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The Comprehensive Care for Joint Replacement model: Balancing risk and opportunity

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After announcing the Comprehensive Care for Joint Replacement (CJR) model in July 2015, the Centers for Medicare and Medicaid Services (CMS) published a final rule describing the model on November 24, 2015.

This model represents a substantial shift in perspective by CMS, constituting a mandatory shift to episode-based payment for certain lower extremity joint replacement (LEJR) services rendered to Medicare fee-for-service beneficiaries in 67 metropolitan areas throughout the country and affecting nearly 800 hospitals. The CJR model requires inpatient facilities to take financial risk for the 90-day period following LEJR procedures, including a broad range of services that could be furnished to these Medicare beneficiaries. Payment under the CJR model is also tied to quality metrics with the possibility of increases or decreases to episode prices based on achievement of certain quality benchmarks.

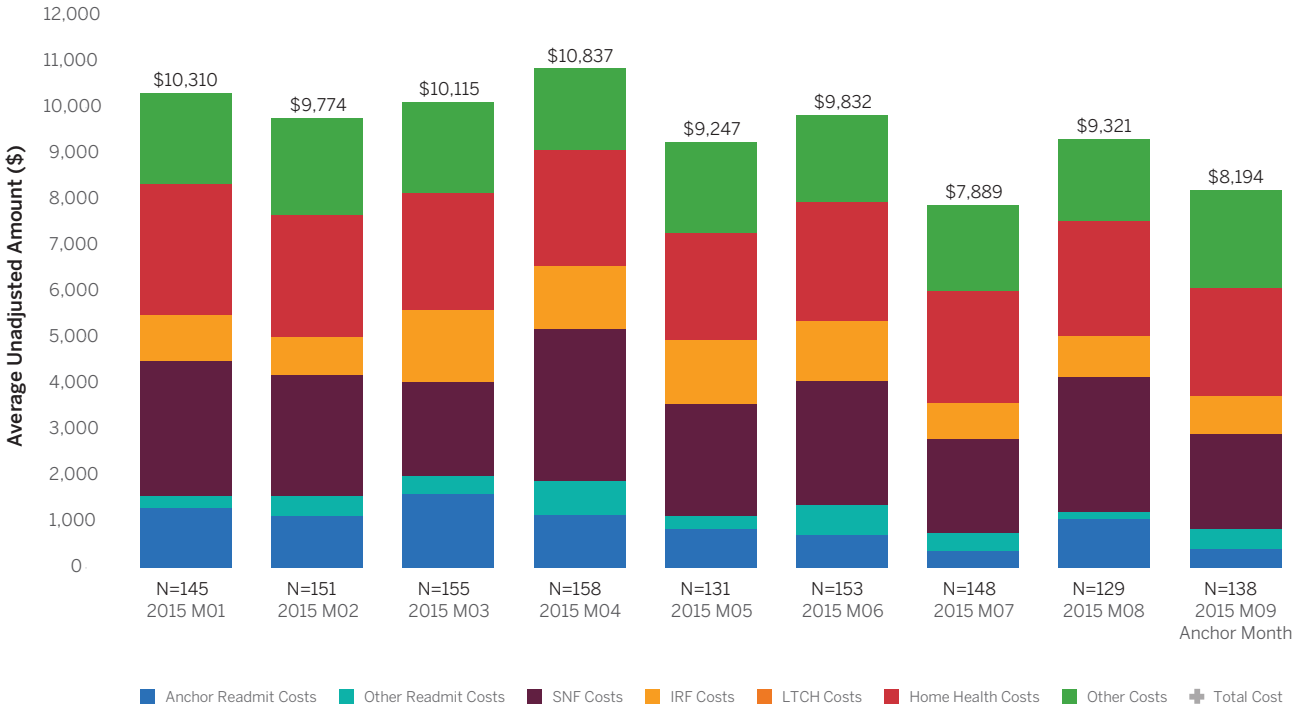
It is imperative that hospitals fully understand the key constructs underlying CJR, because as of April 1, 2016, eligible services that are provided and managed by post-acute providers will directly affect the hospital's payment for an LEJR patient. Financial success or failure under CJR could depend on a given hospital's ability to understand, internalize, and act upon the various data sources CMS plans to make available under this model.

Lower extremity joint replacement episodes of care (mainly hip and knee replacements) have been defined by CMS to include all related services occurring both during the LEJR admission and within the 90 days after discharge. CMS has a broad view of related services, including all institutional post-acute care, most readmissions, and most other services (with only minor exclusions for services it sees as totally unrelated, such as cancer-related services). Unlike CMS's prior bundled payment arrangements such as the Bundled Payments for Care Improvement (BPCI) models, only a portion of the target price for these CJR episodes is based upon a hospital's own historical episodes. Rather, hospitals are compared against a target price that moves from being two-thirds based on a hospital's historical cases and one-third based on historical cases in the region (in performance years 1 and 2) to a target price that is solely based upon regional averages for LEJR episodes (in performance years 4 and 5). Combined with the upside and downside financial risk that is forced upon hospitals starting in the second performance year of this five-year model, hospitals must act quickly to understand what is driving their CJR episode costs and identify opportunities for intervention.

Because the CJR episodes include services rendered after discharge from an LEJR hospitalization, much of the hospital's financial responsibility is tied to services performed outside the walls of the hospital. The only way to fully understand these services is by analyzing the data sets that CMS provides to CJR hospitals throughout the life of the model, beginning with historical baseline data that was provided in early 2016. This data allows hospitals to examine their historical utilization of CJR-included services, particularly high-cost services such as skilled nursing facility stays, inpatient rehabilitation stays, and readmissions to acute care hospitals that may be avoidable. Exhibit 1 on page 2 provides a representation of the variability in utilization of post-acute services for lower extremity joint replacement cases at an example hospital over nine historical calendar months. The representation was constructed based on a combination of the Medicare 100% sample data and analysis of historical data provided by CMS, and does not represent any individual hospital. These types of analyses allow the users to identify the proportion of episode spending attributable to important service categories as well as how these proportions may have changed over time.

While understanding a hospital's own historical utilization on a simulated episodic basis is the first step toward success under CJR, it is also essential for that hospital to compare itself with other hospitals (both within the same census region and across the country) to understand what savings opportunities may be available and how far utilization needs to be managed to achieve the regional target prices enforced through CJR. Looking at regional and national benchmarks can allow a hospital to comprehend the level of achievement that may be possible. By understanding national average and best-performing hospital utilization patterns, it is possible to

EXHIBIT 1: HISTORICAL POST-ACUTE UTILIZATION FOR A LARGE HOSPITAL BY MONTH



initiate conversations about the potential to shift utilization for LEJR patients to lower-acuity post-acute settings. By analyzing the utilization of other hospitals within the census region, hospitals can gain insight related to what they are up against: If the hospitals in a given census region have substantially lower utilization of high-acuity post-acute facilities such as inpatient rehabilitation facilities, hospitals may have their work cut out for them to achieve the target price.

While it may be an uphill battle to align the interests of physicians and hospitals for care redesign, CMS has taken a drastic step to facilitate this by implementing the CJR model. One key success factor for any hospital facing this model is to develop a nuanced understanding of its own historical spending and regional utilization within LEJR episodes. Only then can reasonable care redesign mechanisms and incentives be implemented to work toward achievement of CJR target prices.

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