Bundled Payment Care Initiative (BPCI) and Comprehensive Care for Joint Replacement (CCJR)

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Sample Clients (540+) and Growing!

Surgical Directions has been the trusted partner in helping over 540 hospitals transform perioperative and anesthesia services.
Healthcare Leaders Role

As healthcare leaders our goal is to improve the value of Perioperative Services
Create a perioperative governing body to align incentives
an Operations Committee for all aspects of Perioperative Services

Surgical Services Executive Committee (SSEC)

- Chaired by Medical Director(s) of Perioperative Services
- Administration-sponsored Surgery Board of Directors
- Controls access and operations of OR
- Sponsors and directs Perioperative team activity
I. Overview of BPCI
II. NYU Langone’s Hospital for Joint Diseases (HJD) Journey and Outcomes from BPCI
   - Clinical Management Pathway
   - Results
III. Risk Factor Modification
IV. Introduction of CCJR
V. Summary Impact
NYU HJD’s BPCI Journey

A World-Class Patient-Centered Integrated Academic Medical Center.
Bundled Payment Care Initiative (BPCI)

- 2011 CMS Payment Project “to improve patient care through payment innovation that fosters improved coordination and quality through a patient-centered approach.”

- CMS structured four models of bundled payments, 3 retrospective and 1 with a prospective payment.

- Medicare and the participating hospital agree on a target payment amount for a defined episode of care, based upon historical fee-for-service payments.

- Gain sharing with practitioners is permitted if savings are realized.
NYU HJD’s BPCI Journey

• NYULMC HJD, a large, tertiary, academic medical center with a hybrid compensation system, implemented a Model 2 bundled payment initiative for Total Joint Replacement in January of 2012.

• The episode of care included the inpatient and post-acute care and all costs through 90 days following discharge.

• The patient does not receive financial incentives. CMS requires quality measure reporting. A provider’s participation may be terminated by CMS if quality decreases or if CMS identifies a significant concern.
One Team, One Vision
90 Day Episode of Care

- Evidence-based
- Rapid mobilization
- Optimized care
- High quality
- High value
- Patient satisfaction
- Reduced LOS
- Standard approach for 90% of patients
# 2009 Medicare Payments - Inpatient Stay and 90 Day Bundle
Primary Joint Replacement (MS-DRGs 469-470)

<table>
<thead>
<tr>
<th>DRG</th>
<th>DRG Description</th>
<th>Avg Medicare Payment¹</th>
<th>Inpatient Only²</th>
<th>90D Bundle³</th>
</tr>
</thead>
<tbody>
<tr>
<td>469</td>
<td>MAJOR JOINT REPLACEMENT W MCC</td>
<td></td>
<td>$16,303</td>
<td>$54,233</td>
</tr>
<tr>
<td>470</td>
<td>MAJOR JOINT REPLACEMENT W/O MCC</td>
<td></td>
<td>$12,446</td>
<td>$35,565</td>
</tr>
</tbody>
</table>

¹Data is based on FY 2009-2012 Medicare claims. CMS will be carrying rates forward to 2013 for the Episodes of Care Initiative.
²Inpatient payment includes patient deductible/coinsurance amounts, and excludes IME, DSH, Capital, and GDME payments.
³90D Bundle includes Medicare readmissions exclusions and Part B services exclusions, updated as of January 9th, 2013
What is Included in the Target Price?

Any services during the 90-Day Post-Acute Period such as...

Days 91-120

CMS will be monitoring the period immediately following to ensure that services are not being shifted outside the bundle.

NYULMC will be financially responsible if such behavior is observed and may be removed from the program.
Implementation

CLINICAL PATHWAYS & WORKFLOW STRATEGIES
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
Goal

Develop a pathway that can be used for 90% of the patients with exclusions determined by pathway criteria, not physician preference
Pre-Hospitalization Workflow

Pre-Admission Testing (PAT) and Medical Clearance (optimization) Assisted by Surgical Directions:

- Evaluation and testing 4 weeks prior to the scheduled procedure
- Anesthesia and medical clearance process aligned to minimize cancellations
- ASA 1 and possibly ASA 2 patients may not require preoperative outside medical clearance other than going through PAT process and being evaluated by anesthesia
- Avoid preoperative urinalysis unless symptomatic
- Routine PT/PTT, INR not necessary unless on anticoagulants or with preexisting liver or bleeding disorders
- Blood Glucose 180 or below
Inpatient Workflow

- Governance – Surgical Services Executive Committee
- Standard order sets
- Epic Dashboard
- Goal-driven rounds lead by NPs
- Improved communication with attendings, residents, fellows, social work, NP’s and CCC’s
- Daily emails if patient falls off of the pathway
- Reinforced expectations regarding LOS and discharge setting
- Expectation is a 2 to 3 day length of stay, if stay is potentially longer, admission is reviewed by care team
- Moving toward a same day/next day pathway for healthy TJA patients. Medicare patients are not yet eligible for same day discharge
Post-Acute Care Workflow

- Expansion of GPS into post-acute period
  - Clinical Care Coordinators follow patients through 90 day period
- Standard pathways with post-acute providers
- Improved communication and data sharing
- Educating for post-acute partners on clinical protocols related to TJA
- Focus on reducing avoidable readmissions/re-hospitalizations
- CCC’s follow patients in rehab and at home to monitor progress
- Only 2 post op visits are scheduled during the 90 day episode.
- Targeted medical follow-up by FGP Intensivists for high risk patients
- Adapted the RAPT tool for predicting the need for post acute inpatient stay and prolonged admission and have developed a POSH/RRAT tool to predict readmission
Episodes of Care Initiative

Ways to Improve Quality and Efficiency:

- Reduce readmissions
- Reduce LOS
- Reduce implant, supply, or drug costs
- Reduce OR time
- Alter discharge patterns to more cost-efficient settings
- Decrease excess utilization (e.g., consults, ancillary tests)
- Set benchmarks and goals through each episode and constantly and consistently measure each phase/episode of care
Results

• 721 patients were available for analysis at the end of year one.

• Average of length of stay was decreased to 3.58 days from 4.27 days (Median LOS 3 days).

• Discharge to inpatient facilities has decreased on average from 63% to 44% on average, and 29% for the last month.

• Readmissions have occurred in 80 of 721 patients, 7% of patients at 30 days, 11% at 60 days and 13% at 90 days which is slightly less than prior to BCPI (17% in 2011, 15% in 2009).

• The hospital has seen significant cost reduction in the inpatient component year over year. We have achieved positive margins vs. CMS target price in the first 2 quarters without accounting for the costs of implementation. We hope to maintain or improve these margins when the at risk period begins. Our per case hospital cost has decreased $7,000 and $6300/case for the bundle.
Results

• DRG 470: Primary TJA of the Lower Extremity w/o MCC,
  17% savings vs. target for Q1 and Q2 reconciliation

• For DRG 469: Primary TJA of the Lower Extremity with MCC,
  8.1% savings vs. target for Q1 and Q2 reconciliation

• Reconciliations continue up to 6 months after the 90 day episode ends, claims continue to be filed against the bundle
Conclusions

• **Decreased** length of stay

• **Decreased** discharges to inpatient facilities

• **Decreased** the cost of the episode of care

• We had *not* significantly altered the readmission rates (15% to 12% at 90 days) until recently
Next Phases

RISK FACTOR MODIFICATION
Preventing Hospital Readmissions

- Often suboptimal outcomes are tied to comorbidities or complications associated with their TJA.

- Preoperative optimization of risk factors for suboptimal outcomes is the best method of prevention.

- The use of an integrated preadmission testing and clearance center utilizing the patient’s internist or a hospital affiliated internist associated with a TJA specific education and comorbidity identification process is critical for medically complicated patients.
Comorbidity Prevalence at NYU HJD

- Musculoskeletal comorbidities 73.8%
- Hypertension 60.1%
- Hyperlipidemia 55.3%
- Tobacco use 22.0%
- Diabetes 19.2%
- Depressive disorders 14.5%
- Ischemic Heart Disease 13.5%
- Morbid Obesity 13.8%
- Dysrhythmias 10.8%
- Valve disease 7.8%
- Cerebrovascular Disease 4.4%
- CHF 2.8%
Modifying Risk Factors

- **Peri-operative Orthopaedic Surgical Home (POSH) model** that allows for risk stratification of TJA candidates and clinical treatment to mitigate modifiable risk factors in high-risk patients.
Modifiable Risk Factors

- Infection measures (hard stop if colonized, nasal screening and povidone and chlorhexidene wipes, weight based vancomycin dosing, and betadine washes/vanco powder)
- Thrombo-phyllic screening programs for high risk VTED patients
- 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 (KAST)
- Drug and alcohol interventions
- Fall education prevention
- Physical deconditioning physical therapy interventions
- Diabetes control (hard stop at 180) and nutritional interventions
The Ethics of Risk Stratification and Modification for TJA

Old Health Care Paradigm defined by *volume incentives*

New Health Care Paradigm defined by *value equation*
The Ethics of Risk Stratification

• Orthopaedic surgeons routinely perform TJR on patients that have one or more of these risk factors.

• However, this is elective surgery, and some of these risk factors are modifiable prior to surgery.

• We argue that patients should be expected to take a more active role in decreasing the risks for complication prior to elective total joint replacement surgery.
# Preventing Readmissions: The Role of the Internist

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Points on Risk Stratification Scale</th>
</tr>
</thead>
</table>
| **Infection risk factors:** *Staphylococcus Aureus colonization*  
  Every patient is screened  
  If positive for staphylococcus colonization:  
  - Nasal mupirocin or poisons-iodine, chlorhexidine gluconate (CHG) wipes, and appropriate antibiotic coverage  
  - If these requirements are not met then **Hard Stop** until protocol implemented | Hard Stop |
| **Smoking (Tobacco use)**  
  All tobacco users will be enrolled in tobacco cessation program 4 to 8 weeks prior to surgery | 1 |
| **Obesity**  
  BMI greater than 40:  
  - Enroll in nutritional counseling program  
  - Long-term weight loss program, and  
  - Undergo bariatric consult  
  BMI 35-40:  
  - Patients will be enrolled in nutritional counseling with consideration of acute weight loss program  
  BMI 30-35:  
  - Enroll in nutritional counseling program | Hard Stop |
| **Cardiovascular Disease**  
  Patient has history of coronary artery disease (CAD), stroke, peripheral vascular disease or VTED, age ≥60 years and 2 cardiac risk factors:  
  - Renal insufficiency (GFR < 60ml/min); Diabetes; chronic obstructive pulmonary disease; Hypertension; Recent smoker (<30 days); Cancer; Heart failure  
  - All qualifying patients will be enrolled in OPTIMIZE-OS perioperatively | 1 |
| **Venous Thromboembolic Disease**  
  History of pulmonary embolus or deep venous thrombosis:  
  - Consider inferior vena cava (IVC) filter or aggressive VTED management  
  Has VTED risk factors: CVA, COPD, BMI >30, CAD, stroke, PVD, activated protein C resistance | 2 |
| **Neurocognitive, psychological and behavioral problems (including alcohol and drug dependency)**  
  Alcohol abuse or chronic active narcotic dependency  
  Neurocognitive deficits such as traumatic brain injury (TBI), active psychiatric illness, dementia etc.  
  Score of 7 or more on catastrophizing, PHQ-9 | 1 |
| **Physical Deconditioning**  
  Nonambulatory or needs assistance with transfers status  
  Comorbidities affecting physical function and ambulation | 2 |
| **Diabetes**  
  Fasting blood glucose ≥180  
  - Must be corrected prior to surgery, consider referral to diabetic management clinic (endocrinologist)  
  High A1c > 8  
  - Referred to diabetic management clinic (endocrinologist)  
  Well controlled DM | Hard Stop |

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NYU Langone Medical Center

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<table>
<thead>
<tr>
<th>POSH</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted (A)</td>
<td>21</td>
<td>36</td>
<td>37</td>
<td>45</td>
<td>49</td>
<td>43</td>
<td>24</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>None (B)</td>
<td>89</td>
<td>95</td>
<td>39</td>
<td>31</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ratio = A/B</td>
<td>0.24</td>
<td>0.38</td>
<td>0.95</td>
<td>1.45</td>
<td>4.08</td>
<td>14.33</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>OR (Linear)</td>
<td>0.19</td>
<td>0.41</td>
<td>0.89</td>
<td>1.94</td>
<td>4.21</td>
<td>9.14</td>
<td>19.86</td>
<td>43.12</td>
<td>93.64</td>
</tr>
<tr>
<td>OR (Non-Linear)</td>
<td>0.24</td>
<td>0.38</td>
<td>0.95</td>
<td>1.45</td>
<td>4.08</td>
<td>14.33</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>OR (Linear, Age)</td>
<td>0.18</td>
<td>0.40</td>
<td>0.90</td>
<td>1.91</td>
<td>4.56</td>
<td>10.23</td>
<td>20.20</td>
<td>44.68</td>
<td>104.24</td>
</tr>
<tr>
<td>OR (NL, Age)</td>
<td>0.23</td>
<td>0.37</td>
<td>0.95</td>
<td>1.48</td>
<td>4.26</td>
<td>15.21</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
ALOS and 90 Day Readmission Rates

**Average Length of Stay**

- Q3 2009 - Q2 2010: 5.31
- Q3 2010 - Q2 2011: 4.60
- Q3 2011 - Q2 2012: 4.43
- CY 2013: 3.53
- Q1 2014: 3.12

**90D Readmission Rate**

- Q3 2009 - Q2 2010: 10%
- Q3 2010 - Q2 2011: 15%
- Q3 2011 - Q1 2012: 14%
- CY 2013: 12%
- Q1 2014: 6%
Bundled Payment Initiative - 2014
CCJR

COMPREHENSIVE CARE FOR JOINT REPLACEMENT
CMS proposes to require all hospitals paid under the IPPS and physically located in selected geographic areas (75 Metropolitan Statistical Areas) to participate in the CCJR Model, with limited exceptions.

Eligible beneficiaries who receive care at these hospitals would automatically be included in the model. CMS proposes to test the CCJR Model for 5 years.

CMS estimates that the CCJR Model will cover about 25 percent of all lower extremity joint replacement procedures nationally. According to CMS, the model will involve about $2.261 billion in episode spending in the first year (2016), rising to $2.713 billion in episode spending in 2020.

CMS is responsible for 434,000 TJA annually (2014).
CMS expects that the proposed CCJR Model will result in savings to Medicare of $153 million over the 5 years.

CMS calculates the savings as follows:

- In PY 1, CMS estimates a Medicare cost of approximately $23 million, as hospitals will not be subject to downside risk the first year.
- In PY 2, CMS estimates Medicare savings of approximately $29 million.
- In PY 3, CMS estimates savings of $43 million.
- In PYs 4 and 5, CMS proposes to move from target episode pricing that is based on a hospital’s experience to target pricing based on regional experience, so CMS projects savings will increase to $50 million and $53 million, respectively.
### TABLE 4: DISTRIBUTION OF HOSPITAL CLAIMS FOR PROCEDURE CODES MAPPING TO MS-DRGS 469 AND 470

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>81.54</td>
<td>Total knee replacement</td>
<td>57%</td>
<td>58%</td>
<td>58%</td>
<td>58%</td>
</tr>
<tr>
<td>81.51</td>
<td>Total hip replacement</td>
<td>30%</td>
<td>29%</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>81.52</td>
<td>Partial hip replacement</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>81.56</td>
<td>Total ankle replacement</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>00.85</td>
<td>Resurfacing hip, total, acetabulum and femoral head</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>00.86</td>
<td>Resurfacing hip, partial, femoral head</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>00.87</td>
<td>Resurfacing hip, partial, acetabulum</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>84.27</td>
<td>Lower leg or ankle reattachment</td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>84.28</td>
<td>Thigh reattachment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: percentages or claim counts with "N/A" had no claims. percentages of 0% represent less than 0.5% of total claims.
Gainsharing Allowed within Limits

- 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.
# TABLE 5: COST AND LENGTH OF STAY STATISTICS FOR MS-DRG 470 FOR VARIOUS EPISODE DURATIONS

<table>
<thead>
<tr>
<th>Statistics for DRG 470 (2006 data)</th>
<th>30-day episode</th>
<th>60-day episode</th>
<th>90-day episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Medicare spending per hospital discharge (acute+PAC+physician)</td>
<td>$18,838</td>
<td>$20,343</td>
<td>$21,125</td>
</tr>
<tr>
<td>Mean payment for anchor hospitalization</td>
<td>$10,463</td>
<td>$10,463</td>
<td>$10,463</td>
</tr>
<tr>
<td>Mean payment for PAC</td>
<td>$6,835</td>
<td>$8,339</td>
<td>$9,122</td>
</tr>
<tr>
<td>Mean payment for physicians (during anchor hospitalization)</td>
<td>$1,540</td>
<td>$1,540</td>
<td>$1,540</td>
</tr>
<tr>
<td>Mean payment for readmission (includes all PAC users, even if no readmission occurs during the episode)</td>
<td>$550</td>
<td>$929</td>
<td>$1,242</td>
</tr>
<tr>
<td>Mean length of stay (LOS) for PAC</td>
<td>25.5 days</td>
<td>39.6 days</td>
<td>47.3 days</td>
</tr>
</tbody>
</table>

Note: Data are per PAC user (88% of beneficiaries hospitalized under MS-DRG 470 are discharged to PAC). PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization. Mean LOS for PAC does not include any gap between hospital discharge date and start of PAC.
Alignment

- CMS proposes to use the CCJR episode payment model to incentivize hospitals to work with other health care providers to improve quality of care for Medicare beneficiaries undergoing LEJR procedures while also enhancing efficiency.

- CMS proposes to apply this incentive by paying participant hospitals or holding them responsible for repaying Medicare based on their CCJR episode quality and Medicare expenditure performance.

- Cost savings are not enough, quality must be maintained or increased
### Regional historical average CCJR payments

<table>
<thead>
<tr>
<th>Region</th>
<th>Regional historical average CCJR payments for MS-DRG 469 anchored CCJR episodes</th>
<th>Regional historical average CCJR payments for MS-DRG 470 anchored CCJR episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>$47,928</td>
<td>$24,858</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>$52,028</td>
<td>$27,406</td>
</tr>
<tr>
<td>East North Central</td>
<td>$50,954</td>
<td>$25,480</td>
</tr>
<tr>
<td>West North Central</td>
<td>$46,189</td>
<td>$23,800</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$51,239</td>
<td>$25,989</td>
</tr>
<tr>
<td>East South Central</td>
<td>$50,328</td>
<td>$26,345</td>
</tr>
<tr>
<td>West South Central</td>
<td>$55,448</td>
<td>$27,464</td>
</tr>
<tr>
<td>Mountain</td>
<td>$47,925</td>
<td>$23,734</td>
</tr>
<tr>
<td>Pacific</td>
<td>$48,874</td>
<td>$23,425</td>
</tr>
</tbody>
</table>
CMS recognizes that hospitals may have limited ability to moderate spending for certain high cost cases. Therefore in setting target prices for both MS-DRGs, CMS proposes to set a high outlier limit at two standard deviations above the regional average episode cost. Individual episode costs that exceed the high outlier limit would be truncated to that limit so hospitals’ downside risk would be limited.

CMS does not propose to set target prices based solely on historical hospital-specific data but rather intends to use a blend of historical hospital-specific and regional-historical claim data. CMS proposes to transition to using regional only data to set targets by PY 5. CMS asserts this approach will afford early and continuing incentives for both efficient and less efficient hospitals to furnish high quality, efficient care in all years of the model.
Medicare Discount Factor

- CMS intends to apply a 2 percent discount factor when setting an episode target price for a participant hospital to allow Medicare to partake in some of the savings from the CCJR Model while leaving what CMS characterizes as considerable opportunity for hospitals to achieve savings below the target price.

- If hospitals provide quality numbers and PRO measures, this can be reduced to 1.7%
Quality Performance as Discount Factor

• CMS notes improvement in the quality of care associated with total joint procedures beginning with implementation of the Hospital Acquired Conditions Reduction Program in 2012, but states there is still room for additional improvement.

• CMS believes that the CCJR 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.
The Ethics of Risk Stratification and Modification for TJA

- Hospital-level 30-day, all cause Risk-Standardized Readmission Rate (RSRR) following elective primary THA or TKA, claims-based measure
- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective THA or TKA, claims-based measure
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure

The HCAHPS Survey is a CMS survey and a national, standardized publicly reported survey of patients’ experience of hospital care. It involves 32 questions related to the patients’ hospital experience. The core of the survey contains 21 items that ask “how often or whether patients experienced a critical aspect of care. Other survey measures are summarized to describe how well doctors and nurses communicate with patients, how well staff help patients manage pain, etc.
CCJR Reconciliation

• CMS proposes to make reconciliation payments only to those CCJR 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.
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. In Table 7, CMS summarizes the data for PYs 3 through 5 where the hospitals have full repayment responsibility.
In addition, to limit a hospital’s overall repayment responsibility, CMS is proposing repayment limits referred to as “stop-loss limits.
Per CMS the IPPS price for the hospital makes up approximately 50 percent of the episode target price.

<table>
<thead>
<tr>
<th>Year</th>
<th>No repayment required</th>
<th>No more than 10% of the hospital’s target price for the DRG multiplied by the number of the hospital’s CCJR episodes</th>
<th>No more than 20% of the hospital's target price for the DRG multiplied by the number of the hospital’s CCJR episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>No repayment required</td>
<td>No more than 10% of the hospital’s target price for the DRG multiplied by the number of the hospital’s CCJR episodes</td>
<td>No more than 20% of the hospital's target price for the DRG multiplied by the number of the hospital’s CCJR episodes</td>
</tr>
<tr>
<td>Year 2</td>
<td>No more than 10% of the hospital’s target price for the DRG multiplied by the number of the hospital’s CCJR episodes</td>
<td>No more than 20% of the hospital's target price for the DRG multiplied by the number of the hospital’s CCJR episodes</td>
<td></td>
</tr>
</tbody>
</table>
Maximum Gains Limited to 20% of the Target- Cap on Reconciliation Payments

- CMS asserts it would be reasonable to cap a hospital’s reconciliation payment to safeguard Medicare dollars.

- Thus, for all five PYs CMS is proposing to limit reconciliation payment to 20 percent of the hospital’s target prices for each MS-DRG multiplied by the number of the hospital’s episodes for that MS-DRG.

- CMS refers to this as the stop-gain limit.
Summary

• The ethics of risk factor modification are justified and necessary

• Optimizing patient risk is critical to surviving in a bundled environment

• In today’s bundled payment and quality driven environment, it is no longer economically feasible to simply accept increased risk in poorly managed patients. We have chosen to take an active role in managing modifiable risk factors and will delay surgery until these risk factors are controlled

• Care management coordination, alignment of surgeons and hospitals, control of hospital costs, avoiding post acute in patient care, minimizing complications and readmissions are the keys to success in the value based care expected in a bundled payment episode
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