CJR and Orthopaedic Bundled Payments: The Future Is Now

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After many years of designing, testing, and evolving, the Centers for Medicare & Medicaid Services (CMS) appears committed to transitioning from fee-for-service to bundled payments for several episodes of care. By mandating participation in the Comprehensive Care for Joint Replacement (CJR) program and proposing more mandatory programs, CMS is sending physicians a message that bundled payments are here to stay.

History

Bundled payment models from CMS have been evolving for some time. For years, hospitals have been paid according to the Inpatient Prospective Payment System (IPPS), which reimburses Part A inpatient hospital care under a single price, and orthopaedic surgeons have received a global fee for surgery and fracture treatment.

What is now commonly understood as "bundled payment" began in 2009 with the Acute Care Episode (ACE) demonstration project. The 3-year project tested seven orthopaedic and cardiovascular episodes of care in five hospitals. ACE participating hospitals received a prospective bundled payment that captured all Part A and Part B services provided during acute care hospital stays. In effect, CMS expanded IPPS by adding physician professional fees.

As ACE concluded in late 2011, CMS gave the evolution of bundled payments momentum by announcing a voluntary pilot project, Bundled Payment for Care Improvement (BPCI). Offering tremendous flexibility, BPCI enabled a broad array of providers—hospitals, physicians, and postacute care (PAC) providers—as well as nonprovider third parties—to participate as convening organizations. Originally a 3-year program, BPCI was extended an additional 2 years, until Sept. 30, 2018.

In many ways, BPCI participants could design their own programs by selecting from 48 episodes or diagnosis-related group (DRG) families, 4 program models, episode length, and 3 levels of risk. In addition, participants could define their own quality measures if they chose to do gainsharing.

By design, the pricing methodology created a participation bias because target prices and bonuses are predominantly based on improvement over the participant's own past performance. Thus, BPCI attracted organizations with high-cost (low-performing) histories, effectively giving them the greatest opportunity for improvement that would generate savings or bonuses.

Conversely, many organizations with low-cost (high-performing) histories considered BPCI an unattractive option, because there was not enough margin for improvement to offset cost after the mandatory 2 percent to 3 percent discount to CMS.
In 2015, CMS announced CJR. This program incorporates learning from preceding programs and is modeled after BPCI. However, it differs in three key areas: participation, pricing, and risk.

Implemented on April 1, 2016, CJR mandates participation of nearly 800 hospitals in 67 Metropolitan Statistical Areas; there is no opting out. Participants include hospitals in a variety of settings: academic and community, small and large, rural and urban. In contrast to BPCI's model of competing against oneself on price, CJR's pricing methodology creates regional competition, pitting similar hospitals in a region against one another as they pursue savings and avoid risk of paybacks to CMS.

This phased-in regional pricing methodology gives both high- and low-performing hospitals opportunities to earn bonuses, while increasing the risk of penalty. The regional component increases from one-third of the target price in the first 2 years to 100 percent of the target price in year 4. Hospitals begin bearing risk in year 2. Those facilities that come in over the established target price must repay CMS the difference. That repayment has a stop-loss limit, which increases from 5 percent to 20 percent from performance year 2 to performance year 4.

The combination of regional pricing and downside risk will fuel competition and quicken the pace of cost reductions, creating a "race to the bottom" for episode costs and therefore target prices. A question that remains is "where is the bottom?" This is difficult to estimate; based on current information, however, Fig. 1 http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Nov/managing/article_images/managing01_f1.pdf presents a logical scenario.

**Lowering regional prices**

It remains to be seen whether the CMS bundled payment programs achieve their stated goals of better care, smarter spending, and healthier communities. One certainty is that the CJR price/risk methodology will result in lower average episodic costs and savings to CMS. The impact of CJR on overall utilization is unclear; the program could have an adverse impact on CMS's total cost as high-performing providers may find attractive margins in these bundled payments. It is also unclear how much hospitals need to spend to manage bundled payments, compared to the desired savings by CMS. Will we be spending 75 cents to save a dollar?

A core element of the bundled payment pricing methodology is the target price. This is the price that CJR participants "compete" against. In the mandated programs (CJR and the recently announced surgical hip/hip femur fracture treatment and episode payment models), CMS uses a rolling baseline that is updated in years 3 and 5 to establish individual and regional historical cost performance. As under the BPCI, the base price is discounted to ensure cost savings for CMS. The base price is also adjusted up or down to account for national cost trends and market-specific variations in wages.

Insight into the direction and pace of change in CMS costs can be obtained from national trend factors provided by CMS. As noted in Fig. 2, http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Nov/managing/article_images/managing01_f2.pdf CMS's costs for Medicare Severity (MS)-DRG 470 have been trending down since 2011. The pace is increasing and the impact of BPCI and CJR can be expected to further accelerate the
Impact on the market
Although only 800 of 4,000 nongovernment hospitals and approximately 25 percent of lower extremity joint replacements (LEJR) will be included in the CJR program, the program will affect all providers of the services included in CJR episodes. The greatest and most direct impact is on hospitals mandated to implement CJR, which must develop programs and infrastructure to manage 90-day episodes of care. The pressure on CJR hospitals to perform will increase as they assume a 5 percent downside risk beginning in year 2 (episodes ending on or after Jan. 1, 2017). This downside risk will increase to 10 percent in 2018 and to 20 percent in 2019.

The indirect impact on nonparticipating CJR hospitals is often overlooked. Although hospitals not participating in CJR (or BPCI) may feel lucky to be left out, in the end they may be at greater risk by "getting into the game late." By the time CMS expands CJR to include all BPCI nonparticipants, regional costs will have moved substantially lower, potentially creating an even larger delta between high cost hospitals and regional averages. "Early movers" who have experience in the ACE, BPCI, and/or CJR programs may have the advantage over the "late laggards."

The immediate area of focus for CJR hospitals is to lower episode costs (or CMS payments). With relatively fixed hospital reimbursement through IPPS and surgeon professional global fee structures, the best opportunities to lower CJR episode costs are in postacute care. The greatest cost variation and opportunity for savings is to change the site and utilization rate of postdischarge patient care. These changes adversely affect inpatient rehabilitation and skilled nursing facilities and potentially benefit home health care and outpatient rehabilitation. As CJR hospitals reduce PAC expenses, they will turn their attention to internal cost savings.

For many hospitals, the next best opportunity for savings is revisiting implant costs. Lower average episode costs for CMS translate into lower revenue for bundled payment providers. To counter revenue decreases and ensure acceptable profit margins (or limit losses), episode providers must look beyond CMS claims costs and focus on internal costs to deliver care. Increased productivity, improved efficiency, and lower supply and implant costs are the primary targets. The largest single-cost input for LEJR is the cost of implants and associated products. Significant reduction and less variation in implant costs can be expected as a result of CJR.

Future expectations
CMS episode payments for CJR—specifically for LEJR—are decreasing. Where is the bottom? Based on BPCI and early returns from CJR, regional average episode costs can be expected to decrease by 15 percent or more. This reduction in revenue will be compounded by additional provider costs for managing bundled payments.

Successful management of bundled payments requires investment in new or enhanced capabilities, such as data collection and analysis, technology upgrades, and care coordination resources. When these new investments are combined with payment risk, declining target prices, and the incremental costs necessary to manage a 90-day episode of care, LEJR may become unaffordable for many small-volume hospitals. The unavoidable and, in some cases, unfortunate consequences of the CJR model will be consolidation and closure of low-volume LEJR programs. The critical volume to be effective in LEJR bundled payment services will likely be more than 100 cases a year.
It is important for non-CJR hospitals to begin building the infrastructure to manage bundled payments now. When CJR or similar programs are expanded, national and regional episode costs will already have been reduced as a result of their success. The "low-hanging fruit" of cost reduction will have been harvested. It may be very difficult for new entrants in the bundled payment model to adapt quickly. Forward thinking non-CJR hospitals are working now to prepare for the inevitable future, including the transition to bundled payments by other payers, such as commercial payers and self-insured businesses.

Based on recent results and trends, CMS will probably transition nearly all LEJR and many other orthopaedic procedures to bundled payments within 5 years. As important stakeholders in managing episodes of care, orthopaedic surgeons must understand the implications of this new payment model. The financial impact will be particularly important if these programs allow physician ownership and accountability of the bundle.

Dennis O'Donnell, MHA, PT, was a faculty member for the AAOS course on CJR: Understanding the Economics and Risk. John Cherf, MD, MPH, MBA, was the course director and serves on the AAOS Now editorial board. © Dennis O'Donnell, MHA, PT, and John Cherf, MD, MPH, MBA

References:
