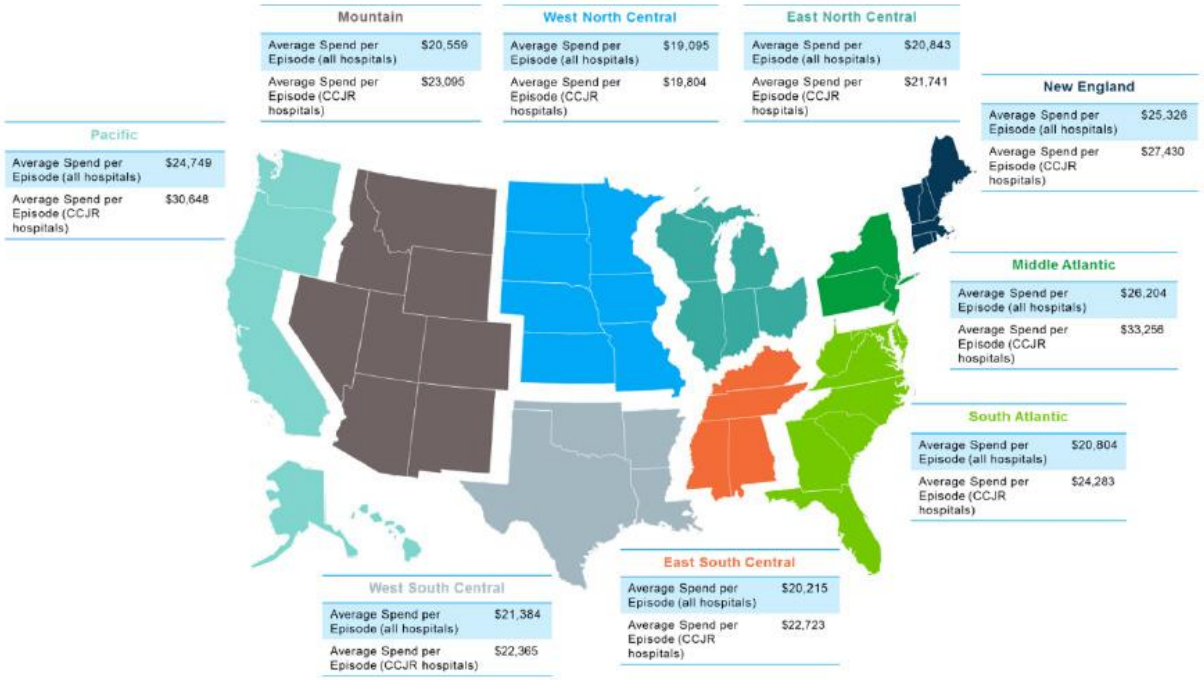
Avalere

Most Hospitals Selected for Medicare's First Mandatory Bundled Payment Model Are Disadvantaged by Regional Pricing Averages

A new Avalere analysis of CMS' proposed Comprehensive Care for Joint Replacement (CCJR) bundled payment initiative finds that 65% of selected hospitals will be subject to target prices based on regional episode spending averages that are lower than hospital-specific spending averages.

Specifically, the analysis finds that the average spending for an episode of care in hospitals selected for CCJR is $3,802 higher than the average of their respective census regions.

Figure 1. Episode Spending by Census Division (MS-DRG 470)



Regions also vary in the number of hospitals whose target price will be lowered by regional spending. For example, 75 percent of CCJR hospitals in the Middle Atlantic region have episode spending above the regional average. Conversely, in the East North Central and West North Central regions, just under 50 percent of hospitals have episode spending above the regional average.

Table 1. Summary Impact of Hospital vs. Regional Prices

Census Division	Percent of Hospitals in CCJR	Percent of CCJR Hospitals with Higher Spend than Regional Price	Number of CCJR Hospitals with Higher Spend than Regional Price	Number of CCJR Hospitals with Lower Spend than Regional Price
New England	8%	78%	7	2
Middle Atlantic	***55%***	***75%***	***126***	***41***
East North Central	23%	49%	51	53
West North Central	29%	49%	32	33
South Atlantic	35%	69%	106	47
East South Central	18%	68%	25	12
West South Central	20%	54%	43	37
Mountain	30%	69%	41	18
Pacific	51%	67%	119	59
All US Regions	32%	65%	550	302

"Unlike prior bundling payment models, such as the Bundled Payment for Care Improvement model, CCJR transitions hospitals to a regional target price, which creates different financial implications for hospitals participating in the program," said Brian Fuller, vice president at Avalere. "Our analysis suggests that under the regional pricing structure, high-spending hospitals will be required to achieve savings significantly higher on average than the 2% savings baseline required to avoid financial losses under the program."

The CCJR model tests bundled payments for lower-extremity joint replacement (LEJR) across a large group of hospitals. All hospitals in 75 metropolitan statistical areas will bear financial risk for services provided to all LEJR patients in the hospital during an episode of care, defined by CMS as hospitalization plus 90 days post-discharge. The hospital's actual spending per episode will be compared to "blended" target prices that consist of both regional and hospital-specific averages. The share of the price derived from the regional average will be phased in over time during the program.

Table 2. Summary of Proposed Target Price Setting

Model Year	Basis for Target Prices
Years 1 and 2	2/3 of the Participant Hospital's Own Historical Episode Payments and 1/3 Regional Historical Episode Payments
Year 3	1/3 of the Participant Hospital's Own Historical Episode Payments and 2/3 Regional
Years 4 and 5	Full Regional Historical Episode Payments

Hospitals will not be responsible for downside financial risk during the first year of the CCJR program. However, after 1 year in the program hospitals will owe CMS payment for any episodes with spending above the regionally-blended target price. If actual episode spending is less than the target price, a hospital will receive payment for the savings achieved from CMS.

Key Takeaway

Broadly defined regional averages bring forth significant variability in the initial financial risk of selected hospitals. To avoid financial losses, hospitals should work proactively to understand their positioning within the regional pricing structure in order to project financial risks and opportunities under different scenarios and guide care redesign investments accordingly.

Methodology

Avalere created LEJR episodes using the 2012 and 2013 100% Standard Analytic Files (SAFs). These files include all Medicare Part A fee-for-service claims for inpatient and outpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies (HHAs) and hospice, in addition to Part B home HHA claims. Episode spending was adjusted for the proposed outlier policy by truncating spending higher than two standard deviations above the regional mean. Episode payment amounts were also adjusted to account for geographic wage differences between hospitals as proposed by CMS under CCJR. Episode spending does not include spending on most Part B services, including physicians and durable medical equipment. In the CCJR model, target prices will be set at the MS-DRG level, with hospitals receiving different prices for MS-DRG 469 and MS-DRG 470 cases. However, our initial analysis of the 2012 and 2013 SAF suggests that 95% of LEJR cases are MS-DRG 470. Therefore, we limited this analysis to only 470 episodes. Only episodes initiated between January 1, 2012 and September 30, 2013 were included in order to allow completion of a full 90-day episode.