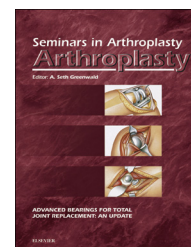


Available online at www.sciencedirect.com

ScienceDirect

www.elsevier.com/locate/sart

Gain sharing in bundled payment TJA: Is it the way forward?

Stephen M. Engstrom, MD, and Ryan M. Nunley, MD*

Joint Preservation, Resurfacing, and Replacement, Washington University Orthopaedics, Barnes Jewish Hospital, 660 S. Euclid Ave., Campus Box 8233, St. Louis, MO 63110

ARTICLE INFO

Keywords:

Gain sharing
Bundled payment
Total joint arthroplasty

ABSTRACT

As health-care costs continue upon a meteoric rise, the Center for Medicare and Medicaid Services has developed a number of strategies designed to curb spending and at the same time incentivize the delivery of high quality care. Joint replacement has been a specific area of interest because of the volume of medicare patients seeking arthroplasty. The introduction of the Bundled Payment for Care Improvement initiative has placed the onus on hospital systems to continue to deliver quality care at lower costs. In an effort to do so, hospitals are beginning to engage physicians in their efforts by offering them financial incentive for keeping costs low—a strategy known as gain sharing. In this paper, we will review the history of gain sharing, the ethics surrounding it, and strategies for implementing a successful partnership between physicians and hospitals that works to eliminate excess spending without compromising patient care.

© 2018 Elsevier Inc. All rights reserved.

1. Introduction

In 2011, the Center for Medicare and Medicaid Services (CMS) initiated the Bundled Payment for Care Improvement (BPCI) initiative for total joint arthroplasty in response to unsustainable health-care costs as a way to streamline patient care and promote the delivery of higher quality services at a lower cost. This program provides a single payment for services rendered in the perioperative period, and places the onus of stemming costs and reducing complications on the hospital system. In 2017, following the initial success of the BPCI program, CMS outlined 67 geographic metropolitan statistical areas across the United States as part of a mandatory program called Comprehensive Care for Joint Replacement (CJR). In these 67 areas, it

became mandatory for all hospitals performing total joint arthroplasty procedures on traditional medicare patients to be part of a bundled program. As the program is implemented over the course of the next several years, hospital reimbursement will be tied to specific “meaningful use” and patient outcome measures, with high performing hospitals reaping the benefit of higher reimbursements, and low performers being subject to fines and financial losses. Given the fact that hospital physician reimbursements are included within the bundle, and the option for gainsharing is encouraged by CMS, surgeons and hospitals alike have a mutual incentive to deliver excellent care at low cost. Gain sharing is the collaboration between physician and hospital to identify and implement strategies designed to improve productivity and quality, while simultaneously

*Corresponding author. Tel.: +1 314 747 2523; fax: +1 314 747 2599.
E-mail address: nunleyr@wustl.edu (R.M. Nunley).

eliminating waste and driving down costs, with both entities reaping a share of the financial incentive for doing so.

2. History of bundled payments and the problem of rising healthcare costs

Bundling of medical payments in the United States is not as new of a concept as it may seem. Congress initiated the first iteration of bundled payments in 1982 with the advent of the Diagnosis Related Group (DRG) payment model. Prior to this, hospitals would submit, and collect payment based upon, itemized bills for care rendered. Subsequent to high variability in costs and overly complex fee schedules, CMS introduced the DRG as a way to classify hospital cases to identify the “products” that a hospital provides. The initial 467 groups were assigned based upon ICD diagnosis, complications, and comorbidities. The DRG assigned to the patient on discharge from the hospital determines the specific payment rendered by Medicare.

A major alteration to the DRG system came in 2008 with the addition of hospital acquired conditions (HAC) revision. This collection of post-operative complications, including catheter-related urinary tract infection, venous thromboembolism, and surgical site infection, would be considered “never-events.” If a post-surgical patient were to develop such a complication, the financial burden of treatment of the condition would fall on the hospital, thereby reducing the cost to Medicare.

Unfortunately, shifting the burden of post-surgical complications to the hospital has failed to combat rising costs and excess spending over the last decade. Currently, the United States devotes nearly eighteen percent of its Gross Domestic Product to the delivery of healthcare, which ranks first among all developed nations, and more than double that of many of our peer-nations [1]. These costs are projected to grow at an exponential rate over the next 50 years. Furthermore, when comparing traditional outcomes measures in the U.S. with other industrialized nations, the U.S. ranks near the bottom in many, making our healthcare considered relatively “low value.”

Recognizing the rise of government spending in healthcare as unsustainable, CMS sought to develop a system that would reward quality care, while at the same time eliminating waste and excess spending. Given the fact that over 400,000 Medicare beneficiaries undergo arthroplasty procedures yearly, and the fact that orthopaedic surgery represents the largest total cost of all surgical procedures in the CMS budget, total joint replacement was the obvious test demographic [2].

In 2009, CMS initiated the Medicare Acute Care Episode (ACE) Demonstration project for total joint arthroplasty. This pilot program was limited to the Southwestern United States and participating centers reported lower costs without any negative impact on patient outcomes. The success of the ACE Demonstration led to the formal launch of the BPCI in 2011, which, at the time, was more flexible and voluntary. Through the BPCI, a bundled payment is defined as “an episode-of-care” fee which covers all services rendered during the perioperative period (e.g., hospital charges, surgeon’s fees, and post-acute care). Additionally, much like the DRG system, the burden of any complications or readmissions fall on the hospital.

Over the last 6 years, the initial BPCI has evolved into the Comprehensive Care for Joint Replacement (CJR) model, which defines 67 geographic areas with a population >50,000 and seeks to establish bundled payments based upon regional costs. The process started in April 2016 and will cover a 5-year span, with increasing financial risks placed on the hospital over this time period. Hospitals that meet designated quality metrics can reap financial rewards up to 5% in the first year and 20% by the fifth year [3]. Conversely, poorly performing hospitals will see no financial penalty in the first year, but can be penalized up to 20% in the fifth year of the program [3]. Early results of the BPCI have been largely positive, with certain high volume centers citing shorter duration of stay, fewer readmissions, and substantial cost reduction [4].

3. The effect on hospitals and physicians

The addition of HACs to the DRG system, which signaled the beginning of the shift away from the traditional fee-for-service model, effectively gave birth to the notion of the hospital as an Accountable Care Organization (ACO). The ACO represents the alignment of the hospital system to assume all liability for the appropriate care of the patient for a predetermined period of time following hospital discharge. It renders the hospital financially responsible for any re-admissions, reoperations, and complications occurring within the set timeframe. Unfortunately, there is no physician burden or incentive in this model, which lead to a persistent variability in costs [5] and quality. Furthermore, there has been little, if any, increase in the DRG payment for total joint arthroplasty in recent years, causing hospitals to seek other methods of increasing revenue and curbing costs. Predominantly, large hospital systems have accomplished this by increasing market share through advertising and acquiring smaller community hospitals and clinics, forming centers of excellence to increase patient volume, aggressively negotiating contracts with insurance companies, and implementing resource utilization committees to help reduce internal costs.

The shift toward value-based care has also had a significant impact on the physician. Over the last two decades, CMS has repeatedly threatened to reduce costs by decreasing physician reimbursements, citing the sustainable growth rate—the notion that Medicare spending cannot exceed inflation [6]. In 2015, physicians feared an estimated 21% decline in payments until the sustainable growth rate was repealed and replaced with the Medicare Access and CHIP reauthorization act of 2015, which significantly changed the way CMS pays physicians, with an emphasis on toward Merit Based Incentive Payment Systems. This act establish several metrics to evaluate physicians, including the use of electronic medical records, meaningful use data collection, electronic prescribing systems, and the implementation of ICD-10. Unfortunately, many of these metrics have proved too costly for individual physicians in private practice to implement, and subsequently orthopaedics has seen a large transition in practice patterns among individual surgeons. Over the last decade, there has been a steady decline in the number of physicians in private practice, and a marked increase in

Download English Version:

<https://daneshyari.com/en/article/8804030>

Download Persian Version:

<https://daneshyari.com/article/8804030>

[Daneshyari.com](https://daneshyari.com)