

Orthopedic Performance Now Impacting Medicare Payments >

More focus put on joint replacement complication and readmission rates



In recent years there has been an increased emphasis to pay for performance as a way to provide better care at a lower cost. The Centers for Medicare & Medicaid Services (CMS) has a number of programs aimed at improving the quality and cost of care. The most recent and wide-spread examples are the Medicare's Hospital Value Based Purchasing (HVBP) program and the Readmissions Reduction Program which offers incentives for leading hospitals, collected by withholding a percentage of participating hospitals' Diagnosis-Related Group (DRG) payments. These programs now include complication and readmission rates for total knee and total hip replacements. Because readmission information from total joint replacement patients along with four other conditions affects Medicare payments for all inpatient admissions, leading orthopedic programs have created and implemented processes and procedures to ensure patients are optimized for surgery, risks and complications are reduced, and discharge planning is included in the patient care plan for a fully integrated and effective continuum of care.

Introduction >

Historically, the United States healthcare payment model has been fee-for-service where services are paid for as they occur. It has been argued that paying for individual services incentivizes caregivers to provide additional treatments because payment is dependent on the quantity of care, not the quality of care.

The current trend is toward pay-for-performance, with the creation of numerous programs and pilots from both private and public payment sources. For example, Alternative Quality Contract (AQC) introduced by Blue Cross Blue Shield of Massachusetts is one of the largest commercial payment reform initiatives in the United States and provides significant financial incentives based upon performance across a broad set of quality, patient outcomes and resource usage measures.

On a national basis¹, the Center for Medicare and Medicaid Services (CMS) has multiple programs that encourage healthcare providers to deliver higher quality care at lower total costs, including the Hospital Acquired Conditions (HAC) payment provision of the inpatient prospective payment system (IPPS), the Hospital Readmissions Reduction Program (HRRP) and Value Based Purchasing (VBP).

Under the IPPS, cases are categorized into Diagnosis-Related Groups (DRGs) and payment weights are assigned. The HAC payment provision stipulates the CMS will not reimburse for the higher cost of care resulting from a hospital acquired conditions that could have reasonably been prevented through evidence-based care. The poorest performing hospitals with regard to hospital acquired conditions will be penalized 1% of their total Medicare payment.

The Hospital Readmissions Reduction Program requires the CMS to reduce payments to IPPS hospitals with excess readmissions for Acute Myocardial Infection (AMI), Heart Failure (HF), Pneumonia (PN), Chronic Obstructive Pulmonary Disease (COPD) and elective Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA). Additionally, the maximum penalty has recently been increased from 2% to 3% of all Medicare payments based on readmissions of these five conditions.

VALUE BASED PURCHASING

VBP applies to hospital payments for inpatient stays in over 3,500 hospitals across the country. It is a zero sum program funded by the withholding of a percentage of participating hospitals' DRG payments for Medicare IPPS contracted hospitals. Higher performing hospitals are reimbursed while lower performing hospitals are penalized. Payments are made based on either: 1) how well a hospital performs to a specific set of criteria, or 2) how much it improves.

The VBP program went into effect on October 1, 2012 (FY2013) with a maximum penalty (and payment) of 1%. The maximum penalty will increase by 0.25% per year, capping at 2% per year in FY2017 and beyond (TABLE 1).

Fiscal Year (FY)	2013	2014	2015	2016	2017+
Maximum Payment / Penalty	1.00%	1.25%	1.50%	1.75%	2.00%

TABLE 1 | HVBP payment and penalty schedule, by year.

¹Select hospitals are eligible for exemption, specifically MD hospitals due to a comparable state-operated program.

At the outset, the VBP program consisted of the Clinical Process of Care Domain and the Patient Experience of Care Domain. Clinical Process of Care focused on a set of scores for AMI, HF, PN and the Surgical Care Improvement Project (SCIP) for surgical infection prevention. The Patient Experience of Care score was (and still is) based on the hospital's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

An Outcomes Domain focusing on 30-day mortality and Hospital Acquired Infections (HAI) was added in FY2014 and an Efficiency Domain was added in FY2015. The Outcomes score provides for a 1% penalty for those hospitals with the highest percentage of medical errors. The Efficiency score is based on the cost to Medicare per beneficiary, for an episode of care.

Performance Domains and Weighting	2013	2014	2015	2016
Clinical Process of Care	70%	45%	20%	10%
Patient Experience of Care	30%	30%	30%	25%
Outcomes		25%	30%	40%
Efficiency			20%	25%

TABLE 2 | Applicable performance domains and percentage of the Total Performance Score, by fiscal year.

FACTORS IMPACTING ORTHOPEDIC PROGRAMS

Through the Hospital Inpatient Quality Reporting (IQR) program, Medicare has been collecting hospital data on surgical complications and readmissions for hip and knee replacement patients since January 1, 2013. Specifically, the definition of the risk-standardized complication rate following elective primary total hip and total knee arthroplasty is as follows:

- AMI, pneumonia, sepsis/septicemia within 7 days of admission
- Surgical site bleeding, pulmonary, embolism and death within 30 days of admission
- Mechanical complication, periprosthetic joint infection/wound infection within 90 days of admission

For the 30-day all-cause risk-standardized readmission rate following elective primary total hip and total knee arthroplasty, the following criteria will be used:

- The patient must be readmitted to an inpatient unit
- If the patient is readmitted more than once within that 30-day period, it will only be counted on as one readmission
- Planned readmissions will not be counted

Each hospital's specific total hip and knee arthroplasty complication and readmission rate is available to the public on the Hospital Compare section of the CMS website (FIGURE 1). This allows consumers to better judge a hospital's performance related to total hip and knee arthroplasty and can be one factor in driving their choice of hospital for their surgery.



FIGURE 1 | Hospital readmission and complication rates for hip/knee patients included on the Medicaid website.

As of October 1, 2014 the complication and readmission rates for total hip and knee arthroplasty as defined above are part of the Value Based Purchasing metrics. Therefore a hospital's performance on these joint replacement metrics will more directly impact their reimbursement in future years.

KEYS TO SUCCESS

What can orthopedic programs do to successfully execute for maximum benefit? The keys to success for hospitals include patient optimization, education, risk reduction and improved discharge planning.

Patient Optimization

Optimizing patients means reducing their chances for complications and readmissions as well as improving their ability to handle pain, the rigors of surgery, and the expectations of them after surgery. This is accomplished through a more intensive history and physical evaluation, patient-specific pre-operative testing to screen for co-morbidities and risks of complications, and working to normalize as many medical issues prior to surgery as possible.

Education

Education is required to fully prepare the patient for the surgical process and expected outcomes. Ensuring patients understand the process and timing of the steps will alleviate uncertainty and help them to adhere to the treatment time line. Making patients take an active role in the process will better prepare them mentally for the rigors of the procedure and recovery thereafter.

Risk Reduction

Complications lead to longer lengths of stay and more costly treatment. Using evidence-based care, hospitals can put processes in place to alleviate or manage complications. Conducting root cause analysis of the source for the most frequent complications will provide the insight necessary to eliminate or minimize the effect, providing for more effective treatment.

Discharge Planning

Throughout the patient stay and during the transition of care from discharge through recovery, the hospital needs to have established 'touch points' to ensure patients are progressing as planned. For example, a physician visit within two weeks post-surgery is appropriate for total hip and knee replacements. It is paramount that patients have a solid understanding of expected outcomes and symptoms that are cause for concern. Too often symptoms go unchecked, resulting in a readmission that could have been prevented through early treatment by a doctor. Likewise, unknowing patients may go back to the hospital for conditions that are normal to the healing process.

SUMMARY

There are multiple programs from both private and public payers focused on improving the quality and cost of care for orthopedic patients. Medicare, for example, has been collecting data on surgical complications and readmission of total knee and hip replacements since 2012 and will include it as part of the VBP metrics in Fiscal Year 2015 (FIGURE 2). For a hospital to ensure maximum payment and avoid penalty requires an efficient orthopedic program with repeatable procedures and processes in place and a culture of continual improvement. As competing hospitals improve their processes and outcomes, the requirements for payment become more stringent.

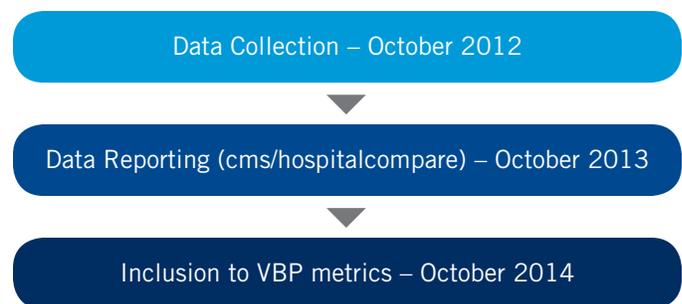


FIGURE 2 | Timing of Total Joint Indicators