

## CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY!

*BRIAN ELLSWORTH, MA, DIRECTOR, PAYMENT TRANSFORMATION, HEALTH DIMENSIONS GROUP*  
*BETH CARLSON, EdD, RN, NHA, MANAGER, CONSULTING SERVICES, HEALTH DIMENSIONS GROUP*  
*ALLEN DOBSON, PHD, PRESIDENT, DOBSON DAVANZO*  
*JOAN DAVANZO, PHD, MSW, CHIEF EXECUTIVE OFFICER, DOBSON DAVANZO*

**Dobson | DaVanzo**

450 Maple Avenue East, Suite 303 | Vienna, VA 22180  
703.260.1760 | [www.dobsondavanzo.com](http://www.dobsondavanzo.com)

 **HEALTH  
DIMENSIONS  
GROUP**  
*Managing. Consulting. Caring.*

4400 Baker Road, Suite 100 | Minneapolis, MN 55343  
763.537.5700 | [www.healthdimensionsgroup.com](http://www.healthdimensionsgroup.com)

# CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY

In what is lightning speed for Centers for Medicare & Medicaid Services (CMS), the July 9, 2015, proposal for mandatory bundling of joint replacement episodes was finalized on November 18, 2015, and will go into effect on April 1, 2016.

In recent weeks, CMS also finalized rules for value-based purchasing for physicians and set in motion a nine-state mandatory value-based payment demonstration for home health. Medicare is continuing to push transformative policies with respect to alternative payment models and value-based purchasing.

The implications of these and other changes, such as the growth in accountable care organizations (ACOs) and the Bundled Payments for Care Improvement (BPCI) program, are profound and will be felt very quickly in many markets. Here is an update to our previous white paper on bundling, concentrating on the things that health systems and post-acute providers need to know right now in order to succeed in the new risk-taking environment.

## MANDATORY JOINT REPLACEMENT BUNDLING IN 67 MARKETS TO START APRIL 1, 2016

Joint replacement care was already undergoing an evolution as a result of the Bundled Payments for Care Improvement (BPCI) program, where it was by far the most frequent diagnostic category selected by BPCI participants (over two-thirds of the hospital-initiated bundlers elected to go at risk for joint replacement episodes). The mandatory aspect of this bundle is unprecedented and will affect about a quarter of Medicare-funded joint replacements, turbocharging the pace and scale of change for joint replacement care in particular and value-based transformation more generally.

In its final rule, CMS retained many of the core aspects from the original proposal:

- Hospitals in the selected regions are the mandatory risk-bearing entity, facing both upside and downside risk through annual reconciliations of target prices to actual expenditures over the five-year life of the model. Hospitals will be in control of the process of care over an episode—a fundamental shift away from the BPCI approach of experimenting with multiple control models.
- Bundled joint replacement episodes include the hospitalization itself and all related Medicare Part A and Part B expenditures for 90 days post-discharge, including readmissions and post-acute care.

### Get Ready!

Bundling imposes two-sided risk, which necessitates rapid-cycle transformation of care delivery and development of robust episodic risk management capabilities. Some markets are experiencing quicker shift to risk bearing than others. Health systems and post-acute providers will need to develop new relationships around value-based care redesign. Are you ready?

## CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY

- For lower extremity (hips and knees) joint replacements, both elective surgery and unplanned fractures are included in the risk-adjusted payment bundle—important because there can be different clinical trajectories between elective and unplanned joint replacements.
- CMS retained the same selection methodology for the mandatory regions, but ended up dropping eight regions because of updated data on participants in BPCI. There are now 67 regions instead of 75.
- The program has the same name, Comprehensive Care for Joint Replacement, but has a new acronym: CJR.

CMS received nearly 400 comments on the proposed rule. As we expected, CMS tweaked some of the components of the model in the final rule, with an eye towards mitigating risk for the hospitals, streamlining the program, and ensuring quality. Notably, CMS added more time for participants to review data and make informed decisions about the program.

Two important concepts from this payment model deserve special attention by health systems and post-acute providers:

- Direct linkage of attainment of gains to quality measures— Unlike BPCI, gains from effective management of costs over an episode are limited to those hospitals that attain a minimum acceptable quality score, based on a composite measure encompassing both joint replacement complications and patient satisfaction. Importantly, additional incentive payments are available for those hospitals with superior quality scores. The composite nature of the quality measure and the scaling of gains in relationship to measured quality are important signals by CMS about how value-based payment will work in the future.
- CJR collaborators—CMS created this concept to facilitate sharing of risk between hospitals and other providers through a process that, under certain circumstances, waives the application of fraud, waste, and abuse laws. CJR collaborators must be Medicare providers participating in the care redesign and can share both upside and downside risk (as well as internally derived cost savings) up to certain limits. These changes are the next step in recognizing that value-based payment transformation requires more flexible application of longstanding fraud, waste, and abuse laws that inhibit well-thought out care redesign.

There are also payment features of particular interest to various provider types. For instance, hospice care is now included in the bundle, whereas under BPCI it is not. Skilled nursing facility (SNF) operators will be interested in the waiver of the three-day prior-stay rule for Medicare coverage. This change starts in year two of the demo and is only applicable to SNFs with a three-star rating or better, signaling CMS' intent to tie regulatory flexibility to evidence of overall quality. Of note, inpatient rehabilitation facilities (IRFs) did not receive waivers of regulatory constraints they had requested.

## CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY

Available evidence, and our experience with BPCI, indicate that joint replacement care will undergo significant change both clinically and in the first setting where patients go after surgery. Post-acute care is one of the largest components in CJR and has the most variability. Figure 1 shows that the first setting after surgery has a profound influence on total cost for the episode (along with whether the patient has comorbidities complications).

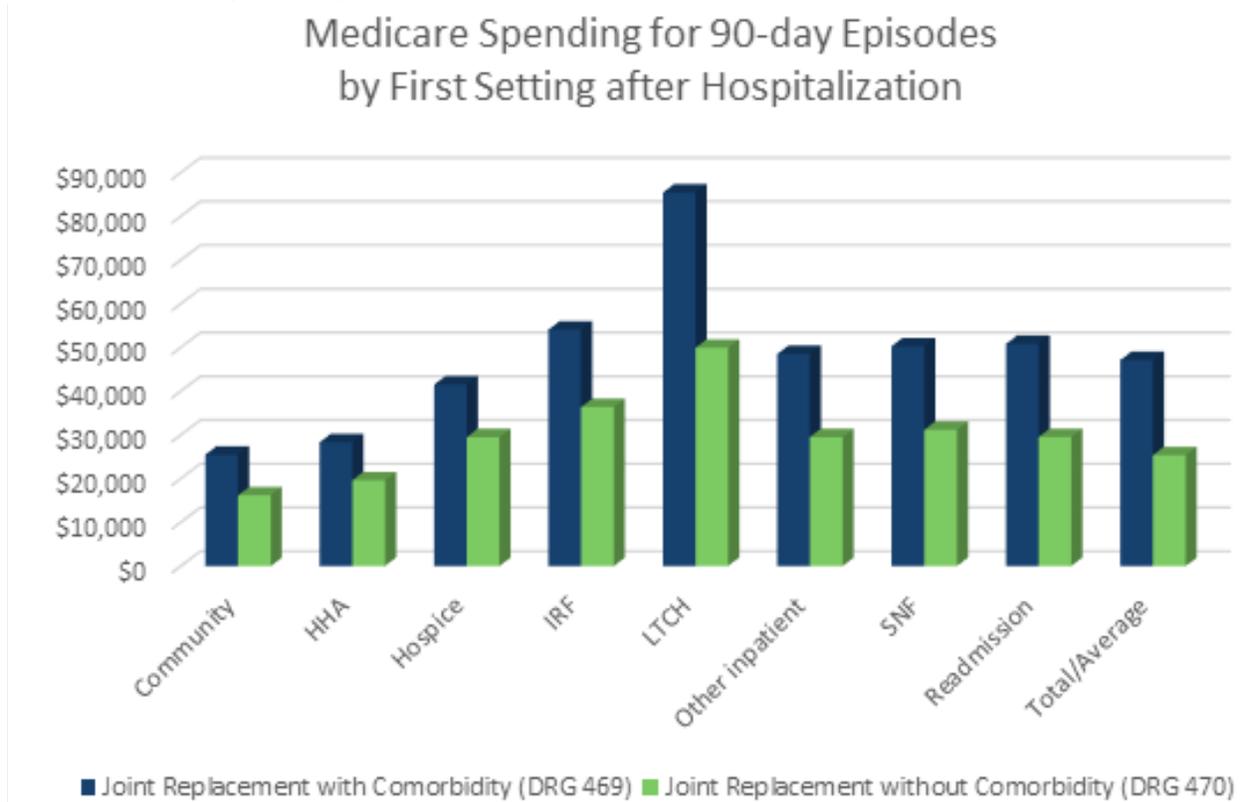


Figure 1. Source: Dobson DaVanzo analysis of Medicare Limited Data Set, 2011-2013

Patients with elective procedures will be shifted to home with outpatient therapy where possible. Although freedom of choice of providers must be maintained under the CJR model, it is safe to assume that CJR hospitals will seek to influence patient choice with information about preferred providers, care redesign, and expected outcomes.

Since this program is starting on April 1, 2016, the time to prepare and inform your decision-making process is now. CMS will be providing claims data to CJR hospitals to inform care redesign. This data, combined with other information, will be used to ascertain preferred discharge destinations and to define the optimal care path.

Our experience with assisting bundlers under BPCI is that hospitals and post-acute providers need to have strong command of the data, as well as thorough understanding of the nuances of bundling, and that this process can take some time to execute depending on the size and scope of the organization. Understanding your strengths in the market is crucial for success.

# CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY

## PARTICIPATION DATA IN BPCI UPDATED: LARGE GROWTH STILL EVIDENT

1,618 episode initiating providers in BPCI risk-bearing phase:

- 415 hospitals
- 723 SNFs
- 305 PGPs
- 103 HHAs
- 9 IRFs
- 1 LTCH

Almost lost in the commotion over CJR is the fact that CMS has updated information on participation in BPCI. As we reported in our previous white paper, voluntary participants in bundling were faced with a “use it or lose it” decision-making process about moving diagnostic categories known as clinical episodes into the risk-bearing phase. There were over 6,500 potential episode-initiating providers that had voluntarily applied to be in BPCI. By July 2015, CMS indicated that 2,046 decided to move forward into risk bearing. Now, the number is 1,618. This should not be taken as a repudiation of BPCI, but rather it likely reflects a thinning of less-motivated participants. It may also reflect more-accurate data reported by CMS, and it makes clear the voluntary nature of BPCI in vivid contrast to the mandatory CJR model.

The next milestone for BPCI participants will be the first round of reconciliations for the wave of providers that joined BPCI in the latest open period. These reconciliations will be where the rubber hits the road for hospitals, physician group practices (PGPs), and post-acute providers as they are reviewing information about their performance under episodic risk and may prompt some BPCI participants to redouble their efforts to implement effective care redesign strategies.

## SOME MARKETS WILL REACH A TIPPING POINT MORE QUICKLY THAN OTHERS

The interactions of these initiatives can be head-spinning and are not yet well understood. Some markets will have a mandatory CJR region, active participation in BPCI, and the presence of ACOs. CMS permits a patient to be in an ACO and also be part of BPCI or CJR. There are rules for determining which programs take precedence over the others—a form of pecking order designed to minimize double payment of savings.

As we reported in our previous white paper, those precedence rules can have the practical effect of rewarding early-adopters and creating mini-land rushes. Where there is a lot of value-based payment transformation activity, it is reasonable to assume that the pace of change will accelerate and that other payers, such as Medicare Advantage, Medicaid, and commercial plans, will get into the act—if not there already. Value-based transformation thrives on scale.

In many markets, post-acute providers should expect that their referral patterns will change (in the direction of increased acuity) and that their value proposition will be challenged by at-risk hospitals and PGPs as they demand exceptional care, high value, and adherence to agreed-upon care processes after the patient leaves their four walls.

# CMS FINALIZES MANDATORY JOINT REPLACEMENT BUNDLING PROPOSAL AND MAKES OTHER MOVES: GET READY

Health systems and post-acute providers need to have a clear understanding of provider relationships in their market, get performance data about themselves and their competitors to inform strategy and decisions, and begin communicating effectively with their clinical and bundling partners about shared goals and redesigning care. Two-sided risk will be here before you know it.

Health Dimensions Group, in association with its data partner, Dobson DaVanzo & Associates, is pleased to provide services to health systems, post-acute care providers, and payers to meet the challenges of value-based transformation in their markets, as well as operational improvements and strategic positioning. Please contact Brian Ellsworth, director of payment transformation at HDG, at [bellsworth@hdgi.com](mailto:bellsworth@hdgi.com) or call at 860.874.6169; or Joan E. DaVanzo, PhD, CEO of Dobson DaVanzo, at [joan.davanzo@dobsondavanzo.com](mailto:joan.davanzo@dobsondavanzo.com).

## ABOUT HEALTH DIMENSIONS GROUP

*Health Dimensions Group is a fully integrated senior living health care management and consulting firm. Health Dimensions Group's principals and staff have expertise in Medicare and Medicaid payment policy and operations, including integrated models of care such as bundled payment and Programs of All-inclusive Care for the Elderly (PACE). For more than 20 years, Health Dimensions Group has helped clients provide outstanding patient care, maintain a healthy bottom line, and plan for the future. For more information, visit [www.healthdimensionsgroup.com](http://www.healthdimensionsgroup.com).*

## ABOUT DOBSON | DAVANZO

*Dobson | DaVanzo is a health economics and policy research firm, established in May 2007. Dobson | DaVanzo's principals and staff have extensive experience in health services research and in Medicare and Medicaid payment policy. The firm has spent the last four years working intensively on bundled payment concepts and applications for a variety of clients. In so doing, Dobson | DaVanzo has gained considerable experience with Medicare "linked" claims files, as well as constructing and pricing acute and post-acute care bundles. For more information, visit [www.dobsondavanzo.com](http://www.dobsondavanzo.com).*

**Dobson | DaVanzo**

450 Maple Avenue East, Suite 303 | Vienna, VA 22180  
703.260.1760 | [www.dobsondavanzo.com](http://www.dobsondavanzo.com)

 **HEALTH  
DIMENSIONS  
GROUP**  
*Managing. Consulting. Caring.*

4400 Baker Road, Suite 100 | Minneapolis, MN 55343  
763.537.5700 | [www.healthdimensionsgroup.com](http://www.healthdimensionsgroup.com)