NYU Langone
MEDICAL CENTER

Keys to Success in the CJR Bundled Payment Program

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Department of Orthopaedic Surgery
HOSPITAL FOR JOINT DISEASES

Disruptive Change: Our Opportunity

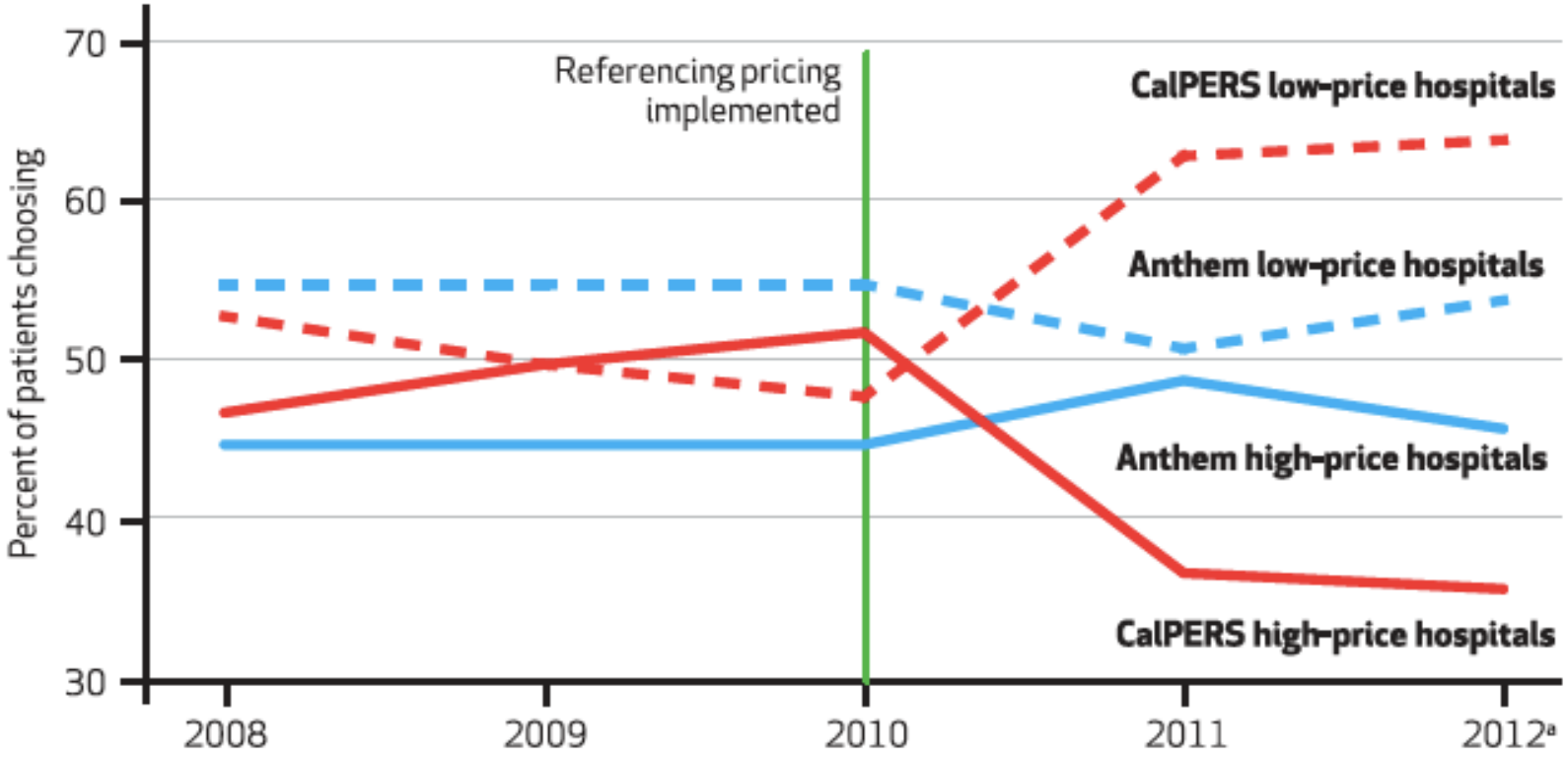
- The change is occurring now
- Agnostic to politics
- Those who accept and embrace win

CREATING VALUE: THE MATH

- Value = Outcomes/cost
  - Outcomes which matter to patients
- Theoretically if we decrease cost by 50% and decrease outcomes by 10% we have created value
- Not acceptable
  - **Any decrease in cost cannot result in a decrease in outcomes**

Volume Shift to Low Cost Centers

Patients Choosing High-Price or Low-Price California Hospitals for Knee or Hip Replacement Surgery, 2008–12



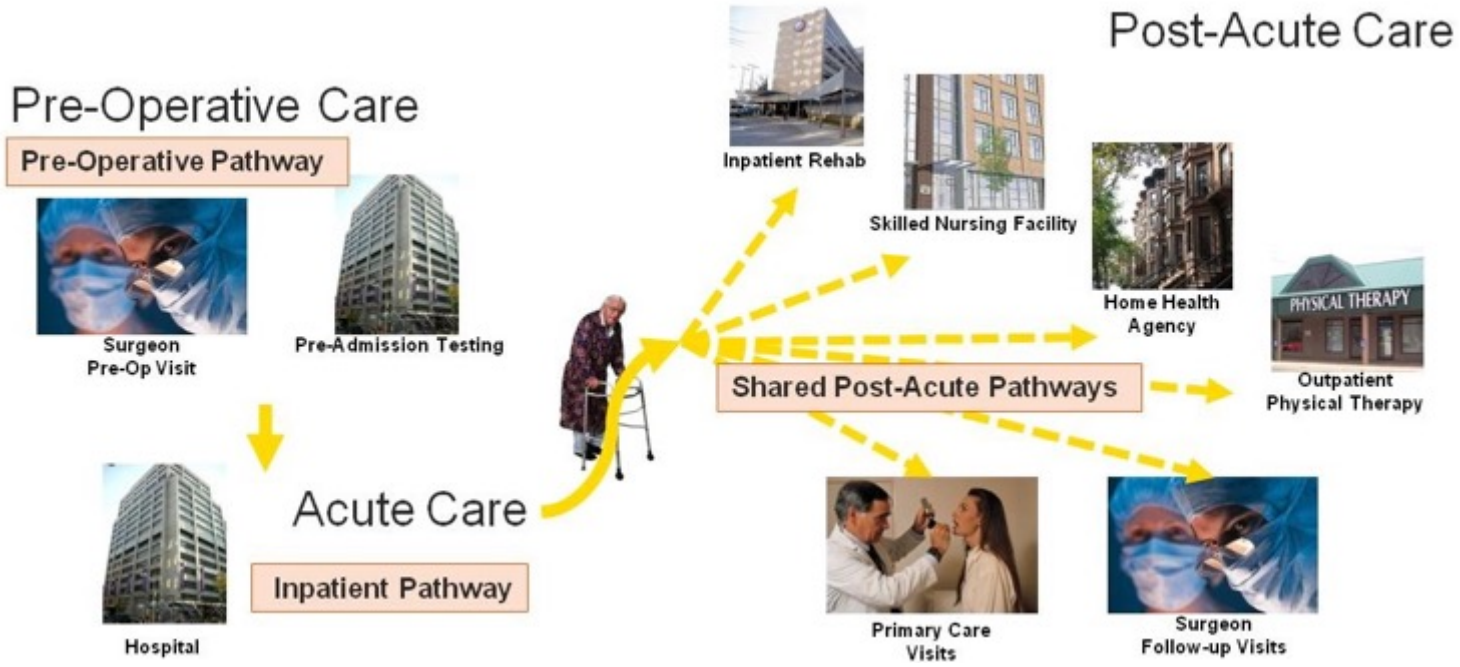
The Seven Pillars

- 1) **Coordinate Care Throughout Episode**
- 2) **Preoperative identification and modification of patient risk factors**
- **3) Identify and Align Stakeholders**
- 4) **Adopt Evidenced based Clinical Pathways**
- 5) **Maximize and Demonstrate Quality**
- 6) **Establish a Robust Data Collection and Dissemination Infrastructure**
- 7) **Control the Post Discharge Care and Costs**

Pillar 1: Care Coordination Throughout the Episode

The Importance of Care Coordination

- Enforces best practices / standardization of pathways, workflows, and order sets
- Improves communication between providers and to the patient
- Ensures follow-up after care transitions
- Optimizes Patient Expectations and Outcomes
- Optimize the patient



Preparing Patients for the Inpatient Setting

- Patients are identified before admission
- Clinical Care Coordinator (CCC) calls patient and family (Guided Patient Services) to:
  - Set expectations for the hospital stay
  - Assess risk and level of care needs (application of RAPT)
  - Work with patient and clinical team to plan discharge before admission
  - Identify support persons and patient's pharmacy to facilitate a smooth transition to the next phase of care

The challenge to maintain seamless consistency begins

RAPT = Risk Assessment and Predictor Tool.

Creating a Smooth Transition

- Interdisciplinary rounds are held daily on inpatient units to keep team abreast of a patient's progress and potential barriers
- Weekly Care Coordination Conferences are held with BPCI team and other members of the interprofessional inpatient team to discuss real-time solutions to facilitate home discharges
- Comments are added to the PRI (if SAR is appropriate)
  - Expected length of stay (LOS) 5-7 days to set the expectations with both the patients and the receiving facilities

PRI = patient review instrument; SAR = subacute rehabilitation.

What Happens After Discharge?

- BPCI CCCs follow the patients for 90 days
- Readmissions for these patients are tracked

Patient Navigation

Patient / Coach

Nurse Care Coordinator

Pre-admission

Surgeon

Pre-Admission Testing

Hospital Inpatient

Hospital

Surgeon

90-Day Post-Acute Period

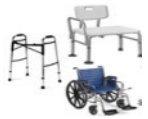
Inpatient Rehab

Skilled Nursing Facilities

Home Health Agencies

Surgeon Follow-Up Visits

Outpatient Services



Communication Modes:

Electronic
- EMR: My Chart
- EMR Light: For providers without EMR

Telephonic

Fax
- For providers without EMR or limited internet connectivity

Care Management/Coordination

Pre-hospital

- ✓ Call/meet with patient before surgery - complete preadmission assessment
- ✓ Confirm contact information
- ✓ Review preoperative office visits/PAT results
- ✓ Ensure Patient Engagement Form is completed and brought to PAT; reinforce Patient Engagement Form
- ✓ Provide preadmission education & discuss hospital processes
- ✓ Review expectations around surgical limitations, preparation for after hospital plan & discharge needs/options.
- ✓ Provide patient with contact information & encourage patient to call back if questions arise
- ✓ Home visit – high risk patients

Inpatient

- ✓ Monitor patient's progress status and readiness for discharge
- ✓ Monitor the Social Worker and Case/Care Manager to ensure that post-discharge services are in place
- ✓ Ensure the patient is on track for the expected discharge date and work with the in-hospital team if there are barriers, as needed
- ✓ Respond to escalation of change in discharge disposition from home to a facility
- ✓ Maintain communication with the surgeon, discharge planning team and other consults, as needed

Post-discharge

- ✓ Timely and ongoing contact with patients/coaches to monitor progress and identify any issues
- ✓ Calls and electronic communication to PAC providers
- ✓ Monitor SNF/IRF patient readiness for CHHA services or outpatient services and necessary follow-up appointments
- ✓ Monitor CHHA patient readiness for self-care care and any necessary follow-up appointments including outpatient PT
- ✓ Alert surgeon and specialty consult(s) when changes have occurred during the post acute period
- ✓ Follow guidance regarding patients who refuse contact and when not able to contact patients
- ✓ Plan for and establish closure at the end of the 90 day period

All communications & activities documented in Epic

Pillar 2: Preoperative Identification and Modification of Patient Risk Factors

- Perioperative surgical homes
- Risk Modification
- Risk Stratification

Perioperative Surgical Homes (POSH)

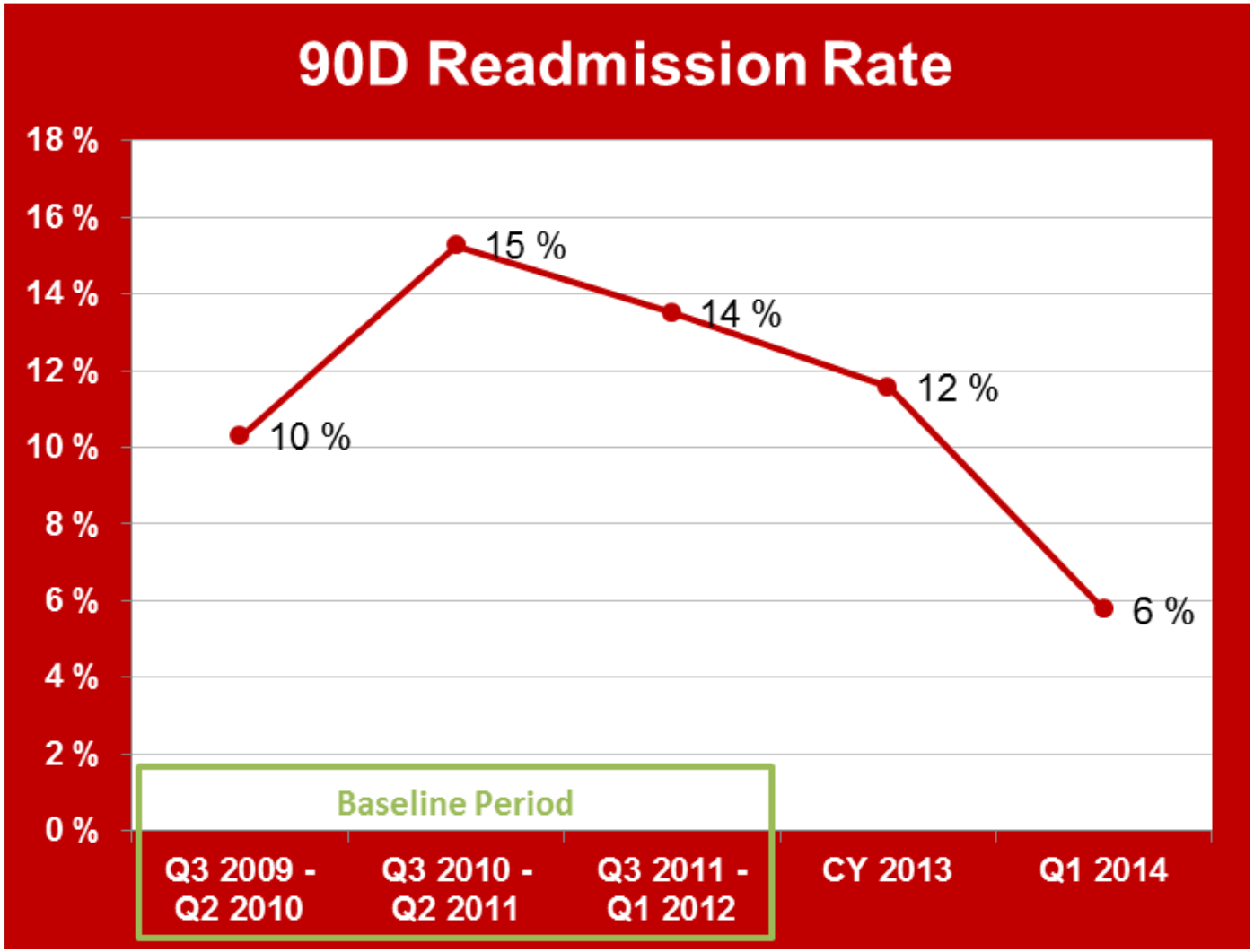
- Identify high risk patients for Shared decision making (SDM)
  - Inform High Risk Patients
- Postpone or cancel interventions based on increased risks
  - Lemon dropping
  - Cherry Picking
- Ethical implications

Bundled Payment Initiative

POSH Readmission Score and OR of Readmission

POSH	0	1	2	3	4	5	6	7	8
Readmitted (A)	21	36	37	45	49	43	24	9	5
None (B)	89	95	39	31	12	3	0	0	0
Ratio = A/B	0.24	0.38	0.95	1.45	4.08	14.33	-	-	-
OR (Linear)	0.19	0.41	0.89	1.94	4.21	9.14	19.86	43.12	93.64
OR (Non-Linear)	0.24	0.38	0.95	1.45	4.08	14.33	-	-	-
OR (Linear, Age)	0.18	0.40	0.90	1.91	4.56	10.23	20.20	44.68	104.24
OR (NL, Age)	0.23	0.37	0.95	1.48	4.26	15.21	-	-	-

MJR 90D Readmission Rates before and after POSH



Interventions for Modifiable Risk Factors

- MRSA Screening and Decolonization, weight based antibiotic dosing, and use of Vancomycin and Gentamycin in high risk patients
- Hepatitis C screening
- Smoking cessation (hard stop)
- Cardiovascular Optimization and Stroke Prevention (using PT, High dose Statins, and ACE inhibitors perioperatively)
- Aggressive weight control (hard stop at a BMI of 40)
- Catastrophizing avoidance
- Drug and alcohol interventions
- Fall education prevention
- Physical deconditioning physical improvement interventions
- Diabetes control and nutritional interventions
- Screening for high risk VTED patients with testing for thrombosis risk
- Risk based stratification of VTED prophylaxis

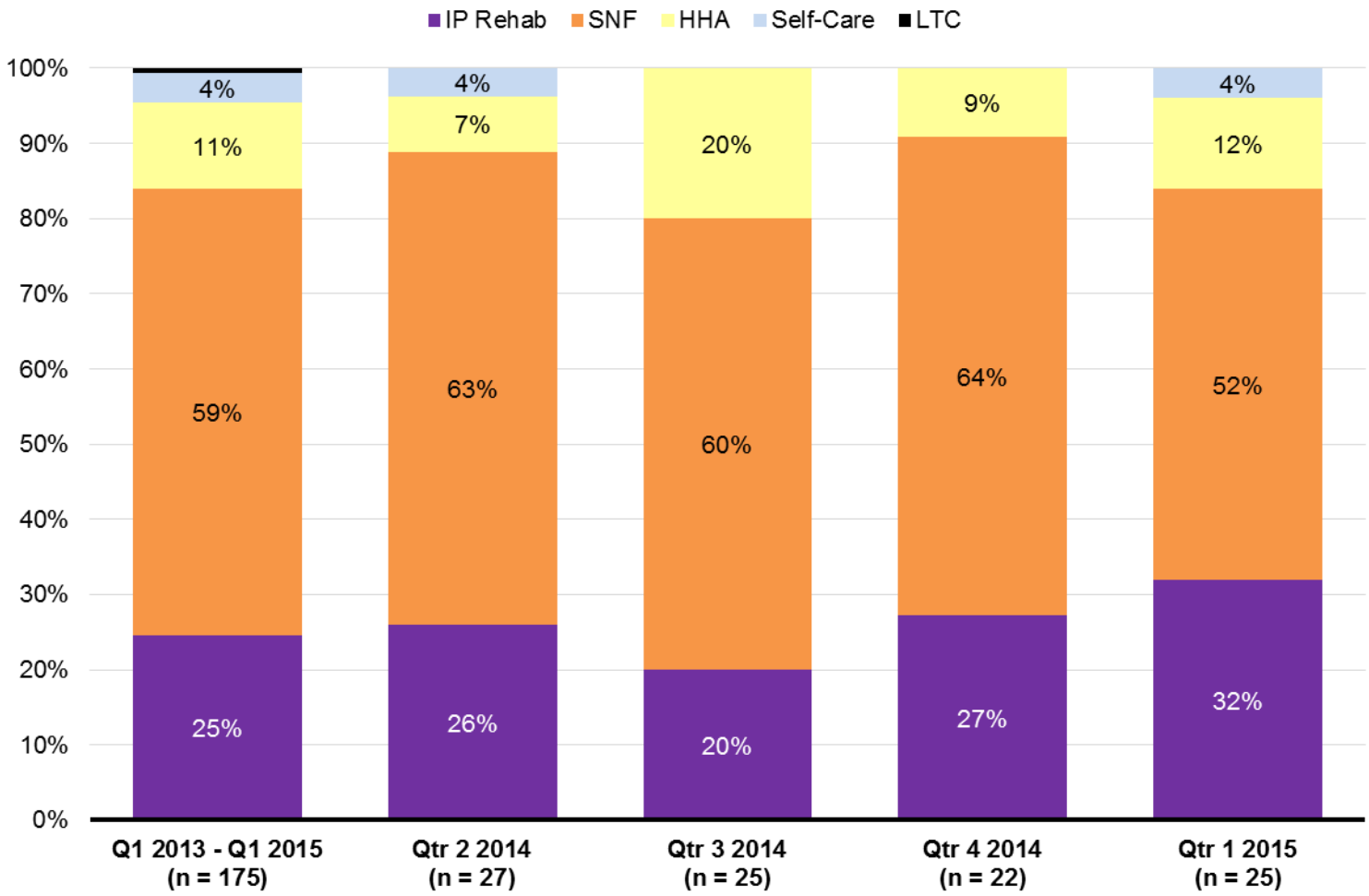
Risk Stratification

- Identification of risk factors allows for risk stratification and the potential of increased reimbursement
  - Much like CMI (case mix index) codes for higher reimbursement
- Allows providers to direct the appropriate level of resources to maximize outcomes
  - Readmissions RAPT tool

Surgical **H**ip and **F**emur **F**racture **T**reatment: SHFFT: New Mandatory Bundle

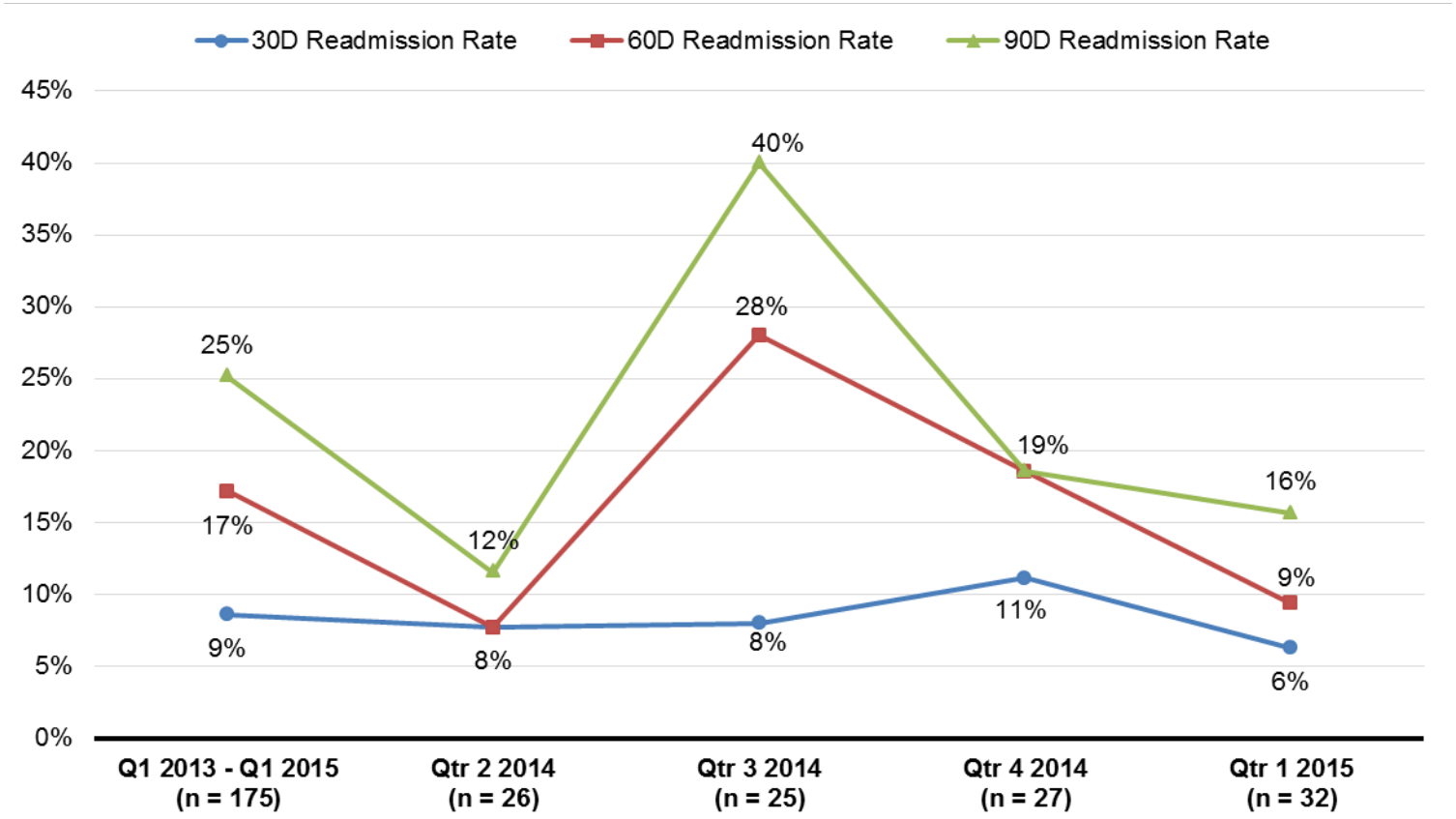
- Beginning in 2017????
- Surgical Procedures for hip and femur fractures
- Including: Plating and IM Rodding
- DRGs 480-482
  - Hip and femur major non arthroplasty
    - With or w/o Mcc or CC

SHFFT: Discharge Disposition Trends



Based on Medicare claims data from January 1, 2013 – March 31, 2015

SHFFT: Readmission Rates



Based on Medicare claims data from April 1, 2014 – March 31, 2015

Pillar 3: Evidenced based Clinical Pathways

- Standardization of care
  - Decreases physician specific variation
- Shares experience and expertise to lower volume providers
  - Able to benefit from institutional learning and experience
- Document value proposition of all interventions
  - Post operative labs
  - Blood management
  - Pain pathways
  - Decrease consults
  - VTE

EXAMINE CARE PATHWAYS AND ORDER SETS

- All interventions should add value
- Scrutinize “Routine” orders for value-add
- Routine Post-op blood tests in PACU
  - HCT
  - Cr/Bun
  - R/O MI
- Bone Cement
  - No need to routinely use two 40g bags
  - Most TKR’s can be done with one bag
  - Strict evidence based guidelines for Antibiotic cement use
    - Hx. Of SSI
    - IDDM
    - Obesity?

Optimal Performance Measures and Multimodal Pain Management

Elimination of patient-controlled analgesia (PCA), peripheral nerve blocks, indwelling epidural and femoral nerve catheters

Use a multimodal approach to preoperative oral preemptive analgesia

- Oxycodone CR 10 mg
- Acetaminophen 1000 mg
- Celecoxib 200 mg
- Pregabalin 50 mg

Minimize narcotic use by using intraoperative periarticular injections

- Administered by surgeon
- Short-acting options – bupivacaine, morphine, ketorolac
- Long-acting option – liposomal bupivacaine

Blood Management and Transfusions: Guidelines

1. Anemia = Hemoglobin <7 gm/dL
2. Active bleeding
3. Acute cardiac ischemia

Sculco & Pagnano. *J Arthroplasty*. 2015;30:518-520.

TXA TO DECREASE TRANSFUSION RATES

- Allogeneic transfusions negatively affect outcomes
  - Increase LOS
  - Increase VTE
  - Increase SSI

- Is TXA a cost effective way to reduce transfusions
- AKA: Improve OUTCOMES

CE FOR TXA

- Cost associated with blood products decreased by 35% in the TXA cohort.
- The per-patient average cost for blood transfusions in 2012 was $198.82 and in 2013 (when accounting for the additional cost of TXA administration) it was $128.45.
- The cost of 1g/10mL TXA and 1 unit packed red blood cells (PRBC) was $25.98 and $414.43, respectively.

TXA Decreased Costs and Resulted in Improved OUTCOMES

VOLUME AND OUTCOMES

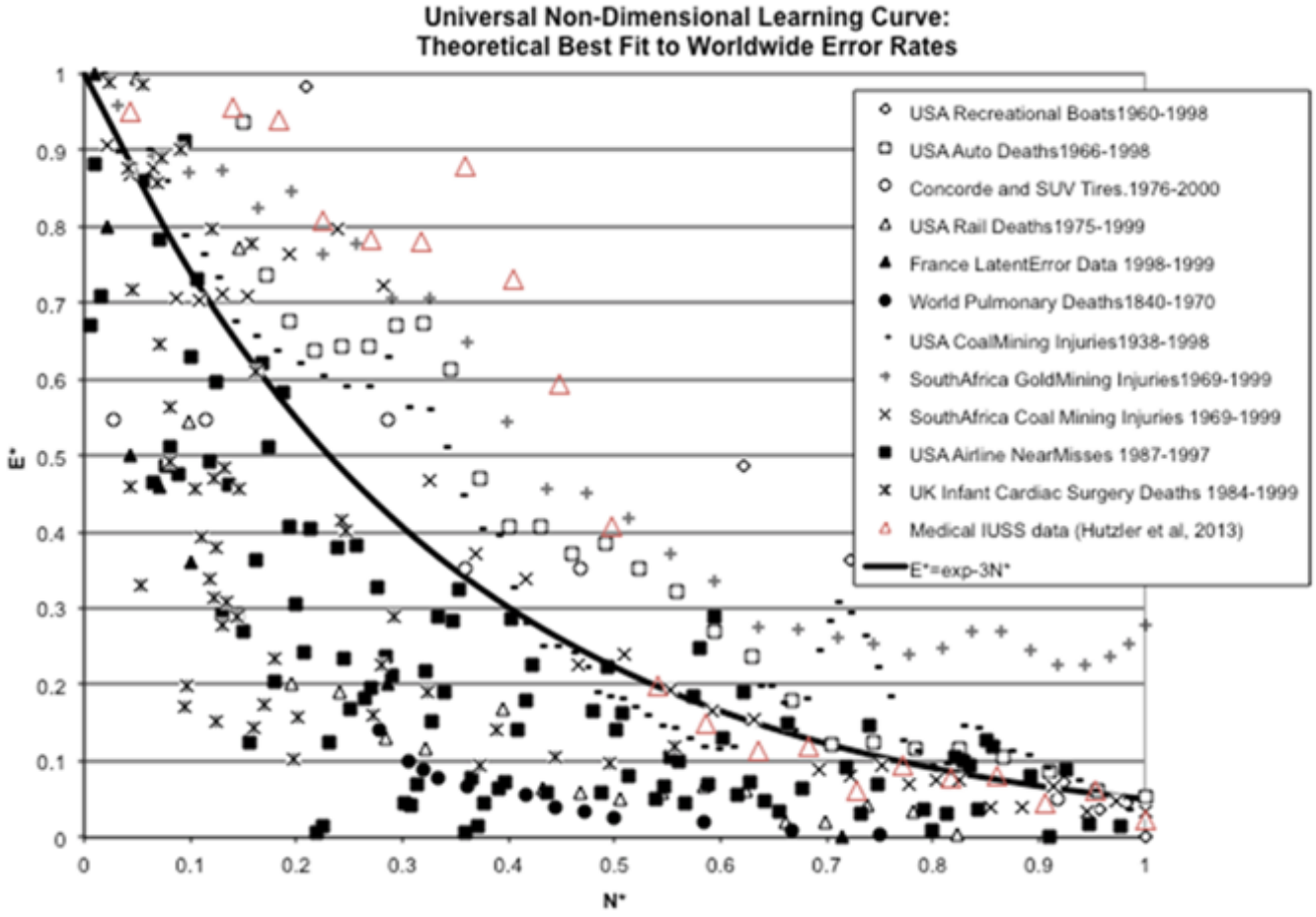
- Higher volume surgeons : decreased dislocation rate THR
- Also have institutional learning curves
- Do Higher volume institutions have improved outcomes?
  - Learning Theory predicts: YES
- What is the evidence

IMPROVED OUTCOMES AT HIGH VOLUME COST CENTERS

Development of expertise is based on volume and rate of errors, and therefore higher volume is conducive to faster learning.

The learning that comes from this accumulation of errors can provide insight into how into how high-volume hospitals learn from experience, enabling the associated improvements seen in quality and outcomes for total joint replacements, and suggests the etiology behind improved orthopaedic outcomes seen in high volume centers.

IMPROVED OUTCOMES AT HIGH VOLUME CENTERS

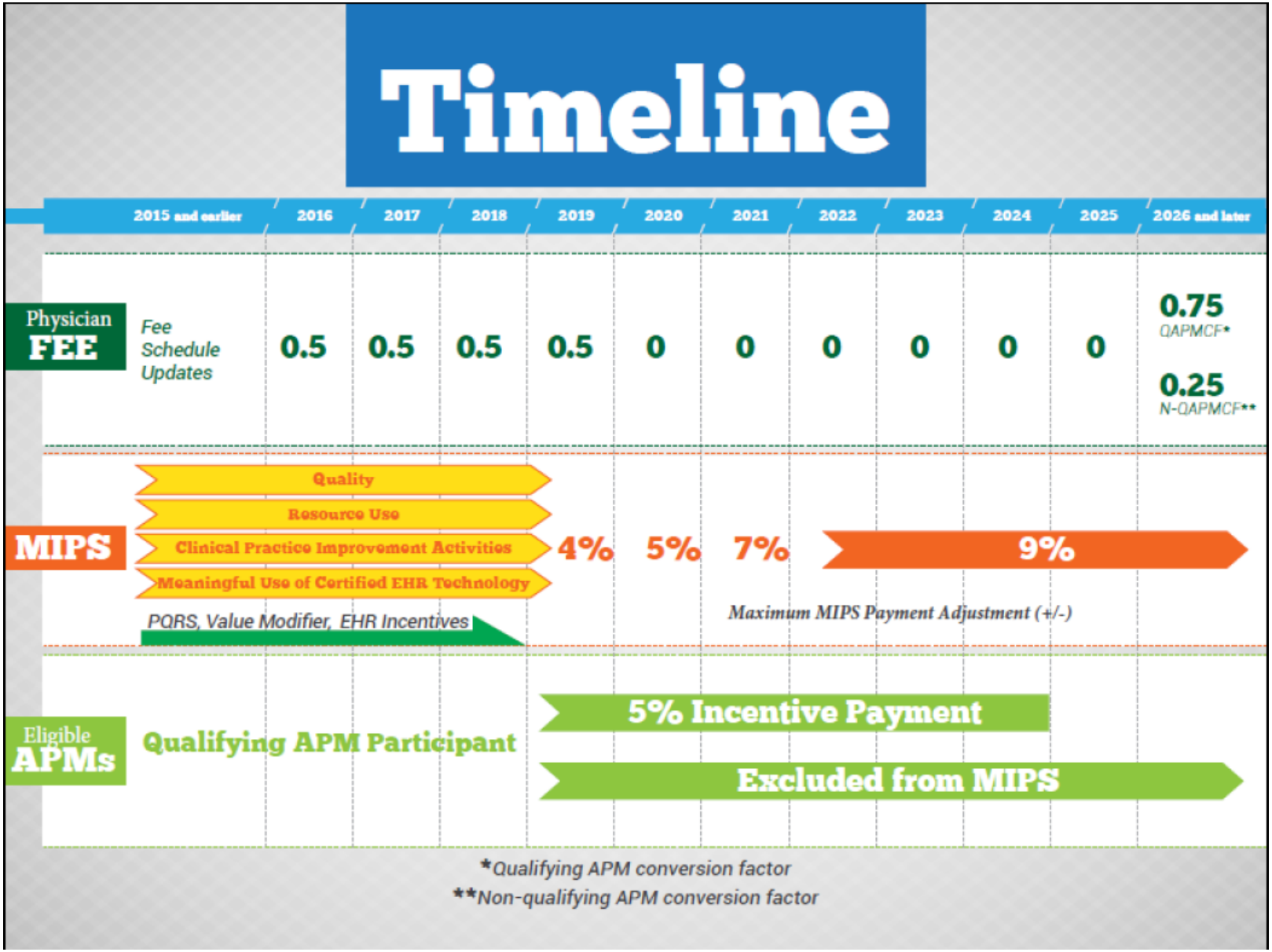


Pillar 4: Identify and Align Stakeholders

- Many different providers affect outcomes and provide care
  - Nursing
  - Therapy
  - Social work
  - Anesthesia
- Align stakeholders with hospital and other providers
  - Gainsharing
    - Encouraged in CJR

Multiple Stakeholders: Interdisciplinary Team

Peri-operative process requires a multilevel interdisciplinary team approach to prepare for surgery


Timeline
2015 and earlier
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026 and later
Physician FEE
Fee Schedule Updates
0.5
0.5
0.5
0.5
0
0
0
0
0
0
0.75
QAPMCF*
0.25
N-QAPMCF**
MIPS
Quality
Resource Use
Clinical Practice Improvement Activities
Meaningful Use of Certified EHR Technology
PQRS, Value Modifier, EHR Incentives
4%
5%
7%
9%
Maximum MIPS Payment Adjustment (+/-)
Eligible APMs
Qualifying APM Participant
5% Incentive Payment
Excluded from MIPS
*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

Alignment

- Essential for success
- All stakeholders
  - Nursing
  - Administration
  - Social Work
  - Supply chain management
  - Post acute care providers
  - Physicians

Gainsharing is Allowed within Limits along with Limited Beneficiary Incentives

- CMS expects that participant hospitals will create financial relationships with other providers (collaborators) to coordinate quality and efficiency goals.
- Currently physician gain sharing is limited to and additional 50% above the surgeon fee currently paid in FFS
- CMS did not address or announce any exceptions or waivers to fraud and abuse laws or regulations and noted all arrangements need to be in writing and payments to collaborators are limited to sharing reconciliation payments and internal cost saving.

Traditional Physician Alignment

- Private Practice
- “Owned” patients
- Financial arrangements to medical industry
- Owned Surgical centers
- Not aligned with hospitals

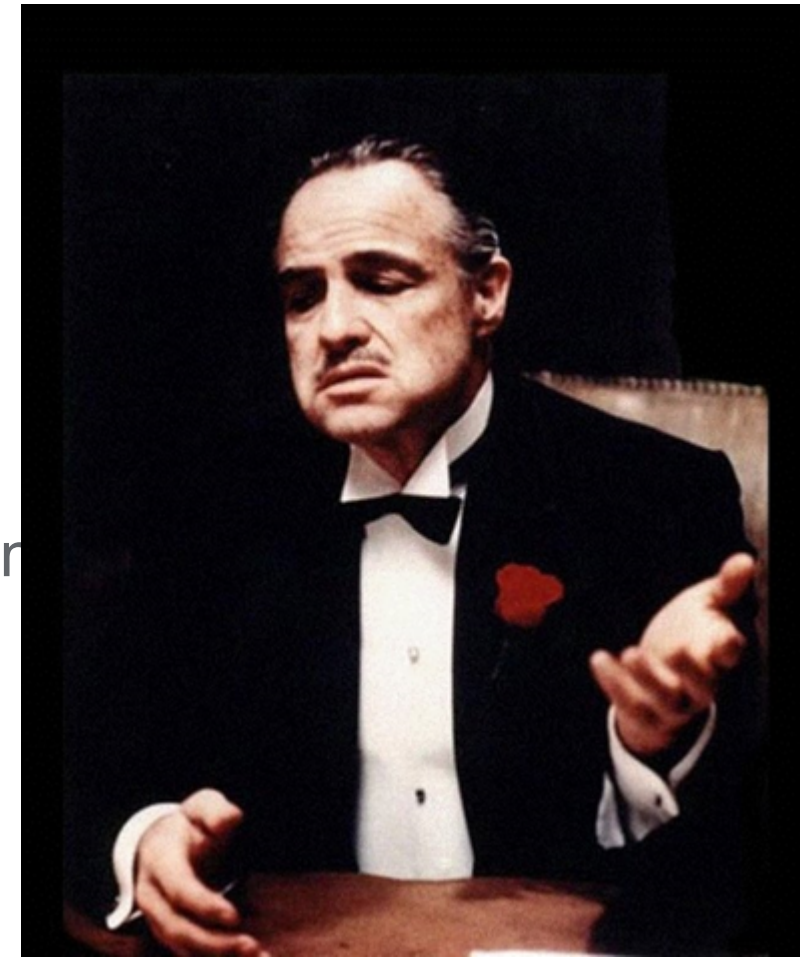
New Alignment Paradigm

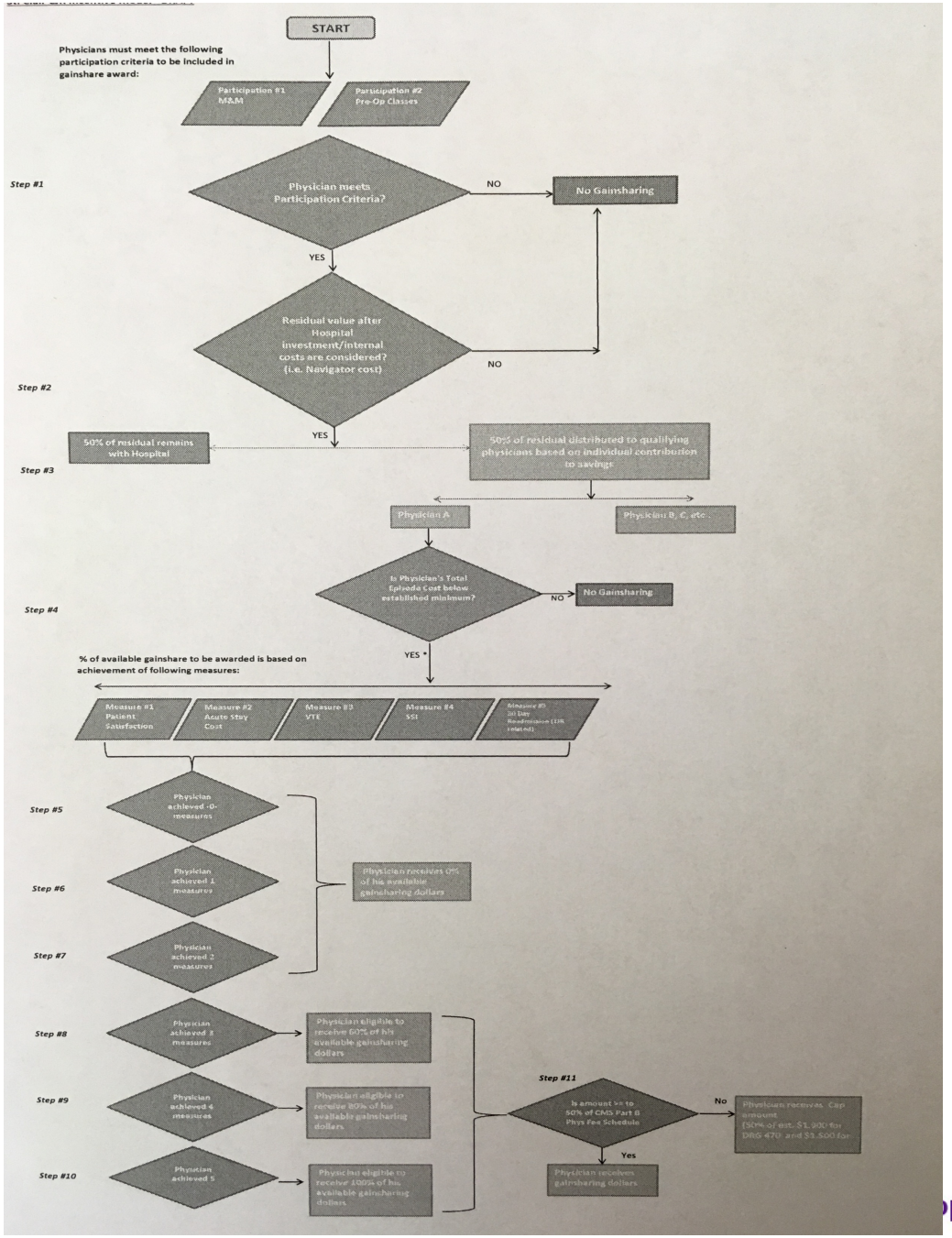
- Millennials
- Educational Debt
- Administrative and compliance burden
- Patients controlled by hospitals
- Grassley Sunshine Act
- DOJ
- Decrease in physician-industry financial arrangements

- **It is what is best for the patient**

Contracting

- Codify alignment
- All stakeholders
- Post acute care providers
- Implant-Supply chain management
- Co-Management Agreemer




START
Physicians must meet the following participation criteria to be included in gainshare award:
Participation #1 M&M
Participation #2 Pre-Op Classes
Step #1
Physician meets Participation Criteria?
NO
No Gainsharing
YES
Residual value after Hospital investment/internal costs are considered? (i.e. Navigator cost)
NO
Step #2
YES
50% of residual remains with Hospital
50% of residual distributed to qualifying physicians based on individual contribution to savings
Step #3
Physician A
Physician B, C, etc.
Is Physician's Total Episode Cost below established minimum?
NO
No Gainsharing
Step #4
YES *
% of available gainshare to be awarded is based on achievement of following measures:
Measure #1 Patient Satisfaction
Measure #2 Acute Stay Cost
Measure #3 VTE
Measure #4 SSI
Measure #5 30 Day Readmission (EIR related)
Step #5
Physician achieved -0- measures
Step #6
Physician achieved 1 measure
Step #7
Physician achieved 2 measures
Physician receives 0% of his available gainsharing dollars
Step #8
Physician achieved 3 measures
Physician eligible to receive 60% of his available gainsharing dollars
Step #9
Physician achieved 4 measures
Physician eligible to receive 80% of his available gainsharing dollars
Step #10
Physician achieved 5
Physician eligible to receive 100% of his available gainsharing dollars
Step #11
Is amount >= to 50% of CMS Part B Phys Fee Schedule
No
Physicians receives Cap amount (50% of est. $1,900 for DRG 470 and $3,500 for
Yes
Physician receives gainsharing dollars

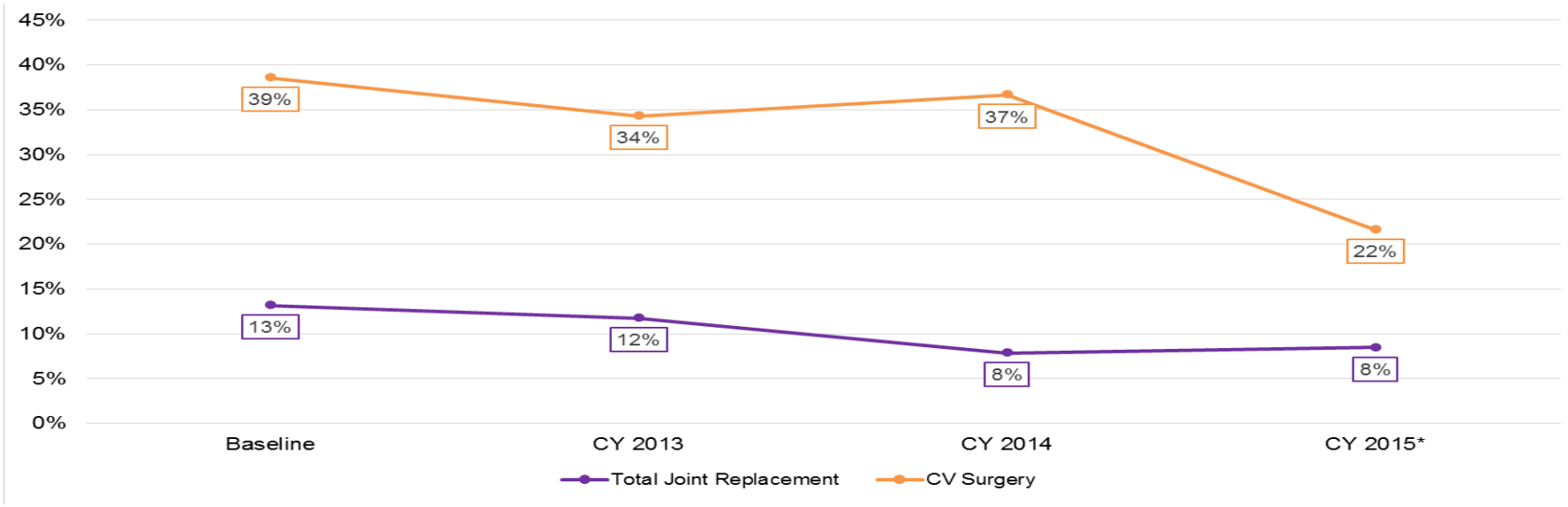
Supply Chain Management (SCM)

- Professionals in logistics and purchasing
- Negotiate pricing
- Implant pricing
- Demand matching
- Reference pricing
- Limit vendors
- All equipment

Pillar 5: Maximize and Demonstrate Quality

- Establish disease or procedure specific quality and outcome metrics
  - Physician specific scores
  - Patient experience
  - Hospital level outcomes
- Minimize complications
  - Readmissions
  - VTEs
  - Surgical site infections
- Identify metrics important to payers
  - Hospital level risk stratified complication rates (RSCR)
    - NQF 1550
- Patient experience
  - HCAHPS
- Patient Reported Outcomes
  - PROs

Readmission Rates
Baseline vs. Performance



*CY 2015 includes incomplete episodes. Not all readmission claims have been processed yet as of February 2016.
Data source: Bundled Payment Medicare claims as of February 2016

Reconciliation

• Reconciliation payments only to hospitals that meet the performance threshold for reporting quality measures and other requirements.

•CMS qualifications for reconciliation payment based on the required three measures:
•The hospital's measure result is at or above the 30th percentile (40th percentile in PYs 4 and 5) of the national hospital measure results calculated for all Hospital Inpatient Quality Reporting program participant hospitals for each of the three measures;
•Failure to achieve the threshold on one or more measures would result in the participant hospital not receiving a reconciliation payment, regardless of whether the actual episode payment was less than the target price for that performance period; and
•For hospitals with insufficient volume to determine performance, CMS will consider that they are performing at the threshold level.

Use of Quality Performance in Setting the Discount Factor

- CMS believes that the CJR Model provides another mechanism to incentivize and reward hospitals that improve care. For this reason, CMS is linking the reporting of three quality measures to eligibility for a reconciliation payment.

- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective THA or TKA, claims-based measure (NQF 1550)
  - 50%
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure
  - 40%
- PROs
  - 10%

Outcomes

- CMS is also proposing to add a voluntary option to track patient-reported outcome measures: the Hospital-level Performance Measure(s) of Patient-Reported Outcomes following THA or TKA (also referred to as THA/TKA patient-reported outcome-based measure or THA/TKA voluntary data).

- For hospitals that submit the voluntary data, CMS will reduce the discount used to set the target price from 2.0 percent to 1.7 percent. The effects of this voluntary reporting payment adjustment would vary depending on the proposed reconciliation payment and repayment policies for that PY.

Pillar 6: Establish a Robust Data Collection and Dissemination Infrastructure

- Accurate
- Transparent
- Actionable
  - Must be as close to real time as possible
  - Do not wait until CMS reconciliation
- Present physician specific
- Institutional specific
- Have infrastructure to operationalize data driven decisions
- Requires organizational commitment

How Does Retrospective Bundling Work?

Claim from hospital triggers a bundle

→

Patient is flagged by CMS

→

***Any* patient having surgery at pilot hospital for one of the MS-DRGs is by default a part of the bundle;**
It is not physician-specific

All providers bill Medicare as normal

→

CMS pays all providers as normal

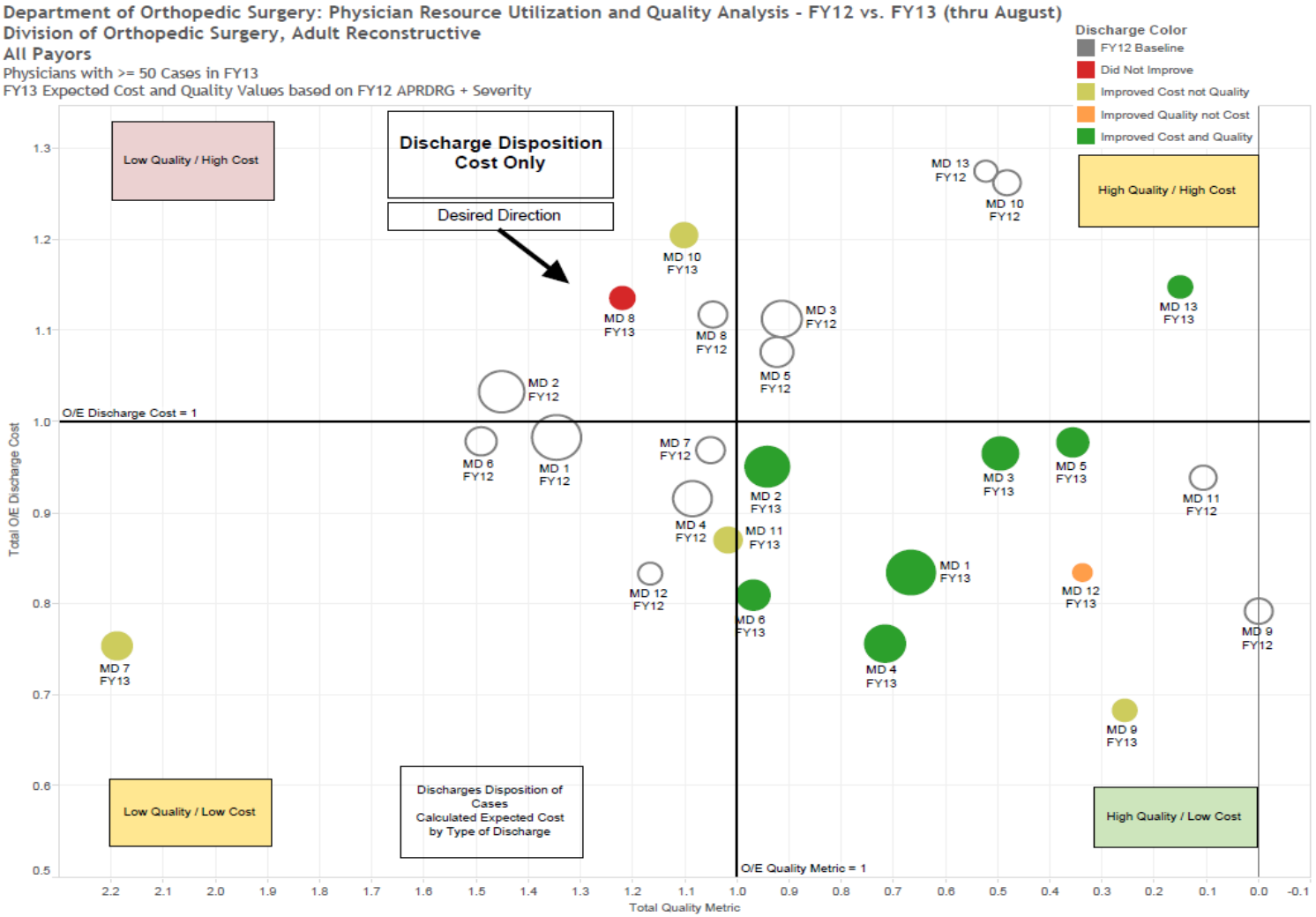
→

Retrospectively the sum of claims is reconciled against the target price

If it is LOWER than the target, the awardee *will receive a check* for the difference

If it is HIGHER than the target, the awardee has to *repay* CMS

PHYSICIAN RESOURCE UTILIZATION AND QUALITY ANALYSIS

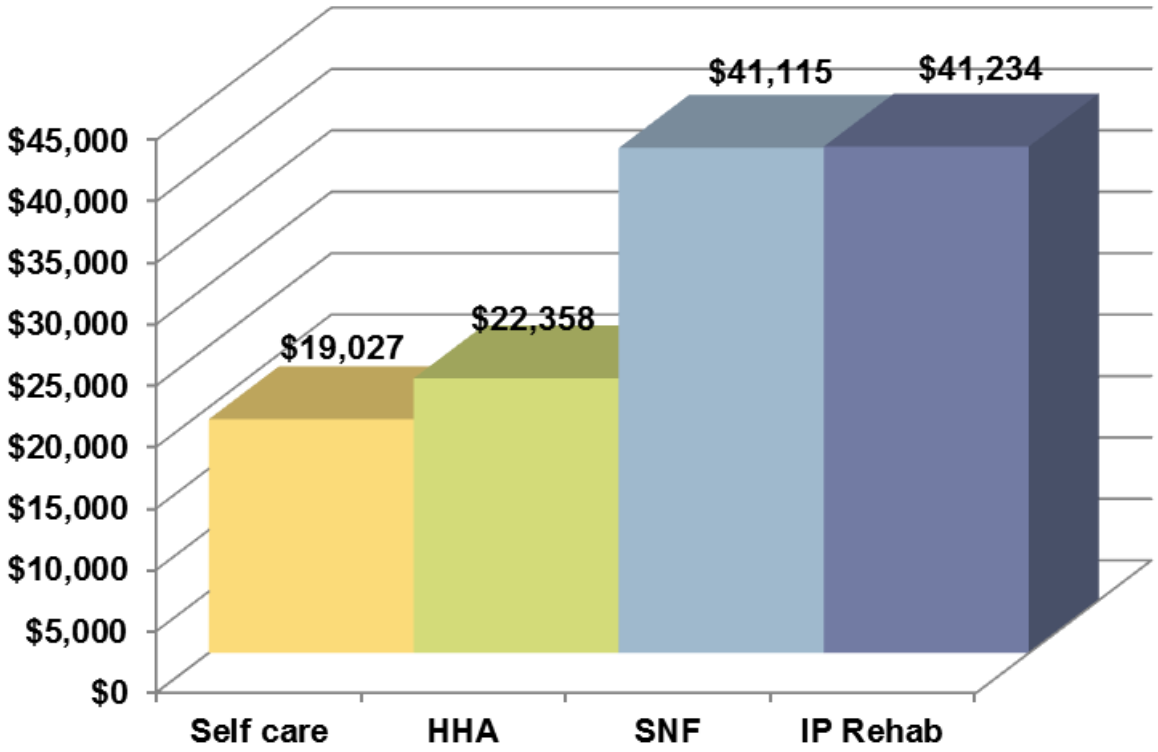


Pillar 7: Control the Post Discharge Care and Costs

- Enhanced post discharge surveillance
- Establish appropriate level of care
  - RAPT risk scores[6]
  - Appropriate post discharge destination
    - Avoid inpatient post discharge care
- Leverage technology to monitor patient progress
  - Web based or phone based programs
    - CHF
    - DM
    - Joint replacement
- Change provider behavior
  - Control post discharge care
- Narrow networks or ownership of Skilled Nursing Facilities
- Utilize visiting nurses

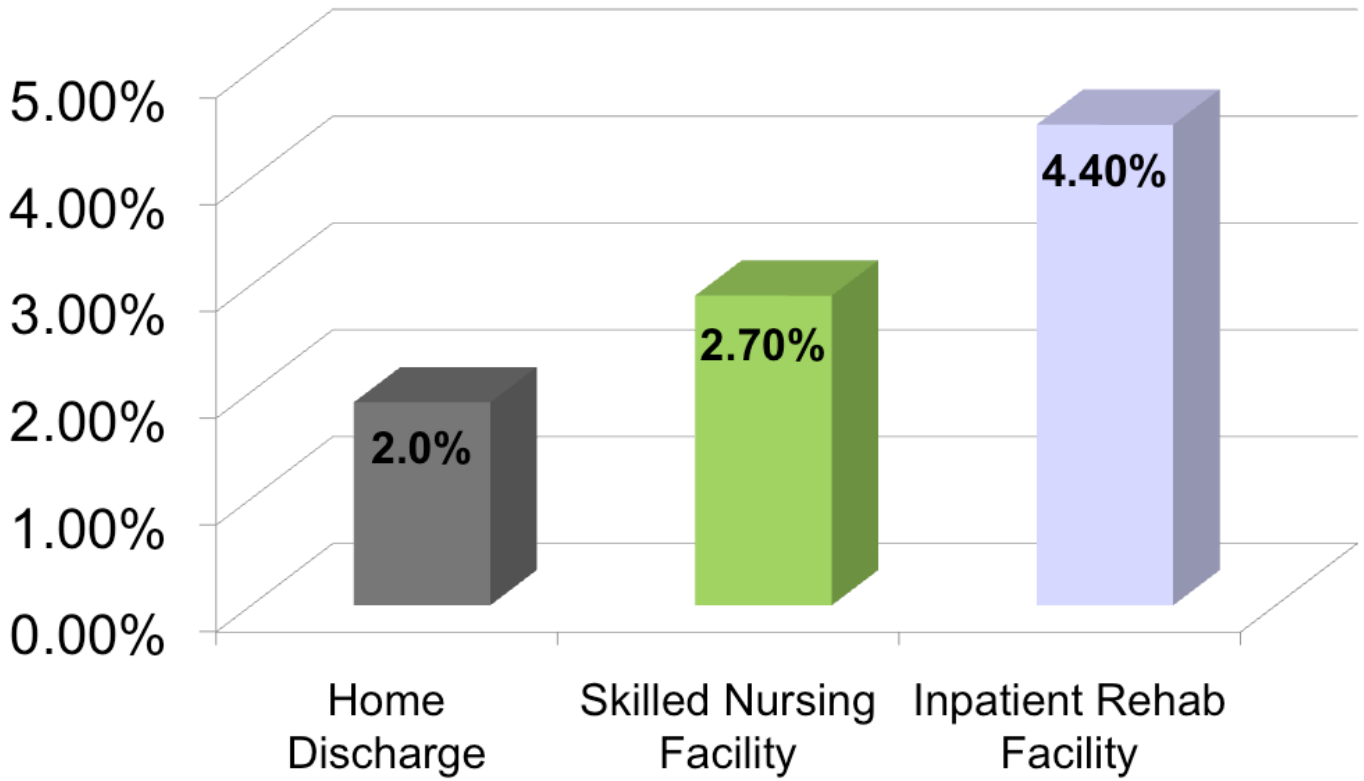
Relative Cost of 90 day Episodes of Care by Post-Acute Setting

3-Yr Baseline Period

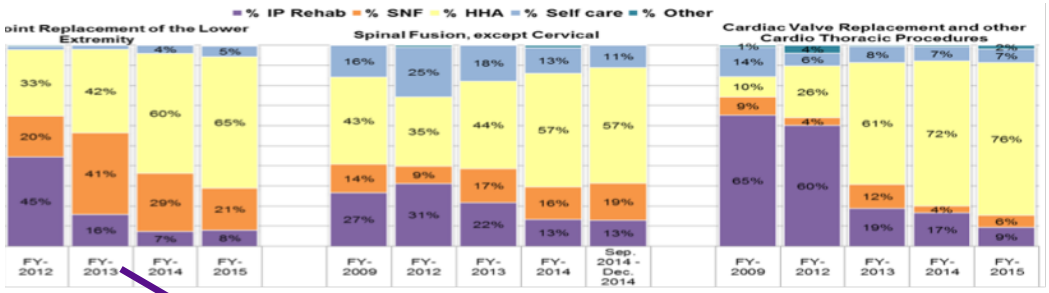


All post-acute Medicare costs incurred within the 90d bundle are categorized by the initial post-acute setting (i.e., includes readmissions and other levels of care following the initial setting)

Readmission Rates by Discharge Disposition



BPCI: Discharge disposition patterns

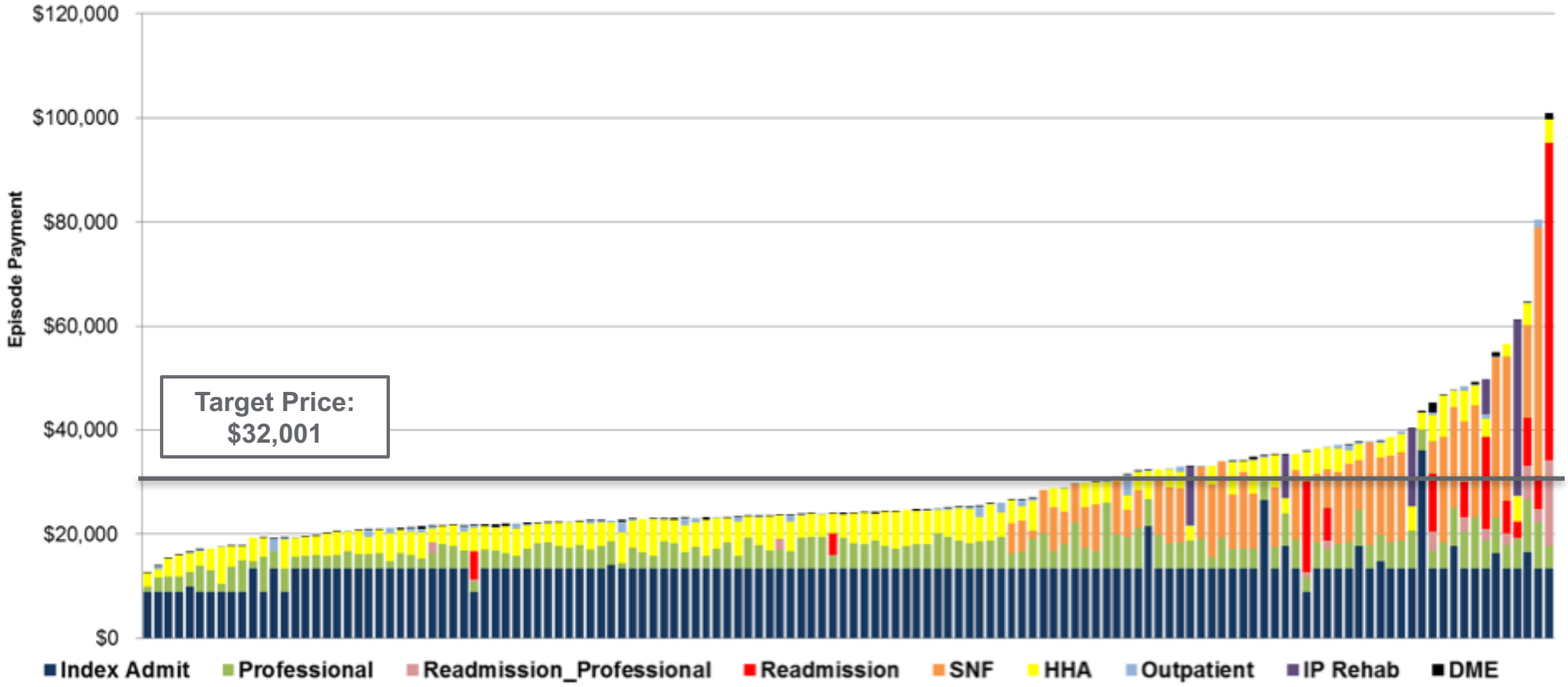


n=	507	680	673	819	869	120	211	167	178	60	187	253	178	253	319
LOS:	5.62	4.27	3.84	3.49	3.20	6.46	4.58	4.67	4.83	4.37	11.81	9.82	9.27	8.70	6.56

Based on NYULMC internal data and Medicare claims data
Fiscal Year: Sept.1 – Aug. 31

Q1 2015 Episode Composition

DRG 470: Primary Joint w/o MCC



National Experience with BPCI Type 2 for LEJR

- Average episode cost decreased from 37K to 32K
- Inpatient portion of episode cost did not change
- All savings were from post discharge costs
- Utilization of Skilled Nursing Facilities (SNFs) decreased 20%

The Seven Pillars: A Review

- 1) **Coordinate Care Throughout Episode**
- 2) **Preoperative identification and modification of patient risk factors**
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Conclusion

- Healthcare delivery and reimbursement is rapidly changing
  - Volume based to Value based
  - MACRA driven
- APM's are the future
  - ACOs
  - PCMHs
  - Bundled Payments
- Care is evolving to Population Health
  - Including Medicaid

- Our experience in APMs and understanding of population health provides us with a competitive advantage

THANK YOU!