mandatory bundled payment  
getting into formation for value-based care

Success under Medicare’s new mandatory bundled payment model will depend on strong collaboration among hospitals, physicians, skilled nursing facilities, home health providers, and others.

In 2016, 10 years after publication of Redefining Health Care: Creating Value-Based Competition on Results, by Michael Porter and Elizabeth Olmsted Teisberg, the Centers for Medicare & Medicaid Services (CMS) will take what is likely to be seen for years to come as a key step toward realizing the vision of a transformed U.S. healthcare system set forth in this groundbreaking work. Beginning Jan. 1, CMS will launch the Comprehensive Care for Joint Replacement (CCJR) Model, the first mandatory bundled payment initiative.

The CCJR Model is similar to Model 2 of CMS’s Bundled Payments for Care Improvement (BPCI) initiative. Where it differs from the BPCI initiative is that hospitals do not get to choose whether to participate—a hospital is either in or out based on geography and other conditions. The CCJR proposed rule states that, beginning on Jan. 1, hospitals will be held accountable for the cost and quality of joint replacement episodes performed at their facilities. A CCJR episode will begin upon the admission for the anchor hospitalization under MS-DRG 469 or 470 and last through a proposed 90-day period after

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a. Go to innovation.cms.gov/initiatives/bundled-payments for additional information about the BPCI initiative.
b. All information regarding the program structure contained in this article is based on the proposed rule that was issued on July 8, and is subject to change based on the input received during the public comment period.

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AT A GLANCE

> Succeeding under Medicare’s Comprehensive Care for Joint Replacement Model will require collaboration among caregivers and financial arrangements to align incentives.

> Priorities for most hospitals will be care redesign, supply-purchasing strategy, and post-acute care provider partnering.

> Pursuing value for your joint replacement program will chart a path for other service lines and lead your organization’s transition to becoming a value-based enterprise.
discharge, and it will include items and services paid under Medicare Part A or Part B related to the joint replacement episode. Thus, hospitals will be accountable for the cost and quality of care delivered not only on an inpatient basis, but also by all other providers involved in the episode.

Throughout each of the demonstration’s five performance years, hospitals and other providers will be paid as usual under the Medicare program for services delivered. After the end of each year, if, in collaboration with the other providers, the hospital has been able to achieve a minimum level of quality, meet reporting requirements, and keep costs below a target price for the episodes, then the hospital will receive a reconciliation payment for the difference between the target price and actual episode spending (up to a specified cap). If, on the other hand, actual costs exceed the target price, the hospital will be required to repay the difference to Medicare up to a specified repayment limit. Additional details of CCJR are readily available through a simple search and will be refined as CMS issues its final rule.

The good news is hospitals and other providers do not need to do anything to qualify or register for this program. There is no application process, and providers involved in a patient’s episode are paid through the usual Medicare payment processes. The bad news: Hospitals that do nothing to improve care processes and quality will very likely owe Medicare a substantial reconciliation payment at the end of each year starting in 2017.

So what should hospitals do? First, they should recognize that CMS is likely to continue to implement similar programs and to do so across broader geographies to achieve its goals of tying 30 percent of traditional Medicare payments to quality or value through alternative payment models by the end of 2016 and increasing that share to 50 percent by the end of 2018. This likelihood should prompt hospitals to seize the opportunity provided by CCJR and fully commit to delivering value through their joint replacement program by collaborating with other providers to redesign care and align financial incentives. Such efforts will not only help ensure success under the CCJR Model, but also create a path that can be extended to other orthopedic services and other service lines, thereby positioning an organization to become a value-based enterprise.

Participation in the CCJR will not be without challenges. With any of the new value-based payment models being proposed or undertaken by payers, hospitals face an inevitable challenge in reconciling the program requirements for reduced utilization in areas such as rehospitalization, acute care rehabilitation, and emergency department visits with the traditional approaches to revenue generation under fee for service, given that the bundled payment requirements translate to lower system revenue under traditional payment models. Nonetheless, as mandatory bundled payment models proliferate, healthcare providers will have little choice but to adapt to these changes.

Driving Clinical and Financial Collaboration
CMS includes the following comment in its July proposal for the CCJR Model:

We expect that participant hospitals will identify key providers and suppliers for CCJR beneficiaries in their communities and then establish close partnerships with them to assist the hospital in redesigning care for LEJR [lower extremity joint replacement] episodes to improve quality and efficiency, coordinating and managing care for beneficiaries, monitoring episode performance, and refining care pathways.

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c. The repayment responsibility would begin in year 2, and the repayment amount limit would increase in year 3. CMS has proposed to truncate individual spending at the 95th percentile to calculate the target price and the spending.

Simply put, hospitals will struggle to achieve the improvements in costs and quality required to optimize Medicare reimbursement unless they collaborate with physicians, skilled nursing facilities (SNFs), home health providers, physical therapy providers, and others. Key requirements will be the exchange of data and relevant information among providers, and a strong understanding and adherence to uniform care practices and processes.

The structures and processes required to drive collaboration will vary depending on the characteristics of a hospital’s joint replacement program (e.g., size, existing provider relationships, number and degree of sub-specialization of joint replacement surgeons). However, regardless of an organization’s situation, the unwavering commitment of senior leadership will be critical to successfully achieve the required collaboration. Many organizations have found the establishment of a multidisciplinary clinical leadership committee effective in assembling the personnel required to design, implement, and continually improve care practices and supporting processes.

Despite its name, the clinical leadership committee should be responsible for not only clinical operations but also financial aspects of the joint replacement program. The committee serves as the enforcement body responsible for all decision making related to the program. The exhibit below summarizes core responsibilities of this committee. Because the committee will be charged with redesigning the care process, it should include orthopedic stakeholders who are well-respected by their peers and therefore likely to be accepted as representatives of their peers’ interests on the care team. Finance leaders will ensure the committee has a thorough understanding of opportunities for cost savings and the overall financial implications of proposed changes to care planning and delivery.

**CORE RESPONSIBILITIES OF THE JOINT REPLACEMENT PROGRAM: CLINICAL LEADERSHIP COMMITTEE**

- Direct and coordinate the program with established quality and efficiency standards.
- Partner across provider organizations to train and educate personnel assigned to the joint replacement program.
- Investigate variances in costs, identifying and rectifying root causes.
- Tightly monitor and manage supply chain and post-acute care costs.
- Implement an operating-room efficiency program centered on evidence-based processes and supply standardization.
- Recommend terms for contracts, leases, and purchases, including equipment, instruments, operating supplies, outside services, and repairs.
- Implement performance measures to track program quality, satisfaction, operational/financial excellence, and development.
- Develop a joint replacement dashboard and annual outcomes report.
- Develop and implement a work plan to improve patient/family communication and education throughout the care process.
- Establish preoperative patient education classes.
- Implement comprehensive patient care pathways through the 90-day episode, including clear, evidence-based daily nursing and therapy goals and standard post-discharge care plans.
- Create, update, and track adherence to standard order sets and clinical care pathways.
Redesigning Care to Improve Efficiency and Quality

The objectives of care redesign are to improve quality and reduce costs through the standardization of care delivery. Eliminating unnecessary variation in care delivery improves utilization of organizational resources, thereby reducing staffing, supply, equipment, and other costs. Furthermore, it reduces risk and improves outcomes.

The process of redesigning care for treatment of joint replacement patients should include the following key steps:

- Identify all preadmission, surgical, postsurgical, discharge, and post-acute procedures.
- Map out current process flows for each procedure.
- Discuss historical practice patterns versus evidence-based clinical practice guidelines.
- Develop, refine, and submit draft protocols to a multidisciplinary review committee with stakeholders from anesthesiology, nursing, pharmacy, infection prevention, rehabilitation, case management, finance, and administration.
- Define variations required to meet individual patient needs.
- Build processes into supporting IT.
- Train all personnel.
- Establish a continuous performance improvement process.

Physician leadership is critical to the successful development—and acceptance—of care protocols. Orthopedic surgeons need to drive this process. Finance personnel serve a support function by providing and interpreting cost data that inform decisions made by clinicians.

CMS has proposed changes to requirements and incentives for engaging patients in their own care that will affect care redesign efforts and promote innovative approaches to delivering more efficient care. For example, CMS has proposed:

- A waiver for the CCJR Model that would allow use of telemedicine for patients undergoing joint replacement who are located in both rural and nonrural settings, including telehealth services in patients’ homes.
- A waiver of the three-day rule starting in Year 2 of the CCJR Model, allowing coverage of a SNF stay at qualifying SNFs following hospitalization of less than three days.
- Options for hospitals to provide Medicare patients requiring joint replacements with engagement incentives (e.g., post-surgical monitoring equipment) to encourage them to better manage their own health and support their recovery.

Successful care redesign efforts will require the participation of providers involved both in a patient’s joint replacement surgery and in the patient’s recovery from the procedure. Thus, incentives must be aligned among these providers.

Developing Financial Arrangements with Collaborators

Although hospitals are not required to share any bonuses received from CMS, most hospitals will establish gainsharing arrangements to share both payments received under the program and the risks of repayments to CMS. In the CCJR Model proposal, CMS details its proposed terms for financial arrangements between a participant hospital and a CCJR collaborator. Many of CMS’s proposed requirements for gainsharing and loss sharing are similar to those under Model 2 of the BPCI initiative.

CMS’s proposal includes the following highlights:

- Collaborators must furnish services directly to Medicare beneficiaries receiving joint replacement services to receive any savings payments.
- Agreements must be auditable with a specific methodology, including funds flow percentages and frequency of payments.
- Gainsharing payments can come only from shared savings payments from CMS and/or from internal cost savings.
- Collaborators receiving gainsharing payments must contribute to the care redesign strategies of the participant hospital.
The CCJR Model: Collaborating to Reduce Spending on Post-Acute Care

“Through the CMS [Centers for Medicare & Medicaid Services] Value-Based Purchasing Program, incentive payments to hospitals are impacted by the overall spending per Medicare beneficiary. The CMS bundle further reinforces that hospitals will increasingly be responsible for the spending in the post-acute care setting. Now is the time for hospitals to begin tracking the cost and quality associated with post-discharge and developing best-practice protocols across the episode of care.”

—Dereesa Purtell Reid, MBA, CEO, Hoag Orthopedic Institute

Medicare per capita spending on post-acute care varies more than on any other covered service. In testimony before the House Committee on Energy and Commerce’s Subcommittee on Health, Mark E. Miller, PhD, executive director, Medicare Payment Advisory Commission, provided evidence that “Medicare spending on post-acute care varies more than three-fold for conditions that often use these services.”

Patients recovering from joint replacement surgery receive treatment from IRFs, SNFs, and home health agencies. Each of these provider types receives a different payment rate for care provided. Furthermore, the choice of settings to which patients undergoing joint replacements are discharged from a hospital is not always consistent with patients’ true needs or the most efficient option. To date, hospitals and orthopedic surgeons have had little incentive to consider the cost of post-acute care services to Medicare. The Comprehensive Care for Joint Replacement (CCJR) Model changes that.

Through the CCJR Model, CMS is solving its inability to effectively reimburse post-acute care providers and ensure high-quality care from them by making hospitals accountable for the costs and quality of services provided in post-acute care settings. Thus, for hospitals, one of the most critical success factors and daunting challenges of the CCJR Model is finding the best way to coordinate care with post-acute care providers. To meet the objectives of the CCJR Model, hospitals must develop a network of post-acute care providers with which they can collaborate.

CMS’s proposal also mandates that the following elements be included in the definition of internal cost savings:

- Must be measurable, actionable, and verifiable
- Must be the result of care redesign efforts
- May not include savings realized by an entity within the health system other than the participant hospital (e.g., therapy clinic, physician clinic)
- May not reflect “paper” savings from accounting conventions or past investment in fixed costs

Given the proliferation of orthopedic comanagement arrangements, hospitals will need to carefully structure CCJR sharing arrangements, and in many cases, they will need to restructure existing arrangements. Physicians in the field of orthopedics historically have tended to maintain independence from hospitals, and many orthopedic surgeons continue to split cases among multiple inpatient facilities. However, this trend has been shifting as orthopedic surgeons increasingly build tighter relationships and collaborations with single hospitals or health systems to improve care coordination, efficiency, and quality.

In many markets, hospitals have captured such a high percentage of primary care providers that orthopedic surgeons (and all specialists) are finding it necessary to “pick a side.”
The CCJR Model may be the final push that orthopedic surgeons need to focus their attention on a single facility. Orthopedic surgeons who choose to enter arrangements to share in the risks and rewards of the CCJR Model will need to invest substantial time to help their partner hospitals achieve the necessary cost and quality improvements for episodes of care. It is unlikely that these providers would invest this amount of time in working with multiple hospitals. Instead, they are likely to choose a hospital or health system with which to collaborate and, in doing so, begin to move all of their cases to a single inpatient provider.

**Following the Playbook**

Successful joint replacement programs under the CCJR Model include five key characteristics: They are well-integrated, demonstrate economies of scale, have rationalized service offerings, keep leadership informed through effective use of metrics, and can muster a quick response to changing circumstances.

**Integration.** In most places, providers involved in joint replacement episodes do not operate as a unit and do not see themselves as a team with joint accountability for treating all of a patient’s needs. Success under the CCJR Model will require hospitals and other providers to collaborate clinically to provide seamless, standardized, and coordinated care across settings, and economically to share financial data, resources, risk, and rewards.

Hospitals should begin developing a gainsharing model to align financially with collaborating providers. To encourage orthopedic surgeons to come on board, hospital leaders should emphasize how such a partnership offers an opportunity for them to deliver better outcomes and improve their position with commercial payers.

**Scale.** High-volume providers of joint replacement procedures offer patients a proven quality and safety advantage. High volume also allows for the achievement of economies of scale, economically justifying investments in resources needed to enhance care management processes and optimize utilization. To develop the means to operate a successful joint replacement program, hospitals should actively work to achieve scale both as they prepare for the CCJR demonstration and while it progresses.

Hospital leaders should consider whether their organization should be in the orthopedics business by building the financial case for the investments the organization will need to make to achieve the level of volume required for long-term success in that service line. Some hospitals will find that they can better serve their communities by shutting down their orthopedic service line and investing their resources in other services.

**Rationalization.** Opportunities for consolidation and redistribution of joint replacement services to optimize resource utilization and ensure high-quality outcomes should be evaluated. Some hospitals may find that they will be unable to recoup the investments necessary to succeed under the CCJR Model, while others will be able to apply their experience and reputation beyond their current facilities. Clinical affiliations allow successful programs to move into new geographies and could help an affiliate avoid penalty payments to CMS.

Health systems with multiple hospitals within close proximity of each other should strongly consider rationalizing delivery of orthopedics to select facilities. Hospitals with low orthopedic volumes, poor quality, and/or high costs should consider clinical affiliations with hospitals that are better equipped to deliver excellence in orthopedic care.

**Informed performance monitoring.** In tracking performance under the CCJR Model, healthcare providers should be able to identify areas for improvement and make data-driven decisions. This includes tracking outcomes, costs, and patient satisfaction to ensure that improvements are being made and that the program is achieving its goals.

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organizations should keep three key points in mind.

The first point is to measure what matters. The CCJR Model will identify quality metrics that organizations must achieve to earn a reconciliation payment. But these metrics may not fully reflect what’s important to a hospital’s patients or what will lead to cost reductions. Hospitals therefore should evaluate metrics that go beyond those specified in the model, for the sake of patient satisfaction and ultimately market share, while keeping in mind that costs for the entire episode of care are what matter.

The second point to keep in mind is to measure and report frequently, transparently, and credibly. Once supporting financial arrangements are in place with collaborating providers, cost and quality information should be shared at least monthly to allow providers to use the information to improve processes and take corrective action. Under the BPCI initiative, many hospitals have struggled to incorporate data provided by CMS and have been prompted to use one of the many data analytics firms in the industry to supplement hospital personnel while they develop capabilities in-house.

The third key point is to manage both the hospital’s and Medicare’s costs. The hospital’s profitability depends on efficient utilization of hospital resources. The hospital’s receipt or payment of a reconciliation payment at the end of the year depends on the collective charges to Medicare for each episode.

Hospital leaders should begin studying their Medicare fee-for-service populations for the joint replacement MS-DRGs 469 and 470; define key performance indicators; understand complications and comorbidities; and prepare hospital, physician, and post-acute care provider scorecards. The goal is to begin to gain a more comprehensive understanding of current performance and develop the tools that will be used to communicate with collaborating providers.

Responsiveness to change. The previously described four characteristics of a value-based enterprise will support a successful joint replacement program only if the hospital and collaborating providers also are responsive—exhibiting the strategic ability to be nimble and act quickly based on reliable information. The financial arrangements among collaborating providers and the associated leadership structures should facilitate responsiveness and foster a culture that supports innovation.

During the CCJR demonstration, hospitals and their collaborating providers will need to make course corrections along the way. Clinical outcomes may inform the organization of problems with infection prevention, for example, or cost variances among SNFs or home health agencies may indicate the need for new partnerships. Responsiveness allows the enterprise to adjust and execute new strategies to become more integrated, scaled, rationalized, and informed.

Senior executives and physician leaders should be engaged in discussions in which the focus is to establish a culture of shared control that promotes accountability and empowers those who are in position to affect the quality and cost of care.

Seizing the Opportunity
For several years, many healthcare provider organizations have been operating with one foot on the fee-for-service dock and one in the value-based payment boat. With CMS’s launch of the CCJR Model, the time has come for organizations to leave the dock by fully committing to a focus on delivering value in their joint replacement programs. Doing so will not only help health systems succeed under the CCJR Model, but also

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1. CMS has proposed that to be eligible for reconciliation payments, hospitals must meet minimum thresholds on risk-standardized complication rates, 30-day all-cause risk-standardized readmission rates, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores.
2. CMS has proposed to provide beneficiary-level claims data for the historical period used to calculate a CCJR hospital’s target price, ongoing quarterly beneficiary-identifiable claims data, and aggregate regional claims data.
create a path that can be extended into other orthopedic services, other service lines, and other payers, leading toward full transformation into a value-based enterprise.

Many hospital CFOs are concerned about the financial impact of the CCJR Model and the direction in which CMS is headed. But consider the words of Rahm Emanuel, mayor of Chicago: “You never want a serious crisis to go to waste. And what I mean by that [is that] it’s an opportunity to do things that you think you could not do before.” The rollout of the CCJR Model is—if not a “crisis”—an opportunity for hospitals across the country to do things they once thought they could not do. Through collaboration with physicians, post-acute care providers, and others, hospitals can use the opportunity presented by mandated bundled payments to achieve levels of cost reduction and quality improvement that have previously eluded them.

About the author

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