The Future Is Here: Bundled Payments and ICD10

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Description of Topical focus and Learning objective:
The Bundled Payment for Care Initiative (BCPI) was begun in 2013 by the Centers for Medicare & Medicaid Services (CMS). However, it may be years until the data can determine whether BPCI enhances value without decreasing quality. In this symposium, the authors report the mid-term results of BPCI and outline the challenges and benefits of their respective healthcare delivery systems as applied to the provision of total joint replacement.

Methods of care management, cost control, quality improvement, and value creation are emphasized. In this review we explore the effect of BPCI on the value equation as it is applied to total joint arthroplasty (TJA).

Under the BPCI, organizations entered into payment arrangements that include financial and performance accountability for episodes of care. BPCI required that quality was maintained, and care was delivered at a lower cost to Medicare. Bundled pricing requires physicians and hospitals to align their interests and orthopaedic surgeons must assume a leadership role in cost-containment, surgical safety, and quality assurance. Because most orthopaedic surgeons practice independently and are not hospital-employed, models of physician-hospital alignment such as physician-hospital organizations or contract arrangements between practices and hospitals may be necessary for bundled pricing to succeed. Under BCPI hospitals, surgeons, or third parties can assume the risk for the bundle.

For patients, cost savings must be associated with maintenance or improvement in quality metrics. How quality is defined and measured and what processes and outcomes are rewarded can vary. Risk-stratified allowances for non-preventable complications must be incorporated into bundled pricing agreements to prevent the exclusion of patients with significant comorbidities, and higher care costs, such as hip fractures treated with a prosthesis. Bundled pricing depends upon economies of scale for success. CMS recommends a minimum threshold of 100 to 200 cases per year within a bundle for successful risk management. Furthermore, significant investment in infrastructure is required to manage quality data, and to distribute payments. Bundled pricing may not be appropriate for smaller orthopaedic groups or hospitals.

Detailed DRG understanding for the models and which procedures are included in the DRG's selected is essential. The formula for successful implementation of a cost effective episode for primary TJA patients involved initially a three pronged approach: 1. Improved care coordination and preoperative education of patients to set expectations and maximize communication; 2. Clinical pathway implementation and standardization of care utilizing evidence based medicine standards that all clinical providers could be comfortable with; and 3. Minimization of post-acute care inpatient facilities when unnecessary and utilization of the more cost effective clinical care coordination infrastructure. However, there are nuances to the BPCI value equation that can optimize the success of the initiative.

This symposium reports the learned experience of those who have early results with BPCI and how they have been successful with the implementation of the initiative.

This symposium will also discuss ICD 10 implementation and how it will impact your practice as an adult reconstruction surgeon.