Would receiving a single payment for procedures like total hip and knee replacement bring hospitals and surgeons into closer alignment? Would care be delivered in a more coordinated manner with higher quality and greater cost-effectiveness?

It’s the way more Medicare reimbursement may be going. The Centers for Medicare and Medicaid Services (CMS) is conducting demonstration projects on bundled pricing (sidebar, p 9). In these projects, Medicare pays one amount to a hospital for an episode of care, and the hospital splits the payment with physicians and other providers. CMS sees bundled pricing as one path toward more coordinated and cost-efficient care.

Hillcrest Medical Center in Tulsa, Oklahoma, was the first of 5 hospitals to participate in the original bundled pricing pilot, the ACE (Acute Care Episode) Demonstration Project, launched in 2009. The pilot involves certain orthopedic and cardiac procedures. Hillcrest placed a bid with CMS to accept a discounted amount for each of the 9 orthopedic DRGs. In turn, the hospital shares the payment with the participating physicians, including surgeons and anesthesiologists.

The idea is that the hospital will gain volume, and Medicare will reap savings. In the demo, Medicare saves 4.4% on the base rates for total joint surgery. Patients receive a small financial incentive from Medicare for using Hillcrest—50% of the amount Medicare saves; that is, the difference between the usual DRG payment and the contracted amount, or about $250 to $300 for a total joint replacement.

“The payment to the hospital includes all facility and professional services incurred during the visit, from admission to discharge,” explains Nancy Harrison, ACE demonstration director for Hillcrest’s parent organization, Nashville, Tennessee-based Ardent Health Services.

Hillcrest pays the surgeons 100% of their usual Medicare fee. The surgeons are also in a gain-sharing arrangement with the hospital. Gain sharing is a structured arrangement in which the hospital and physicians share savings on specific procedures if quality thresholds are met.

What’s in it for the hospital?

Why participate in bundled payment?

“One thing we wanted to do was to improve our quality of care while reducing our costs and working more closely with providers, which is one of the goals CMS has for the project,” says Harrison.

“We wanted to be on the cutting edge of global pricing because we felt that some type of global pricing was going to be in our future.”

Indeed, CMS rolled out 4 new bundled payment models in August 2011 and has invited providers to participate. The new models do not include an incentive for patients.

Tracking quality

As part of the project, Hillcrest is required to track 11 quality measures for hip and
knee surgery, which are reported to CMS and to the participating surgeons in quarterly meetings.

The metrics are primarily those CMS expects all hospitals to report, including many of the Surgical Care Improvement Project (SCIP) measures as well as length of stay, 30-day postsurgical mortality, and readmission rates, among others.

Beverly G. Morris, BSN, RN, Hillcrest’s administrative director of surgical services, says the hospital has either maintained or improved on the metrics since joining the project.

Changing dynamics

Morris says she’s noticed a change in the dynamics of working with the surgeons since the project began.

“It’s almost like comanagement with the physicians. We are both invested in being successful for the patient. It’s made these physicians want to align with us in looking at products, equipment, and processes so we can identify any inefficiencies and correct them.”
Early on, the lead orthopedic surgeon, Yogesh Mittal, MD, was involved in streamlining instrument sets and orthopedic supplies.

Regarding total joint implants, an expensive part of the procedure, Hillcrest has not said that surgeons must use a particular vendor. “It is very collaborative,” says Harrison.

Notes Morris, “It’s no longer a matter of surgeons saying, ‘This is what I want to use,’ but also looking at the cost and comparing the desired implant with how well the other implants work before making a decision.”

The director of materials management coordinates a quarterly business review with the orthopedic surgeons in which they discuss implants, supplies, and other costs. The director of materials management then works with vendors on implants and pricing.

Morris says there is also more collaboration with the postop nursing unit to coordinate care processes and product decisions.

The project has entailed some additional costs in marketing the project to patients and developing educational materials, Harrison says.

**Focused orthopedic unit**

Hillcrest already had a dedicated orthopedic unit, which focuses care for these patients. With 4 ORs, the unit has its own admission area, postanesthesia care unit, and postop nursing unit. Two additional orthopedic ORs are in the main surgical suite.

Most of the staff, from housekeepers and orderlies to surgical technologists and preop, intraop, and postop nurses, is dedicated to the unit, with other staff supplementing as needed.

To aid case turnover, surgeons can move from one OR directly to another. All surgical site verification steps, including the time-out in the OR, are performed appropriately, Morris notes.

Total joint replacement patients attend a seminar before surgery where they learn what to expect before and during surgery as well as after they go home.

Morris acknowledges there could be anxiety about having physicians so involved in decision making. But she has found the experience to be positive. “What I have found is that they truly are aligned. It has made dealing with all of the issues, whether they are personnel issues, processes, or the cost of supplies and implants, easier to work on with the physicians.

“Having this good experience has made me a believer,” she says.

—from Pat Patterson