CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

BUNDLING BADLY:

The Problems With Medicare's Proposal for Comprehensive Care for Joint Replacement

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On July 9, 2015, the Centers for Medicare and Medicaid Services (CMS) proposed regulations to create what it described as an "episode payment" for hip and knee surgery. However, what sounds like a desirable patient-centered payment reform – "Comprehensive Care for Joint Replacement" or CCJR – turns out to be primarily a plan to penalize hospitals when patients receive higher-than-average amounts of post-acute care services after knee or hip surgery. Moreover, the plan is implemented in a way that could lead to many very problematic results, including:

- Encouraging further consolidation in the healthcare industry, fewer choices for consumers, and higher prices for private purchasers; and
- Discouraging truly innovative approaches to managing hip and knee problems and encouraging unnecessary surgeries

Most people won't have the stamina to read through 394 pages of preamble and 45 pages of regulations to figure out the complex structure CMS developed, so here's an explanation of why what sounds like a good idea turns out to be exactly the opposite.

True Episode Payment Would Be Desirable, But This Is Just P4P

Creating an episode payment for joint replacement is a good idea – a patient shouldn't have to worry about whether their surgeon, the hospital, other doctors, physical therapists, the rehabilitation facility, home health nurses, etc. are coordinating their services, and Medicare shouldn't have to pay more if patients receive services they don't really need to achieve a good outcome. In a true episode payment structure, all of those providers would work together to deliver care in a way that achieves the best outcomes at the lowest cost, and because they are working together, they can take a single, bundled payment and divide it among themselves. Moreover, under a true episode payment, the providers would have the flexibility to completely redesign the way they deliver care, including providing services that aren't paid for at all today, but they would also have accountability for ensuring that the different approach to services achieves similar outcomes at a lower cost or better outcomes at the same cost.

However, the Medicare CCJR proposal isn't a true episode payment and there isn't any requirement that all providers whose services are included in the episode work together to redesign the way they deliver care. CMS is telling every individual provider – the doctors, the home health agency, the skilled nursing facility, the hospital, and any others – that they will continue to be paid exactly the same way they are paid today for doing the same things they do today. The only difference is that at the end of the year, the hospital – and only the hospital – would get a penalty or bonus based on the grand total of the payments for all of the services billed by all of those providers. The hospital wouldn't be given any control over which services the Medicare beneficiary received (the patient could use whichever physicians, skilled nursing facilities, home health agencies, etc. they wished) and those providers would have no obligation to control how many services they provide. But if the beneficiary received "too many" of those services, the hospital would be expected to pay for the excess.

So even though the proposed regulation calls CCJR an "episode *payment*," it's actually just a new *pay-for-performance* system for hospitals based on Medicare's retrospective analysis of *spending* that occurred during an episode.

It May Look Like a Bundled Payment But It Isn't Really

What most people will likely find confusing is that many true episode and bundled payment systems are being implemented using a retrospective reconciliation process that looks similar to what Medicare is proposing to do. Under those systems, during the course of the time period covered by the episode payment, the providers who are involved continue to bill a payer using traditional fee-for-service billing codes. The payer then adds up all of those bills, compares them to the episode payment amount, and either sends the providers an additional payment for the difference, or tells them they need to pay back any overage. That retrospective reconciliation process is really just a convenience for the providers; it enables them to get interim payments during the episode and avoids forcing one of the providers to take on the responsibility of paying all the other providers for their individual services. As a practical matter, though, the system functions as though the providers were getting a single bundled payment of a predefined amount and then distributing it among themselves based in part on the services they delivered.

What Medicare is proposing in CCJR sounds similar, but the details differ in several key ways:

- In a true episode payment system, the providers determine how much it will cost them to deliver the complete bundle of services in the episode and the payer decides whether to pay that. In Medicare's proposed CCJR system, Medicare decides what to pay for the episode (the "spending target") based on its average spending on knee and hip surgery patients in the prior year for all hospitals, and each individual hospital is then forced to accept that amount.
- In a true episode payment system, the providers decide in advance which other providers to partner with in order to deliver a complete set of coordinated services. In Medicare's proposed CCJR system, the beneficiary decides which providers will deliver which services in the episode, regardless of whether those providers work together or even know each other.
- In a true episode payment system, the providers have the flexibility to deliver services that they could not bill for under the fee-for-service structure, knowing that they will ultimately be paid for those services when the reconciliation occurs. In Medicare's proposed CCJR system, this would only happen in the short run; over time, providers would ultimately lose money if they delivered services that are not billable under Medicare's fee-for-service payment systems.

It's a Payment Design That Penalizes Innovation Instead of Encouraging It

The last point is particularly important, but it may be very difficult to understand because there is a lot of confusion today about the difference between healthcare *spending* and healthcare *costs*. Sustainable innovation in any industry occurs when products and services can be redesigned in ways that lower their costs so they can be sold at lower prices. In contrast, simply cutting payment amounts may lead to shortages of services and other undesirable effects.

Here's an example: Suppose orthopedic surgery practices and hospitals felt that instead of discharging some knee surgery patients to a skilled nursing facility (SNF) for the kinds of rehabilitation services Medicare will pay for under the SNF payment system, the patients would recover faster and at lower cost with a new home-based rehabilitation program. This hypothetical new program is not covered by Medicare, so if a surgery practice or hospital began offering this new service to patients, they would not be able to bill or be paid for it directly. But for patients who received the service instead of going to a SNF, the total cost of services would decrease. In this scenario, however, Medicare's *spending* would decrease more than the actual *cost* of services would go down, because Medicare would be paying nothing for the new home-based service even though it clearly would cost the surgery practice or hospital something to deliver it.

Under a true episode payment structure implemented using retrospective reconciliation, the entity that's managing the payment, whether it was the hospital or the surgery practice, would ultimately receive enough revenue to cover the cost of the new service. That's because the lack of billing for SNF services would create a surplus in the "budget" defined by the episode payment; that surplus would be paid to the entity at the end of the year and it could use the surplus payment to cover the cost of the unbillable new service.

In the CCJR program Medicare has proposed, there would be a similar surplus payment in the first year in which the program was in effect. In this hypothetical example, total billings with the new home-based service would be lower than the episode spending target established by Medicare because the target was based on average billings in the prior year when SNF services were still being used more frequently. However, over time, if many providers begin offering the new service that's not directly billable instead of using SNF services that are billable, Medicare will reduce the amount of the CCJR "episode price" it pays below the cost of actually delivering the services. That's because under the proposed CCJR regulations, CMS will base the episode spending target each year on the amount it *spent* on services it was *billed for* in the prior year, not on the *costs* the providers incurred for the services they *actually delivered*. In a true episode payment system, the providers wouldn't agree to an episode payment that low because they couldn't afford to deliver the full package of services at that price. But Medicare isn't planning to assess whether the lower spending target is adequate or not; under the proposed CCJR system, Medicare will simply reduce the target and penalize the providers if their spending is higher.

The key thing to remember is that what Medicare and health insurance plans *spend* on services isn't the same as what it *costs* providers to deliver those services, and in some cases, the services payers *do* pay for may not deliver as much value as the services they *don't* pay for. A well-designed bundled payment system sets a price and then lets providers decide which services provide the best combination of cost and quality. The providers could accept a lower price for care than what is being spent by payers today, because they'd have the flexibility to substitute a higher-value service that's not paid for today and to define an episode payment amount that's adequate to cover the new, lower costs of the new set of services. But the price has to be set based on the services the providers plan to deliver, not determined through a retrospective analysis of the payer's spending on the services it pays for. (See *The Payment Reform Glossary* (www.paymentreformglossary.org) for more detailed explanations and comparisons of the terms "bundled payment," "episode payment," "spending," "cost," etc.).

Instead of encouraging providers to innovate, the proposed CCJR regulations attempt to specify exactly how care should be delivered. For example, the regulations state that "a home visit of once a week to a non-homebound beneficiary who has concluded PAC and who could also receive services in the physician's office or hospital outpatient department as needed, along with telehealth visits in the home from a physician or NPP, should be sufficient to allow comprehensive assessment and management of the beneficiary throughout the LEJR episode." That's CMS defining how care should be delivered, rather than the physicians, hospitals, and other providers who know what the patients actually need.

Moreover, the most innovative approaches of all would be completely precluded by the design of the CCJR payment model:

- The CCJR only applies to patients receiving surgery during an inpatient hospital stay, even if surgery could be delivered in an outpatient setting. (The regulations say "There is little opportunity for shifting the procedures under this model to the outpatient setting," even though many providers are now beginning to use outpatient joint surgery for appropriate patients.) If some patients can be treated on an outpatient basis, the average costs for those who do continue to need inpatient surgery may be higher, and that could result in a financial penalty under CCJR.
- There is no reward under CCJR for helping a patient address their knee or hip problem without surgery, and there may be a financial penalty for doing so. The reason is that if lower-acuity patients are treated non-surgically, the patients who do get surgery will likely be those who need more extensive post-acute care services; that would make the hospital's average costs for surgery cases increase, causing them to be penalized under the CCJR structure.

The bottom line is that Medicare's model would discourage innovation and it could bankrupt innovative providers, whereas a true episode payment structure could encourage innovation and allow patients, providers, and Medicare to all benefit – a genuine win-win-win.

CCJR Will Likely Accelerate Provider Consolidation and Increase Prices for Private Payers

In addition to discouraging innovation, Medicare's proposal would likely encourage fewer choices for patients, more consolidation of providers, and higher prices for private payers. If you're a hospital and Medicare is going to penalize you when total episode spending is high because post-acute care providers and physicians order or deliver too many services after patients leave the hospital, what are you going to do? One logical strategy would be for the hospital to buy the post-acute providers (i.e., the nursing homes, the home health agencies, etc.) and buy the physician practices so the hospital could directly control how much those providers spend following hip and knee surgery. Smaller hospitals who don't own their own post-acute care providers may be even more nervous about the financial risks they'd face under CCJR if the post-acute care providers are owned by a competitor hospital, and so another potential result would be for smaller hospitals to get out of the business of delivering hip and knee surgeries altogether or to consolidate with the larger hospitals. The net result either way would be fewer choices of hospital and post-acute care providers who deliver care for knee and hip surgery, and that in turn could result in higher prices for private purchasers and patients who rely on competition to hold down prices.

The CMS regulations seem to assume that all of the post-acute care providers will willingly sign contracts with hospitals to share their financial responsibility, since there is a lot of detail in the regulations designed to control what those contracts would look like. But if you're a post-acute care provider, why would you want to voluntarily agree to lose revenues by delivering fewer services in order to help a hospital avoid a penalty? And if you're a hospital, why would you want to try and define a contract that CMS would approve if you could just acquire the post-acute care provider and avoid the need for the contracts altogether?

Similarly, there would be a strong incentive for hospitals to acquire orthopedic surgery practices and preclude independent practices from performing surgeries at the hospital since any extra services ordered or delivered by the physicians after discharge could turn into financial penalties for the hospital.

The problem goes beyond just the providers directly involved with hip and knee surgeries, however. The way the CCJR proposal is defined, hospitals would be accountable for essentially all of the healthcare services that beneficiaries receive after discharge from the hospital, whether they are directly related to the surgery or not. So if a Medicare beneficiary with COPD, diabetes, hypertension, etc. receives hip or knee surgery at the hospital, the hospital would then be at financial risk for how the beneficiary's primary care physician, pulmonologist, endocrinologist, cardiologist, etc. manage their care for those diseases after discharge. That means CCJR is much more than an "episode payment" for hip and knee surgery; it forces a hospital that delivers hip and knee surgeries to become a mini-Accountable Care Organization during the 90 days after patients are discharged.

Poorly Designed Risk Adjustment Could Both Reduce Access and Result in More Unnecessary Surgeries

Under the proposed regulations, CMS wouldn't adjust the episode spending targets based on differences in the kinds of care Medicare beneficiaries needed after they left the hospital. Although CMS will have different spending targets for the two different hospital DRGs used to pay for hip and knee surgeries, the current DRGs were designed to risk-adjust spending for *care in the hospital*, not to risk-adjust spending for *both hospital and post-acute care*. So the patients in the same DRG at two different hospitals could have very different needs for care after they leave the hospital. If one hospital had a higher-than-average number of patients who live alone or have other problems that require them to go to a skilled nursing facility for rehabilitation rather than return home, the average episode spending would be higher for the patients treated at that hospital (even if the cost of the care during the hospital stay was the same), and the hospital could be forced to pay for part of those additional nursing home stays. In the regulations, CMS implicitly acknowledges that differences in patient characteristics could affect episode spending more than what is accounted for by the two DRGs, but the regulations say that since there is no consensus on what the right risk adjustment system should be, no risk adjustment system at all will be used.

Two types of serious problems result from using no risk adjustment or the wrong risk adjustment system. First, it may become more difficult for patients to find a hospital to do surgery if the patient would need higher levels of post-acute care after surgery, because the hospital could be penalized if those higher-need patients caused the average episode spending to increase. Since the hospital would be accountable not just for services and complications related to the surgery, but for chronic disease care for patients with chronic disease, it might also be more difficult for patients with chronic disease to get surgery from a hospital if the patient's other physicians weren't affiliated with that hospital.

Second, CCJR would create a financial incentive for hospitals to encourage younger, healthier patients with joint osteoarthritis to undergo surgery, even if the patients could have managed with non-invasive treatments such as physical therapy, medications, and exercise. The reason is that since those patients would likely need less post-acute care, they would reduce the hospital's overall average spending per episode, helping it avoid a penalty and potentially receive a bonus. There is nothing in the CMS regulations that would penalize a hospital for doing surgeries that could be avoided by delivering other services, but there is plenty to penalize them for spending more than average on the surgeries that are done. The net result could be more surgeries and higher *total spending*, even though the average *spending per surgery episode* would be lower.

There's No Reward for Higher Quality, Just Smaller Bonuses If Quality is Low

The provision of the Affordable Care Act that gave CMS the authority to issue the CCJR regulations (Section 1115A of the Social Security Act) states that Congress's goal was to "reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending." However, under the proposed CCJR program, there's no reward for a hospital that achieves better outcomes for its patients at the same cost, e.g., if its patients had less pain during the recovery period or less pain or discomfort with their new knee or hip after they completed rehabilitation. The CCJR includes quality measures, but they're only applicable if spending is lower, and they're only used to give a hospital a smaller bonus than it would have otherwise received if quality is lower than the standards CMS establishes. If spending is the same but quality is higher, there's no bonus. If spending is higher, the hospital is penalized the same regardless of whether quality is better, worse, or the same. So clearly savings is the primary focus, not improving quality.

A Mandatory "Test" Would Preclude Other, Better Approaches

Under the proposed regulation, in 75 regions of the country, every hospital that is paid under the DRG system would be subject to these new penalties during a five year "test" period. The regions are selected through a randomization process, and as a result, the hospitals in one of two neighboring regions might be subject to the penalties while those in the other region would be excluded.

There would be no opportunity for either the hospitals or the physicians in CCJR communities to develop and implement true episode payment models while the test was underway unless they were already doing so under the CMMI Bundled Payment for Care Improvement (BPCI) program. This is both unfortunate and surprising, since CMS is currently testing several other bundled and episode payment models as part of BPCI, and the lessons and impacts from those projects are not yet available. Moreover, in the proposed Medicare hospital payment regulations issued earlier in the year, CMS explicitly invited comments on whether and how to expand the BPCI program, but the CCJR program would appear to preclude that in the communities it requires to participate.

Going Back to the Drawing Board

The inescapable conclusion is that CMS should go back to the drawing board on this proposal. Rather than truly reforming payment systems, the proposed Comprehensive Care for Joint Replacement program would add a problematic layer of new incentives on top of the undesirable incentives in the current fee-for-service payment systems, and the undesirable consequences of those new incentives could easily outweigh any of the benefits that are intended.