Creation of “Value”
The CJR: Bundled Care in Arthroplasty

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Extended Disclosure

- TEP for CMS/Yale-CORE measure team for risk adjusted hospital cost of TJR for use within Hospital Compare
- TEP for CMS Resource Utilization Measure
- TEP for CMS/Acumen Physician Compare
- Standing Surgical Committee for the National Quality Forum
- MEDCAC
- Chair of the AAHKS EBM Committee
“A profound and powerful critique of America’s health-care system.” — The Economist

Michael E. Porter
Elizabeth Olmsted Teisberg

Redefining Health Care
Creating Value-Based Competition on Results

HARVARD BUSINESS REVIEW PRESS
Affordable Care Act

- Signed March 23, 2010
- Contained the creation of The Center for Medicare and Medicaid Innovation (CMMI)
- $10 billion/10 years
- Authorized to test models to lower costs and improve outcomes
- Donald Berwick referred to it as the "jewel in the crown of health care reform"
Acronym Soup

- PQRS, P4P, MACRA, MIPS
- APM/AAPM/QP/CMMI/CJR
- VBP/HAC/HAI/PSI
- QRUR/RUM
- Commercial Public Reporting
- CMS HospitalCompare/PhysicianCompare
- Local and National Registries/QCDR
- Profiling/Reference Pricing
- Global Payment (Bundles)
Why the Focus on TJA?

- When combined, THA and TKA the largest procedural cost for CMS
- Elective surgery
- Known variability in costs and outcomes
VBP

- Value-based purchasing: 1% in 2010, 2% in 2012
- 30-day readmissions: 1% in 2011, 2% in 2012, 3% in 2014
- Hospital-acquired conditions: 1% in 2012

Total: 2% in 2010, 3% in 2012, 5% in 2014, 6% in 2016

AAOS ICI #63
CMS Measures

- NQF 1550 (complications)
  - Used in VBP, CJR and being promoted for the HCPLAN

- NQF 1551 (readmissions)
  - Used in Readmission Reduction Program

- Episode of cost measure (final IPPS rule 2016 without NQF endorsement)

- HCAHPs (Press Gainey)
VBP

- Risk of payment penalty leveraged across ALL CMS reimbursement
- TJA contributes to 30 day readmission penalty with losses up to 3%
- TJA contributes to the complication portion of the VBP as well the HAI component of the HAC for between 1%-2%
VBP

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Figure 2. Distribution of Hospital-Specific Risk-Standardized Complication Rates (2008-2010 Cohort; N=3497 Hospitals) - Hierarchical Logistic Regression Model

Figure 2 – Distribution of hospital 30-Day TJA/TKA RSRRs between July 2009 and June 2012. N=1,992 hospitals
Validity and Risk Adjustment

- ICC of 45% (fair)
- C Statistic of 0.65 (poor)
- Validity (of NQF 1550) at best 10% error rate using administrative data
IPPS 2016
Episodic Cost of TJA

- All hospitals
- Even the bundled
- Measure 90 day costs
- Risk adjusted
- Exceptions
- For use in VBP

42 CFR Part 412
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals; Final Rule
Bundled Payment

Figure 1. Comparing Episode Costs
Average episode costs for total knee replacement for Medicare and commercially insured patients.

- Medicare: $10,058
- Medicare (average professional): $10,870
- Medicare (average stay): $1,683
- Commercial: $6,568
- Commercial (average professional): $17,292
- Commercial (average stay): $2,012
Global Payment

Bundled Payment

- Discount from expected total
- Reward for reduction of the unexpected
- Insurance/actuarial risk
- Potentially avoidable complications (PAC)
- Can be 30 days pre, IP stay, 90 days post
- Can be all parties
BPCI

- Bundled Payments for Care Improvement
- Multiple procedures/conditions
- Most in TJA used the Model two retrospective 90 day target/reward model
- No loss of quality with reduction in expenditures
Alternative Payment Models

- Sylvia Burwell announced 1/26/2015 that 30% of CMS spending by the end of 2016 would be through alternative payment models and that by 2018 the number would be 50%.

- APM’s include bundles and ACO’s
Comprehensive Care for Joint Replacement

Rule Proposal July of 2015 to start in 2016

Allegheny and six surrounding counties

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services
42 CFR Part 510
CMS-5516-P
RIN 0938-AS64
Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Proposed rule.
SUMMARY: This proposed rule proposes to implement a new Medicare Part A and B payment model under section 1115A of the Social Security Act, called the Comprehensive Care for Joint Replacement (CCJR) model
Other PA MSA’s

- Harrisburg-Carlisle
- Those parts of MSA 35620 that are in the NY-NJ-PA MSA
- Reading
CMS Bundle

- Target Price is average cost over three years minus 3% (for first three years) but actually close to 10%-18%
- Under, reward (up to a 10% cap)
- Over, penalty (with stop-loss)
- No penalty first year
- Target includes regional partially 1st - 3rd year and only regional years 4 and 5
Quality Measures

- NQF 1550 (total joint complications)
- HCAHPS
- Capturing or patient reported outcomes a performance measure for process
- No relief from 3% risk from readmissions and up to 2% risk for complications
- No reward if not in top 70th percentile for all three years 1-3, and 60th percentile 4-5.
PROM

- Incentives for collection of patient reported outcomes measures (to be finalized)
- 3% set point reduced to 1.7%
- Need 50% of patients to report
- Again, cannot gain this if not in the top percentiles of complications and readmissions
PROMS

- 8/31 meeting of AAHKS, AAOS, Hip and Knee Society, AJRR, Yale-CORE, CMS, Insurers
- Agreement on HOOS-JR/KOOS-JR
- Agreement on either PROMIS Global or VR-12
- Limited risk factors not captured in EMR
Risk from Bundle

- The hospital is the convener
- Language for being able to share the risk and rewards not clear
- Could be surgeons, consultants, SNF’s, therapists, and even the patient
- Full disclosure legislated
- Patient can be incentivized
Not Unprepared

- Prosthetic cost standardization
- Pathway group and resultant order sets
- Experience with shared saving program
- Preliminary work on registry
- Readmission and complication efforts in place
- Vertical integration with SNF’s and rehab
UPMC Response

- Finance, Wolfe Center, Hospitals, CMI, UPP, CRS, Health Plan, Supply
- Master Committee (Since 13 months ago)
  - Pre-op Committee
  - Inpatient (Pathway)
  - Post-Acute
  - Contracting
  - PROM
- Health Plan Mirroring the CJR
Opportunities

- Post-acute care
- Reduction of complications
- Reduction of readmissions
- Reversible risk reduction
- Prehabilitation
- Preop classes
- Reduction of readmissions
New Rules Added July 2016

- New cardiac bundles
- Operative treatment of hip fractures
- Required bundles eligible for advanced APM status, with qualified provider (QP) status and exclusion of VBP
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
The concept of value based reform assumes competition in a zero sum or decreasing sum environment.

It assumes moving benchmarks from competition.

To reach a higher percentile ranking, when risk adjustment is poor or absent, providers will turn to risk shedding (PC for cherry-picking).
\[ V = \frac{Q}{C} \]
"Healthy"

\[ \uparrow\uparrow V_h = \uparrow O_h / \downarrow C_h \]

"Sick"

\[ \downarrow\downarrow V_s = \downarrow O_s / \uparrow C_s \]

The Payers decide on the tools to measure value and usually in the aggregate; the patients have no voice in the assignation of value for their unique circumstances.
Treating a person as being part of a class and not as an individual is the definition of discrimination.

"Healthy people don't need a doctor, but sick people do."
Mark 2:17 (CEB)
Bending the Curve Ain’t Free

- The assumption of inefficiencies has flaws
- Physicians and hospitals will act rationally
- Volume gets squeezed at the higher risk margins
- Hiding behind “rules” is easier/safer than variable unique assessments
- Condition classes are at risk for being left behind
Control the Data/Perfect the Input

- Appropriate coding
- Get all potential risk adjustment co-morbidities into the notes and the record
- Prosthetic coding
- Registry with analytics
- Realize your local trends
Future

- Expect more bundles
- Bill to delay CJR not likely to pass
  - CBO asking for $4 billion offset
- CMMI subject of Congressional hearings
  - More in response to hospital drug payments
- Pressure on CMS to use risk adjustment already in use through the TJA Cost measure
Future

- Health Care Payment and Learning and Learning Action Network (HCPLAN)
- CMS/CMMI sponsored
- Blueprints for bundled payments that would apply to private sector and Medicare Advantage
- Keeps performance measures, admits need for risk adjustment
Thanks