THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

BUNDLED PAYMENTS: EXPANDING RISK FOR POTENTIAL REWARD

Collaboration is the key to success in new payment model

A Change in the Air

The program holds hospitals responsible for all costs, processes, and outcomes for CMS hip and knee replacements within 90 days of the initial hospitalization. For five years starting April 1, 2016, 794 hospitals in 67 metropolitan statistical areas, and about 107,000 joint replacement cases annually, will be impacted. The bundled payment price is specific to each provider and, as the program progresses, is increasingly based on regional performance until the bundle cost is 100% weighted to the regional price.

Doing nothing is simply not practical. Non-action in 2016 might give hospitals a higher baseline in program year three, but the regional price will in all likelihood drop as competitors take action to reduce their costs in order to qualify for the incentives. Late starters might find it difficult to chase a declining regional price baseline; a potentially costly consequence. In the short term, hospitals that organize early should benefit from gain sharing, potential increases in market share and, in the long term, from applying the cost-efficient platform they develop to future payer- and market-driven value-based reimbursement initiatives both public and private.

CJR success demands a deliberate, well-coordinated effort blending data, analytics, care model redesign, financial modeling, and care system development within and outside the hospital walls. CMS specifically identifies SNF's and others operating outside the hospital walls as "collaborators," recognizing the important role they play in successfully managing the entire episode of care.

Data Drives the Program

Using CMS program and comparative data, hospitals start by modeling their CJR program's financial exposure and post-acute care cost exposure. They also develop a clear understanding of their own internal processes and where they have room to reduce costs and improve quality. (See Figure 1.)

Data, rather than past relationships or ownership, must now also inform partnership decisions with regional collaborators. While patient choice must be preserved, CJR success depends on building an end-to-end clinical system winnowing providers to high performing network partners that can be highly coordinated around the patient circumstance to deliver cost advantage, readmission rate reductions, and high quality scores among other metrics. (See Figure 2.)

The CJR program provides certain waivers to facilitate development of effective care systems. Among these, the "3-day stay" rule for Skilled Nursing Facilities is waived. Only facilities with 3-star ratings or better can participate under this waiver. Nationally, about 34% of the Skilled Nursing Facilities would be precluded from the waiver simply because their ratings are below 3-Star. Again, the do-nothing option here is potentially costly; working directly with skilled nursing facilities to get them the guidance and resources they need to improve their star ratings will facilitate development of high quality and accountable post-acute care systems.

CJR PAC Prevention: Example Steps

- Analyze like-patient data to forecast readmission odds and anticipate challenges
- Explain potential pain levels to avoid post-surgery emergency department visits
- Store patient blood pre-surgery
- Reduce infections by adhering to antibiotic start/stop guidelines
- Develop skill-building teams to train physicians focusing on those whose outcomes are outliers for either quality or cost.
- Begin discharge planning pre-admission to match patient need to post-acute level of care

Designing a Value-Based Care Model for Now … and for the Future

Having assessed care processes and identified the right partners, hospitals will need to conduct a gap analysis and develop a care model redesign pathway, modeling potential gains against the initial program cost model. Clinical next steps will include anticipating and reducing potentially avoidable complications (PACS - see sidebar) as well as establishing acute-stage guidelines. Hospitals can focus on perfecting peri-operative processes, for example, focusing on reducing potential complications; standardizing the supply chain (e.g. one source for implants) and other measures that save money and promote excellent surgical outcomes.

Because the CJR program ties finances to process over a 90-day episode, the hospital care pathway can be customized around optimal results and an attempt to minimize post acute care resources. For example, increasing length of stay to allow for additional patient education, early rehabilitation, fall avoidance training and the like, should result in lower post-acute risk utilization exposure. Within the CJR program context, resource delivery and utilization across the entire episode is completely within the purview of the Hospital.

The importance of clinical process cannot be underestimated in the CJR program design. The planning for a total joint patient's care must begin far in advance of the actual procedure. It needs to start in the surgeon's office. The care pathway for the patient should be laid out in advance, the patient engaged in a "pre-hab" program that addresses physiologic and chronic disease risk factors, and every effort should be made to further engage the patient in a shared decision-making process.

Gain sharing with collaborators is an important part of the CJR program structure. The CJR rules allow for distribution of program gains among collaborators. Further, the program allows for the distribution of certain internal cost savings as part of the total gain sharing distribution.

As the post-acute-care network develops, hospitals will strive to invest their collaborators meaningfully in the care model redesign process, develop and execute collaboration and gain sharing agreements with collaborators, and harmonize program elements with institutional governance and compliance systems insuring CJR program guidelines are fulfilled.

Program operations are supported via a specialized care management workflow platform and performance dashboards. A rolling reconciliation process based on quarterly data feeds from CMS will help leadership update the program to account for the latest care outcome data and the overall performance of the care system from admission through the 90-day program period.

Conclusion

The CJR program is a true value-based program in the mathematical sense, in which value = quality ÷ cost. Potential cost gains that the hospital and its network might enjoy as CMS claims are retrospectively reconciled depend on achieving quality scores, which, in turn, depend on accurate, validated measurement of both old and new performance metrics.

Hospitals should carefully consider the implications of this program on the total joint service line and the opportunity presented to establish and deploy more effective care models across all service lines. Hospitals have the opportunity to attract more total joint business as their systems of care become more effective both clinically and economically. A well designed and executed CJR program should be a net business attractor for hospitals.

While the program challenge is undeniable, the CJR program presents an undeniable opportunity to invest in change. It is likely that CMS will construct similar programs in the near future, and that other payers will continue to follow their lead.

FIGURE 1:
Hospitals' cost exposure and program opportunities are calculated by assessing each CJR-eligible episode, like the example above, and totaling all categories for all episodes.*

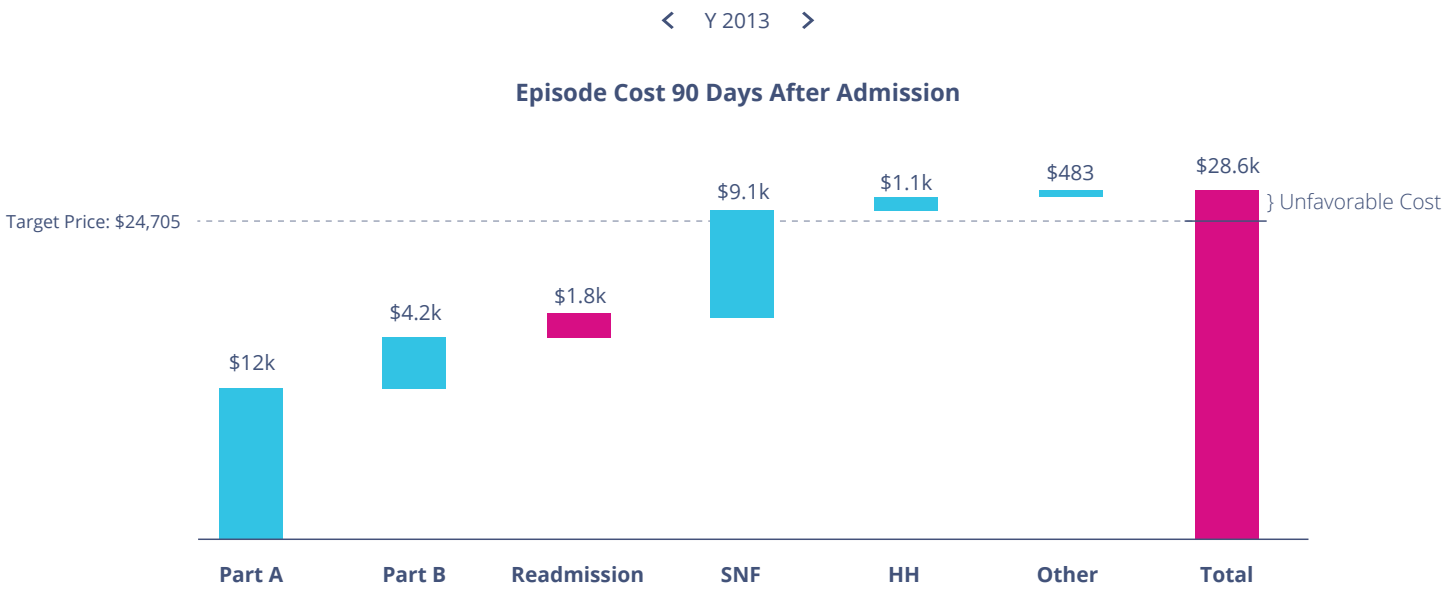
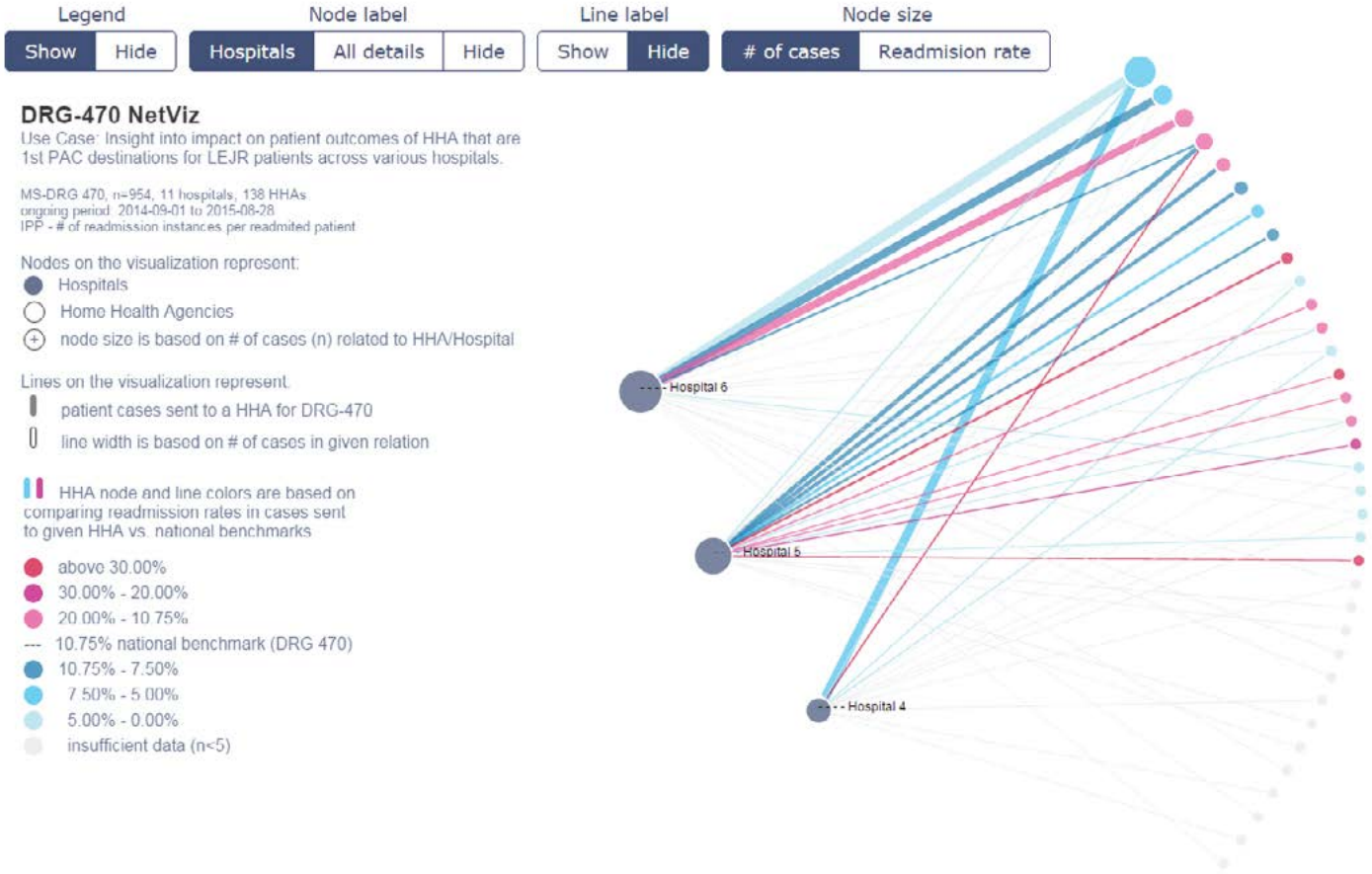


FIGURE 2:
Three hospitals in a system discharged to various home health agencies. Blue dots indicate strong partners with favorable readmission rates; while pink dots indicate unfavorable rates. Of the five agencies receiving the most discharges, three performed poorly.*



** Developed in collaboration with Owned Outcomes. O2 is a software platform that analyzes and delivers value based care analytics to healthcare providers and payors enabling them to make more informed, data-driven decisions.*

OWNEDOUTCOMES

How BDO Can Help

Initial analyses

- Data: Analyze and use program data to model performance.
- Performance: Where are you leaking volume? How do you compare to national and regional benchmarks?
- Network: What are your current referral patterns? With whom should you partner more closely?
- Volume/Referrals: What is your share of wallet? Where is it leaking? What's driving leakage?

Program development and implementation

- Care planning: (including optimal PAC plan) at the pre-procedure stage
- Discharge planning: Facilitate optimal site of care, length of stay and most capable provider for each patient and effect an e-referral for PAC

Gain Sharing

- Design model and administer programs to align collaborators

Program Operations

- Financial projections
- Financial reconciliation

Abstract results/capabilities to support commercial bundle expansion

- Extend bundled payment operations expertise to other clinical processes and conditions

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