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Six Key Points About the Orthopedic Bundled Payments Initiative

By Kim Heller, CPA, Partner

(Part 1 of a 4-part series.)

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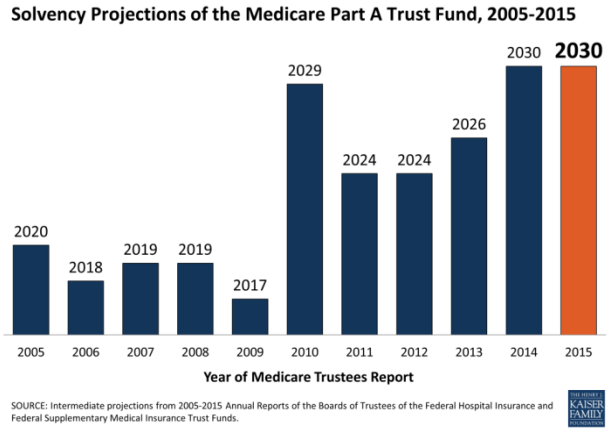
The Centers for Medicare & Medicaid Services (CMS) and the federal government are working hard to ensure current and future Americans have access to high-quality health care and those same Americans don't go to the "poor house" because of the current unsustainable health care system. Two critical challenges are the financial burden health care places on preretirement Americans and our predicted inability to provide health care for seniors after 2030.

The Medicare Part A Trust Fund (which pays for inpatient hospital, skilled nursing facility (SNF), hospice, and home health agency (HHA) services) is expected to become insolvent in 2030. This is unchanged from 2014 predictions but slightly better than insolvency predictions in 2011-2013.



In addition to the predicted Medicare program insolvency, health care places a huge burden on the average American during their working years. According to CMS, the average American spent $9,600 on health care in 2014, up significantly from $7,700 in 2007. Health care spending is expected to exceed $10,000 per person in 2016 and reach $14,900 in 2023. This is an important deterrent to U.S. economic growth.

The Comprehensive Care for Joint Replacement model (a.k.a. "orthopedic bundled payments") being rolled out by the Center for Medicare and Medicaid Innovation is designed to determine if bundling payments for orthopedic services will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS expects this initiative to result in savings to the Medicare program of $343 million over the five performance years of the model.

Hospitals, physicians, SNFs, and HHAs need to understand the orthopedic bundled payments initiative. In this four-part article series, we will cover key aspects of the orthopedic bundled payments initiative in greater detail.

The following are six key points related to the orthopedic bundled payments initiative:

1. It is not voluntary. Hospitals within 67 geographic areas across the nation will be initially required to participate.
2. There are two diagnosis-related groups (DRGs) that will be part of the orthopedic bundled payments initiative. The two DRGs are MS-DRG 469 (Major joint replacement with major complications or Comorbidities) and MS-DRG 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities).
3. The initiative will span a five-year period beginning with episodes that start on or after April 1, 2016.
4. Hospitals will be the only provider type held financially accountable, by CMS, for outcomes. If hospitals submit certain voluntary data related to total hip arthroplasty (THA) or total knee arthroplasty (TKA), 1.7% of their payments would be at risk. For hospitals that do not submit the voluntary THA/TKA data, 2.0% of their payments would be at risk.
5. Hospitals will be forced to include financial and quality outcomes for related and unrelated post-acute providers that provide services to a covered beneficiary within the 90-day episode.
6. Payments will be adjusted based on several financial and nonfinancial metrics. Because they will be held financially accountable, the incentive is for hospitals to work with physicians, SNFs, and HHAs to achieve positive outcomes.

Additional Topics

In this article series, we will cover the following key aspects of the orthopedic bundled payments initiative.

Orthopedic Bundles - A Primer

The first article will include additional information on the orthopedic bundled payments initiative including:

- What providers, conditions, and services will be impacted.
- The time frame for patient episodes, as well as Medicare measurement of outcomes, payments, and settle-up reconciliation.
- The financial and quality metrics that will be used to determine payments.
- Why providers that are not in the affected geographic areas should still pay attention.

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Orthopedic Bundles - Critical Analysis of the Current State

The second article will arm providers with strategic analysis to perform now, including "how to" tips on:

- Evaluating the financial effect
- Understanding current clinical pathways
- Understanding current referral patterns
- Brainstorming about optimum future clinical pathways and referral patterns
- Developing key performance metrics (KPMs) for partners who will contribute to maximizing financial benefits

Orthopedic Bundles - Essential Strategies for the Future

The last article will prepare providers to implement strategies for:

- Deciding whether to "partner" or "own" all services in the bundle
- Creating new internal clinical pathways
- Creating new clinical pathways with external partners
- Monitoring effects on KPMs
- Monitoring expected financial implications of strategies adopted

We hope you find this series informative as you navigate the sea of change in today's health care industry. Look for the next article "Orthopedic Bundles - A Primer" to be available soon.

We welcome your calls and questions regarding this topic.

About the Author

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With over 20 years of experience, Kim Heller is a CPA and partner in Wipfli LLP's ("Wipfli's") national health care practice. She takes pride in providing outstanding services to hospitals, SNFs, assisted and independent living organizations, and HHAs. In addition to her client service responsibilities, Kim leads Wipfli's efforts to enhance and increase services provided to the senior living industry. Contact Kim at 715.843.8336 or kheller@wipfli.com.

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