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Are Hospitals Prepared For Downside Risk In Year Two Of CJR?

To Our Healthcare Clients and Friends:

In April of 2016, CMS launched a mandatory bundled payment initiative in 67 MSA's throughout the country. This initiative, the Comprehensive Care for Joint Replacement (CJR), focuses on hip and knee replacement procedures; which account for more than $7 billion in acute and post-acute costs for over 400,000 procedures nationwide. More importantly, as this initiative enters into its second year, providers may be liable for substantial paybacks. In this edition of *IMA Insights*, we offer some possible solutions to this risk.

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BACKGROUND

CMS previously announced it is the Administration's goal that, by 2018, 50% of traditional Medicare payments will be in alternative payment methods. Currently, 30% of Medicare payments are through alternative payment systems. A major portion of these percentages will be in bundled payment methodologies or episode payment models. According to CMS, the CJR model is designed to promote better care coordination between the various provider settings and improve quality of care for beneficiaries with a lower extremity joint replacement procedure (MS-DRG's 469 and 470).

Under CJR, the acute hospital will be accountable for all cost from the time of the acute inpatient surgical stay through 90-days following discharge from the hospital. Of the patient's total plan of care cost, approximately 45%, on average, is for post-acute services. The acute hospital will be liable for managing the total cost of the patient's episode of care to the CMS issued target price for the respective procedure. Hospitals that exceed the target price will be subject to possible paybacks to CMS. According to HFMA, early reports have indicated more than half of participant hospitals will be exposed to this downside risk beginning January 1st, 2017.

Conversely, if a hospital is able to manage their cost below the target price, and maintain an acceptable quality standard, CMS could make an incentive payment to the hospital. The following are examples of the retrospective reconciliation calculation:

	Target Price	Number of Episodes	Target Payment Amount	Actual Episodic Cost	Reconciliation Amount
Example 1:	$10,000	10	$100,000	$120,000	($20,000)
Example 2:	$10,000	10	$100,000	$90,000	$10,000

Under the CJR initiative, hospitals will not be exposed to downside risk in performance year 1, which began April 1, 2016 and ends December 31, 2016. Below is the phased in downside risk schedule for participant hospitals:

- *Performance Year 1: No repayment responsibility*
- *Performance Year 2 & 3: Partial repayment responsibility*
- *Performance Year 4 & 5: Full repayment responsibility*

However, providers do have the opportunity to receive full incentive payments in each of the performance years.

CMS has allowed acute providers to enter into collaboration agreements with physicians and post-acute providers to have a shared financial incentive. Through these agreements, all parties, in theory, would cooperate with each other to better coordinate care provided to a patient, hopefully improving the quality of care while reducing the cost.

CMS has made historic and current claims data available so that participating hospitals can better understand their performance, utilization and practice patterns around MS-DRGs 469 and 470. A validation period and appeals process exists within the model, which presents providers the opportunity to validate and verify CMS' data and calculations are correct and accurate prior to the retrospective reconciliation period.

CHALLENGES

The biggest challenges hospitals will face under the CJR initiative will be to control costs that the hospital does not directly manage and to ensure any revisions of clinical pathways still ensures quality outcomes. However, according to a recent survey performed by FORCE-TJR, 91% of participant hospitals are not fully prepared to meet these challenges. The use of data analytics can assist hospitals in addressing these challenges and provide guidance to the hospital in reducing their downside risk and increasing any potential incentive payments.

Available Resources: Converting from a volume based payment system to a value based payment system is a real drain on hospital resources. However, the technological infrastructure, data capabilities and a comprehensive reporting package is absolutely critical in optimizing your hospitals success in the CJR model. Having the resources to produce dashboards, reports and data to indicate opportunities for quality, outcomes and cost improvements is an absolute must have.

Data Analysis Reporting: Receiving CMS' available CJR claims data is the first step in maximizing your potential in the CJR program. The sooner this data is in your hands, the sooner you will be able to analyze acute and post-acute cost and utilization patterns. It's important to understand the potential financial impact of this mandatory program. However, identifying cost reduction opportunities will require the participant hospital to analyze how their utilization patterns measure against similar comparison groups such as peers in their regional area, best performing physicians practicing at their hospital and, if part of a health system, best performing hospital in your system. Doing this will allow the hospital to analyze and study various post-acute utilization patterns and measure the impact to the total cost of the patient's episode.

Analyzing physician patterns at the hospital setting could identify physicians that may serve as a "Physician Champion" to some of the higher cost physicians practicing at your facility. Understanding and identifying where and why the high cost variables exist allows the provider to form a root cause analysis and educate on common best practices within the marketplace.

Data analytics will also play a key role in identifying your hospital's top potential collaboration partners. Analyzing cost and utilization patterns by surgical physician and post-acute provider allows the receiving hospital to quickly identify the best partners with which to form a collaboration agreement. Ideally, data analytics reporting should include, at a minimum, reports that identify where patients are going for their post-acute services, providers with lowest cost per episode, providers with the lowest utilization of days or visits and readmission patterns.

Predict Future Cost: Analyzing claims data to understand, historically, how the participant hospital would be impacted or how the cost and utilization patterns compare to your peers is very important in identifying where your program needs improvement. The historical data can also be leveraged to predict post-acute cost based on specific patient and procedure variables. According to an Advisory Board survey, 52% of providers say their top priority is reducing post-acute cost. When the average cost of surgery, hospitalization, and recovery ranges from approximately $16k - $33k having a predictive model to estimate post-acute cost is critical in identifying potential high-cost patients before the start of care. This will enable a hospital to closely manage and monitor these patients throughout the care episode.

Care Redesign (Operations Improvements & Collaborations): For the hospital provider to truly maximize their opportunity in the CJR program, the use of data analytics arms the provider with the information needed to reduce readmissions and length of stay. This results in cost reduction and an increase in potential shared savings. Failing to identify strong, high performing partners in this episode payment model will create even more risk and uncertainty during the 90 day post discharge period of the episode. Operational implementation of marketplace best practices such as, a "Physician Champion", patient participation in "Joint Camps", and promotion of cross provider collaboration will educate all parties involved in eliminating waste throughout the patient's plan of care.

Redesigning care delivery in the acute hospital setting and developing strong relationships or collaboration agreements with post-acute providers prepares all providers to prevent avoidable, unneeded post-acute utilization after discharge from the hospital.

INSIGHTS

Though more challenges exist when preparing for the downside risk era in the CJR model or future episode payment models, the following list of insights will help hospital providers prepare for that potential risk and support efforts in maximizing their opportunity and staying one step ahead of the regions improvement efforts:

Analytical Insights:

1. Analyze and evaluate acute and post-acute claims data to understand how your current performance and utilization patterns measures against various comparison groups such as peers in their regional area, best performing physician practicing at their hospital and if part of a health system, best performing hospital in your system. Understanding how you compare to your peers allows you to identify high performing and improvement areas.
2. Conduct root cause analysis on areas of improvement to develop cost reduction strategies and deploy best practices.
3. Analyze physician patterns identifying an internal "Physician Champion" to assist in educating other physicians on best practices to reduce cost and utilization variabilities.
4. Evaluate post-acute providers with the best outcomes, lowest cost, and lowest utilization & readmission rates to identify as top collaboration and gainsharing partners.
5. Develop and implement physician and post-acute provider scorecards to promote accountability.
6. Leverage historical data to develop a predictive post-acute cost model based on critical procedure and patient variables. This allows the acute provider to remove some of the uncertainty and develop the best plan of care for the patient during the post discharge period.
7. From a CMS claims data perspective, validation of acute and post-acute costs, number of episodes, eligible patients, and target prices are highly recommended. CMS allows the opportunity to dispute and appeal any errors in the data that could negatively impact the reconciliation amount.

Care Redesign Insights:

1. Explore a model where patients participate in a "Joint Camp", being seen by a Physical Therapist (PT) and nursing for education prior to admission to the hospital for the joint replacement surgery. This will serve to better prepare the patient for admission by beginning the education prior to the actual surgery and establish patient expectations up front, resulting in a smoother hospital course and timely discharge.
2. Consider the use of clinical pathways to manage the patient progression throughout the hospital course.
3. Explore the use of Nurse Navigator or Patient Discharge Planner positions to facilitate post-acute care coordination in a timely manner.
4. Have CMO, VPMA hold one-on-one discussions with physicians who are outliers with cost and patient outcomes.
5. Involve Utilization Review, Case Management and Infection control in these cases pre-op or on first day of admission to manage length of stay.
6. Attempt standardization of prosthetics used to decrease expense, gaining concurrence by physicians. Include central supply representatives in these discussions.
7. Evaluate best practice for Post-Acute care whether it be Outpatient Rehabilitation, Inpatient Rehabilitation (Rehab), Skilled Nursing Facility (SNF) or Home Health Agency (HHA) depending on patient age, co-morbidities and available assistance at home.
8. Conduct meetings with SNF, HHA and Rehabs to communicate the CJR implications and conduct open dialogue on the necessity to achieve better outcomes in the least amount of time.

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SUMMARY

Hip and knee replacements are the most common inpatient procedures for Medicare beneficiaries and require a lengthy recovery period. There are a number of moving parts or variables during the 90 days following discharge from the hospital. Being fully prepared by leveraging claims data analysis is key in reducing post-acute cost for the risk bearing acute hospital in the CJR model and in future episode payment models to come.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance with evaluating your hospital's exposure to the information presented above, please do not hesitate to contact me at (610) 742-4033.

Truly yours,

Chris Strano

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Chris is a healthcare professional with over 8 years of experience in the Medicare compliance and revenue cycle management field. He is experienced in using big data to impact business insights for performance management, business development, and financial services for hospital providers across the nation. Areas of concentration include leveraging healthcare claims data for metrics, benchmarking, reporting, data modeling, and visualization dashboards.

In Chris' current role as a Manager, Data Analytics for IMA Consulting, Chris is responsible for overseeing the analytics and reporting solutions team to enhance the decision making for all of IMA's hospital clients.

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