NYU Langone Medical Center: The Future of Episode-Based Payment

Joseph Bosco, MD, and Richard Iorio, MD
Interview by Coleen Kivlahan, MD, MSPH

Bundled Payment for Care Improvement: Examples in Practice

The Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payment for Care Improvement (BPCI) initiative as part of an effort to encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs. As of January 2016, the AAMC was supporting the efforts of more than 30 hospitals to implement BPCI through the AAMC Facilitator-Convener Group.

The Examples in Practice Series highlights the challenges faced and strategies used by leaders at five health systems while participating in BPCI. These examples offer potential lessons for other academic medical centers pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing alternative payment models.

For more information on bundled payments, go to aamc.org/bundling.

The following Q&A is with Joe Bosco and Rich Iorio from New York University (NYU) Langone Medical Center. Lorio is the Susan and William Jaffe Professor and chief of adult reconstruction of the NYU Langone Department of Orthopedics, and Bosco is professor and vice chair at the NYU Langone Department of Orthopedics. In this informative exchange, Bosco and Iorio discuss their experiences and dramatic cost and quality results in the CMMI BPCI initiative.

When it was passed, some considered the Affordable Care Act a natural disaster, but NYU Langone was struggling to cope with a far more challenging disaster in their back yard: Hurricane Sandy. It would take years to clean up the effects of the storms on coastlines, homes, and electrical power structures, and for NYU, the impact was especially acute. After safely evacuating more than 300 patients during the storm, their emergency and operating rooms were closed for four months. Surgeons operated in neighboring hospitals and, out of necessity, began sending patients home after joint replacement rather than to the gold standard inpatient rehabilitation facility, which was also damaged in the storm. At that time, it was believed that patients discharged to home would have a longer length of stay (LOS) and a greater readmission rate than those discharged to inpatient rehabilitation. The exact opposite occurred: the LOS and readmission rates dropped as more patients bypassed inpatient rehabilitation.

When the hospital and orthopaedic physicians had the chance to join the Medicare BCPI initiative, they were the first AMC in the nation to do so. In December 2015, two years after NYU began accepting financial risk under BPCI, Coleen Kivlahan talked with Bosco and Iorio about their progress to date.

Why did your organization choose to be an early adopter of BPCI?

It was important for us to be leaders in this program. We thought that alternative payment models [APMs] were the way of the future and BPCI would be a good way to become facile with the skills needed to assume risk. We've been fortunate to have good physician alignment and the organizational commitment to put resources into the structure needed to be successful. At the very least, we believed this would be a great learning tool for us and enable us to provide better care for our patients.

Another reality for us was that we were losing revenue on Medicare surgical cases. It was time for us to develop and implement an alternative strategy for improving care and efficiency. We knew that improved care and outcomes would not only benefit our patients, but would benefit our bottom line as well. So, our organization set a goal to improve the value of care we provided to our patients.

What barriers have you encountered to successful participation in the BCPI initiative?

Our biggest and most surprising barrier was the broad band of involvement of staff needed to improve care. Initially, we were somewhat naïve about the number and wide variety of caregivers required to provide the high level of care our patients received—to name only a few types: senior leaders, social work, finance, IT, nursing, home health, emergency department, physical therapy, preoperative admission testing, and care management. The commitment of a wide range of stakeholders has been essential, and we quickly gained an appreciation of the work each member provided. The need to manage all care across 90-day periods demands contributions from multiple types of providers and sites of care. This program has absolutely increased our organizational alignment.

We have a hybrid physician-compensation model, with some of our attending physicians serving as full-time faculty and others with no financial ties to the medical center. However, regardless of our compensation model, we all "swim in the same pool." We're all focused on solving the same

problems. The outcome has been an improved, complete product line for patients requiring joint replacement, and the impact has reached well beyond Medicare patients.

Our participation in BPCI has increased our awareness of the total cost of procedures and the entire episode of care. It has also trained our physicians about alternative payment models early in the evolution of BPCI. We regularly find that many of our colleagues were not aware of the impact of government-mandated APMs on their practices. We're proud that we were early adopters of this model, deciding early that investing both financial and clinical resources in BPCI would benefit our patients and institution. We've observed a "halo effect" with our participation, as many of the improvements in quality are applied to patients beyond BPCI and Medicare.

Describe your experience to date.

In a word, "eye-opening"—or is that two words? One thing we know is that it's time for CMMI to be more transparent with inter-institutional data. We all must be able to learn from both our successes and failures nationally. While we do not need to see organization-specific financial data at a granular level, there is a need for transparency about who generated savings and who sustained losses, and in what clinical conditions. We need to understand *why* there are winners and losers, to identify and disseminate best practices, to identify which conditions may not be right to bundle, and where additional innovations must occur to create a win-win for patients, providers, and Medicare. We need to know where we stand.

As a discipline, we have greatly improved clinical and financial outcomes for patients requiring joint replacement, yet we all know there's still undesirable variation across hospitals and providers. The next level of improvement will occur when we not only know our comparative costs, but when there is a clear quality threshold for us all. So how do we increase the speed of dissemination of high quality across the country? What incentives work?

We believe that cost data must be transparent and we should be held to a quality threshold such that all patients, regardless of where they receive their care, are positively impacted. Judging quality on a "curve" creates a competitive environment, resulting in a zero-sum game. In that case, for every winner, there's a loser, and this discourages cooperation and dissemination of best practices between hospitals. It may be that over time, well-configured cost metrics may actually reasonably represent quality of care; we support measures of functional status and patient engagement as well. Overall, a threshold for high quality should be set for all of us.

What were some of your organization's upfront investments?

The most significant early decision is to buy or build your care-management infrastructure. A strong care-management team helps preoperatively, within the hospital stay, and during the long period after hospital discharge.

We have significantly changed how we manage our decisions concerning which patients need joint replacement, when they need it, and how we optimize risks in the preop period. We're now engaged in far smarter preparation prior to surgery. The best time to prevent complications is prior to surgery through a program of risk-factor identification and mitigation. We're not reducing the case mix index [severity of illness] of those on whom we operate, but we are more disciplined about reducing unnecessary risk for our patients. We are not "cherry picking," but we are helping with smoking cessation, weight loss, and diabetic control prior to surgery, and this is good care for our patients.

Finally, our alignment with skilled nursing facilities [sub-acute rehabilitation centers, or SARs] has changed. In addition to sending far fewer patients to post-acute care facilities, we're using home health in better ways. Our patients are hearing a consistent message from our whole team: we can work with you to make sure you're safe at home, and you may recover better and more quickly at home. We work with them and our community partners to make sure they are safe.

What has changed for your patients?

We inform all of our patients that they are participating in a bundle. However, few really care about this. What patients do care about are better access to the team, more information, education and clear expectations, and improved outcomes. Initially, our patients struggled with why, just several years ago, patients were discharged directly to inpatient post-acute facilities after surgery and now we discharge them home after surgery. The alignment of messages from our team and improved outcomes made all the difference. Soon, patients saw how the BPCI program was benefitting them: they get more resources when they need them, care is less expensive at many levels, and the outcomes they care about are better.

What would you say to AMCs that have not yet engaged in an alternative payment model?

Do not be intimidated about joining BPCI or an equivalent APM program. Assess your AMC's overall strategy, and select a model that fits with your risk tolerance and opportunities. In some models, you're compared with your own historical price, so if you're serious about improving your performance,

you will do well. Many APMs have a risk-free or upside-only ramp-up period, further allowing learning to occur early on.

The big fear for all of us is a mandated "race to the bottom" price spiral, where a low threshold price will be set and even that price will be cut further over time. Some fear regional pricing for this reason. We choose to believe that regulators recognize that while good care can cost less, it's not free, and that quality of care can only be improved if the basic resources are in place to provide it. Eventually, we hope that national leaders will create models that:

- Reward care based on a threshold for good quality,
- Include transparent risk adjustment for sociodemographic and medical risk,
- Provide a savings bonus for simultaneously beating cost and quality thresholds, and
- Reserve penalties for those few providers who fall short of quality and cost thresholds.