over the negotiated amount.

4. SHARED SAVINGS:

A shared savings model is a precursor to the shared risk model. Providers participate in a standard FFS model, but they receive additional incentives annually if they are able to reduce costs based on a spend level established by a payer. This model may offer less financial incentives for providers, but it also does not carry the same financial risk for the providers as the other models.

Supporting these models requires a variety of metrics to be tracked throughout the care continuum to demonstrate the achievement of care quality and cost savings. As an example, **CMS measures care quality for an ACO using 33 quality measures across four key domains:**

1. **PATIENT/CAREGIVER EXPERIENCE (8 MEASURES)**
2. **CARE COORDINATION/PATIENT SAFETY (10 MEASURES)**
3. **AT-RISK POPULATION:**
   - Diabetes (2 measures evaluated as 1 composite measure)
   - Hypertension (1 measure)
   - Ischemic Vascular Disease (1 measure)
   - Heart Failure (1 measure)
   - Coronary Artery Disease (1 measure)
   - Depression (1 measure)
4. **PREVENTIVE CARE (8 MEASURES)**

These quality measures are collected by CMS through a variety of methods, including:

1. **CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEYS**
2. **CLAIMS DATA**
3. **MEDICARE AND MEDICAID ELECTRONIC RECORD (EHR) INCENTIVE PROGRAM DATA**
4. **DATA SUBMITTED THROUGH THE ACO GROUP PRACTICE REPORTING OPTION (GPRO) WEB INTERFACE**

Quality data collection and reporting methods such as these ensure accountability to care outcomes parallels aims to reduce costs.

Unfortunately, many hospitals may have issues to overcome before they can fully transition away from an FFS model, many of which may require significant time and money. This transition can be especially impactful to the OR since it may receive additional scrutiny due to the high cost of procedures. **Issues hospitals may need to address can include:**

1. EXPANDING ROLES AND RESPONSIBILITIES:

Most physicians are accustomed to operating independently, primarily focused on the services they provide; however, a VBC model will require physicians to participate more closely with other care providers and hospital personnel. Value-based care relies on a team approach to be successful, including working together to coordinate services across the episode of care, defining services and fees as part of the overall episode of care, and discussing ways costs can be lowered without affecting care quality.

2. IMPLEMENTING A DATA COLLECTION AND ANALYSIS PROCESS:

While there may still be some high-dollar opportunities for a few hospitals to reduce costs, most hospitals will need to identify numerous smaller ways to generate savings. Data collection and analysis on specific procedures is one of the most efficient processes for identifying these cost savings opportunities, which may range from finding ways to reduce the amount of supplies used during an operation to streamlining OR processes so "first case of the day" and "turnover times" are efficient and adhere to the OR schedule. Unfortunately, some hospitals may not have the software or IT infrastructure in place to support this data collection and analysis process. Establishing this infrastructure will take time and money, as well as the time needed to gather sufficient data on which to base cost saving decisions.

3. ENGAGING NEW PARTNERS:

Some hospitals may be reluctant to engage new partners to manage certain processes for them. This lack of engagement may be costing them significant money and reducing care quality. As an example, an outsourced partner can serve as a resource to provide specialized clinicians on an as-needed basis in the OR, rather than hospitals maintaining these positions internally. In this instance, hospitals are losing money by maintaining this personnel even when they are not engaged in supporting OR procedures. Additionally, the clinicians provided by the outsourced partner are solely focused on providing a certain service, so they are more likely to be experts in those services, which can positively impact care quality. Top tier partners also focus on collecting data and providing insightful analysis on ways to decrease costs and improve care outcomes. Hospitals must review their existing processes and procedures to identify areas where engaging a thirdparty to support them provides cost savings opportunities.

While the ACA may have helped accelerate the healthcare industry's transition from an FFS reimbursement model to a VBC model, a transition such as this was inevitable. Healthcare in the United States has reached a cost level that seems unsustainable, and an FFS reimbursement model is just one of many factors contributing to those costs. Hospitals that are unprepared to embrace new payment models can expect to experience steadily eroding revenues related to OR profitability.

SpecialtyCare works with more than 1,000 hospitals nationwide and supports 375,000 procedures annually through a variety of services, such as Perfusion, Intraoperative Neuromonitoring (IONM), Surgical Assistants, and Minimally Invasive Surgical Support. Our associates work with physicians in ORs across the country every day to improve the quality of healthcare and reduce costs. Our cost reduction methods are based on extensive data collection and analysis methodologies to ensure all cost-saving initiatives are focused on improving patient care outcomes. **Examples include:**

- SpecialtyCare participates in more open heart-related procedures than any other organization. The data SpecialtyCare gathers from these procedures provides us with the ability to improve perfusion processes for our customers. Between 2013 and 2015, SpecialtyCare's customers lowered the use of blood in over 4,400 patients, resulting in a savings of over $3 million in acquisition costs alone.

- The same research also indicated that this reduction in blood transfusions also reduce associated patient complications, such as acute kidney injury and pneumonia, which can result in increases in length of stay. This reduction in blood preparation and administration helped achieve $8 – $13+ million savings on costs of complications.

- SpecialtyCare's services helps our customers achieve greater OR cost savings through a reduction in supply costs. Due to the volume in which SpecialtyCare orders equipment and supplies, we are able to negotiate lower costs for all of our customers than a single hospital ever could.

- SpecialtyCare assists customers to reduce costs through a reduction in recruiting and training processes. If we provide clinicians to a customer, such as for Perfusion or IONM, they are no longer burdened by the expensive and time-consuming task of managing, training, and maintaining certification for these specialized clinicians in-house. OR directors can then spend more time focused on identifying other costsavings tasks and less time managing these clinicians.

- SpecialtyCare's services are certified by the Joint Commission, and our IONM services are accredited and certified by the Joint Commission. Additionally, our focus on compliance helps us and our customers comply with applicable federal and state statutes and regulations, which reduces the risk of fraud, waste, and abuse allegations. Ultimately, our compliance program results in better outcomes through the conscientious delivery of healthcare, and it minimizes the financial risks to our customers.

With more than 1,500 clinicians providing superior quality care, SpecialtyCare has a national presence that gives our medical team access to extensive, unmatched clinical data for conducting research to identify trends, determine benchmarks, disseminate best practices, and foster innovation that advances patient care. As such, SpecialtyCare has the data, the services, and the expertise to work with hospitals transitioning to new reimbursement models to reduce costs in the OR while improving patient outcomes and care quality.

SpecialtyCare is your partner for improved outcomes, patient safety, and financial results. We work with thousands of physicians every day, assisting in the delivery of exceptional care. Our expert clinicians are highly trained, certified, and work as integrated members of your team, dedicated to helping make your operating room as efficient as possible. When you want the certainty of clinical excellence, choose SpecialtyCare.

- Perfusion
- Autotransfusion
- Intraoperative Neuromonitoring
- Deep Brain Stimulation
- Neurodiagnostic Services
- Surgical Assist
- Minimally Invasive Surgical Support
- Sterile Processing Consulting

866.932.8633 | 3 Maryland Way Suite 200 Brentwood, TN 37027