Preparing for CCJR

Lessons from a Bundled Payment for Care Improvement (BPCI) Pilot Program

AHA Long-Term Care and Rehab Section

William H Restum, Ph.D

- Detroit Medical Center (DMC) – Pioneer ACO
- CEO and President – Rehab Institute of Mich
- System Executive, Ambulatory Services – DMC
- Professional Hx – Post – Acute Rehab Services
- PAC management HH, Outpatient Rehab
- Model 2 BPCI Award – DMC – DRG 469/470
- JUMP = Joint Utilization Management Program

Arnie Cisneros PT

- 30+ year Post-Acute Provider (Hosp, SNF, HH)
- 30+ year Home Health rehab clinician
- Home Health Strategic Management (2004)
- Hospital-2-Home Strategic Management (2014)
- Pioneer ACO (x3) – Post – Acute Strategist
- Model 2 BPCI Award – DMC – DRG 469/470
- JUMP = Joint Utilization Management Program

Comprehensive Care for Joint Replacements (CCJR)

Comprehensive Care for Joint Replacements

The CCJR model tests bundled payments for lower extremity joint replacements (MS DRG 469/470) across a broad cross-section of hospitals. The goals: better care through increased coordination, healthier patients by connecting hospitals and PAC Providers, & smarter spending by holding hospitals accountable for ALL episode costs.

ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations

An ACO is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

CARE TRANSITIONS MANAGEMENT

Care Transitions Management

Care Transition refers to the movement patients make between health care settings *as their condition and care needs change* during the course of a chronic or acute illness; each shift from care providers and settings is defined as a care transition.

EPISODIC CARE DELIVERY

Episodic Care Delivery

The re-engineering of the acute episode derived from acuity-based expectations of patient care requirements, devoid of Provider preference, and driven by the least restrictive/costly care environment.

SILO EFECT ON THE CARE CONTINUUM

The Silo Effect

The Silo effect refers to the lack of communication and support often found in acute care episodes. Provider types focus primarily on their own goals, often ignoring the needs of others.

Making Sense of CMS Alternative Payment Models

(Volume to Value)

Alternative Payment Models (APM)

Alternative Payment Models (APM) are the basis of the ACA – mandated shift from the fee-for-service programming of the PPS era. By tying programs and payment to quality and value, ACA goals are achieved and the shift from volume to value begins, and will mature and refine over time. CMS APM projection – 90% by 2018.

Alternative Payment Models (APM)

Alternative Payment Models represent a new set of incentives that build on the progress of healthcare over recent years. They are slated to improve the efficiency and personalization of care programming by emphasizing care coordination and outcomes by controlling costs. Early returns form APM trials or pilot programs demo improved quality/cost results.

CCJR – 2016 Alternative Payment Model

- First ACA Alternative Payment Mandate
- CCJR slated for 1/1/16 Kick – Off
- BPCI Pilot – Model 2 - MS DRG 469/470
- 90-Day Total Joint Replacement Bundle
- Mandatory for 75 Metro Statistical Areas
- Over 700+ Hospital systems nationally
- Involves Hospital/MD/Patient Buy-In

CCJR – 2016 Alternative Payment Model

- Anchor Hospital fiscally responsible 90 day
- Hospital becomes both Provider & Payer
- *CMS Target Prices limit PAC selection*
- Data – Based Approach includes silo hx
- Utilization Review (UR) Model Required
- Clinical Indicators manage PAC Utilization
- Mimics Acute Care DRG Model Evolution

Development of a CCJR Episodic Bundle

Development of an Episodic CCJR Bundle

- Establishment of a Governance Committee
- MD Participation - Buy-in and Support
- Post-Acute Vendor Selection – Vet for CCJR
- Selection of Vendor Roster – Agreement, $$
- Reduction of Post – Acute Silo Behaviors
- Development of a CCJR Clinical Protocol
- Addressing Re-admissions for PAC mgmnt

Development of an Episodic CCJR Bundle

- 90 Day Bundle Concerns – Acute vs. Sub-Acute
- Patient and Family Education & Participation
- Addressing CMS Target Pricing
- Schedule for Ongoing CCJR Utilization Review
- Outpatient Management Issues
- Equipment, Care Transitions, CT Protocols
- Maturation of CCJR over time

Services and Costs included in a CCJR Episodic Bundle

Episodic CCJR Bundle Services and Costs

- Inpatient Hospital & MD Services
- LTCH, IRF, SNF, Home Health
- Outpatient Part B Services
- Laboratory, DME Costs, X-Ray, ER charges
- Part B Drugs
- Hospice Care
- Inpatient Psych Services

J.U.M.P.
Joint Utilization Management Program

Detroit Medical Center/HHSM

J.U.M.P. - Joint Utilization Management Program

- The Centers for Medicare and Medicaid Innovation's (CMMI) Bundled Payment for Care Improvement (BPCI) initiative
- Detroit Medical Center (DMC) was awarded BPCI **Model 2**
  - MS DRG 469/470 – Lower Extremity Joint Replacements
  - includes acute and post-acute claims
- **Three-year project** that will involve **pre-operative care transition** planning; ends December 2016
- **Straight Medicare** cases (no Medicare Advantage included)
- ACA CMS MANDATE - All acute care DCs Bundled 1/1/18
- Effect on Care expected to mimic DRG Evolution
- Basis of CMS Comprehensive Care for Joint Replacements (CCJR)

Model 2 BPCI

Clinical Basis of CCJR Total Joint Programming

Clinical Basis of CCJR Total Joint Programming

- Evolution of Total Joint Rehab Protocols x 30 years
- Generic Total Joint Rehab Protocols – Knee/Hip
- Clinical Breakdown – Knee – Range of Motion (ROM)
- Clinical Breakdown – Hip – Strengthening/Gait
- Establish Refined Post-Surgical Rehab Assessment
- Rehab Volume established on basis of clinical findings
- Wound, Edema, Pain, DC disposition, Complications

Clinical Basis of CCJR Total Joint Programming

- Concerns re current Total Joint clinical management
- Concerns re Joint patient as ambulatory patient
- Daily Rehab Programming = Over Utilization Model
- Lack of Lower Extremity Global Strengthening
- Poor insight regarding soft tissue ROM approach
- M.E.D. – Measuring Everyday Device for TKR ROM
- Cycles, Static therex, lack of skilled PREs

Vetting Post – Acute CCJR Vendors to Create a PAC Vendor Network

JUMP Post – Acute Vendor – Analysis/Chronology

- Quality Ratings, Meds, Falls, Re-admits, Stats,
- On – site Inspection and Analysis
- Orientation re ACA, Episodic Bundling, Develop Protocol
- On – Site PAC Vendor Clinical Staff Orientation
- Establishment of Contractual ACA agreement
- Establishment/Orientation of Connecting Software
- PAC Ongoing Education, Webinars, Onsite In-services
- Therex Demo, Quality Metric Clinical Management
- Dismissal or Addition of Post – Acute Vendors

Reducing Post-Acute Utilization through Clinical Indicators

CCJR Fiscal Breakdown re PAC Costs

Statistics for DRG 470	30-day episode	60-day episode	90-day episode
Mean Medicare spending*	$18,383	$20,343	$21,125
Mean payment for PAC	$6,835	$8,339	$9,122

*Spending hours per hospital discharge (Acute+PAC+Physician)

Skilled Nursing Facility (SNF) Bundle Utilization

Using Clinical Indicators to Reduce Post-Acute Utilization			
SKILLED NURSING FACILITY			
Prior to BUNDLE Program		**Initial BUNDLE Program**	
LOS	average **21** days	LOS	average **11** days
Average Therapy Utilization	**600 mins/week**	Average Therapy Utilization	**325 mins/week**
Cost/episode	**$12,000 - $14,000**	Cost/episode	**$4,000**
RUGs	**Very High/Ultra High**	RUGs	**High**
DC Focus	Patient managed at Day 20	Reduction in LOS/Cost	**48% / 64%**
		DC Focus	able to safely DC to HH

Home Health (HH) Bundle Utilization

Using Clinical Indicators to Reduce Post-Acute Utilization			
HOME HEALTH CARE			
Prior to JUMP Program		**Initial JUMP Program**	
Standard total joint protocol	average **11-14** therapy visits	Acuity based on total joint protocol	average **7** therapy visits
Average HHRG Total	**$ 3,300/ episode**	Average HHRG total	$1,950/ episode
DC Focus	Ortho revisit/protocol	Reduction in Cost	**40%**
		DC Focus	ability to safely DC to OPT

Home Health Partner Utilization Tracking

PAC Provider	2014 Target	Q1 2014	Q2 2104	Q3 2014	Q4 2014	2015 Target	Q1 2015
HH Provider #1	7	12	10	5	6	6	7
HH Provider #2	7	7	8	7	8	6	6
HH Provider #3	7	7	-	-	7	6	6
HH Provider #4	7	11	11	10	9	6	9
HH Provider #5	7	9	5	5	3	6	-
HH Provider #6	7	7	6	7	6	6	5
HH Provider #7	7	15	14	12	10	6	9
HH Provider #8	7	5	12	12	9	6	10
HH Provider #9	7	7	-	-	6	6	-
HH Provider #10	7	8	15	12	8	6	6
HH Provider #11	7	9	7	11	17	6	8
HH Provider #12	7	-	-	-	7	6	-

What is the most appropriate level of Care for a Joint Replacement patient upon acute discharge?

Post-Acute Placement – Clinical/Support Parameters

- Pre-Surg Disposition and Functional Performance
- Living situation, caregivers in-home or nearby
- Post-Surg Disposition, Function, Orientation
- Level of Skilled services required at discharge
- DC Concerns – IV antibiotics, Wound, CGVR
- Home Layout, Equipment, Co-morbidities, OPT
- Promote Cost/Risk/Opportunity of PAC sites
- DC analysis Work from bottom up – HH,SNF,IRF
- Safety is bottom line or post-DC placement

Post-Acute Placement – Care Site Specifics

- **HH** – Ind Safety ? – CGVR available? – DME?
- Avoid Reinfection/Readmission risk – Value ID
- Assertive HH management works – LUPA?
- 24 hr admit – Daily Rounds – Compliance/MV?
- **SNF** – Unsafe patient w no CGVR available
- Wound issues, IV antibiotic, Clinical Deficit Issues
- Manage RUG volume/DC Plan - for CCJR value
- **IRF** – Significant/Functional Co-morbidities
- Lack of post-surg Safety, Strength, Mobility

CCJR Episodic Bundling Readmission Concerns

BPCI Episodic Bundling Readmission Data

- Primary Readmission Reasons were Infection & Anemia
- > 75% Readmissions occurred Day 11-12
- Readmissions create a negative fiscal bundle scenario
- Readmissions add approximately $8949 to each patient that is readmitted
- Readmissions difficult to track fiscally when the patient is admitted to a separate health system
- Assertive Post – Acute management limits readmissions
- MD Education re APM necessary for readmission mgmt
- Episodic Readmission goal - < 5%

CCJR Episodic Bundling Savings Projections

CCJR Episodic Bundle Savings Projection

- Redesign improves care under decreased LOS
- First CCJR year costs CMS $23 Million
- 2nd – 5th year CMS savings - $175 Million
- CCJR Total 5 year savings - $153 Million
- Bundling will establish new dx cost baselines
- Replicates DRG evolution during PPS era
- ALL diagnoses CMS DCs Bundled by 1/1/18

CCJR Episodic Bundle Two- Sided Risk Structure

CCJR Episodic Bundle Risk Structure

- Providers and Suppliers paid FFS
- Year One – Performance year only (no risk)
- Year 2 – Payback capped 10% Target Price
- Year 3-5 – Payback capped 20% Target Price
- Target Price = Medicare discount (3 yr data)
- Target Price exceeds spending = Reconciliation
- Target Price less than spending = Payment Due
- Opportunities lie in Post – Acute care

Establishment of a CCJR Gain-Sharing Agreement

Episodic CCJR Bundle Gain – Sharing Agreement

- Specific Accounting formula to determine gains
- Description of specific Accounting formula
- Description of Methodology/Payment schedule
- Description of Methodology for risk payments
- Management and Staffing for all CCJR patients
- Identifying PAC CCJR qualification records
- Compliance Agreement for CCJR model

CCJR lessons from Model 2 469/470 BPCI Pilot Programs

Barriers to Meeting Episodic Bundling Goals

- Pre – Bundle Physician Post – Acute Alliance/Preference
- Acute Case Management Understanding/Participation
- Legacy of Silo Post- Acute Behavior
- Ultra High 21 days (SNF), 60 day programs (HH)
- Beliefs re patient home alone, no bed/bath on main floor
- Patients pre-registering for (SNF) prior to admission
- Readmission concerns and care site re-adm rates
- Inpatient hospital therapy identifying post-DC placement
- Entire Bundle characterized in Volume vs. Value manner

Bundling Opportunities/BPCI Lessons Learned

- Involve Both Operations and Clinical early in process
- Post – Acute Scorecards necessary for compliance
- Create ongoing Value via managed performance metrics
- Entire Bundle Focus is on Patient – centered outcomes
- Create CCJR culture of Eliminating struggling Providers
- Pre-surgical Joint Camp - explain the goal of going home as early as possible post surgery
- Regardless of quality – Current Post-Acute Providers are NOT PRODUCING EPISODIC CLINICAL PROGRAMS
- Communicate/Communicate/Communicate

Bundling Opportunities/BPCI Lessons Learned

- Specific/Value-based PAC vetting ESSENTIAL
- Target prices limit PAC programming specifics/choices
- IRF use severely limits Bundle success
- SNF care standard of 21 days outspends CCJR
- SNF RUG group usage (UH) a silo behavior
- Clinical Acuity Profile - Hub of programming ESSENTIAL
- Ortho MD/PCP/PAC administration must support Bundle
- Little/No Bundle recognition from PAC clinicians
- Ongoing IT documentation is a PAC challenge

Success under the CCJR Care Redesign Model

- Identify and Internalize Potential of Care Redesign
- Utilize CCJR program to prepare for 2018 Bundling
- Promote DRG-like evolution with changing LOS/$$ results
- Assertively connect/assist participating MDs for results
- Investigate MD Post-Acute Provider preferences
- Seek and Address reluctant Providers, clinicians, patients
- Change the Culture in your System – pre to post-surgical
- Daily report of Clinical Status via Connecting Software
- Patient response to treatment offers additional savings
- Don’t apologize for this Exciting New Care Program

Closing Summary and CCJR Predictions

Closing Summary and CCJR Predictions

- Systems initially under–perform w CCJR development
- CCJR allows for APM Episodic Bundle Development
- Post-Acute Providers must be sold on CCJR care
- Gain – Sharing/Risk – Sharing propels Culture Change
- Acute Case Management legacy compromises CCJR
- Expect 2017 CCJR Expansion into additional MSAs
- CCJR will invert current care continuum DC management
- Data – Based Approaches fail compared to clinical acuity
- Progressive systems use CCJR to achieve ACA success
- Successful systems - Market Improved CCJR Care

CAN YOU *MANAGE* TO IMPROVE YOUR CARE?

William H. Restum, Ph.D.
CEO
Rehabilitation Institute of Michigan
Detroit Medical Center
313-745-9710
wrestum@dmc.org

Arnie Cisneros
President
Home Health Strategic Management
1- 877- 449 – HHSM
www.homehealthstrategicmanagement.com