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Review Article

Direct to Employer Contracting in Orthopedics

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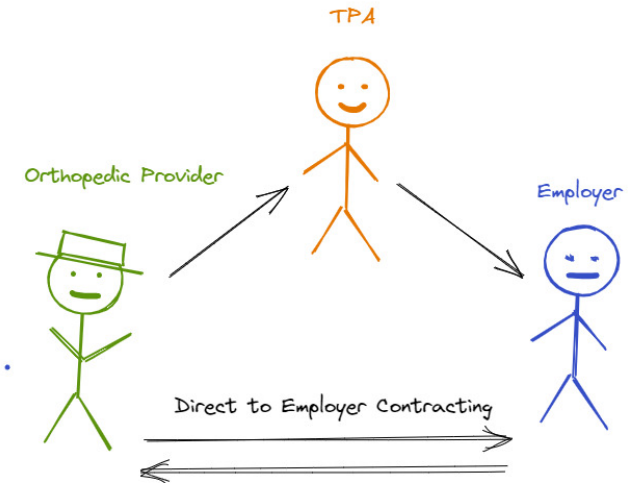

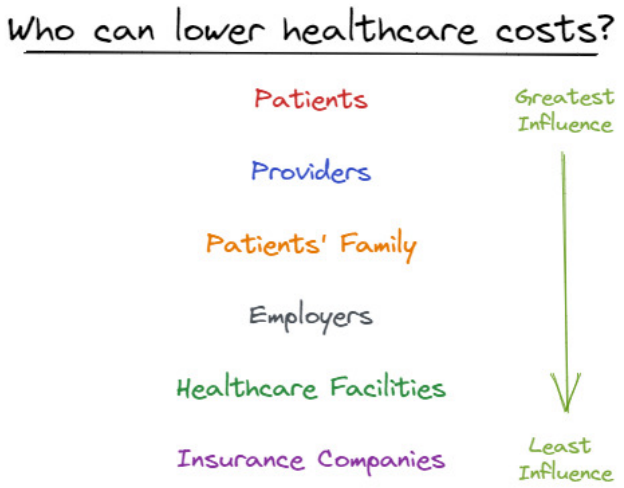

INTRODUCTION

Open enrollment is right around the corner. **Is your orthopedic practice ready to offer directly to employer contracting?**

Direct to employer contracting for MSK services is popular now that large employers are self-funded for their healthcare benefits. These self-funded employers can use their TPA (third party administer) for their non-orthopedic claims and contract with sophisticated orthopedic provider groups for value based MSK services. When employees go to the preferred orthopedic practice, the orthopedic practice directly bills the employer (adjudicates claims) without involving the TPA. Since the employer is paying all of the claims anyway, bypassing the TPA provides immediate savings of about 20%, which is the typical overhead of a TPA.

In order to understand the difficulties in lowering healthcare cost, you have to understand who has the greatest influence and willingness to lower healthcare costs.

With high deductible health plans, patients are motivated to lower their healthcare cost. They can decide on the appropriateness of different treatment options and price shop to find the most cost effective care. In contrast, when patients are shielded from their healthcare cost, they can also drive up healthcare cost. Providers authorize all medical treatments and therefore are the gatekeepers of most healthcare cost. How a provider presents treatment options

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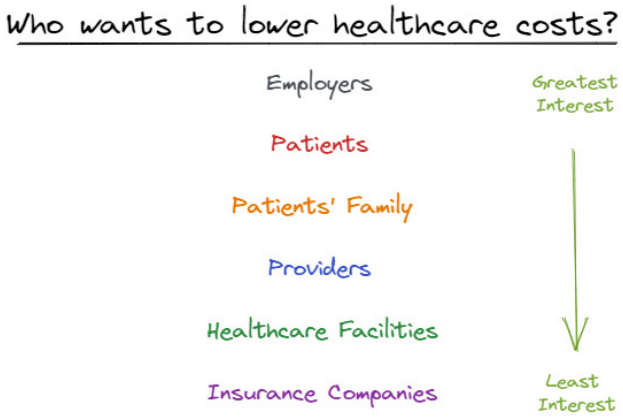


to patients can dramatically impact the cost. Patients' family and friends often increase healthcare cost as they often believe that expensive care means better care (cost = quality) and recommend unnecessary procedures as a way to show their concern for their loved ones. Employers are often reluctant to actively decrease healthcare cost because they do not want their employees to think the employer is choosing dollars over their employees' health (top down approach). Employers (HR directors) would prefer to lower cost through a bottom up approach where employees are motivated to make cost-effective healthcare decisions. The HR director's main goal is to attract and retain great employees, and a top down approach of limiting healthcare options does not attract or retain great employees. Healthcare facilities have little influence over lowering healthcare cost since their site of service is generally the most expensive, but they can increase cost if they promote unnecessary procedures and hospital admissions. Insurance companies negotiate contracts with providers and hospitals; when they negotiate lower rates or increase the management of care (denial of inappropriate services), they can lower cost. Insurance companies administrative costs are typically 20% of the entire healthcare spend, so they are incentivized to keep cost as high as possible without losing the employer to another TPA during the next open enrollment.

Employers and patients ultimately pay for the higher healthcare cost and have the greatest interest in lowering the healthcare cost in the aggregate. Employers want their employees to make the healthcare decisions that lead to lower cost instead of having the employer force a lower cost option on their employees. Patients want lower healthcare premiums but do not necessarily want any restrictions on their personal healthcare choice. Providers have historically had little incentive to lower healthcare cost because providers have not previously been given an option to share in the savings. With BPCI, gain sharing and commercial bundles, orthopedic providers have learned how to manage and coordinate care to lower cost and share in the saving. Orthopedic providers ability to lower cost along with the employers recognition of which orthopedic providers deliver cost effective MSK care has lead to the increase in direct to employer contracting in the MSK space.

There are three types of direct to employer contracting:

- **Add ons**
- **Carve outs**
- **Comprehensive Care**

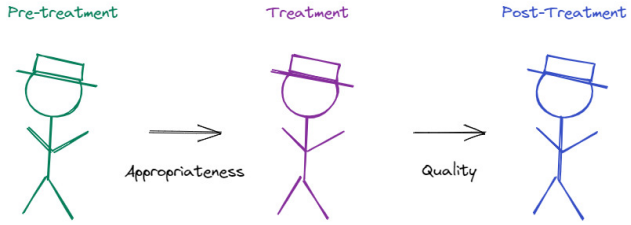
Examples of add on programs are the free gym membership, digital care programs, telehealth second opinions (Grand Rounds), and tele-physical therapy apps (Hinge Health). Add ons typically lower cost, improve overall health, drive high patient satisfaction, and act as an adjunct to traditional care. Employers pay for these add on programs to attract great employees. Because these add on programs are optional, the employers don't have to worry about upsetting employees who may not want to participate in the "add ons". Carve out programs include bundle payment programs and centers of excellence (COE). These programs are typically optional for the employee, but employers will get buy in from their employees through shared saving like waived co-pays or cash back programs (Healthcare BlueBook). With bundle payments and COE, providers assume the financial risks of certain procedures. Bundle payments or COE are a natural starting point for orthopedic providers interested in value based care since these programs are easy to start. Mastering the costs and care coordination of one procedure is easier than mastering all of the issues with all MSK care. Comprehensive direct to employer contracting involves providers assuming all of the risks for all of the employees' care. Examples include direct primary care, population health, and/or capitation. One or two orthopedic groups have master all of the skills (data analytics, care coordination, access) to provide comprehensive direct to employer contracting for all MSK care. These orthopedics groups might work closely with a PCP group to provide population health for the non-MSK care.

The key strategies to an orthopedic provider's direct to employer strategy are best thought of through the eyes of the employer (HR Director). These HR Directors want their employees to have an easy low cost, high quality option, but do not want to force their employees to see only one provider group. The five key strategies for direct to employer contracting are:

- **Access**
- **Appropriateness**
- **Change in site of care**
- **Data Analytics**
- **Narrow networks**

ACCESS

Access to quality healthcare providers saves employers money through limiting delays in treatment, decreasing complications through better communication, and selecting more appropriate site of care. Orthopedic urgent care clinics that operate on weekends and extended hours help patients save money by not utilizing expensive emergency rooms for mundane problems. Patient engagement apps improve communication, help identify post op complications early, and begin treatment before problems spiral out of control and increase cost. Telehealth helps patients start



their MSK journey at work and home and avoid expensive ERs. Virtual physical therapy allows employees to get therapy during their lunch hour and not miss a day of work. Online appointment scheduling apps prevent patients from seeking after hours ER care when they can rest easy knowing that they have already scheduled a clinic appointment for the next day. Access to cost effective providers helps prevent patients from starting their journey with expensive providers who may perform unnecessary tests and procedures.

Access also refers to the geographical area that a provider group can cover. Large employers often have a large geographic footprint. With employees spread over an entire state or region, these large employers need a single orthopedic group to provide orthopedic coverage across a large geographic region. Having state-wide orthopedic access is already happening in most states with many orthopedic groups having over 100 surgeons within a state.

APPROPRIATENESS

For the past 2 decades, HCPs have defined value in healthcare as quality divided by cost. Quality has been defined as what happens after a treatment is provided (i.e. outcome measures). Typical quality measures have included PROMs, infection rates, complication rates, readmission rates, reoperation rates, and return to work rates. Outcomes measures have served as a proxy for quality care, but employers are now paying attention to how providers decide which treatment to offer. After all, a provider with great outcomes on unnecessary surgeries may have a better quality score than a provider who choses more appropriate, non-operative treatment. Outcome measures are important, but appropriateness measures better predict true cost savings and quality care.

It is hard to set proper criteria for measuring appropriateness across different providers. One orthopedic provider's practice may differ greatly from another orthopedic provider's practice. A sub-specialist will likely do more surgeries or procedures per clinic visit than a generalist who handles more common conditions. A traumatologist may operate on every new patient they see because ever new patient has a broken bone. Although it is hard for outsiders to judge appropriateness between different provider, giving providers their own cost, utilization, outcomes, and patient experience data and benchmarking those numbers to their peers has motivated providers to change their practice patterns. Dr. Marty Makary's book, the Price We Pay, has many examples of providers self-correcting their inappropriate practice patterns when they are presented with their own data like OBGYN (C-section rates) and dermatologist (Mohs biopsy rates).

While there are no current appropriateness criteria for orthopedics, some examples of possible appropriateness criteria for orthopedics could be:

- The ratio of MRI scans to clinic visits.
- The number of clinic visits before scheduling an elective surgery.
- The ratio of surgeries to clinic visits.
- The ratio of non-operative physical therapy visits to surgery. (more PT is cost affective and therefore should be higher)
- The percentage of total joint patients with modifiable risk factors (obese, smoke, have a HgA1C greater than 8.0, or Hgb less than 10.0.
- Obtaining a mental health score on all surgery patients to detect anxiety and depression.

TOA's appropriateness policy helps our orthopedic surgeons know how their practice patterns stacks up with their colleagues'. Transparency between our surgeons on cost, utilization, outcomes measures, and patient satisfaction helps motivate change and improve physician outliers.

CHANGE IN SITE OF CARE

Employers like to promote providers who utilize cost-effective facilities. Orthopedic providers like to change the site of care because they are often taking business away from a hospital where they have no financial interest and adding business to an ambulatory surgery center where they have a financial interest. Changing the site of care (recovering at home instead of a SNF) may not only save patients money but may also improve outcomes. Some hospitals might offer more cost-effective care than another hospitals. Operating on healthy patients in an ambulatory surgery center (ASC) will often save money compared to a hospital setting. Some procedures like ESIs can be done in the office setting instead of the ASC.

The site of care is typically determined by the surgeon and can save the employer money without the orthopedic surgeon losing revenue or diminishing the quality of the patient's care. These issues are why ASC joint replacements are so popular right now.

DATA ANALYTICS

What is the ROI on an analytics platform? It depends on what you do with your data. Analytics platforms break down into 4 topics.

- **Cost**
- **Utilization**
- **Outcomes**
- **Patient Experience**

Cost data is best determined by asking your benefits broker or a major employer to share their de-identified MSK

claims data for the previous few years. You need to know where your group stands compared to the other orthopedic groups in your area. You also need to break down the individual charges (facility cost, anesthesia cost, PT cost, etc.) for your major MSK procedures. Orthopedic providers generally try to drive savings through decreasing utilization of resources that are outside of their group like minimizing SNF and out patient joint replacements. Utilization data looks at the appropriateness criteria that was mentioned above. Utilization rates should be monitored to show both over-utilization and under-utilization. Outcomes data is patient reported outcome measures (PROMs), and complication rates (Readmit, infection, etc.). Patient experience data is typically HCAHPS scores or net promoter score (NPS). The goal of every orthopedic provider should be to deliver such amazing care that the patients tell their HR director how great their orthopedic service was.

Obviously, this data acquisition and analysis requires significant investment by the orthopedic providers.

NARROW NETWORKS

Narrow networks are arrangements between employers, providers (physicians and/or health systems), and sometimes TPAs where providers agree to a reduced fee schedule for the promise of increased patient volume through steerage of patients by the employer or health plan. In a tight labor market like today, employers often shy away from narrow networks because narrow networks can upset their employees. Narrow networks can be rigid where patients have to choose an in-network provider or pay the entire cost of the care. Narrow networks can also be flexible where patients receive a small financial incentive when they choose a preferred provider or health system. A patients' copay may be waived, or a patient may receive a $100 check from Healthcare Bluebook or Health Joy if they have surgery with a lower cost provider or COE. Narrow networks often fail to deliver increase patient volume (i.e., failure of steerage) because employers do not want to be seen as meddling in their employees' affairs and health plans don't follow through with their promises.

Orthopedic providers need to learn how HR directors think about direct to employer contracting. All to often, providers think the issues comes down to money when the HR director's chief motivation is to delight their workforce with great cost effective healthcare options. Providing great access, appropriate care, and cost-effective site of care are good business strategies for providers because these issues delight patient while controlling cost. Forcing patient to select your practice through the benefits plan will be meet with some resistance. The newer narrow networks that apply gentle financial steerage seem to be better tolerated than older narrow networks with a single in-network healthcare facility.

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