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Bundled Payment in Total Joint Care: Survey of AAHKS Membership Attitudes and Experience with Alternative Payment Models

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ABSTRACT

The goal of alternative payment models (APMs), particularly bundling of payments in total joint arthroplasty (TJA), is to incentivize physicians, hospitals, and payers to deliver quality care at lower cost. To study the effect of APMs on the field of adult reconstruction, we conducted a survey of AAHKS members using an electronic questionnaire format. Of the respondents, 61% are planning to or participate in an APM. 45% of respondents feel that a bundled payment system will be the most effective model to improve quality and to reduce costs. Common concerns were disincentives to operate on high-risk patients (94%) and uncertainty about revenue sharing (79%). While many members feel that APMs may improve value in TJA, surgeons continue to have reservations about implementation.

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Total joint arthroplasty (TJA) has been widely successful in eliminating pain and restoring function in patients with degenerative arthritis, and procedure volumes have risen due to an aging population, advances in technology, and expanded surgical indications [1,2]. As demand for TJA continues to increase, costs are expected to rise as well, with 4.6% of all Medicare hospital payments allocated to joint arthroplasty in 2008 [3]. Physicians, hospitals, payers, and policymakers all seek to optimize value, attempting to minimize costs while improving the quality of TJA, while maintaining or advancing patient experience.

Value-based alternative payment models (APMs), such as episode-of-care or bundled payments, have been proposed as an effective strategy to align incentives between hospitals and physicians, thereby accelerating the shift of focus from volume to value. By paying providers a fixed fee for all costs associated with the episode of care, each stakeholder is incentivized to work together to deliver high quality care at the lowest possible cost. Congress authorized the Centers for Medicare and Medicaid Services (CMS) to test bundled payment models from 2009 to 2011 in three hospital regions in the United States, under a program known as the Acute Care Episode (ACE) project [4]. While data demonstrated that bundled payments in TJA decreased the cost of each episode of care by 10% to 15% and reduced length of stay, orthopedic surgeons continue to have concerns about this APM, including the role of implant costs, variability in length of stay, and inability to control costs for post-acute care [5]. Other issues, such as appropriate risk stratification, risk-adjusted payment models, and surgeon autonomy, complicated this picture. The Patient Protection and Affordable Care Act authorized CMS and its innovation arm, the Center for Medicare and Medicaid Innovation (CMMI) to conduct an additional pilot program aimed at expanding the episode to include the post acute portion of care in addition to the hospital portion. This program has piqued the interest of many providers, including joint arthroplasty surgeons, with

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total joint arthroplasty episodes appearing to garner the most interest. CMS has yet to release the experiences or outcomes of the program.

The purpose of this study was to explore the experiences of bundled payment initiatives among arthroplasty surgeons in the United States. Specifically, we surveyed the membership of the American Association of Hip and Knee Surgeons (AAHKS) to answer the following questions: 1) what are orthopedic surgeons' familiarity and experiences with episode-of-care or APMs?; 2) what are the perceived cost savings and drawbacks of current models?; and 3) are there any differences in demographics or practice types with respect to surgeons' familiarity and participation in APMs?

Materials and Methods

We surveyed the AAHKS membership with a 41-response questionnaire (see Appendix 1) over a three-month period, from May 2014 to July 2014. This study was granted an exemption from our Institutional Review Board, and received approval by the AAHKS Research Committee. We utilized the Dillman's Tailored Design Method [6–8], which has been developed and validated to achieve an adequate response rate from professional groups [5,9]. The research design for this study was a two-stage, single mode (online), self-administered, descriptive survey of all 1562 AAHKS members. The survey had been approved by the Research Committee of the AAHKS. The entire membership was contacted with an e-mail prenotice and cover letter, followed by a link to an electronic, anonymous survey instrument (SurveyMonkey, Inc., Palo Alto, CA). Non-responders were sent an initial reminder to complete the survey and, at six weeks, remaining non-responders were sent a final notice with a new electronic questionnaire.

Respondents answered questions regarding demographic data on clinical volume, location and scope of practice, and current practice models. Geographic location was determined by practice location within one of the four defined United States Census Bureau regions [10]. We focused on members' opinions on changing reimbursement schemes, hospital relationships, cost control, Medicare reimbursement, and payment structures. Finally, we queried each member's prior or present involvement in APMs, along with the member's understanding of these new payment models and potential enrollment in proposed plans.

According to the survey sample power analysis of Dillman et al [6], a 13% response rate (203 respondents) was needed to achieve a 95% confidence level (95% CI), plus or minus a 5% sampling error for the study results. Results of all questions were tabulated and descriptive statistics for each response category were reported. Data analysis was then performed comparing different physician demographics about their knowledge and participation in APMs. Categorical variables were analyzed using a chi-square test. If any expected or observed value was less than or equal to 5, a Fisher's exact test was used. Continuous variables were analyzed using an unpaired, two-tailed, Student's t-test. Statistical significance was set at $P < 0.05$.

Of the 1562 AAHKS members contacted to complete the survey, there were 395 respondents (25.3%), which satisfied the pre-study Dillman's threshold for response rate. The average age of the survey participants was 50 years (range, 32–75 years), which is similar to available AAHKS roster demographic data for all active members (average age 53 years; range, 33–80 years). The mean length in practice for respondents was 17 years (range, 0–40 years). The average surgeon in this survey performed 336 arthroplasty cases per year, with a mean of 3369 clinic visits in 2013. A plurality of respondents worked in a single-specialty private practice group (134 surgeons; 34%), followed by multi-specialty private practice (89 respondents; 23%), and academic practice (75 respondents; 19%). All participants in the survey were accepting new patients, and 96% of respondents accepted Medicare patients. The mean percentage of Medicare patients from all participants in 2013 was 45.5% (range, 10%–80%). Complete demographic data from respondents in our survey are detailed in Table 1.

Table 1
Demographics and Practice Types of the AAHKS Membership Survey Respondents.

Demographics (n = 395)	Number (%)
Type of Practice	
Solo practitioner	24 (6)
Single-specialty private practice	134 (34)
Multi-specialty private practice	89 (23)
Employed by hospital	43 (11)
Employed by group	26 (7)
Academic Medical Center	75 (19)
Government or Military	4 (1)
Participation in American Joint Replacement Registry in 2014	
Yes, participating	97 (26)
Yes, application submitted	66 (17)
No	215 (57)
Electronic medical record (EMR) Implementation	
Implementation Complete	310 (81)
Started, but not yet complete	50 (13)
No plans for implementation	22 (6)
May choose to retire in response to EMR	2 (1)
Geographic Region	
Northeast	86 (23)
South	126 (33)
Midwest	90 (24)
West	78 (21)
Prospectively collect outcome scores	201 (53)
Mean percentage of Medicare patients 2013	45.5
Mean percentage of Medicare patients 2014	45.8
Mean number arthroplasty cases in 2013	335.8
Mean number arthroplasty cases in 2014	355.0
Mean number clinic visits in 2013	3369
Mean number clinic visits in 2014	3442
Mean age (years)	49.7
Mean number years in practice	16.9
Mean number orthopedic surgeons in group	18.8
Mean number adult reconstruction surgeons in group	3.9
Fellowship training in arthroplasty	290 (76)

Results

Most of the AAHKS members responding to the survey were familiar with the concepts of APMs, with 30% (120 respondents) reporting a good working knowledge, and 33% (130 respondents) reporting a basic knowledge of the subject. Of all survey respondents, 220 (61%) participated in or were planning to participate in an APM at their institution. The majority of respondents had a fee-for-service model in place (326 respondents; 86%). Hospital administrators drove discussions regarding APMs at 49% of institutions (129 responses), while physician leadership led discussions at 46% institutions (121 responses). For reference, the large majority of AAHKS respondents (194 responses; 49%) felt that physicians should be driving the discussions regarding APMs. Most bundled-payment models currently in place included inpatient plus post-discharge care (167 respondents; 71% of all respondents employing bundled care models). Current bundling systems most commonly engaged Medicare (162 respondents; 69%) and private insurers (146 respondents; 62%), while only 39 respondents (17%) had agreements with Medicaid to bundle episodes of care. Table 2 examines the respondents' participation and familiarity with APMs.

Many survey respondents felt that a bundled payment system would be the most effective model to improve quality while reducing costs (162 respondents, 45%), while only 89 respondents (25%) felt that a fee-for-service system would be most effective in achieving these goals. A majority of respondents believed that bundled payments, if optimally managed, could reduce the cost of a TJA episode of care. When asked to project how much cost savings could be achieved, the

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