NAVIGATE EFFECTIVELY THROUGH MEDICARE'S CJR PROGRAM – AN OVERVIEW

As seen in Healthcare Informatics.

Experience is no substitute for expediency.

Consider the example of Edward John Smith, Captain of the maiden (and final) voyage of the RMS Titanic in 1912. Despite being one of the world's most experienced sea captains, Smith failed to change the Titanic's course or reduce speed, even though he knew his ship was headed straight into a massive iceberg zone. We all know how that story ends.

Similarly, despite a massive sea change in health care from fee-for-service payments to bundled outcome-based reimbursement, experienced health care executives appear slow to change course or adapt to this transformation, potentially impairing the future viability of their organizations. While many health care systems are addressing (or making plans to address) the changes from fee-for-service to bundled payments, there are still gaping holes.

For example, up to 60 percent of hospitals participating in Medicare's mandatory new Comprehensive Care for Joint Replacement (**CJR**) reimbursement model, which began on April 1, 2016, could face financial penalties in year two of the CJR program when downside risk begins, based on an analysis from this past spring from Avalere, a health care advisory firm. It doesn't need to be this way.

Act Quickly

Sophisticated, high-performing providers that are managing their CJR patients across the care continuum will reap the benefits of the new CJR program, which rewards hospitals that meet its quality and cost goals. Conversely, hospitals that wait until 2017 to begin to address CJR's quality and patient experience requirements will likely pay a steep price – literally and figuratively – in terms of reduced Medicare reimbursements (discounts begin in 2018-see Freed Associates CJR Discount Table, below) and potentially negative reputational costs. Hospital CJR performance, which is specific to fee-for-service Medicare, is publicly available.

With a wave of additional bundled payment models expected in the future, the CJR model is only the tip of the proverbial iceberg, as the Centers for Medicare and Medicaid Services (CMS) continue to push the industry toward value-based payments. On July 25, 2016, the Department of Health and Human Services (HHS) announced that the next bundle will include cardiac patients including those who have had surgery, heart failure, etc. Acute care providers should be using the relatively simple CJR diagnostic group to develop care coordination and post-acute care strategies to prepare for the cardiac bundled payment model and other mandatory bundled payment models coming from HHS that are much more complex and have historically higher post-acute care utilization and

readmission rates.

Based on initial CMS reports of value-based payment cost savings, the rationale for this shift could not be clearer. The Obama administration announced in March 2016 that it had reached its initial goal to tie a larger percentage of Medicare payments to alternative payment models (APMs). Early last year, HHS said it would seek to make 30 percent of Medicare payments for hospitals and physicians through APMs such as accountable care organizations and bundled payments by the end of 2016, and make 50 percent of Medicare payments through APMs by the end of 2018.

Hospitals seeking to comply with the bundled payment changes – especially those with a high volume of fee-for-service Medicare patients, as well as those that haven't been participating in one of the Bundled Payments for Care Improvement (BPCI) programs – should be evaluating, testing (or piloting) and implementing their CJR response efforts by the end of 2016 to comply with the new CJR mandate.

To help determine where your hospital system stands in terms of CJR preparedness, below is a comparative readiness checklist.

Initial CJR Action Steps

By now, every hospital participating in CJR should have completed at least the following four initial action steps:

1. **Use the CJR calculator**. Every acute facility under the CJR mandate should have obtained the CMS CJR data file and calculated its actual performance against the target price. Evaluating the episode costs from both an acute and post-acute perspective will allow the provider to focus on quality and/or cost issues as the CJR program is fully implemented.

2. **Evaluate care coordination expertise**. Providers should evaluate their care coordination expertise and practices (e.g., staff, protocols, pathways, technology) to ensure that high-risk patients are identified and managed in both the acute and post-acute care (PAC) environments. High-risk CJR patients can be identified using a functional assessment tool, such as the Activity Measure for Post-Acute Care (AM-PAC), prior to their admission, during their stay, and in the post-acute care setting.

3. **Determine PAC networks**. Providers need to evaluate their PAC provider network from both a quality and cost perspective and identify the organizations they wish to include in their own preferred PAC networks. The CMS site Nursing Home Compare has detailed information about every Medicare- and Medicaid-certified nursing home in the country.

4. **Review Five-Star Quality Ratings –** In 2015, CMS modified the skilled nursing facility (SNF) star rating system to more accurately measure SNF quality. There are more than 15,500 Medicare/Medicaid-certified SNFs in the United States and more than one-third have overall

ratings of only one or two stars (out of five stars). To see a database of state-by-state star ratings of SNFs, click here.

We address action steps one and two in further detail below. Action steps three and four, on PAC networks and CJR quality and cost data, are in part two of this two-part article series.

Calculate the Target Price

CMS' CJR initiative is funded by the 3 percent reduction that CMS is taking off the target price for CJR procedures. Acute providers should have a goal to reduce their payment discount. To reduce the payment discount, it is advantageous to improve surgical complication rates and achieve higher patient experience scores.

To assist you with these calculations, Freed Associates has made available a complimentary CJR table – see accompanying image, below.

In calculating target CJR prices, CMS plans are to:

- rely on three years of historical Medicare payment data grouped into episodes of care
- update the set of years used about every six months

Historically, CMS has indicated approximately 55 percent of lower extremity joint replacement episode spending was attributable to hospital inpatient services; 25 percent to post-acute care services; and 20 percent to physicians, outpatient hospitals, and other services.

Patient experience scores and surgical complication rates are key to CJR reimbursements. If your hospital is experiencing patient satisfaction scores below national norms and/or surgical complication rates above national norms, it is time to identify the root causes for these issues and put improvement plans in place.

Evaluate Care Coordination

Acute care providers have not historically been responsible for post-acute care patient and cost management. Under the current fee-for-service (FFS) Medicare model, each entity has been paid for services rendered. With the CJR initiative, every participating hospital will be responsible for 100 percent of care-related costs for 90 days, post-discharge, regardless of who provides the services.

Hospitals have personnel with the skills and expertise to manage patient care in the acute setting. What is new for most facilities is the need to evaluate the patient's comprehensive care needs in the post-acute environment for 90 days. Participating CJR facilities will need to:

1. Identify high-risk patients that require support throughout the 90-day post-acute care period

2. Use evidence-based medicine practices to select the best post-acute care setting for every CJR patient

3. Manage the high-risk patient's care for the entire 90-day, post-discharge period

Hospitals that perform well in terms of cost and care quality, will be rewarded by CMS. Conversely, hospitals that do not will be penalized and have to repay a portion of their CJR reimbursements to CMS.

Many acute care providers find they need to hire a PAC leader to develop and manage their PAC management strategy, especially as CMS adds additional bundled payment mandates. Additionally, under the bundled payment model, some providers will need external assistance to manage patients that require PAC management once they have been discharged from the acute facility. Care coordination across the entire care continuum is new to most acute providers. A provider may be best served by engaging with an external firm that can provide the analytics, tools, best practices and training to facilitate care continuum coordination.

When evaluating potential external resources, ask about the organization's expertise managing high-risk patients in the post-acute environment, assessing level-of-care requirements, leveraging existing IT systems, providing post-discharge care management, etc. Some questions might include:

- Does the vendor offer a turn-key IT solution that can provide real time access to patient data?
- How does the vendor track the PAC provider's performance and how is this information shared with the acute provider?
- Can patients be referred, using the same platform, to nonclinical providers?
- What utilization and analytics does the PAC provide to the acute care provider, and how often?

Providers should forecast actual-to-target price spend for all CJR patients. This requires obtaining utilization data in both the acute and post-acute environments. External (third-party) post-acute care coordination costs need to be included in the provider's total costs for CJR and compared to the target price.