New Mexico Coalition FOR HEALTHCARE VALUE

Presentation to
Interim Legislative Health and Human Services Committee
Healthcare Costs and Quality Case Study
Hip and Knee Replacements

by
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Case study: Utilizing the CMS Comprehensive Care for Joint Replacement Initiative

- CMS designated over 500 hospitals across the county to participate in this mandatory delivery system reform
- Mission – Fosters healthcare transformation by finding new ways to pay for and deliver care that can lower costs and improve care
- Better care, healthier people, smarter spending

Case study: Utilizing the CMS Comprehensive Care for Joint Replacement Initiative

Priorities

- Testing new payment and service delivery models
- Evaluating results and advancing best practices
- Engaging a broad range of stakeholders to develop additional models for testing

History of Medicare Hip and Knee Replacements

- Most common inpatient surgery for Medicare beneficiaries
- More than 400,000 procedures in 2014, costing more that $7 billion just for hospitalization
- Quality and cost of care for these hip and knee surgeries still varies greatly
- Rate of complications, infections or implant failures after surgery, can be more than 3x higher for procedures performed at some hospitals than others
- Average total Medicare expenditure for surgery, hospitalization and recovery ranges from $16,600 to $33,000 (across geographic areas)
- There have not been enough incentives to coordinate the whole [illegible] of care from surgery to recovery

Reasons for the Initiative

Approaching care without seeing the big picture leads to...

- more complications after surgery,
- higher readmission rates,
- protracted rehabilitative care, and
- variable costs

Model Focuses on Quality and Value

The Comprehensive Care for Joint Replacement (CJR) model addresses the following:

- low quality and high costs that come from fragmentation by promoting coordinated patient centered care
- aims to improve the care experience for the growing numbers of Medicare beneficiaries who receive joint replacements, so that patient's experience a successful surgery and recovery and that it is a top priority for the healthcare system
- requires the hospital in which the hip or knee replacement takes place be accountable for the costs and quality of related care from the time of surgery through 90 days after Hospital discharge (called an episode of care)

Finances

Hospital's quality and cost performance during the episode can result in the following:

- financial reward, or
- beginning with the second performance year, repayment to Medicare a portion of the costs above an established target

CMS designed payment structure is designed to provide hospitals with an incentive to work with physicians, home health agencies, skilled nursing facilities and other providers to make sure that the beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications.

- Those in the model will receive additional tools

Tools

Tools available to those in the model include:

- Spending and use of data and sharing of best practices to improve the effectiveness of care coordination
- Additional flexibilities that are otherwise not available under Medicare so they can better manage the care of patients, including patients who are at home

Finances

CMS designed payment structure to provide hospitals with an incentive to work with the following:

- physicians,
- home health agencies,
- skilled nursing facilities, and
- other providers

Goal is to ensure beneficiaries receive the coordinated care they while reducing avoidable hospitalizations and complications

NM Participants

Now testing in 67 geographic areas in the U.S. hospitals in those geographic areas are required to participate if they have a population of at least >500,000

Albuquerque and its three main hospitals were designated:

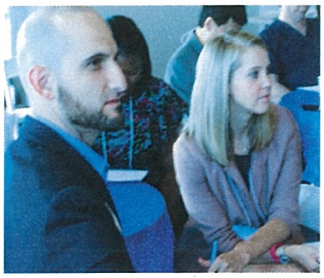
- Lovelace Health System
- PRESBYTERIAN
- UNM Sandoval Regional Medical Center, Inc.

New Mexico Coalition for Healthcare Value Asked the Questions:

- If you are doing this for Medicare, can it be extended towards Medicaid patients and commercial insurance?
- In the spirit of transparency, will the hospitals inform us as to how they are implementing this initiative?
- Can we identify some best practices that can be shared locally in order to accelerate or fast track this work?
- What do the surgeons who are actually participating and doing this surgery think of this initiative?
- Can we have you identify the leads and your lead physicians who can participate in an educational event and tell the audience more about this initiative?

Response = Yes

- Set a date for a community educational event which was scheduled for Friday, July 15, 2015
- We asked the leader of the initiative from CMS (Medicare to attend) and she participated virtually
- Two physicians provided their insights about this type of work
- Representatives from New Mexico Orthopaedics and UNM Orthopedic committed to Attend
- Hospitals provided representatives for a panel



Educational Seminar

Presenters

- Dr. Jeff Racca - Board Certified Orthopedic Surgeon, New Mexico Orthopaedics
- Dr. Dustin Briggs, UNM Hospital Health System, Sandoval Regional Medical Center, Orthopedic Attending
- Claire Schreiber, Lead for the CMMI Joint Replacement Initiative

Panel members

- Derrick Jones, CEO Lovelace Health System
- Dr. Vesta Sandoval, Lovelace Medical Center, Medical Director
- Beth Tibbs, Surgery Service Line Administrator Presbyterian Central New Mexico Delivery System
- Dr. David Arredondo, Executive Director, Presbyterian Medical Group
- Petra Bergenthal, RN Quality Consultant, UNM Sandoval Regional Medical Center
- Paul Huckabee RN, Orthopedic Program Coordinator for UNM Sandoval Regional Medical Center

Highlights From Presenters

- New Mexico Orthopaedics
  - Had been developing an integrated care model that saves real money
  - Had been negotiating with their insurance partners for bundle payments for commercial products
  - Working to eliminate silos and believe that by providing for sharing of cost savings it encourages collaboration
- UNM Physician Provider
  - Correlated idea using example value meals – they exist everywhere and the concept should be applied to healthcare
  - Initiative encourages improved patient communication as well as a team approach
  - Initiative designed for cost containment and likely early success will cut spending

Seminar participants

Questions

- Will the Initiative limit patient access? (medical co-morbidities, underserved patient populations, academic vs private sector
- Are we paying for the right things?
- Should pay reflect compliance to "best practice guidelines, not readmission and complications?
- Will the Initiative ultimately create value (higher quality for lower cost)?
- Can it improve pre-operative optimization, teamwork and patient communication and responsibility?

Medicare's Goals – CMS Presenter

- Better care for patients through more coordinated higher quality care during and after a lower extremity joint replacement
- Smarter spending of healthcare dollars by holding hospitals accountable for total episode spending, not just inpatient costs
- Healthier people and communities by improving coordination in healthcare and by connecting care across hospitals, physicians, and other healthcare providers

(Additional)

- 85% of Medicare FFS will be tied to quality or value by end of 2016, 90% by end of 2018
- 30% of Medicare payments will be tied to quality or value through Alternative Payment Models, with achieving 80% by end of 2018

How Will this be Done?

- Providers and suppliers will continue to be paid via Medicare FFS
- Participating hospitals will receive prospective episode target prices that reflect spending for an episode. After the performance year, actual episode spending will be compared to the episode target prices
- If aggregate target is greater than actual episode spending, hospitals will receive a reconciliation payment, pending their quality performance (shared savings)

Additional

- If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare
- Responsibility for repaying begins in year 2 with no downside in year 1
- This is what we need to begin encouraging and incentivizing our health plans and delivery systems to do within our State through our various mechanisms, (Medicaid, Commercial/Employer to align with Medicare)

What are Hospitals and Medical Providers Doing Different? (View from the Panel)

- Now focusing on the pre-operative part of the process by reviewing medical requirements before surgery to optimize outcomes during and after surgery
- Working with the patient collaboratively to determine their care needs during surgery
- Assessing patient needs after surgery, encouraging same day physical therapy
- One of the biggest changes and challenges for them is have the hospital delivery system strongly connect and communicate with the post acute providers

New Ways To Function

- Identifying high quality-post acute providers (under Medicare regulations there were limitations on what the hospital delivery system could do on their referrals)
- Positioning themselves to manage downstream escalations
- Tracking readmission rates, patient satisfaction, complication rates and functional gains to ensure quality
- Controlling the costs of post acute care

Critical to have the right tools (which are now a standard part of the business)

- an EMR access to accurate on time data through a data warehouse
- a scorecard for skilled nursing facilities that are reviewed on a monthly basis
- Similar rating for home health agency work

Conclusion

We need to:

- accelerate and encourage more of our delivery systems and health plans to move forward with value based payment systems
- identify and remove and/or change policy and regulations that are barriers to moving towards more innovation
- clearly articulate and identify what is the infrastructure needed both in the delivery system and the payer system to achieve these new models of healthcare such as a fully functioning health information exchange and an all payer claims data base
- provide incentives that encourage new processes and aim for efficiency and increased value while continuing to provide high quality results and lower prices

Conclusion cont....

- In time of current budget challenges we should aim at not just across the board cutting budgets, but assessing what is working and supporting those efforts and determining what is needed for the future of healthcare in our State
- An area might be to begin looking at what is happening with pharmacy costs and encouraging and incentivizing initially at least moving towards group purchasing to decrease costs
- Perhaps it is time to have an office of health innovation in our State that is aimed at aligning our delivery system, (both private and public) and our payer system to provide better access and improve the health status of New Mexicans

For More Information

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Blue Cross and Blue Shield of New Mexico
DELTA DENTAL
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NEW MEXICO MEDICAL SOCIETY
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