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Plastic Surgery Practice Models and Research Aims Under the Patient Protection and Affordable Care Act

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Abstract

As the healthcare landscape in the United States changes under the Affordable Care Act (ACA), providers are set to face numerous new challenges. Although concerns about practice sustainability with declining reimbursement have dominated the dialogue, there are more pressing changes to the healthcare funding mechanism as a whole that must be addressed. Plastic surgeons, involved in various practice models each with different relationships to hospitals, referring physicians, and payers, must understand these reimbursement changes in order to dictate adequate compensation in the future. Here we discuss bundle payments and Accountable Care Organizations (ACOs), and how plastic surgeons might best engage in these new system designs. In addition, we review the value of a focused and driven health-services research agenda in plastic surgery, and the importance of this research in supporting long-term financial stability for the specialty.

Keywords

Affordable Care Act; ACA; Obamacare; medical devices excise tax; Accountable Care Organizations; ACO; bundle payments

Introduction

The Patient Protection and Affordable Care Act (ACA), known to many as “Obamacare,” ushers in a new era of health care policy in the United States (US).¹ Along with Mexico and Turkey, the US is one of only three developed nations without universal health care coverage for its citizens and legal residents.² This legislation brings a substantial shift in US health care delivery and financing, and although the ACA does not institute universal

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coverage, the role of government in establishing parameters for the health care industry is substantially increased (Table 1).^{1, 3} Some of these elements, including removing insurance exclusions for preexisting conditions and expanding parental plan coverage to children until age 26, are more willingly accepted and already in effect. However, certain provisions, including Medicaid expansion, contraception coverage, and the individual mandate, are still intensely contested.⁴⁻⁷

Although many of these issues have dominated political rhetoric and media coverage, providers are likely to be more directly affected by components of the ACA that change practice workflow and payment structuring. This includes the development of new value- and quality-based payment systems, along with other changes to how health care is financed and compensated. The ultimate results of the ongoing debates on the ACA are still unknown; however, the changes in payment and care delivery put forth by the ACA have begun to take effect, and providers must be aware of the impact of this legislation.

All plastic surgeons are already facing new challenges. The effects vary across different practice models and locations, but in many situations it is private practice surgeons, especially those relying on third-party payers, who are most vulnerable. Maintaining a small or solo mixed community practice is likely to become increasingly difficult as insurance payments are reduced and restricted.^{8, 9} Procedural reimbursement rates are predicted to decrease even further than they have in recent years, and the future of payment structuring through the Center for Medicare and Medicaid Services (CMS) as well as private third-party payers remains unclear.^{8, 10} Certainly being paid less for performing a procedure will affect a surgeon's bottom line. However, going beyond the issue of reimbursement amount, changes in payment mechanisms promulgated by the ACA will add new challenges for plastic surgeons offering reconstructive services.

These changes will lead to new practice and payment structures, moving away from fee-for-service models that reimburse for procedure volume, to systems aimed at improved quality, value, and efficiency of care as benchmarks for compensation.¹¹⁻¹⁴ However, there are opportunities for new successful practice models within these payment systems. Additionally, a broad and impactful health services research agenda for plastic surgery will have a substantial role in informing the importance and unique value of reconstructive surgery in an evolving health care market. In this article we review key changes to health care financing and structuring, and discuss novel ways plastic surgeons can approach these new care models to optimize opportunities for success and practice stability. In addition, the crucial role of advancing plastic surgery research within these evolving systems is reviewed.

Bundled Payments and Accountable Care Organizations

Many plastic surgery procedures are performed as a component of broader comprehensive care (cancer treatment, obesity management, etc). In the current payment model, different physicians and providers involved in the care of each patient separately bill CMS and insurance companies. Reimbursement is usually based on procedures performed and/or level of care provided. This is the fee-for-service model (Figure 1). In this model, surgeons are

often major sources of profit, because higher case volume generates revenue to cover hospital and system operating costs.

Bundled payments are a mechanism of reimbursement proposed to improve the clarity and simplicity of financing care, while also improving quality and efficiency (Figure 1).^{15, 16} Although details of the different types of bundle payments vary (Table 2), the core difference from fee-for-service is that with bundle payments, the diagnosis and indications for care dictate payment amount, rather than receiving payment for each component of care delivered.^{15, 17} Thus far, bundle payments are used for acute-stay inpatient hospital care or post-acute care, with pilot programs in place to evaluate quality of care under different bundled pay structures (Table 2).

Although many pilot programs are using retrospective payment models that still have elements of fee-for-service, prospective designs will bring about the most substantial changes for physicians. In prospective models, the institution is provided a lump sum based on the patient's diagnosis, and divvy up that payment across the involved providers.¹⁵ As opposed to the fee-for-service model that made surgeons into major profit centers, in this lump sum payment model surgeons become more of a system cost, as the reimbursement for care is set and the procedures provided are often the most expensive component of care.^{16, 18} Therefore, the concern for plastic surgeons is how to ensure reimbursement remains adequate and appropriately balanced in these new systems. As of now, there are no guidelines or precedents on how this is to be done.

Similar attempts to streamline and reduce costs have driven interest in the Accountable Care Organization (ACO) model.¹⁹ Under ACOs, providers are grouped together to provide continuity of care for a group of patients, with the proposed benefits of improved quality of care along with cost efficiency. If those goals are met, the group earns financial incentives. These models are increasingly more common, and with ACA provisions allowing CMS to enter into contracts with ACOs, the numbers of these arrangements have grown substantially (Figure 2).^{19–22} There are various payment structures that can be used in an ACO.²³ Although these payment models allow components of fee-for-service to remain the core mechanism, most ACOs will likely transition to some form of advanced payment model in which up-front payments are made based on number of beneficiaries and anticipated shared savings.^{24, 25} Like with bundle payments, this up-front payment model in ACOs will make the surgical provider more of a direct system cost than a profit source. The goal of an ACO is to reduce spending by improving care quality and value and decreasing waste, in part by involving fewer expensive specialists in a patient's care.^{11, 25}

The payment structure in ACOs is similar to the Health Maintenance Organization (HMO) model; however, the difference with ACOs is that in removing the HMO level there is increased provider flexibility in workflow and payment structuring (Figure 3a/3b).^{26, 27} And although the degree of provider risk varies, each payment model depends on providers finding cost-savings in order to benefit from the shared responsibility. Although many of these stipulations for primary care providers have been laid out, numerous providers – including reconstructive surgeons – remain on the outside of these plans and shared-savings designs.²⁸ As a result, subspecialty providers must actively engage, with the institution as

well as with other care providers, to ensure that an adequate component of care financing is available to cover complex services.

Specialty providers do have some leverage in this arena, as patients in ACOs are able to receive care outside of the group if ACO providers do not adequately meet their needs.²⁶ This is the major difference for patients in ACOs as compared to HMOs. As a result, multidisciplinary as well as hospital-based ACOs are given an incentive to provide as much comprehensive care as possible to keep patients from needing to go elsewhere, which would decrease ACO profits and limit efforts at true coordination and integration of care. As ACOs attempt to recruit providers, controlling referral stream and hoping to reduce patient self-referrals to specialists,²⁹ the unique services of reconstructive surgeons can be a benefit for a group or hospital system.³⁰ These services include procedures only offered by plastic surgeons, as well as the unique value added as plastic surgeons manage complications of other medical and surgical care. This goes beyond providing surgical treatment for complications (eg. chest wall and sternal reconstruction, hardware coverage, etc) to include cost savings and reduced length of stay after these complications and wound issues are treated, as well as improving patient satisfaction by providing the full complement of necessary and desired reconstructive services.³⁰

As a result, a critical element in practice planning and reimbursement modeling is establishing the value of reconstructive services. The more a plastic surgeon can market their services as a benefit – to the patient, the hospital, and the group of providers – the more they can maintain an active role in the practice and in reimbursement decisions. As payers tie quality metrics and value-based decision-making criteria to reimbursement,^{31, 32} it becomes increasingly important to have high-quality evidence to support the value, effectiveness, and overall utility of different procedures.^{33–35} The better we understand how different surgical procedures benefit the patient and fit in to the larger health care delivery system, the more likely it is that procedures will be adequately reimbursed and remain critical elements of care. Additionally, as quality improvement initiatives are increasingly important for hospitals, demonstrating the benefits of reconstructive surgery in managing complications, reducing length of stay, and increasing patient satisfaction will establish the value of reconstructive surgeons to the hospital system.^{30, 36–39}

To help clarify this issue, consider post-bariatric body contouring surgery. To start, many of the health plans being offered on the health care exchanges do not cover bariatric surgery – only 22 states currently include obesity management and bariatric surgery on their mandatory coverage list of essential health benefits.^{40, 41} Even if a plan does cover bariatric surgery, post-bariatric body contouring may not be covered; or, if it is, reimbursement might be lumped in to the bariatric surgery payment bundle. In this setting, where payments for post-bariatric body contouring come as a bundle and not in a fee-for-service design, the surgeon must have a direct role in determining compensation. As coordinating care with medicine and general surgery providers has been important to developing a proper referral stream, it may begin to dictate reimbursement as well.

Because physicians are increasingly enticed to align under ACOs, plastic surgeons relying on third-party payers may need to group with general surgeons, endocrinologists, and others

caring for the obese. Although this may be a challenge, it also provides opportunities for plastic surgeons to build into the ACOs and become a marketable asset. Promoting the plastic surgeon's role in bariatric care can add a competitive advantage to a group looking to attract these patients or to keep their enrolled patients from seeking care elsewhere. If an acceptable pay structure can be established, which will likely require the plastic surgeon's active involvement in ACO organization and model design³⁰, body contouring options will optimize the obesity management services a group of providers offers. This level of involvement will require the plastic surgeon actively engage ACO leadership and fellow providers, and put in the necessary time and effort to work with these new groups to come to amenable terms. Although, in general, plastic surgeons have rarely engaged in these elements of care delivery, as systems evolve under the ACA that tacit approach must change. Even for plans that do not cover body contouring, a surgeon aligned with a group providing obesity management has a direct referral stream of patients willing to pay out of pocket for these services.

Plastic surgeons currently have an undefined place within these integrated systems.²⁸ However, the success of an ACO is affected by the degree to which providers are aligned and willing to participate and coordinate care. Therefore, fitting into these models is of strategic importance, and if surgeons can demonstrate value within the group, these new payment structures can be an advantage for a specialist providing unique services. Although all of these changes will likely require adjustments to practice models, there are great opportunities for plastic surgeons to become engrained in these growing care systems. The traditional solo practice model may need to be reexamined, as integration of care becomes the practice paradigm of the future.^{8, 9}

Research Opportunities

Under the ACA, the Patient Centered Outcomes Research Institute (PCORI) has been charged with identifying and supporting high-quality research that aims to address utility and patient preferences in care delivery.^{34, 42} This supports the importance of understanding outcomes and utility to guide value and appropriateness of decisions in care delivery. Rather than continue to accept voids in these areas, plastic surgeons must focus research resources on addressing these issues for our procedures and patient populations before we lose the opportunity to do so. Through such research, plastic surgeons are also able to establish and support the value of their services to patients and hospital systems.

To elaborate on this, continue to follow the above example on bariatric surgery. It has been reported that nearly 40% of patients who had bariatric surgery would have pursued post-bariatric reconstruction if they had known more about it, and an additional 30% did not pursue strictly due to cost.⁴³ Understanding this helps show the value of these reconstructive procedures to bariatric surgery patients. To approach this issue going forward, it is important to understand patients' motivations for bariatric surgery as well as post-bariatric body contouring. Survey and qualitative studies evaluating patients' perceptions and preferences regarding plans for body contouring surgery, even before undergoing bariatric surgery, will help establish the link between treating obesity and subsequent desire for body contouring.⁴⁴

With this information, a surgeon can then demonstrate potential value to an ACO or hospital system that provides bariatric services.

Additionally, cost data are needed – not only to assess the value of these procedures for the patients, but also to help plastic surgeons understand appropriate reimbursement.^{45–47} This includes the costs and outcomes of body contouring procedures as well as costs for treating chronic complications of massive weight loss. There are also emotional and lifestyle costs for massive weight loss patients with persistent soft tissue excess that should be explored in order to understand the value of these procedures. Evaluating these considerations, alongside more traditional cost-effectiveness and cost-utility analyses, will help clarify the important role of post-bariatric body contouring as a component of obesity management, providing data necessary to demonstrate value of plastic and reconstructive surgeons in care delivery systems. These additional elements are also important when considering the ACA goal of providing comprehensive and integrated care with a patient-centered viewpoint.

Although body contouring is the example used here, understanding these aspects for other bundled cosmetic and reconstructive plastic surgery procedures, including breast reconstruction and extremity reconstruction, will be of similar importance. Actively establishing the value of reconstructive surgery is critical to owning a piece of this case volume and payment. Now that PCORI has become a major instrument of health services research, projects addressing these types of patient-centered issues have potential to be competitive for funding.

Conclusion

The ACA will change the US health care landscape. Providers must adjust practice and reimbursement models to stay ahead of changes in delivery and management of care. The diversity in plastic surgery practice models makes it difficult to make comprehensive recommendations; however, there are elements that affect all providers and we have attempted to address some of them here. The other end of this discussion focuses on the potential research avenues through which plastic surgeons can begin to define and dictate their value and role in health networks. With a growing focus on health services and patient-centered research, the plastic surgery research agenda must adjust to remain competitive. With a well-organized research agenda, and projects that help establish the value of plastic surgery, this specialty can stay ahead of pending changes in US health care. Plastic surgeons must engage in these changing systems, as the opportunities to establish some control of how surgical care is delivered and reimbursed are dwindling.

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Figure 1. Schematic of fee-for-service and prospective bundle payment models. Dark Green represents third-party payments, blue represents surgical care, yellow represents billing claims, black represents hospital profits, and light green represents payments to surgical providers.

Figure 2. Growth of ACOs since the beginning of 2011. Source: Leavitt Partners Center for Accountable Care Intelligence²² (©2014 Leavitt Partners)

Medicare HMO-IPA model

ACO model

Figure 3.

Schematic of HMO and ACO payment models. 3a) Medicare HMO-IPA model. Other HMO models that did not use IPAs had payments to PCPs, Specialists, etc come directly from the HMO. 3b) ACO model. Note the additional “shared savings bonus” payment that is earned by the ACO if quality health care is delivered with cost savings. Within the ACO, the role of the PCP is central to success as the PCP level is mostly where the cost-efficiency measures will be implemented (controlling utilization, appropriate specialist referrals, testing, prescriptions, etc)

Table 1

Key elements of the Patient Protection and Affordable Care Act.

KEY ELEMENTS	ADDITIONAL INFORMATION
INCREASING ACCESS TO AFFORDABLE CARE	
Individual Mandate	Most Americans will be required to have insurance by March 31, 2014 or obtain an exemption; a fee will be charged on year-end taxes for every month without insurance coverage.
Access to Insurance for Uninsured Americans with Pre-Existing Conditions	The Pre-Existing Conditions Insurance Plan (PCIP) provides new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition.
Extending Coverage for Young Adults	Young adults will be allowed to stay on their parents' plan until they turn 26 years old.
Allowing States to Cover More People on Medicaid	States will receive federal matching funds for covering additional low-income individuals and families under Medicaid.
Increasing Payments for Rural Health Care Providers	Provides increased payment to rural health care providers to help them continue to serve their communities.
Increasing Access to Medicaid	Americans who earn less than 133% of the poverty level (approx \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid if their state has agreed to Medicaid expansion.
NEW CONSUMER PROTECTIONS	
Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions	Prevents insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.
Prohibiting Insurance Companies from Rescinding Coverage	Prevents insurance companies from searching for an error, or other technical mistake, on a customer's application to deny payment for services when he or she gets sick.
Prohibiting Discrimination Due to Pre-Existing Conditions or Gender	Prevents insurance companies from denying coverage, renewing policies, or charging higher rates because of an individual's pre-existing condition, gender, or health status.
Preventative and Wellness Services for Women	Women will benefit from access to a large number of preventative services (i.e. testing, screening, and counseling) as well as guaranteed access to maternity care.
Bans On Annual Dollar and Lifetime Limits	Prevents insurance companies from setting annual dollar as well as lifetime limits on an individual's medical bill.
IMPROVING QUALITY AND LOWERING COSTS	
Excise Tax on Medical Devices	2.3% medical device tax meant to collect approximately \$38 billion of excise tax revenues over the next 10 years, resulting in \$29 billion of net revenues.
Linking Payment to Quality Outcomes	Hospital Value-Based Purchasing program (VBP), which offers financial incentives to hospitals to improve the quality of care based on required reporting of measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, patients' perceptions of care, and others.
Encouraging Integrated Health Systems	Incentives for physicians to join together to form "Accountable Care Organizations," which are groups that allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions
Expanding Authority to Bundle Payments	Hospitals, doctors, and providers will be paid a flat rate for an "episode of care" as opposed to separate billing, which will align the incentives of those delivering care.
Making Care More Affordable	Americans with incomes between 100% and 400% of the poverty line (approx \$43,000 for an individual or \$88,000 for a family of four) who are not eligible for other affordable coverage will be eligible for tax credits to offset costs of health insurance.

Table 2

Bundle payment models. Participants can select up to 48 different clinical condition episodes for each model.

MODEL	EPISODE OF CARE	DESCRIPTION
<i>Retrospective; Acute Care Hospital Stay Only</i>	Inpatient stay in acute care hospital	Medicare pays hospital discounted amount based on established payment rates; Physicians remain on fee-for-service payments
<i>Retrospective; Acute Care Hospital Stay Plus Post-Acute Care</i>	Inpatient stay in acute care hospital and all related services during the episode	Ends 30, 60, or 90 days after discharge; Medicare pays hospital discounted amount based on established payment rates; Physicians remain on fee-for-service
<i>Retrospective; Post-Acute Care Only</i>	Post-acute care services with participating facilities and hospitals, or home health agency	Must begin within 30 days of discharge and end at minimum of 30, 60, or 90 days after initiation of episode; Medicare pays hospital discounted amount based on established payment rates; Physicians remain on fee-for-service
<i>Prospective; Acute Care Hospital Stay Only</i>	All services during inpatient stay by hospital, physicians, and other practitioners	Related readmissions for 30 days after hospital discharge included; Physicians receive payment from hospital out of prospectively paid amount