BUNDLED PAYMENTS FOR CARE IMPROVEMENT

Medicare test would make hospitals bear risk for hip and knee surgeries

The CMS is planning to require hospitals in 75 geographic areas, including Los Angeles and New York City, to participate in a test of bundled payments for hip and knee replacements.

The procedures are among the most common that Medicare beneficiaries receive, and the price varies significantly. The average Medicare payment for surgery, hospitalization and recovery ranges from $16,500 to $33,000, the CMS said in a news release announcing the initiative, which would be administered by the CMS Innovation Center.

Hip and knee replacements are among the procedures included in Medicare's voluntary Bundled Payments for Care Improvement initiative. But the CMS has determined certain kinds of hospitals aren't signing up. The approach of the new program, the agency said in a proposed rule, would capture hospitals with a variety of utilization patterns, roles within their local markets, access to capital and other factors.

The initiative should send a clear message that the Obama administration is serious about rapidly moving away from the fee-for-service model. This is the first really strong signal that this is where the industry is going.

The program would begin Jan. 1 and run for five years. Episodes included in the bundle would begin with the admission to the hospital and end 90 days

after discharge. The hospitals would bear financial risk for the procedure, the inpatient stay and all care related to the patient's recovery.

The hospitals would continue to get paid for their services under Medicare's fee-for-service system. At the end of the year, depending on the hospital's quality and cost performance, the hospital would receive an additional payment or be required to repay Medicare for a portion of the episode costs. Hospitals will not be at risk the first year but must absorb losses starting in year two.

The CMS, though, said the program will give hospitals an incentive to work with physicians, home health agencies and nursing homes to make sure Medicare patients get coordinated care and reduce avoidable hospitalizations and complications. The program would include quality measures for complications, readmissions and patient experience.

"We're doing this because we believe there's an opportunity to improve care for Medicare beneficiaries who are undergoing hip and knee replacements," said Dr. Patrick Conway, the deputy CMS administrator for innovation and quality.

An early test of bundles, the Medicare Acute Care Episode Demonstration, did save Medicare $319 per episode during a three-year program with the largest savings from orthopedics. However, published results are very limited for the Affordable Care Act's Bundled Payments for Care Improvement initiative. The CMS acknowledged the lack of data from that program but asserted the results have been positive and that the experience would inform the new experiment.

In January, HHS announced a goal to have 50% of its fee-for-service spending under contracts that include cost and quality incentives.

In 2014, approximately 430,000 Medicare beneficiaries had discharges for lower-extremity joint replacements, costing Medicare more than $7 billion for the hospitalizations alone.

The CMS estimates that the new bundled-payment test will cover about 25% of the hip and knee replacements that Medicare pays for. The program would put about $2.2 billion in Medicare spending in the new bundles in 2016, and that figure would grow to $2.7 billion in 2020. The agency expects the model to yield $153 million in net savings during its five-year run.