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Commentary

A Specialist-Led Care Model: Aligning the Patient and Specialist for the Greatest Impact

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ABSTRACT

In the previous paper, discussing "Risk and the Future of Musculoskeletal Care," we reviewed the basic concepts of the risk corridor, implications on health care overall if we maintain a fee-for-service model, and the need for musculoskeletal specialists to begin taking on/managing risk to reinforce our presence in a "value-based care" system. This paper discusses the successes and failures of recent value-based care models and provides the framework for the paradigm of a specialist-led care model. We posit that orthopedic surgeons are the most knowledgeable physicians to manage musculoskeletal conditions, create new and innovative models, and lead value-based care to the next level.

Musculoskeletal specialists (surgeons) have become all too familiar with the Centers for Medicare and Medicaid (CMS) implementing initiatives and programs to achieve two main goals: improve patient outcomes and reduce the overall cost of care. Hip and knee surgeons have been at the tip of the spear with regards to these programs. However, more recently we have seen CMS produce guidelines (such as moving procedures from the in-patient only to outpatient eligible list) showcasing future initiatives that will impact our entire specialty and continue to marginalize the specialist's voice in patient care decisions.

Where did these initiatives begin? Some attribute it to the Center for Medicare and Medicaid Services Innovation (CMMI) department, introduced in 2010 by CMS [1]. The CMMI was tasked with developing value-based models to transition from a traditional "fee-for-service" system, which incentivizes volume, to "pay-for-performance" models, which incentivize value, value being defined as quality over cost. Alternative Payment Models such as bundled payments for care (BPCI) and comprehensive care for joint replacement were introduced in 2013 and 2016, respectively [2,3]. These specifically targeted total joint arthroplasty (TJA) as those procedures account for the single largest spend for any surgical procedure made by CMS.

While these initiatives were initially largely embraced by the TJA community, (program participating was over 50% which is much higher than any other medical specialty), the continued program implementation declined due to a reimbursement formula that does not capture the essential preoperative optimization work that has been integral to the program's success [4].

Were the main program goals achieved by CMMI? Yes, CMS saved hundreds of millions of dollars over the last decade and improved quality outcomes. When looking at the leading driver to this success, it can mostly be attributed to the substantial work from surgeons (musculoskeletal specialists) and their clinical teams outside of the initial surgical consultation and actual procedure [5–7]. A major amount of perioperative medical optimization, patient education, and workflow change across the entire care continuum led to better patient outcomes at a lower overall cost of care. However, reimbursement to the TJA surgeon community did not reflect the time and protocol adjustments that helped achieve these results.

This concept of target payment rebasing was positioned to the musculoskeletal specialist through the concept that when the target price reached the actual cost for the episode of care, CMS would provide that global reimbursement to an accountable care organization's arthritis model. This proposed global payment

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presented two main challenges: (1) the "cost for the episode of care" was not made public nor agreed upon up front by both parties and (2) the shared global payment to the accountable care organization would create a competitive environment between orthopedic surgeons and generalist for their shared portion of the musculoskeletal dollar management [8]. As you can imagine, most institutions pulled out of these programs as the cost of delivering care became too great to the specialists. Figure 1 displays the recent Medicare Fee Schedule trends over time.

The historic failure of these value-based care initiatives makes it imperative for orthopedic surgeons to educate themselves and band together. A group of progressive surgeons and health care leaders believe that one way to maintain a close patient/specialist alignment is for surgeons to begin taking on/managing risk and implementing what we refer to as "Specialist-Led Care." Orthopedic surgeons are the most knowledgeable physicians to manage musculoskeletal conditions due to our extensive training in this area, more-so than any other practitioner. A "Specialist-Led Care" model would continue to enhance patient outcomes, reduce the overall cost of care through a movement away from the fee-for-service model, and reimburse the specialists for the value they have created to the health care system overall.

As we alluded to in the introduction, CMMI initiatives have been focused on TJA procedures and all signs point to the rest of the musculoskeletal community being next in line. Now that CMS has produced cost savings and enhanced outcomes for the TJA acute care 90-day episode, they are looking toward a "comprehensive condition-based care" model for arthritis. Their goal is to have "100% Medicare beneficiaries enrolled in accountable care relationships by 2030" [9]. Why this focus on arthritis as a comprehensive condition-based payment? Because of the tremendous cost savings opportunity due to the suboptimal, fragmented, and varying degrees of cost and patient care quality, despite clear evidence-based measures and clinical practice guidelines [10] that have been developed and validated across orthopedic societies such as the American Academy of Orthopaedic Surgeons [11].

If we delve deeper into what opportunities exist within specialty care and why CMS is targeting the entire musculoskeletal sector for future Alternative Payment Models, the picture becomes clearer. "Specialist-Led Care" is a key driver of cost and service utilization across the health care system [12]. More than 60% of all office visits are attributable to specialist care and services account for more than 90% of professional expenses. Figure 2 demonstrates only a small number of specialty conditions drive a major share of Medicare beneficiary disease burden namely, musculoskeletal care and cardiac care [1].

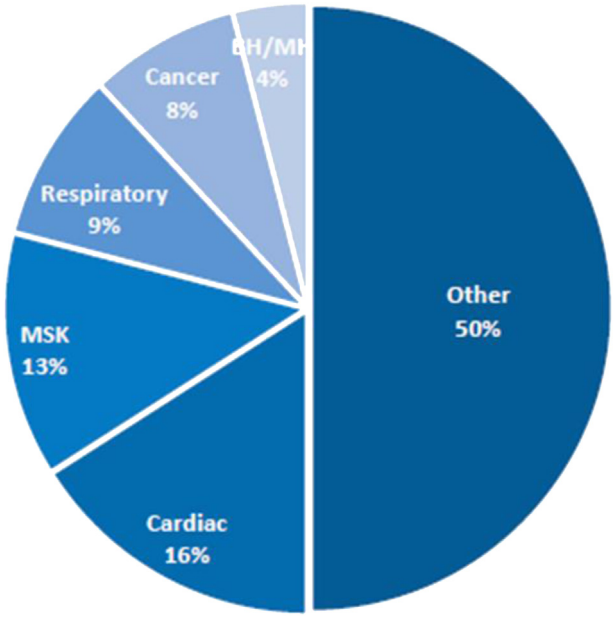

Fig. 2. Only a small number of specialty conditions drive a significant share of Medicare beneficiary disease burden namely, musculoskeletal care and cardiac care.

A specialist-led care model is key to achieving the Quadruple Aim, which focuses on lowering the cost of care, improving patient outcomes, enhancing patient experience, and improving the work life of health care providers [13]. In this model, the specialist, who is the orthopedic surgeon in the case of a musculoskeletal care model, is the individual who would lead the care decisions with respect to musculoskeletal care management. However, the specialist alone cannot manage every aspect of the model. To make a specialist-led care model successful, an integrated team is required. This team would consist of numerous patient care members such as advanced practice providers, physical therapists, social and behavioral therapists, dieticians, and care managers [13,14]. Partnerships with programs including weight and wellness, pain management, exercise, and behavior health are also essential for developing this model. Finally, as we have learned from our experience in BPCI, BPCI-A, and comprehensive care for joint replacement, the model must not be a "race to the bottom," rather one that is sustainable and rewards the creation of value for our patients and the health care system.

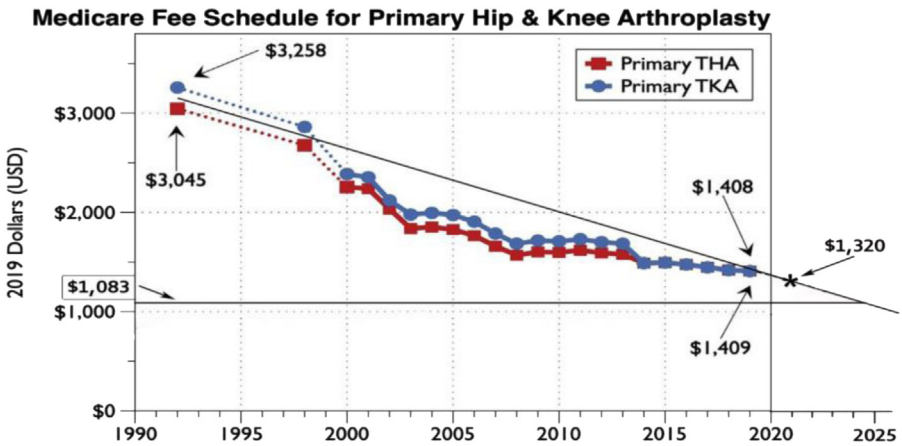

Fig. 1. The trend in Medicare reimbursement based on the Medicare physician fee service schedule over time.

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