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HEALTHCARE MANAGEMENT ADVISORS

Getting Ready For CJR

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If your hospital is in one of the 67 regions affected by the Comprehensive Care for Joint Replacement (CJR) program, you probably are wondering what you can do to prepare. The program will start on April 1, 2016.

The good news is that because there is a tremendous amount of similarity between the CJR and Bundled Payment for Care Improvement (BPCI) initiatives, there is a lot to be learned from the providers who have been successful in BPCI bundles for Major Joint.

SIMILARITIES AND DIFFERENCES

Both initiatives include:

- Patients with Medicare Part A&B
- A retrospective payment model that looks at how costs compare to historical costs
- Gainsharing on both internal costs and episode costs
- Similar waivers for 3-day stay, telehealth, and home health direct supervision

The primary differences in the CJR model are:

- There is no choice of bundle length--90-day bundles are required
- The target price is based more heavily on regional cost averages, putting more cost pressure on organizations with above-average costs
- Payments are contingent on meeting specified quality performance targets

The differences are delineated in the table below.

Comparison of CJR and BPCI		
	CJR	**BPCI**
Participants	All hospitals in 67 regions (excluding those already in BPCI)	Voluntary. Hospital, physician group or post-acute provider participation
Bundles	469 and 470 only	48 families, including major joint (469/470)
Episode length	90 days	30, 60 or 90 days
Notable Exclusions	• Acute clinical conditions not arising from existing episode-related chronic condition/complication of the lower extremity joint replacement (LEJR) surgery • Chronic conditions not affected by LEJR procedure/ post-surgical care	• Hospice
Target price	• Separate target price for hip fractures Based on 3 years historical data: • Years 1 and 2: 2/3 hospital, 1/3 regional • Year 3: 1/3 hospital, 2/3 regional • Years 4 and 5: 100% regional	Based on 3 years historical data: • If high volume, mostly based on hospital • If low volume, mostly based on regional
Discount	3%, may be lowered to 1.5-2% based on quality scores	2-3% depending on episode length
Risk	• No downside risk year 1 • Stop-loss and stop-gain limits, increasing by year (ranging from 5% in Years 1 & 2 to 20% in Year 4 & 5) • Hospital's sharing of risk limited to 50% of the total repayment amount to CMS • Hospital could share other 50% of repayment amount with providers/suppliers, although repayment responsibility cannot exceed 25% for other collaborators.	• Waived downside risk through December 2014 for participants starting in or before January 2014 • Participant at risk 100% for costs up to 99 percentile; at risk for 20% of costs beyond the 99th percentile • 20% stop-loss and stop-gain limits
Quality	Must meet targets for two measures to receive payment: complications, and patient experience	Monitored but not requirement of payment model
Participation period	5 years (2016-2020)	3 years from start 1st group of participants 2014-2016

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WHERE TO START

We know that hospitals that have been successful in BPCI for Major Joint have succeeded by reducing costs in the post-acute stage of the episode. That will only become more important with a mandated 90-day episode. Hospitals have had some luck at managing which type of setting patients go to immediately after post-acute care, but have had more difficulties in lowering length of stay for patients that go to SNFs. That should be a first target for providers in the CJR program.

The second target is the process of setting patient expectations for post-acute care, even prior to hospitalization, and certainly early in the acute care stay. Patients need to understand that it may be entirely appropriate for them to take a different post-acute path than that of friends who have had the same procedure. That reduces pressure on physicians and lowers the time to post-acute placement.

Finally, it's important to change the way patients are managed during their hospital stay—the actual model of clinical care. Not only does this have the potential to shorten the length of the acute care stay with better patient outcomes, it can also allow a shorter stay or less intense level of post-acute care.

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