Payment Models for the Perioperative Surgical Home

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While there is general consensus on the structure of a Perioperative Surgical Home (PSH) model and the types of services it will provide, there is less agreement on who will pay for those services or how those payments will be structured. At the ASA's PRACTICE MANAGEMENT 2015 conference in Atlanta, a number of presentations centered on payment models. Although these talks did not exclusively address the PSH, much of the information presented can be applied to this model of care.

A PSH is primarily a method of organizing and delivering optimal medical care for the patient's particular condition and co-morbidities, but it may also be considered an alternative payment model (APM). In fact, ASA intends to have the Centers for Medicare & Medicaid Services (CMS) recognize the PSH as an APM, which would provide two benefits: to validate a PSH as a payment mechanism and simplify quality reporting. Part of last year's failed legislation to repeal the Sustainable Growth Rate (SGR) formula would have consolidated the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM) and Meaningful Use reporting requirements into the Merit-based Incentive Payment System (MIPS). The legislation proposed that physicians receiving a specified percentage of their income from APMs would be exempt from some of the MIPS requirements.

Once a hospital and its associated providers establish a PSH and determine the services it will provide, it will need to negotiate payments for those services. A properly implemented PSH should result in reduced costs, but it is necessary to design payment methodologies that fairly compensate the participants in a PSH for it to be truly sustainable.

Some examples include:

1. Fee-for-service (FFS) payments for services provided;
2. Discounted FFS, plus an opportunity to share in savings generated by the PSH;
3. A percentage of bundled payments made to the hospital;
4. A portion of shared savings paid to the hospital as a result of the PSH;
5. Co-management agreements that identify additional services provided by the PSH and track quality improvements; and
6. Bonuses for meeting quality and cost-saving metrics.

It is also possible that entities paying for PSH services will propose novel payment methodologies; the PSH must carefully evaluate such proposals to determine whether they are feasible given the challenges of providing those services.

The PSH can evaluate payment proposals starting from two very different reference points. One is the cost of providing all the services requested by payers or the hospital in which the PSH operates; the other is the usual payments that would likely result from providing the services in an FFS environment. If cost is the starting point, it is necessary to determine the costs of providing all services associated with the PSH, including preoperative and postoperative professional services, laboratory tests, imaging studies, EKGs, echocardiography studies and other tests. Once the PSH determines the true costs of providing its services, it needs to incorporate a reasonable "profit margin" and compensation for the assumption of financial risks to determine the minimum payment amount for its services. If FFS payments for services are the starting point, then it is necessary to determine the maximum discount willing to be accepted for those services.

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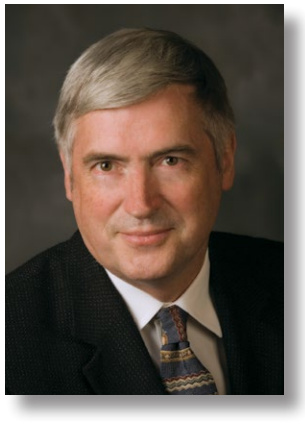

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Additionally, if a portion of the total payment to the PSH is at risk via "shared savings" or bonuses that are tied to meeting quality and/or cost performance metrics, then it is necessary to consider the potential magnitude of those payments and the likelihood of achieving them. Multiplying the potential payments by the probability of achieving those metrics establishes an estimate of the expected additional revenues the PSH will receive for its services.

Whether the PSH begins with the cost of providing its services and adds an expected profit margin and compensation for taking financial risks or starts with its usual FFS payments and applies a discount factor, the result is its "bottom line" for providing services. The PSH should consider rejecting proposals that are less than its calculated bottom line, including expected additional revenues, because they are not likely to contribute to the long-term sustainability of the PSH.

For patients, the PSH may improve patient care, reduce the risks of complications and streamline surgery, leading to a better surgical experience. When negotiating with payers, the PSH should emphasize its abilities to reduce overall costs. Several different entities may be interested in paying for PSH services, including insurers and the hospital in which the PSH operates. The PSH benefits these two types of payers differently; the PSH must understand the interests of the entities with which it negotiates. For hospitals, the PSH should demonstrate how it can decrease the costs of providing services to surgical patients. Examples of advantages for the hospital include fewer inpatient days for surgical patients (an advantage if it is paid under a DRG system), decreased utilization of blood products, only-necessary laboratory and imaging tests, fewer cancelled surgical cases and improved patient satisfaction scores.

For insurers, potential advantages include fewer inpatient days (if it pays a per-diem rate for inpatient stays), fewer laboratory and imaging studies, more rapid patient recovery, decreased utilization of postoperative physical therapy, decreased use of narcotics, more rational use of post-discharge care and other cost-saving benefits.

In addition to negotiating appropriate payment arrangements, a PSH can take other measures to mitigate its financial risks, including risk stratification and stop loss insurance. Risk stratification strategies (based to some degree on comorbidity) provide for payments that are partially based on patients' overall health in addition to the underlying surgical procedures. Risk stratification strategies allow the PSH to be paid appropriately for the anticipated level of services required by its patients, with lower payments for healthier patients and higher payments for patients with significant co-morbidities. Risk stratification can be calculated for individual patients or can be done on an aggregated basis for all patients receiving services in the PSH.

Another method of decreasing financial risks is for the PSH to secure stop loss insurance for its operations. This can protect the PSH from severe losses due to unanticipated demands for its services. Similar to risk stratification strategies, stop loss insurance can be structured on a per-patient or aggregated basis.

PSH payment analyses are complex and a PSH may require expertise in evaluating some of those proposals. To effectively evaluate proposals, it is important for the PSH to obtain as much data as possible. This data may come from a number of different sources, including hospital records, providers' claims, insurance company data, etc. The more data the PSH obtains before entering into contractual arrangements for its services, the more accurately the PSH can evaluate its potential risks.

In summary, there is no single payment system that is best for every PSH. Each situation is unique. A PSH must evaluate its particular circumstances with respect to its services, the patients to whom it will provide care and the mix of payers it will contract with for that care.