Bundled Payments
Advantage

KEY CAPABILITIES

for working with the Comprehensive Care for Joint Replacement (CJR) model

DePuy Synthes
COMPANIES OF Johnson & Johnson

CJR Takes Aim at Variations in Care Cost and Quality

Hip and knee replacements are among the most common surgeries in Medicare. The cost of an ***episode of care***, from surgery through recovery, can vary dramatically. That's why the Centers for Medicare and Medicaid Services (CMS) has developed the CJR model. CJR is a ***bundled payment*** arrangement for total hip and knee replacement that compensates providers for an entire episode of care, not the individual components of care.

How CJR works

- Hospitals and downstream providers are paid on a fee-for-service basis. At the end of 1 year, CMS reconciles claims paid against its ***target price*** (see *How target prices are set* on page 3) for all services related to an episode

If claims total is less than the target price and minimal quality thresholds are met, the hospital receives a *reconciliation payment*[1]

If claims total exceeds the target price, the hospital pays the difference back to CMS[1]

- CMS is giving participants 1 year to gain experience with the program before 2-sided ***risk*** begins in Year 2.[1] To protect hospitals from catastrophic loss and to prevent providers from withholding necessary care, CMS has implemented stop-loss and stop-gain ceilings and quality-of-care metrics[2]

Considerations for participants

- Hospitals should **coordinate care, develop efficiencies, and align clinical practices** with ***collaborators*** who care for patients during discharge (skilled nursing facilities; home health agencies; long-term care and inpatient rehabilitation hospitals; physician group practices; and physician and non-physician practitioners and providers of outpatient therapy)[2]
- **CMS holds the hospital accountable for all costs** 90 days after discharge. The hospital may set up financial arrangements, such as ***gainsharing*** or division of 2-sided risk, with collaborators[2]

Words in ***italics*** are defined in the *Glossary and Resources* brochure.

CJR at a Glance

What?	■ Covers most Medicare fee-for-service patients hospitalized for lower-extremity joint replacement ***(DRG 469 or 470)***[1]
Who?	■ Applies to 800 ***IPPS***-paid, acute care hospitals[1] ■ 67 ***MSAs*** selected; all hospitals must participate, with the exception of current ***BPCI*** participants and critical access hospitals[1,3]
When?	■ Effective April 1, 2016[1]
Why?	■ Improve quality through adherence to best practices and care coordination[1] ■ Reduce costs through efficiency and alignment of provider incentives[1]
How?	■ Target price based on 3 years of historical claims data, shifting over time from the hospital's own cost data to regional averages[2] ■ To earn reconciliation payments, hospitals must meet minimum thresholds on ***HCAHPS*** and complication rates for ***THA/TKA***[2]

BPCI=Bundled Payments for Care Improvement initiative; DRG=diagnosis-related group; HCAHPS=Hospital Consumer Assessment of Healthcare Providers and Systems; IPPS=Inpatient Prospective Payment System; MSA=metropolitan statistical area; THA=total hip arthroplasty; TKA=total knee arthroplasty.

How target prices are set

CMS establishes a target price for each hospital based on 3 years of historical claims data. Over the life of the program, this price is adjusted periodically.

1. Initially, CMS calculates average ***index admission*** costs for patients with a discharge diagnosis of MS-DRG 469 or MS-DRG 470, risk adjusted for hip fracture. It also calculates average total post-acute care (***PAC***) claims for these patients for 90 days from the start of the index admission.[2]
2. To arrive at the basis for target prices during the first 3 years of CJR, CMS adds these 2 averages together, then subtracts 3% (the ***discount***) from the sum.[3] (Based on performance on quality metrics in CJR, however, hospitals can effectively reduce this discount to as low as 0.5%.)[3] After the first 2 years, the weighting of the averages used to arrive at a target price (prior to the discount) begins to shift from hospital-specific to regional averages[2]:
   - In Years 1 and 2, the weighting is two-thirds hospital-specific, one-third regional pricing
   - In Year 3, the weighting is one-third hospital-specific, two-thirds regional pricing
3. In Years 4 and 5, the target price is based entirely on regional claims experience for both the index admission and PAC.[2]

4 Key Capabilities for Succeeding With CJR

A report commissioned by the American Hospital Association and the Association of American Medical Colleges identified several success factors in a bundled payment arrangement.[4] Four are particularly relevant under CJR.

1. Network Formation

For a hospital to be able to develop and implement a seamless continuum of care for lower-extremity joint replacement (***LEJR***) patients, it is critical to select the right partners. Hospitals have an imperative to drive conversations about network formation and care protocols, coordination, and costs, because a hospital is the entity ultimately held accountable.[2]

Hospitals will want to choose partners with which they can best integrate services, control quality, and share information.[4] Under Medicare law, however, fee-for-service patients may see any post-acute provider they choose—and the same is true under CJR.[2] The significance of this is that, when patients are referred from—and discharged back to—providers that are not among your network partners, it will be important to communicate with that provider about a patient's care plan and to monitor the patient's progress.

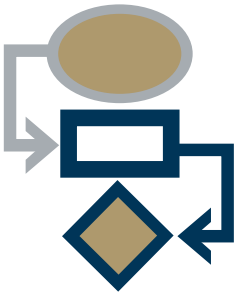
When evaluating partners for inclusion, consider the following[4]:

- Clinical criteria and their potential impact on ***variations in care***
- Detailed financial analyses
- Information technology capabilities
- Affiliations with competing institutions

What is a network?

In the context of CJR, a network is not the same as provider networks we associate with health insurers or integrated delivery systems. Rather, for CJR purposes, network is a general term for PAC providers with whom a hospital forms a clinical alliance. At the early stage, hospitals may use the term network interchangeably with collaborators, which refers to a formal alliance of providers who work with the hospital to redesign care protocols[2] (see *Collaborators vs conveners* on page 6 for more information).

2. Clinical and Administrative Processes

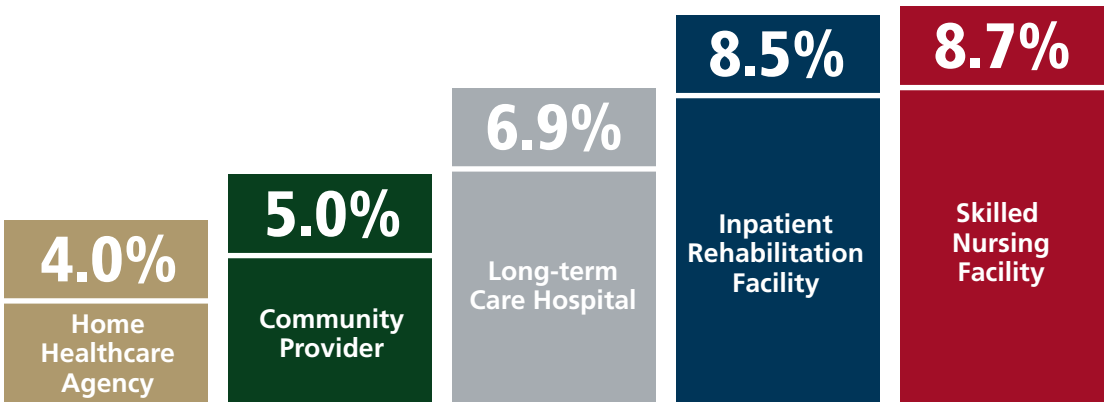


Clinical quality and operational-improvement projects are central to improving quality and increasing efficiency. These go hand-in-hand with network formation.

Clinical processes: A hospital should demonstrate leadership while building relationships with external partners through trust and transparency. Empowering physician leaders and treating them as partners, for instance, will help to integrate clinical expertise while increasing cooperation and credibility of the network.[5]

Clinical partners may be engaged to re-engineer site-of-discharge criteria for specific types of patients—a critical step for reducing total costs of care.

For patients discharged under MS-DRG 470, the percentage of episodes resulting in a 30-day readmission varies considerably by the first post-discharge setting[4]:



Administrative processes: Contracting experience and technological acumen for managing the financial aspects of network operations are important. Partners that have a practice-based, managed care–like infrastructure, such as an ***accountable care organization***, may be well suited for success with bundled payments.

Within a network, partners can become champions for administrative changes they might otherwise view as a threat. For instance, episode costs fall as the number of physicians seen decreases.[4] In the ***Medicare Heart Bypass Center Demonstration***, cardiac surgeons reduced the number of consults by performing them themselves, reducing fee-for-service payments to cardiologists outside the network.

DePuy Synthes Companies of Johnson & Johnson offers resources that can help:

AdvantageCare 90

Coding and Reimbursement Information

3. Ability to Manage Risk

In a ***risk*** arrangement, individual providers in a network go from being a revenue center to a cost center. It is essential for the hospital to have the capacity to manage and mitigate risk. Many individual providers don't have experience with it.[4]

Types of risk to be managed include the following:

- Size of the discount[2]
- Global risk (most important to hospitals who spread the risk across a network)[4]
- Patient characteristics and health status (of interest to network partners, as characteristics not captured by risk adjustment may increase the intensity of care required)[4]

Collaborators vs conveners

In the BPCI initiative, a convener is a party that either takes on financial risk (eg, a hospital) or provides managerial and technical support for an affiliated network of providers (often, a third party). These are known in BPCI as awardee conveners and facilitator conveners, respectively.[3]

The definition of convener, however, represents one key difference between BPCI and CJR. Under CJR, only the hospital can assume the risk for the financial performance of the bundle and enter into formal collaborator agreements if it chooses to do so.[3]

Collaborator refers to a post-acute care provider and/or a surgeon that works with a hospital or health system to redesign care protocols. A collaborator may also enter into a formal gainsharing arrangement with a hospital to share savings generated under CJR.[2]

DePuy Synthes Companies offers resources that can help:

- **Advanced Care Center Visitation**
- **Episode of Care Coordination**
- **Partnership With Ethicon**
- **Perioperative Efficiency Analysis Tool**
- **Supply Chain Efficiencies**
- **Tray and Instrument Optimization**

4. Data Capabilities

The lead hospital needs information technology that can integrate clinical, financial, and billing data to produce various reports for network partners. These reports include quality performance, comparative costs, and predictive modeling.[4]

Care integration relies on access to real-time data, either through systems developed in-house or offered through a contractor. To use our previous site-of-discharge example, defining the role of the first post-acute provider and creating discharge pathways are important steps, but having tools for managing these in real time enables best practices and cost efficiencies. Being able to generate utilization data for post-acute providers, for instance, and empowering partners with IT-based decision-support tools engages them in performance improvement.[4]

Managing the bundle well requires aligning vision with partners on clinical, procedural, and financial matters—and providing them with robust tools to realize that vision with you.

DePuy Synthes Companies offers resources that can help:

- **CareSense***
- **Episode of Care Coordination**
- **Partnership With Ethicon**
- **Perioperative Efficiency Analysis Tool**
- **SOLO Health**
- **Supply Chain Efficiencies**

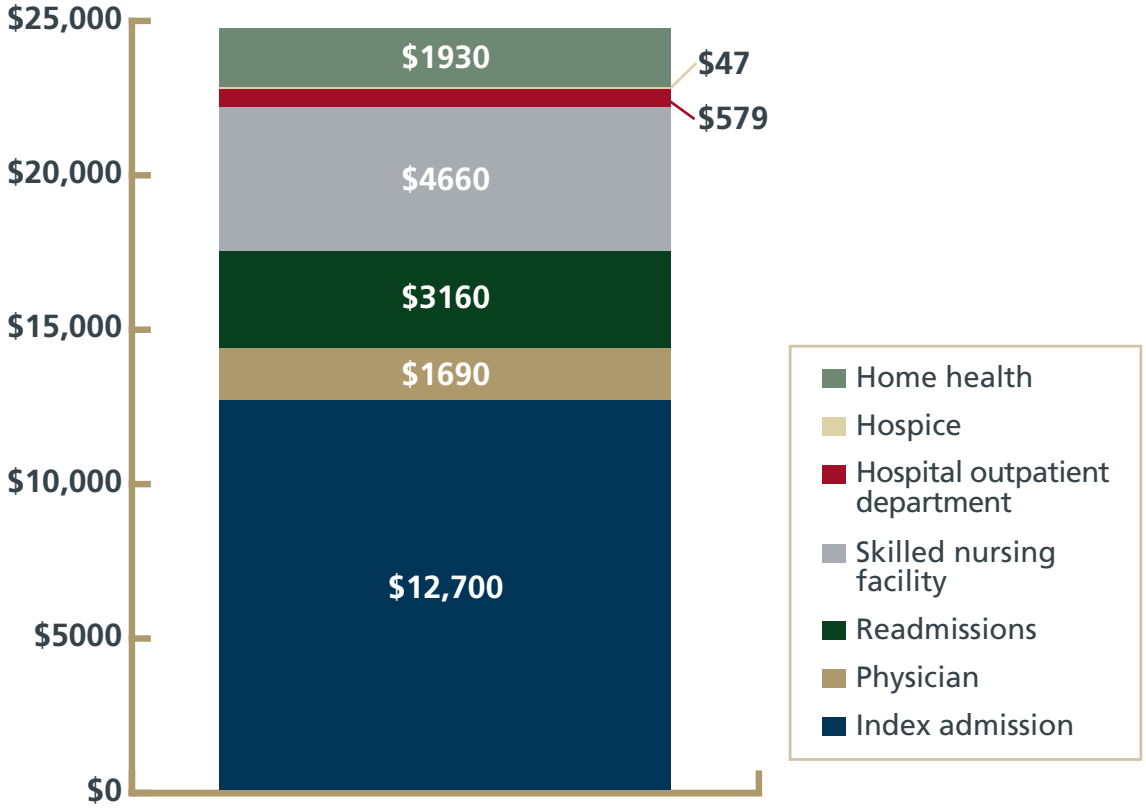
*Costs associated.

Cost Considerations Under CJR

Reducing episode-of-care costs

To succeed under CJR, consider where costs occur in a typical episode of care.

Average 90-day episode costs for LEJR (2013)[6]



At the inpatient level, maximizing efficiencies in input costs (such as devices and supplies), managing operating room productivity, and preparing patients before their surgery to manage their recovery may also have an impact.

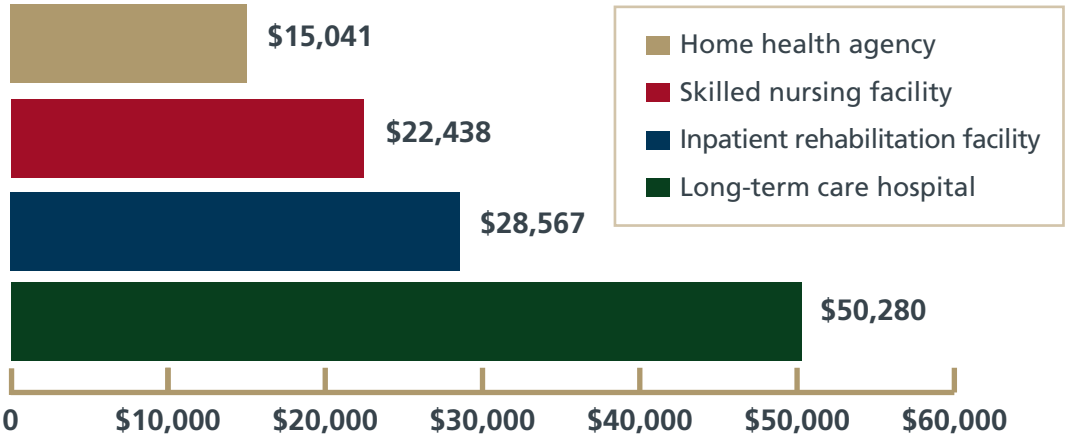
At the outpatient level, cost efficiencies may be realized through improving coordination of care, promoting adherence to guidelines, and reducing the intensity of post-discharge services to the level required for optimal patient care.

At every level, complication rates and readmissions should be considered. While readmissions are not a specified quality care metric under CJR, they can impact the cost of an episode.

Manage discharges to the first post-acute provider

For patients undergoing LEJR, the first provider they see represents a key variable in total cost of care. This underscores the importance of defining the right pathway of care for the right patient.

Average 30-day episode costs, MS-DRG 469/470, by first post-acute care setting*[4]



*In 2009 dollars.

The sequence of providers a patient sees after discharge also has an effect on costs: the more stops along the way, the higher the costs.

Average 30-day episode costs, MS-DRG 470, by top 5 patient pathways*[4]

Pathway	Average episode cost
A-H-C	$14,519
A-S-H-C	$20,039
A-S	$23,396
A-C	$12,078
A-I-H-C	$26,925

A = Index admission
C = Community physician
H = Home health agency
I = Inpatient rehabilitation facility
S = Skilled nursing facility

*In order of volume. In 2009 dollars.

The first PAC setting following discharge has a major impact on episode costs. Hospitals and partners will need to consider discharge planning carefully.

The key capabilities in this brochure have application across the treatment spectrum, starting with the decision to seek care through the preadmission, acute, and post-acute care phases.

In addition, "the A-B-C-Ds" of success—Analyze, Balance, Coordinate, Deliver—described in this kit are critical for hospitals participating in CJR.

Solutions Brought to You by DePuy Synthes Companies

CMS developed CJR to encourage providers to meet the goals of the ***Triple Aim***: increase patient satisfaction, reduce costs, and improve clinical outcomes.

DePuy Synthes Companies recognizes the importance of CJR to our customers and is positioned to help you meet the challenges of bundled payments.

DePuy Synthes Companies Offerings

The DEPUY SYNTHES ADVANTAGE™

A suite of customized, measurable, patient-focused programs, products, and services that can help hospitals and health systems optimize one or more Triple Aim segments for total joint replacement patients

AdvantageCare 90

A program for hospitals to share risk with suppliers for total joint replacement procedures

Advanced Care Center Visitation

An educational offering for all stakeholders involved in total joint replacement. These events allow interaction and access to sites of care that have achieved success in both outpatient and bundled payment care offerings

Anterior Approach*

DePuy Synthes Companies is a recognized leader in Anterior Approach training for surgeons and their teams. Clinical studies have demonstrated that this tissue-sparing technique can reduce recovery time and length of stay when compared to traditional approaches[7-9]

Coding and Reimbursement Information

Find the general coding, coverage, and reimbursement information you need

Hip Fracture Pathway (HFP)

The Geriatric Fracture Program (GFP)* provides inspired solutions by providing a standard team-based approach to treating these patients from the time they arrive in the emergency department through discharge. This approach has been shown to improve outcomes and to get patients back to their pre-injury status faster

Market Analytic Profile

Provides comparative data of patient-satisfaction scores for hospitals at the local, state, and national levels

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Readmissions performance
- Hospital-acquired conditions performance

PATIENT ATHLETE™ Program†

A self-guided, video-based training program designed to help patients preparing for surgery to take their experience beyond merely reducing pain

Patient Ambassador Program

This grassroots program provides educational information for patients and enables advocates to share their total-care experience with friends and families

*Anterior Approach is not cleared for use with ceramic-on-ceramic constructs.

†Costs associated.

Perioperative Efficiency Analysis Tool
DEPUY SYNTHES ADVANTAGE Tracker iPad® Application (DATA) evaluates operating room productivity to identify opportunities in your operating room through graphic comparisons of actual and optimized operative times

Tray and Instrument Optimization
Helping you achieve efficiencies through standardization, digital templating, and unique product-efficiency trays

DePuy Synthes Companies Partnerships

CareSense Mobile Digital Tracking System‡
Provides real-time clinical data and patient-experience information that may lead to improved outcomes, increased patient satisfaction, and reduced costs. See **www.caresense.com**

Episode of Care Coordination
Offers alignment strategies and orthopedic service line establishment

Partnership With Ethicon
Offers a portfolio of wound care, biosurgery, and energy solutions that can provide value to surgeons while helping to drive better healthcare outcomes

SOLO Health
A health screening offering that also educates patients by directing them to joint pain educational resources, physician locators, and community education events

Supply Chain Efficiencies
Provides tools and analytics to help evaluate and enhance important measures within the hospital: productivity and performance during the perioperative process, workflow efficiency, supply standardization, inventory cost reduction, and overhead savings

‡Costs associated.

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