JOINT REPLACEMENT & OUTPATIENT BUNDLED PAYMENTS

Chris Bishop, CEO
Regent Surgical Health
HISTORY OF JOINTS IN THE OUTPATIENT SETTING

• Initial Headwinds to Change
  ➢ Payors
  ➢ Surgeons
  ➢ Clinical Staff

• Strong leadership was required to overcome challenges
RESULTS OF THE CHANGE

• Quick change in attitudes and volumes

• Regent: 300+% Increase in Total Joints from 2015 to 2016 – Similar growth expected for 2017 and beyond
WHAT DROVE THE CHANGE?

• Clinical Benefits – Ex) ASC A
• Advancements In Technology
• Professional Influence
• Financial Benefits

<table>
<thead>
<tr>
<th>REGENT PARTNER AMBULATORY SURGERY CENTER</th>
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<tbody>
<tr>
<td><strong>Year</strong></td>
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<tr>
<td>2015</td>
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<tr>
<td>2016</td>
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*Expected to exceed 100 Total Joint Procedures in 2017
DEVELOPING CLINICAL PROTOCOLS FOR OUTPATIENT JOINTS

• PATIENT PROTOCOLS:

  ➢ Patient selection criteria
    ▪ ASA I or II
    ▪ BMI < 35
    ▪ No diabetes, cardiac history, or sleep apnea

  ➢ Patient Home Assessment

  ➢ Pre-Admission visit, education, and testing

  ➢ Standardized post-operative follow-up protocols
DEVELOPING CLINICAL PROTOCOLS FOR OUTPATIENT JOINTS

- PAIN MANAGEMENT PROTOCOLS:
  - ASCs are at an advantage relative to hospitals because teams collaborate & create a seamless process for patients

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<thead>
<tr>
<th>Phase</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Pre-operative</td>
<td>Preemptive analgesia (non-opioid)</td>
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<tr>
<td>Intra-operative</td>
<td>Nerve conductor block (Adductor canal block)</td>
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<td>Standard intravenous medicine</td>
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<td>• Fentanyl</td>
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<td>• Hydromorphone</td>
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<td>• Optional: Ketamine</td>
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<tr>
<td>Post-operative</td>
<td>Standard intravenous and oral medications</td>
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<td></td>
<td>• Fentanyl</td>
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<td></td>
<td>• Hydromorphone</td>
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<td>• Percocet</td>
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PROJECTED GROWTH IN THE OUTPATIENT SPACE

- By 2030, annual total hip and knee joint replacements are expected to grow from $1M to $4M
- 45% of procedures could be outpatient by 2025
OUTPATIENT JOINTS & BUNDLED PAYMENTS

- Outpatient surgery will play an integral role in a value based healthcare system
- ASCs provide equal or better outcomes at a lower cost
  - ASCA study – ASCs = $38B in Commercial Payor Savings
  - US Berkeley Study – ASCs = $2.5B in Medicare Savings
COST DRIVERS OF A 90 DAY TOTAL JOINT EPISODE

• Pre-Operative Cost Drivers
  ➢ Patient decides in-network ($$) v. out-of-network ($$$$$)
  ➢ Surgeon/Patient Decide Hospital ($$$) v. ASC ($)

• Intra-Operative Cost Driver: Surgeon decides implant

• Post-Operative Cost Drivers
  ➢ Surgeon/Patient decide post-discharge care
    ▪ SNF ($$$$)
    ▪ Home with home care ($$$)
    ▪ Home under self care w/ PT ($$)
    ▪ Home under self care w/ digital PT ($)
  ➢ Readmission
90 DAY COST BREAKDOWN

* Source: Journal of Arthroplasty
DEVELOPING A BUNDLED PAYMENT STRATEGY

- There is no Surgeon-Centric model that is one size fits all
- Developing the proper strategy for a market requires a detailed analysis of the following:
  1. Relevant overall market
  2. Key Stakeholders: ASC, Surgeons, Hospital, Other Surgeon Partners
  3. Effectively align incentives of key stakeholders
- Success depends on the ability to align incentives so key decision makers make the value driven choice
MACRO ENVIRONMENT

CMS is aggressively pushing to have “Value” replace “Volume”

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- 2016: 30% All Medicare FFS, 85% All Medicare FFS (Categories 1-4)
- 2018: 50% All Medicare FFS, 90% All Medicare FFS (Categories 1-4)

Legend:
- Dark Blue: All Medicare FFS (Categories 1-4)
- Light Blue: FFS linked to quality (Categories 2-4)
- Gray: Alternative payment models (Categories 3-4)
DEVELOPING A BUNDLED PAYMENT STRATEGY

- Hospital Based Strategy
  100% hospital owned
  - BPCI/CJR

- Large Practice Group Strategy
  100% Practice Owned
  - Ex) OrthoCarolina

- MSO Based Strategy
  X% MSO owned, X% Practice Owned
  - Ex) Regent

- Facility Based Strategy
  100% Facility Owned
  - Ex) Orthopedic Surgery Center of Orange County
• Key behind value creation is a surgeon centered model – surgeons take risk, and benefit from the upside reward
• Alignment of incentives!
COST VARIATIONS FOR TOTAL KNEE/HIP REPLACEMENT

Greater than $18,701
$11,501-$18,701
$5,501-$11,500
$0-$5,500

Source: Blue Health Intelligence
CAUSES OF VARIATION
A Bundled Payment Strategy Can Address these Issues

Causes of Variation
- Poor Communication
- Examinations Duplication
- Unnecessary Post Acute Care
- Negociating Power
- Variance in Standard Procedures
- Poor Coordination

A Bundled Payment Strategy Can Address these Issues
WHAT’S INCLUDED IN THE BUNDLE

- Facility Fee
- Anesthesia
- Implant, Supplies, etc.
- PT, Home Health, SNF
- DME
- Readmission
- Physician Fee
- Patient Education

Bundle Price
4 KEYS TO BUNDLED PAYMENT STRATEGY SUCCESS

1. Cost Containment
2. Risk Mitigation
3. Effective Patient Coordination/Communication
4. Surgeon Leadership
KEYS TO SUCCESS: COST CONTAINMENT

90 Day Cost Breakdown

* Source: Journal of Arthroplasty
KEYS TO SUCCESS: COST CONTAINMENT

Hospitalization = High Cost Option
• Traditional Procedure has an average LOS of 3-4 Days
• Redundant & Unnecessary Testing
• Lower Patient Satisfaction

Regent Pathway
• Good Patient Selection for Same Day Procedures
• Operational efficiencies that lower cost
• Early and Effective Patient Education
• Higher Patient Satisfaction

Result = Average LOS < 1 day / No Cost
Redundancies
KEYS TO SUCCESS: COST CONTAINMENT

90 Day Episode Cost Drivers

- Unnecessary Readmission
- Poor PAC Provider Selection
KEYS TO SUCCESS: RISK MITIGATION

• Re-Insurance

• Negotiated Stop Loss or Risk Corridor with Payers

• Inclusion/Exclusion Criteria for the Episode
KEYS TO SUCCESS: PATIENT COORDINATION/COMMUNICATION

Dedicated Care Coordinator to Guide the Patient through the Episode
KEYS TO SUCCESS: PATIENT COORDINATION/COMMUNICATION

Technology Based Communication System to Connect Patient, Surgeon, & Care Coordinator
KEYS TO SUCCESS: SURGEON LEADERSHIP
Surgeon involvement & leadership through entire process

PRE-OP
- Patient Education
- Surgeon Visits
- Care Coordinator Visits

INTRA-OP
- Payor Negotiations
- Anesthesia
- Supply & Implant Standardization

POST-OP
- PT, Home Health
- Care Coordination
- Patient Communication & Compliance
KEYS TO SUCCESS: CONCLUSION

Bundled Payments align incentives the way they should be – it is truly a win-win-win!

1. Patients: Receive better more involved care at a good value. Increased involvement and coordination by providers. Increased outcomes and patient satisfaction

2. Regent/Physician Partners: Greater financial returns through increased success, higher patient volumes being funneled to the bundle, and higher payers contract rates. First Mover Advantage!

3. Payors: Decreased overall payments per patient
BUNDLED PAYMENTS: EARLY ADOPTION  
= FUTURE MARKET LEADER

1. Q4 2016: Regent executes first bundle
2. End of 2016: CMS Targets 30% of Medicare Cases tied to an alternative payment model (85% of payments expected to be linked to value)
3. End of 2018: CMS Targets 50% of Medicare Cases tied to an alternative payment model (90% of payments expected to be linked to value)
Stop by booth #511 to connect with a member of the Regent team