How to Prepare for CMS Bundled Payments
Mandatory bundled payments for joint replacement will serve as many hospitals’ first pilot program for value-based reimbursement in 2016. Combined with the five-star rating system for nursing homes, the Comprehensive Care for Joint Replacement Model (CJR) from the Centers for Medicare and Medicaid Services will change the way hospitals evaluate and work with orthopedic groups, skilled nursing partners and others along the care continuum. It demands internal and external cost and clinical performance analysis, as well as collaboration along the continuum of care that many providers have not yet attempted.

While the mandatory CMS bundles apply only to hip and knee replacement surgeries at about 800 hospitals in 67 metropolitan statistical areas (MSAs), it is likely that this is the beginning of a trend of CMS-directed participation in value-based reimbursement. (See Exhibit 1.) This emerging trend should have the impact of motivating hospitals that have been on the value-based care sidelines into the game in 2016. Providers are preparing now to assess their value-based care readiness, evaluate their options and develop a strategy and a tactical response to meet not just the April 1 hip and knee bundle pilot program start date, but to anticipate future payor-driven shifts in the broader move toward value-based reimbursement.

**FACING THE CHALLENGE**

According to CMS, the average Medicare expenditure for joint replacement surgery, hospitalization

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**Exhibit 1:** The CJR program encourages collaboration among acute care providers, post-acute care providers and specialists along the care continuum in 67 regions.
HOW TO PREPARE FOR CMS BUNDLED PAYMENTS

and recovery ranges from $16,500 to $33,000, and the rate of complications that increase the chances of readmission can be more than three times higher at some facilities than at others.

The CJR model fixes the price that Medicare will pay for all care associated with hip or knee replacement, identified as diagnosis-related groups (DRGs) 469 and 470. The total cost of everything from admission for surgery through 90 days post discharge must fall within that set amount, from the cost of the replacement joint itself to anesthesia, hospital fees, surgery and any rehabilitation at a skilled nursing, rehab or home care facility. (See Sidebar.)

Hospitals have been made responsible for administering these bundled payments. Their administrative leadership must work together with the medical staff to set protocols to determine which patients must rehab in skilled nursing or other facilities as opposed to those who can rehab at home at a lower cost, formalizing required written agreements with bundle partners such as skilled nursing providers and orthopedic groups, coordinating the network of community providers according to established protocols and distributing—or collecting—Medicare payments.

They must also understand their total cost of care, and how each component fits into it, in order to remain within the set price, which varies with each MSA. Further complicating calculations and community relationships, CMS is incentivizing discharge to certain skilled nursing facilities. The usual three-day hospitalization requirement for Medicare to cover a skilled nursing discharge is waived in year two of the program if the hospital discharges to a facility with a CMS rating of three stars or more. The waiver creates an additional opportunity for providers to reduce the total cost of care by eliminating an entire day of care at the higher end of the cost spectrum—for those that meet the quality standards CMS sets.

HOW BUNDLED PAYMENT PRICES ARE CALCULATED

Each hospital will have multiple target prices for its DRGs that vary depending on the risk factors of each patient. Each target price is based on DRG total medical expenses for the hospital and the region from 2012, 2013 and 2014, and the calculation will change from years one through five of the pilot. In year one, the target price is based 66% on hospital experiences and costs and 33% on regional experience with care providers such as skilled nursing or home health. By year three, however, that percentage flips to 33% hospital and 66% regional—and in year five, target prices are based 100% on regional experiences and costs.

This ramp-up in coordinating care inside and outside the hospital coincides with the rapid ramp-up to two-sided risk. (See Exhibit 2.)

Each care provider along the continuum is paid on a fee-for-service basis. If the total medical expense of the episode is within the set price—and specific quality measures are met—then the providers receive a bonus payment from Medicare. Bonus payments can be up to 5% of the target price in years one and two of the five-year pilot, 10% in year three and up to 20% in years four and five.

Conversely, if the care they provide costs more than the set price, they must pay back Medicare. Repayments are waived in year one, but stop-loss limits of 5%, 10% and 20% will be in place for years two, three and four through five, respectively.

The program, therefore, actually favors hospitals and provider networks that are underperforming—it’s not until year four that the upside opportunity for entities with value-based expertise and good performance are fully rewarded with up to a 20% bonus payment.
CJR provides an opportunity for hospitals to reexamine their own roles in value-based care.

GET READY. ASSESS. GO.
CJR provides an opportunity for hospitals to reexamine their own roles in value-based care. Some will find that they do not perform enough CJR procedures to justify continuing the services—or physicians will make the shift for them, choosing to work with higher-volume, more cost-effective hospitals that can offer greater savings. Others will realize that existing relationships with strong post-acute and orthopedic organizations make them the natural choice to lead the charge, not just on CJR but on other value-based initiatives as well.

The starting point for approaching the targeted and complex CJR model, and any value-based care initiative, is to build a program planning task force responsible for overseeing a comprehensive readiness assessment and gap analysis, post-acute care provider market analysis, strategy development, and program planning.

A readiness assessment serves to guide the hospital’s strategic direction, align stakeholders to shared goals and create excitement and commitment among players who must work closely together to develop new protocols to quickly ramp up to two-sided risk. Comprehensive evaluations will help the hospital evaluate its own service-specific costs and find opportunities to reduce them and identify its strongest and weakest external partners.

Such assessments also lay the groundwork for addressing any legal or compliance hurdles that may be faced on the journey to creating formal bundled payment partnerships. Of note: CMS and the Office of Inspector General are both issuing

Exhibit 2: The target price CMS pays for hip and knee replacements, and providers’ related risk assumption, will vary over the course of the program.

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Episode Year</th>
<th>Historical Data</th>
<th>Risk (% of Target Price)</th>
<th>Target Price (Hospital/Regional)</th>
<th>Target Price Discount to CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>4/1/16 to 12/31/16</td>
<td>2012, 2013, 2014</td>
<td>Upside only +20%</td>
<td>66%/33%</td>
<td>2% for reconciliation, no repayment</td>
</tr>
<tr>
<td>2017</td>
<td>2017</td>
<td>2012, 2013, 2014</td>
<td>Downside/Upside: -10%/+20%</td>
<td>66%/33%</td>
<td>2% for reconciliation, 1% for repayment</td>
</tr>
<tr>
<td>2018</td>
<td>2018</td>
<td>2014, 2015, 2016</td>
<td>Downside/Upside: -20%/+20%</td>
<td>33%/66%</td>
<td>2%, 2%</td>
</tr>
<tr>
<td>2019</td>
<td>2019</td>
<td>2014, 2015, 2016</td>
<td>Downside/Upside: -20%/+20%</td>
<td>0%/100%</td>
<td>2%, 2%</td>
</tr>
<tr>
<td>2020</td>
<td>2020</td>
<td>2016, 2017, 2018</td>
<td>Downside/Upside: -20%/+20%</td>
<td>0%/100%</td>
<td>2%, 2%</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services
waivers for certain fraud and abuse, Stark, and Anti-Kickback Laws during this pilot program.

On the CJR roadmap, these strategy and planning processes eventually lead to a forum to develop treatment protocols across the bundled payment care delivery group.

Those that move forward with the value-based CJR model will likely:

» Reduce the variation in the care that is being delivered, resulting in a lower cost per unit of service and higher quality scores.

» Increase physician engagement.

» Shift market share by providing physicians with greater economic benefits.

» Understand claims data showing total medical expense and cost variation for CJR procedures across the continuum of care.

» Learn which of the region’s orthopedic and post-acute providers will make the strongest partners, given the value they provide.

» Develop processes, IT infrastructure and a network for successfully implementing other commercial or CMS-sponsored bundled payments.

» Formalize relationships with key, high-value providers in the care continuum and establish protocols that govern them.

» Eliminate provider relationships that are not cost-effective. Hospitals that discharge to multiple skilled nursing and home health providers could realistically find, for example, that half are not strong CJR partners.

» Establish or strengthen their funds flow capabilities, if a gainsharing program is involved.

» Build a program that evolves over years one through five to fully capitalize on payment incentives.

Laying this groundwork with CJR will set up hospitals for future value-based care initiatives by setting the administrative, financial, operational and clinical foundation for such care coordination.
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