Comprehensive Care for Joint Replacement:

Hospitals Not Ready for Medicare's New Bundled Payment Model

On April 1, the CMS Comprehensive Care for Joint Replacement (CCJR) model went into effect for nearly 800 hospitals in 67 markets nationwide. Essentially, CMS converted its voluntary payment model—Bundled Payment for Care Improvement (BPCI)—into a regulatory mandate that will hold hospitals accountable for spending by all healthcare providers for 90 days following the initial episode of care.

56% of hospital orthopedic programs are unprepared

A recent survey, however, found that 56% of hospital orthopedic programs said they are unprepared for the CCJR model.[1] Following is a brief review of the CCJR model, its potential financial risks (and rewards) and how your hospital can become better prepared for this latest example of the trend to link payments to quality-of-care metrics.

How does the CCJR Model Work?

According to CMS, CCJR model aims to support better and more efficient care for the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements. It is intended to "encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery."[2]

The payment initiative begins with discharges occurring April 1, 2016 and ends with episodes completed by Dec. 31, 2020. During this time, hospitals will continue to be paid according to existing Medicare fee-for-service rules. However, the hospital where the surgery takes place will bear financial responsibility for the quality and costs of care from the time of surgery through 90 days after discharge.

The CCJR model will determine financial penalties or incentive payments using a retrospective bundled payment, in which the submitted Medicare claims for lower extremity joint replacement surgeries will be aggregated to form the episode payment at the end of each performance year. This amount will be compared to the pre-episode target price and adjusted for pay-for-performance quality metrics. Hospitals are eligible to receive an additional payment or may be required to repay Medicare for a portion of the episode costs, depending on the quality of care and hospitals' cost performance.[3]

CMS will use its updated Composite Quality Score (CQS) payment methodology to assess quality of care. The CQS reflects a hospital's performance and improvement on two quality measures:

1. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey measure, and

2. The total hip arthroplasty/total knee arthroplasty (THA/TKA) complications measure, which includes acute myocardial infarction, pneumonia, wound infection, sepsis, pulmonary embolism as well as surgical site bleeding and mechanical complications.

A hospital's CQS determines eligibility for any reconciliation payment and can vary the amount owing to or owed by the hospital by 1.5 percentage points.[4]

What are the Financial Risks or Rewards?

Each year, CMS will compare the actual total cost of care for all episodes to a predetermined episode target price. If this is less than the target price, the hospital will receive a reconciliation payment equal to the difference, provided the hospital has met certain performance standards such as an "acceptable" CQS. If it is more than the target price, the hospital will be required to pay the difference to CMS (except during the program's first year) subject to a cap to protect hospitals from "excessive risk."

Repayments are capped at 5% of the applicable target episode price in Year 2, 10% in Year 3, and 20% in Years 4 and 5. For example, if a hospital's target episode price was $10,000 and there were 100 episodes per year, the hospital's potential liability would be limited to $50,000 in Year 2, $100,000 in Year 3, and $200,000 in Years 4 and 5. A lower stop-loss limit applies to rural hospitals, sole community hospitals, Medicare-dependent hospitals, and rural referral centers.[5]

Concurrent Review: Reduce Complications that Increase Risks and Costs

Since hospitals will still receive a flat amount for services, the CCJR model strongly incentivizes them to be more aggressive, collaborative and proactive in managing patient care. One survey found that 75% of orthopedic department respondents are actively planning to hire new staff to better meet the demands of coordinating patients and collecting data across the entire episode of care.[6]

A key area of focus should be preventing complications, since these affect both reconciliation payments/penalties and post-discharge costs. To reduce complication rates for total joint procedures, hospitals need to more effectively monitor and manage relevant process and outcome measures that drive compliance with best practices.

Q-Centrix's Concurrent Review services for the CCJR model helps hospitals accomplish this in several ways. First, our quality improvement specialists can monitor relevant process and outcome measures and alert personnel of non-compliance issues. Physicians, nurses, infection control practitioners and quality control managers can use our Q-Apps dashboard to track compliance for each patient in real time and take corrective action when necessary.

Hospitals also can analyze this data to identify trends and quickly adjust processes to improve performance. The Concurrent Review services can also improve clinical documentation improvement efforts by correctly classifying complications for coding prior to discharge.

In addition to supporting CCJR participants, Concurrent Review can benefit all hospitals that perform total joint procedures and participate in the Blue Cross Blue Shield Blue Distinction Program or The Joint Commission Disease Certification program.

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[1] http://www.prnewswire.com/news-releases/survey-shows-more-than-half-of-hospital-orthopedic-programs-unprepared-for-new-mandatory-joint-replacement-program-300229978.html

[2] https://innovation.cms.gov/initiatives/cjr

[3] http://www.beckershospitalreview.com/finance/ccjr-model-takes-effect-this-week-13-things-for-healthcare-leaders-to-know.html

[4] http://healthcareblog.pyapc.com/2015/11/articles/healthcare-reform/no-fooling-mandatory-medicare-bundled-payments-for-hip-and-knee-replacements-start-april-1/

[5] http://healthcareblog.pyapc.com/2015/11/articles/healthcare-reform/no-fooling-mandatory-medicare-bundled-payments-for-hip-and-knee-replacements-start-april-1/

[6] http://www.prnewswire.com/news-releases/survey-shows-more-than-half-of-hospital-orthopedic-programs-unprepared-for-new-mandatory-joint-replacement-program-300229978.html