Bundle Payment for Musculoskeletal Care

Current Evidence (Part 1)

Meghan A. Piccinin, MSc[a], Zain Sayeed, MD, MHA[b,*], Ryan Kozlowski, MD[c], Vamsy Bobba, MD[c], David Knesek, DO[c], Todd Frush, MD[c]

KEYWORDS

• Total joint arthroplasty • Total knee arthroplasty • Bundle payments • Bundled contracts • BPCI • Value-based care • Financial analysis

KEY POINTS

- The implementation of the Bundled Payments for Care Improvement (BPCI) program by the Centers for Medicare & Medicaid Services demonstrated significant cost savings and improvements in quality of care.
- A thorough financial analysis of bundled contracts incorporates the evaluation of settings of care, episode period, patient population, revenue and quality terms, and distribution of payments to ensure the economic viability of the payment model.
- Preoperative risk factor modification, enhanced coordination of care, standardization of implant costs, and optimized postacute care utilization may allow orthopedic groups to maximize the advantages of bundled payment models on both costs and care quality.

INTRODUCTION

In the United States, total knee arthroplasty and total hip arthroplasty are 2 commonly occurring surgeries expected to undergo significant growth through 2021.[1–3] Although the Centers for Medicare & Medicaid Services (CMS) remain the largest payer for these procedures, private insurance providers comprise a majority of financers for lower-extremity total joint arthroplasty (TJA) patients under 65 year old.[4,5]

Traditionally, TJAs have been reimbursed through fee-for-service (FFS) models, incentivizing the quantity of services rendered rather than quality of care or cost control, which has been a primary contributor to high health care costs in the United States.[6] In the face of the anticipated future surge in TJA procedures, CMS has begun to transition from FFS reimbursement to alternate payment models (APMs).[7] One of the most widely instituted of these APMs is bundled reimbursement models, including the Bundled Payments for Care Improvement (BCPI) and Comprehensive Care for Joint Replacement (CJR) initiatives. Many institutions have experimented with the implementation of bundled payment models, with a majority realizing cost savings and quality improvements.[8–12]

Funding Sources: No additional funding sources were used for this article.
Conflicts of Interest: No conflicts of interest are evident for authors of this article.

[a] Department of Orthopaedic Surgery, College of Osteopathic Medicine, Michigan State University, Detroit Medical Center, 4707 St Antoine Street, Detroit, MI 48201, USA; [b] Department of Orthopaedics, Institute of Innovations and Clinical Excellence, Detroit Medical Center, 4201 St Antoine Street, Detroit, MI 48201, USA; [c] Department of Orthopaedics, Musculoskeletal Institute of Surgical Excellence, Detroit Medical Center, 4201 St Antoine Street, Detroit, MI 48201, USA
* Corresponding author.
E-mail address: zainsayeed@gmail.com

Orthop Clin N Am ■ (2017) ■–■
https://doi.org/10.1016/j.ocl.2017.11.002
0030-5898/17/© 2017 Elsevier Inc. All rights reserved.

Because Medicare is the largest payer of health care costs in the United States, changes to the CMS reimbursement systems are able to drive provider and hospital financial decisions.[13] With the implementation and preliminary successes of BPCI and CJR, hospitals, providers, and patients seem to be embracing the notion of bundled payment models due to the improved quality, decreased costs, enhanced coordination of care, and simplicity.[14] Many orthopedic surgeons believe that bundled payments are the most successful payment model in decreasing costs and enhancing quality.[15] With 83% of hospitals interested or already participating in bundles, the opportunity is presented for private payers to similarly take advantage of the cost savings anticipated to be provided by these models.[14] Although CMS' implementation of bundled payments involved primarily unilateral determination of target pricing, for private payers to make use of this model, they must collaborate with hospitals and provider groups to negotiate mutually beneficial reimbursement schedules. This article presents a stepwise model (**Box 1**) for the financial analysis of bundled contracts for use in the negotiations between hospitals and private payer organizations.

Box 1
Outline of financial analysis of bundled contracts with private payer organizations

1. Define the bundle clinically
   - Identify primary episodes of care
   - Outline stakeholder responsibilities
   - Define inclusions and exclusions of the care agreement
2. Determine the different settings of care
   - Determine inclusion or exclusion of inpatient stay, outpatient care, and PAC settings
3. Identify the episode period to be included
   - Determine episode start date
   - Determine episode end date
   - Incorporate rate and cost of readmissions
4. Refine the patient population for analysis
   - Stratify patients based on risk factors
   - Optimize modifiable risk factors
5. Incorporate bundled payment revenue and quality terms
   - Evaluate impact of more streamlined care pathways on episode volume
   - Integrate provisions for financial outlier cases
   - Evaluate costs of administrative and procedural changes
6. Perform the financial analysis
   - Calculate episode payment required for desired margin of profitability
   - Identify areas of potential cost reductions or quality improvements
7. Determine how to distribute payments
   - Involve surgeons, administrators, and other stakeholders in development of reimbursement models
   - Develop guidelines to evaluate provider performance

FINANCIAL ANALYSIS OF BUNDLED CONTRACTS

Define the Bundle Clinically

Of premiere importance in negotiating bundled payments is the precise determination of what procedures the contract is to cover. In orthopedic surgery, the primary episodes considered for bundles are Medicare Severity Diagnosis Related Groups (MS-DRG) 469 and 470 (major joint replacement or reattachment of the lower extremity with and without major complications and comorbidities, respectively), which have several unique qualities that allow for feasible implementation of bundles, as described previously. Some other orthopedic surgeries, such as spinal surgery episodes, were available for implementation under BPCI but failed to produce cost savings or quality improvement and actually led to a significant increase in Medicare claims.[8] Selection of the episode of care to be included in the bundle must ensure that there is adequate potential for cost savings to be realized to ensure economic viability of the contract for all involved stakeholders.

Additionally, it is crucial to establish accountability and to outline the responsibilities of each stakeholder involved in care delivery. All of those involved need to share the common goal of quality improvement and cost reduction and collaboration in the provision of care. Determinations need to be made regarding specific inclusions and exclusions of the care agreement, conditions of any warranties, definitions of cost parameters, and best clinical protocols/standard of care.[16]

Determine the Different Settings of Care

Medicare's BPCI and CJR programs offer the option of several different models, consisting

Download English Version:

https://daneshyari.com/en/article/8802523

Download Persian Version:

https://daneshyari.com/article/8802523

Daneshyari.com