Bundle Payment for Musculoskeletal Care

Current Evidence (Part 2)

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KEYWORDS

• Total joint arthroplasty • Total knee arthroplasty • Bundle payments • Bundled contracts • BPCI • Comprehensive care for joint replacement • Private payers

KEY POINTS

- In general, orthopedic groups that elected to implement Model 2 of the Centers for Medicare and Medicaid Services' (CMS) Bundled Payments for Care Improvement (BPCI) program realized significant reductions in medical costs without deterioration in the quality of care.
- Bundled contracts between orthopedic groups and private payer organizations have demonstrated initial successes in reducing expenditures and improving outcome measures.
- The advantages realized through both the CMS's and private payers' experimentation with bundled payments are likely to be succeeded by further implementation of bundled reimbursement models.
- Before entering into a bundled contract, it is important to weigh the potential benefits of such an arrangement against the possible risks and barriers to implementation in order to determine if bundled reimbursement is a viable model for a specific institution.

INTRODUCTION

Total hip arthroplasty (THA) and total knee arthroplasty (TKA) are among the most commonly performed surgical procedures in the United States, with approximately 300,000 THA and 700,000 TKA procedures performed annually and a high patient satisfaction rate.[1–3] Although the annual number of the procedures has undergone significant growth since 1990, the number of lower extremity total joint arthroplasty (TJA) procedures performed is anticipated to increase exponentially through 2021 and beyond.[4–6] Most TJAs are reimbursed by the Centers for Medicare and Medicaid Services (CMS), with these procedures comprising the largest proportion of inpatient surgical procedures for Medicare beneficiaries.[5,7]

Despite its ubiquity, TJA is plagued by wide variations in cost and quality.[8–16] With such a vast volume of cases being performed annually, even a small global reduction in individual episode costs could yield a substantial financial impact on national health care resource consumption. The traditional fee-for-service (FFS) model used by various payers incentivizes the quantity of services provided, with less focus on the quality or cost of care, which may lead

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

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Orthop Clin N Am 49 (2018) 147–156
https://doi.org/10.1016/j.ocl.2017.11.003
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to fragmented care with poor coordination and collaboration between stakeholders involved in care delivery.[17] With the anticipated forthcoming surge in demand for TJA, it has become imperative to overhaul Medicare's FFS payment system in favor of novel models that promote higher quality with simultaneous cost saving by hospitals and individual providers.

The CMS has already successfully transitioned more than 30% of payments from FFS to an alternative payment model (APM), with the goal of increasing this to 50% by 2018.[18,19] Of particular interest as an APM is bundled payment reimbursement models, which provide all necessary care required by patients during a defined episode of care over a specified duration for a predetermine price, rather than billing for discrete procedures and visits.[20] Optimistic estimates suggest that implementation of bundled payment systems could result in a 5.4% reduction in national health care spending.[21]

TJA represents the ideal procedure for bundling because of the significant variation in price and quality, potential for standardization and reproducibility, and high volume. The inconsistency in the CMS' disbursements and quality measures for TJA demonstrates that there is great potential for cost reductions through the emulation of best practices and care coordination.[22] The clear, evidence-based guidelines for TJA allow for accurate assessment of outcomes, which can provide guidance for distributing payments. Additionally, the large volume of procedures performed annually allows for the potential of a substantial savings margin, making the administrative costs of implementing an innovative payment model worthwhile. In this review, the authors assess the current economic and quality outcomes of various bundle payment programs for TJA and outline a financial analysis strategy for use in the negotiation of bundled contracts.

CENTERS FOR MEDICARE AND MEDICAID SERVICES' IMPLEMENTATION OF BUNDLED CONTRACTS

In 2011, the CMS instituted the Bundled Payments for Care Improvement (BPCI) initiative for several Medicare Severity-Diagnosis Related Groups (MS-DRGs) to test novel care delivery models aiming at reducing Medicare expenses while maintaining or improving the quality of care.[23] The episodes of care that BPCI participants were able to choose from included both MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complication or comorbidity) and MS-DRG 470 (major joint replacement or reattachment of lower extremity without major complication or comorbidity).[17] Providers voluntarily elected to participate in the initiative, selecting from 3 retrospective models and one prospective model outlined in Table 1.[17] Any cost savings realized less than the target price were to be shared among the providers, whereas expenditures in excess of the target price required repayment to Medicare. Ongoing outcome measures are monitored under BPCI, although there is no defined threshold for quality of care.[24]

Based on the preliminary results of the BPCI initiative, in April 2016, the CMS further implemented the Comprehensive Care for Joint Replacement Model (CJR) for TJA at 800 hospitals in 75 metropolitan statistical areas (MSA), excluding BPCI-participating hospitals.[25] The aim of this initiative was to support more efficient, high-quality care in TJA for Medicare beneficiaries while shifting from historical pricing to MSA-specific geographic pricing.[25,26] Although similar to the BPCI initiative, there are several important distinguishing features (Table 2).[24,25] Under the CJR, an episode of care begins with the admission of a Medicare beneficiary for an MS-DRG 469 or 470 to a

Table 1
Medicare reimbursement schedules under the voluntary Bundled Payments for Care Improvement initiative

Models	Coverage
Model 1	Retrospective payment covering acute inpatient hospital admission only
Model 2	Retrospective payment covering acute inpatient hospital stay & certain postdischarge care
Model 3	Retrospective payment covering 30 d of postdischarge care, excluding the acute inpatient hospital admission
Model 4	Prospective payment covering acute inpatient hospital admission only

BPCI-participating hospitals selected from one of 4 retrospective or prospective payment models. Most hospitals participating in the orthopedic surgery bundled payments elected to implement Model 2.[23]

Data from Centers for Medicare and Medicaid Services (CMS). Bundled payments for care improvement (BPCI) initiative: general information. Available at: https://innovation.cms.gov/initiatives/bundled-payments/. Accessed January 30, 2017.

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