Rainfall HEALTH

TWENTY YEARS INSIDE BUNDLED PAYMENT

At the head of the table

A surgeon who built a joint replacement institute from scratch on why mandatory episodes are the best deal orthopedics has been offered — and why physicians have to lead them.

Dr. Steve Schutzer
Co-founder & CMO, Upswing Health
Founding medical director, CJRI

Eddie Qureshi
Founder & CEO, Rainfall Health
Host, Rainfall Health Podcast

INTRODUCTION

He wrote some of the language, then didn't take the deal

In 2006, Dr. Steve Schutzer got ten orthopedic surgeons from ten competing practices into one room in Hartford, Connecticut, and proposed building a center of excellence before that was a fashionable thing to do. What became the Connecticut Joint Replacement Institute went from 2,000 cases to 4,000 in two years, ran at a 1.5-day length of stay, sent more than 90% of patients straight home, and kept a validated registry of every patient it ever touched — 56,000 of them and counting.

He also helped write some of the policy language behind BPCI, Medicare's first big bundled payment program — and then declined to participate, because his own numbers were already better than the targets. That is an unusual vantage point from which to assess what CMS is doing now.

This guide distills his conversation with Eddie Qureshi on the Rainfall Health Podcast. It is for hospital executives, service-line leaders, and the surgeons who will live inside CJR-X and TEAM. His verdict on mandatory episodes is blunt and bullish. His verdict on who should be running them is blunter.

THE THROUGH-LINE

“Not only have a seat at the table — preferably at the head of the table. You don't need an MBA from Harvard to do this.”

Dr. Steve Schutzer

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FEATURED VOICES

Dr. Steve Schutzer

Thirty-six years of orthopedic trauma and joint replacement surgery in Hartford. Founding medical director of the Connecticut Joint Replacement Institute and physician executive over four institutes for sixteen years. Contributor to the policy language behind BPCI. Now co-founder and chief medical officer of Upswing Health, a front-end musculoskeletal on-ramp built on technology, athletic trainers, and orthopedic physicians.

Eddie Qureshi

Founder and CEO of Rainfall Health and host of the Rainfall Health Podcast. Some of the company's earliest backers were orthopedic surgeons.

1 BUILT FOR EPISODES

Joint replacement fits a bundle almost too neatly

Schutzer describes himself as a disciple of Michael Porter and Robert Kaplan, ninety miles east of Hartford at Harvard Business School — and the argument he takes from them is that healthcare should not be a zero-sum game. In a six-trillion-dollar industry, there should be plenty to go around.

WHY THE ANATOMY SUITS IT

Pregnancy is the classic episodic payment: a few possible outcomes, one roughly nine-month arc. Joint replacement behaves the same way. Most complications occur inside thirty days. Almost all of them occur inside ninety.

A defined start, a knowable window, a measurable end. That is what makes an episode payable.

WHY FEE-FOR-SERVICE ISN'T

His analogy: flying south tomorrow, he doesn't pay the agent at the desk, then the TSA officer, then bag check, then the pilot, then the flight. He pays one price for one journey.

Paying separately for each pair of hands is how the parts stop adding up to a whole.

> “I've drunk the Kool-Aid from Porter and Kaplan. Fee-for-service is the root of all evil.”
>
> Dr. Steve Schutzer

Three iterations, each one smarter than the last

He is, in his own words, impressed with CMS — not because the models are perfect, but because they have compounded. For years the agency tried to boil the ocean. Changing a system this size takes years of data, learning, and experience.

BPCI

The first real attempt. Voluntary, and priced off each participant's own history.

CJR

Mandatory in selected markets. Proof that geography-based assignment could work at all.

CJR-X

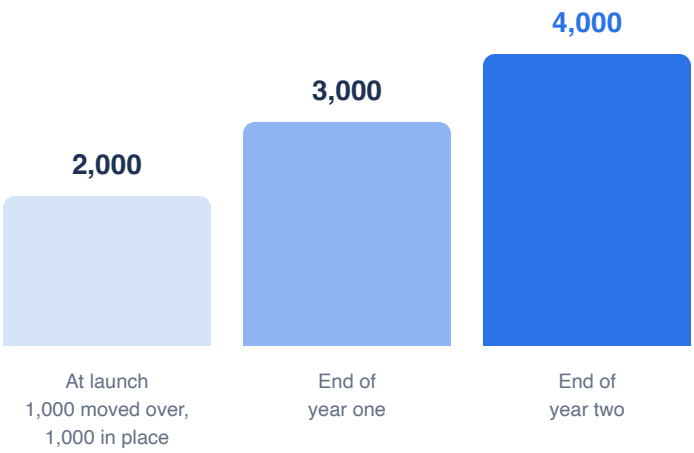
Better risk adjustment, a quality gate, and protection for the hospitals least able to absorb a bad year.

2 TEN SURGEONS, ONE ROOM

A center of excellence before that was a thing people said

The year was 2006. Surgeons were doing three cases a day and had no input into operations beyond the operating room itself. An epidemic of joint replacement was visibly coming — a million a year or more. So ten orthopedic surgeons from ten different groups, in his affectionate telling ten egomaniacs, formed a management company, signed a co-management agreement with a hospital partner, and went to work.

CASE VOLUME AT CJRI



Same surgeons. Same patients coming through the door. The difference was an operation designed around the procedure — one he says ran as well as any freestanding ambulatory surgery center, or better.

Physicians manage it

Not advisory input. Operational responsibility, held by the people doing the surgery.

A separate cost center

You cannot manage what you cannot see. The institute's economics had to be legible on their own.

A registry on day one

Asked for at the outset, with four full-time equivalents behind it — not added later as a reporting obligation.

A co-management agreement

Not gain sharing, and not ownership. A stipend to manage the space and the staff, paid for their expertise — and, in the hospital's words, stay within the law.

It worked well enough that they launched three more institutes — spine, sports, and trauma — and ended up on the conference circuit alongside Cleveland Clinic, Johns Hopkins, and Mayo. A private hospital in Hartford with a group of private orthopedic surgeons. Not highly academic, he says. Business savvy.

3 TWO SENTENCES FROM THE C-SUITE

Alignment is the whole thing, and it sounds like this

Asked what made the difference, Schutzer keeps returning to the relationship with the hospital partner — from day one, they bought into each other's vision. He offers two things his counterparts at St. Francis said to him, and suggests executives read them as a script.

THE CEO

“Steve, we know you guys can run this better. We're here to support you.”

THE COO

“My job is to say yes, Steve, and get out of your way.”

Tell your CEOs that's how you start this relationship, he says. The counterexample is just as clear: if administration regards the surgeon as another vendor, it isn't going to work. He is direct about the mechanism, and it is not goodwill. The hospital administrators he has met mean well. What separates the ones who win is a willingness to collaborate with the people whose hands are in the case.

What alignment bought them

A doubling of volume in two years, a 1.5-day length of stay, and an institute efficient enough to be studied by academic medical centers.

And what it cost

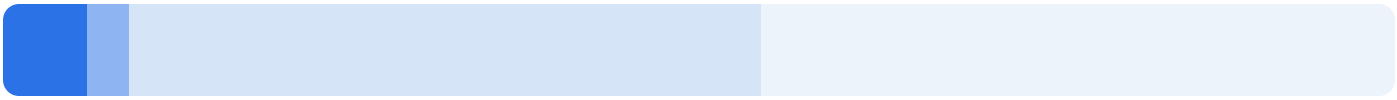
A stipend, a co-management agreement, and an executive team willing to let clinicians run a service line inside their own building.

4 SIX CENTS ON THE DOLLAR

The smallest share of the dollar, the largest share of the decisions

Eddie put it to him plainly: the surgeon may be the quarterback, but they are not the biggest line item in the episode. Schutzer agreed on the money and pushed back on the influence — and both halves of that answer matter for how a bundle should be governed.

WHERE A JOINT REPLACEMENT DOLLAR WENT, AS HE DESCRIBES IT



6%
Surgeons

3%
Anesthesia

A big chunk
The device industry

A big chunk
The hospital

Somebody has to be in charge

His evidence is what happened when the group left its original hospital. The administration told them they wouldn't go. They went, and the volume went with them — because the relationship was never with the building.

“Dr. Steve, you can operate on me in a telephone booth. I'll go with you.”

Which is why gain sharing is the interesting part

Six percent of the dollar buys very little leverage over the other ninety-four. A gain share tied to outcomes, patient satisfaction, quality, and total episode cost changes the surgeon's relationship to the whole episode rather than just their part of it.

Eddie's read: it makes participation a strategic move, not a billing decision.

> Assuming some risk is itself the intervention. “That changes your mindset. Hey, wait — maybe I better manage this diabetes a little bit better.”
>
> Dr. Steve Schutzer, on prospective bundles

5 CREDIBLE DATA CHANGES BEHAVIOR

He was surgeon number eleven for two years

Physicians have a natural aversion to data, he says, and they earned it: for twenty years the reports arriving from carriers were polluted enough that everyone laughed at them. What breaks that reflex is not more data. It is data the surgeons believe — which is a process, not a purchase.

56,000
patients in the registry — every one operated on since July 2007.

5
steps in the adjudication process, one of which was showing it to the surgeon.

2
independent validations — the orthopedic board and the Validation Institute.

The moment the numbers got worse and everything got better

They started calling every patient at ninety days. Every one, tracked down wherever they had gone. It cost money and it required hiring someone to do it. The reported infection rate doubled.

He was relieved. He had never believed 0.2% — and the infections they had been missing were the ones managed somewhere else, in another state, by someone who never told them.

REPORTED INFECTION RATE

0.2% Before follow-up → **0.4%** After 90-day calls

The rate didn't change. The measurement did — and the measurement is what surgeons will argue with.

Then he put his name on it

For the institute's first two years he was doc number eleven — unwilling to be identified until he believed the numbers. Once he did, he became Dr. Schutzer in the report, and so did everyone else. A bad month became a conversation. No shame, no blame.

And then they made it auditable

The institute became ISO 9001 certified — processes reviewed every month rather than annually reconstructed. That, he says, is what took a very good program and made it great.

Of all the assets they built, he rates the database the most valuable. Not just data — credible data. It changes everybody's behavior.

6 OUTSIDE THE FOUR WALLS

Surgeons are control freaks. Episodes are not controllable.

This is the part that challenged them for years. After day zero the patient goes home, or to home health, or to a skilled nursing facility, and touches a series of what Medicare calls episode components — none of which sit inside the surgeon's building or share their data. Their answer was not to control it. It was to shrink it.

Fewer vendors, closer in

They worked primarily with two or three extended care facilities and pulled them as close to the team as possible, so those partners felt they had a role in it. About 90% of post-acute care went to vendors they knew.

It was harder for surgeons in other parts of the state. He doesn't claim a perfect answer — short of being Kaiser or Geisinger, where it's all one organization.

A virtual extension of the care team

They adopted a patient engagement platform early — his own advanced practice nurse of twenty-five years was the human anchor, and patients knew they could reach her with any question.

Not around the clock. But a message sent at night was answered in the morning, and that was enough to keep most problems small.

Why the people who wrote part of BPCI didn't join BPCI

Because bundle targets were set against historical performance, and theirs was already excellent. They had squeezed the fat out years earlier. The targets were simply too low to be worth taking.

1.5 days
Average length of stay, before the program existed.

90%+
Discharged directly home rather than to a facility.

0
Upside available to them under BPCI, having already earned it.

Worth holding onto as a caution about program design: a model priced off your own history pays you for the improvement you haven't made yet. The organizations that moved first can be the ones with the least to gain.

7 THE ASYMMETRY

One party holds the risk. The other holds the scalpel.

This is his sharpest criticism, and he keeps circling back to it. Under CJR-X the hospital carries the downside. But the decisions that drive the episode's cost are made by hands that carry none of it.

HOLDS THE RISK

The hospital

All of the downside on the episode, reconciled after the fact — a deal he calls not a great one either.

MAKES THE CALLS

The surgeon

“It's my hands that buy the five-thousand-dollar widget or the two-thousand-dollar widget. It's my hands that send a patient to an extended care facility or send them home.”

Meanwhile the professional fee is heading the other way. He cites a proposed joint replacement reimbursement near $900 against a practice cost of roughly $500 an hour, and says plainly that you cannot stay in business on that.

HIS HYPOTHESIS — AND HE HOPES HE'S RIGHT

Maybe the asymmetry is deliberate. Squeeze the professional fee until the surgeon says there has to be a better way. Put the full episode risk on the hospital until it says it can't carry this alone. Then permit gain sharing — and let the two parties find each other.

“You shouldn't need that. But if you have to be forced to it, here you go.”

The precedent for it

Eddie's addition: nothing like a good old mandate to get healthcare to innovate. It's what happened with HITECH, and with Star Ratings. It starts imperfect, and the solution gets found together.

And a second data point

He expected a recent CMS specialty model to pay $300–400 per member per month. It came in near $180. His read: CMS is deliberately pricing for automation and low capital input.

Three changes that make the expanded model fairer

Asked what he'd tell CMS, he starts by conceding how much they've fixed. He has said publicly that there's no downside to the model — which is not the same as saying it's easy. Implementation challenges are real. But set against fee-for-service, he'd challenge anyone to argue the old way is better.

A QUALITY GATE

Bar first

You are not even eligible for reconciliation until you clear a minimum set of quality metrics. Savings can no longer be earned by cutting alone — the outcome has to hold up first.

RISK ADJUSTMENT

3 → 29

Roughly twenty-nine risk adjustment factors where the earlier model had three. The practical effect is that treating genuinely sicker patients stops looking like poor performance.

DOWNSIDE CAP

5%

A stop-loss for rural and dual-eligible hospitals, so a bad year is survivable. Inherent protections these organizations did not have in earlier programs.

The one he still can't explain

How CMS chose the markets. CJR landed on 34 metropolitan areas and his was not among them. His guess is that they picked the most dysfunctional ones, because that's where the opportunity was — and that Hartford was left out because there wasn't much margin left to harvest.

> “Each iteration gets better. CMS has made some mistakes, but heaven knows it's difficult to change.”
>
> Dr. Steve Schutzer

9 SMALL HOSPITAL, REAL ADVANTAGES

Fourteen post-acute partners isn't the only way to win

Eddie raised the fairness problem directly: Medicare was fairly indiscriminate in naming mandatory participants. Rural hospitals, safety-net hospitals, and highly profitable metropolitan systems are all in. What happens to the hospital that wants a curated post-acute network and doesn't have one to curate?

Schutzer's answer is characteristic. He looks at every challenge and asks where the opportunity is — and he thinks the small hospital's disadvantages are more visible than its advantages.

Agency over your own decisions

They may not have fourteen extended care facilities nearby, but they almost certainly have one or two — and far more control over how they work with them than any national system could manage. “You can't get anything done anymore” in a very large organization.

Beds already sitting fallow

Many of these hospitals have open beds doing nothing. His suggestion: petition CMS and convert ten of them to short-term stay. It can be done — and it turns the biggest constraint into owned capacity.

Flexible | **Nimble** | **Adaptive** | **Innovative**

The four words he uses for what a smaller hospital can be that a national system cannot. Combined with the 5% stop-loss, he doesn't see these participants as victims of the model.

> Eddie's reframe: don't try to be something you're not. Find your structural advantages and lever them — that's the whole play for a smaller participant.

10 STEP UP AND LEAD

The button he most likes to push

Asked what they hadn't covered, he went straight here. After the Second World War, he argues, medicine handed its own administration to MHAs and MBAs, and the thinking turned transactional — the why behind the transaction became the dollar rather than the patient. Doctors got busy, specialized, and let it happen. He doesn't think complaining about the fee schedule is a strategy.

The evidence he points to

By anybody's metric, including MedPAC — the government's own data — physician-owned hospitals perform better. Over and over again, he says, and yet physicians are largely precluded from owning one.

Private equity can own a hospital. Insurers can. The people who know how to run one can't.

Two ways to lead, one of which fails

By fiat, which he guarantees will not work. Or with credible data — which is why the registry mattered more than any of it. Physicians are not always the easiest people to lead, and data is the only argument that survives the room.

Two hundred employees. A research department of five or six. Nobody with an MBA required.

> **“You just want to do it, you learn about it, and you bring in people that are smarter than you to fill in your gaps.”**
>
> Dr. Steve Schutzer, on what physician leadership actually requires

Eddie's version, borrowed from a mentor: if you're not at the table, you're on the menu. Schutzer extended it — not only a seat at the table, preferably the head of it. That's his bias, stated as one.

11 WHO THE VALUE IS FOR

What other industry doesn't focus on the end user?

There's real pushback now on the phrase value-based care — that it's overused, and that every stakeholder has bent it toward themselves. Schutzer's response is not to defend the term. It's to fix the referent.

> **The value has to accrue to one stakeholder. That's the patient. Value and competition should be measured at the level of value to the patient, period.**
>
> Dr. Steve Schutzer, on what the term is supposed to mean

Which is, in the end, why he's bullish

1. The model has teeth on both sides now, upside and down, which is what aligns incentives back toward the patient.
2. Everybody wins in a positive-sum arrangement — the surgeons, the hospital, and the patient. Nobody had to lose for CJRI to work.
3. Physician-led alignment from beginning to end is where the better outcomes have consistently shown up. Collaborate, know your boundaries, and let the physicians help.

> “If you believe in taking care of patients, it's not a chore, it's not scary. It's really fun.”
>
> Dr. Steve Schutzer, on doing the data work

Set against fee-for-service, he'd challenge anyone to name the better option. He has been inside every version of this since 2006, wrote part of one of them, and passed on the deal when the numbers didn't justify it. That's the résumé behind the optimism.

WHERE RAINFALL FITS

The registry he built by hand, running live

Rainfall Health is an accountability and accessibility platform powered by AI — the first and only company certified for these Medicare-mandated programs. What CJRI assembled over twenty years with four full-time equivalents and a phone, Rainfall is built to do continuously, inside the episode rather than after it.

Credible data, in real time

Episode analytics clean enough for surgeons to argue with — available while the 30- or 90-day window is still open, not at reconciliation.

Coverage past the four walls

Around-the-clock patient support with escalation pathways, spanning the post-acute partners who don't share your chart.

Built for the mandate

Quality-gate metrics, risk-adjusted episode performance, and the reporting CJR-X and TEAM require — as one system, not a stack of vendors.

FROM THE HOST

> “We put on the hat that this is happening live right now — whether it's a 30-day episode or a 90-day episode under CJR-X. It's about what we can do with these episodes as well as the future ones.”

Eddie Qureshi, founder & CEO, Rainfall Health

As Eddie noted in the conversation, you don't need all of it to start making things better. But the thing Schutzer says he'd protect above everything else — the database — is the part that gets easier to build every year.

GET CONNECTED

Take your seat before the model takes it for you

If you're standing up a bundled payment program under CJR-X or TEAM — or working out how surgeons and administration share the risk — we'd like to help. Rainfall is the end-to-end solution, technology and services, for hospitals and health systems.

LEARN MORE	**www.rainfallhealth.com**
START A CONVERSATION	**sales@rainfallhealth.com**

Watch for the next episode of the Rainfall Health Podcast.

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