CHA Member Call: Comprehensive Care for Joint Replacement (CJR) Bundled Payment Program

January 13, 2016

You can download today's presentation at
http://www.calhospital.org/resource/cjr-model-final-rule-resources

CALIFORNIA HOSPITAL ASSOCIATION

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Agenda

- Overview of the CMS CJR Final Rule
  - What has and has not changed,
- Overview of CMS Waivers
- Overview of CHA DataSuite Analysis
- Key Considerations and Next Steps
- Questions

January 2015
HHS Announced Goals for Value-Based Payments Within the Medicare FFS System

Medicare Fee-for-Service

GOAL 1:

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

30%

GOAL 2:

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

85%

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

Source: CMMI, May 2015

Overview of CJR Final Rule Provisions

CJR Overview

- CMS Issued Proposed Rule on July 9th
  - ✓ CHA member call in August
  - ✓ CHA Comments Submitted September 8

    www.calhospital.org/regulatory-tracker under Final Rules
  - ✓ CHA Final Rule Summary available at www.calhospital.org/regulatory-tracker
  - ✓ CMMI CJR Website https://innovation.cms.gov/initiatives/cjr
- Final Rule Issued **Nov 16**
- Joint CMS OIG Waivers Released **Nov 16**
- Effective Date – **April 1, 2016**

Summary of Major Changes from Proposed Rule

	Proposed Rule	Final Rule
Start Date	January 1, 2016	April 1, 2016
Target Prices	Separate targets for DRGs 469 and 470; no adjustment for hip fractures	Separate target prices for DRGs 469 and 470 with and without hip fractures
Quality Measures	Three mandatory measures + one voluntary measure	Two mandatory measures + one voluntary measure
Quality Performance	Must meet minimum thresholds for all three mandatory measures in order to share in savings	Must meet a minimum score on one composite measure in order to share in savings; Discount percentage varies by score.

Summary of Major Changes from Proposed Rule

	Proposed Rule	Final Rule
Discount Factor	2.0%	1.5% - 3.0% dependent upon quality performance
Stop-Loss Limits	Year 2: 10% Years 3-5: 20%	Year 2: 5% Year 3: 10% Years 4-5: 20%
Stop-Gain Limits	Capped at 20% for all years	Year 1-2: 5% Year 3: 10% Years 4-5: 20%

CJR Overview

- Program Duration: **4 years and 3 Qtrs.**
  - April 1, 2016 – December 31, 2020
- **Required Participation** of *most* short term acute care hospitals in *randomly selected* MSAs
  - 75 MSAs proposed, **67 finalized**
  - California MSAs Unchanged: Los Angeles-Long Beach-Anaheim, Modesto, and San Francisco-Oakland-Hayward Second (CHA website for complete list)
  - 135 California hospitals - 794 total
  - +/- 3 percent of all cases subject to program

CJR Overview

Not Subject to Mandatory CJR Model:

- Critical Access Hospitals
- BPCI Model 1 participants
- BPCI Model 2&4 LEJR participants

- **Unlike BPCI, short term acute care hospitals are the episode initiator and are accountable for risk associated with the 90 day episode**
  - Physicians and conveners cannot be episode initiators under CJR program

CJR Episode

- Applicable to Medicare FFS Beneficiaries only
- Triggered by inpatient admission for LEJR
  - Defined as MS-DRG 469 or 470
  - 95% of the volume is in MS-DRG 470
  - commonly referred to as the “anchor admission”
- Episode includes the hospitalization and ALL Part A & B services related to the major joint replacement 90 days post discharge

CJR Episode

Included Services	Excluded Services*
• Physician Services • Inpatient hospital, including readmissions • IPF • LTCH • IRF • SNF • Home Health • Hospice • Outpatient Therapy • Clinical Lab • DME • Part B Drugs • Hospice	• Unrelated hospital admissions (based on MS-DRG) • Unrelated Part B Services (based on ICD-9 codes) • Hemophilia clotting factors • New Technology add-on payments * Additional Episode definition and exclusions available on the CMMI CJR website

CJR Episode

- **Exclusions:** Medicare Advantage enrollees, those without both Part A and Part B, Medicare ESRD enrollees and deaths occurring during the IP admission
- There is no program opt-out for beneficiaries, and they can no longer choose to exclude their claims data that is shared with providers

CJR Payment Methodology

- A "Bundled Payment" ≠ A Prospective Capitated Payment
- CJR is a **Retrospective Two-Sided Risk Model**
  - Hospitals bear all the risk
  - **All providers continue to receive FFS payments as they do today throughout the duration of this program**

CJR Target Price

- After each performance year, the actual episode spending would be compared to the historical spending episode target price

Historical Spending (3 Years of Data)

- Physician Services
- Inpatient hospital, including readmissions
- IPF
- LTCH
- IRF
- SNF
- Home Health
- Hospice
- Outpatient Therapy
- Clinical Lab
- DME
- Part B Drugs
- Hospice

- Discount (Variable 3% to 1.5%)
= Target Price

Actual Episode Spending (in Performance Year)

- Physician Services
- Inpatient hospital, including readmissions
- IPF
- LTCH
- IRF
- SNF
- Home Health
- Hospice
- Outpatient Therapy
- Clinical Lab
- DME
- Part B Drugs
- Hospice

Actual Performance

CJR Target Price

Hospital Specific
Target Price

Regional
Target Price
(AK, WA, OR, CA, HI)

Target Price Components	Performance Year				
	1	2	3	4	5
Hospital-specific Data	2/3	1/3		0%	
Regional Data	1/3	2/3		100%	
Discount Factor	Variable 3% - 1.5% depending on quality performance				
Baseline Period	CY2012-2014		CY 2014-2016		CY 2016-2018

Example

DRG	Performance Period Episode Count (a)	Performance Period Episode Target $ (b)	Total Performance Target $ (a*b)	Total Actual Performance $ (c)	Reconciliation Amount $ ([a*b]-c)
470 w/o fracture	100	$24,000	$2,400,000	$2,200,000	$200,000
469 w/o fracture	10	$40,000	$400,000	$550,000	-$150,000
Hospital A Total	110	$24,455	$2,800,000	$2,750,000	$50,000

- First reconciliation will take place 3 months after the end of the first performance year.
- First reconciliation will be revised 12 months later to ensure all claims run-out is captured
- Same process for years 2 through 5

Discount Factor by Performance Year

		Repayment Discount		
Quality Score	Reconciliation Discount	Year 1	Years 2 & 3	Years 4 & 5
Below acceptable	N/a	N/a	2.00%	3.00%
Acceptable	3.00%	N/a	2.00%	3.00%
Good	2.00%	N/a	1.00%	2.00%
Excellent	1.50%	N/a	0.50%	1.50%

CJR Quality

- CMS adopts 2 quality measures currently used in CMS in the Inpatient Quality Reporting Program
  1. Hospital Level Risk Standardized Complication Rate (RSCR) Following **Elective** Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550); (Medicare FFS patients only)
  2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (NQF #0166) Survey. **(All patients)**
- CMS Adopts Voluntary reporting of "THA/TKA patient-reported outcome-based measure" (PRO measure) as a "yes or no measure"
  - CMS notes that it is considering mandatory reporting of this measure in years 4 and 5
- https://innovation.cms.gov/Files/x/cjr-qualstrat.pdf

Quality Measure Performance Periods

TABLE 3.2: SUMMARY OF FINALIZED QUALITY MEASURE PERFORMANCE PERIODS BY YEAR OF THE CJR

Measure Title	CJR Model Year				
	1st	2nd	3rd	4th	5th
THA/TKA Complications*	April 1, 2013 – March 31, 2016	April 1, 2014 – March 31, 2017	April 1, 2015 – March 31, 2018	April 1, 2016 – March 31, 2019	April 1, 2017 – March 31, 2020
HCAHPS**	July 1, 2015 – June 30, 2016	July 1, 2016 – June 30, 2017	July 1, 2017 – June 30, 2018	July 1, 2018 – June 30, 2019	July 1, 2019 – June 30, 2020

*Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550).

** Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166).

Note: The PRO voluntary reporting measure time periods are outlined at https://innovation.cms.gov/Files/x/cjr-qualstrat.pdf

Composite Quality Score

Percentile	Complications Points (	HCAHPS Points
≥ 90th	10	8
≥ 30th to <90th	5.50-9.25	4.40-7.40
<30th	0	0

+

Data Submitted?	PRO Measure Points
Yes	2.00
No	0.00

Composite Quality Score	Quality Category
<4.0	Below Acceptable
≥ 4.0 to <6.0	Acceptable
≥ 6.0 to ≤ 13.2	Good
> 13.2	Excellent

Source: AHA Member Slides, November 2015

Stop-loss and Stop-gain Limits by Performance Year

Performance Year	Stop-loss Limit	Stop-Gain Limit
1	N/a	5%
2	5 % (3%)	5%
3	10% (5%)	10%
4	20% (5%)	20%
5	20% (5%)	20%

- First reconciliation will take place 3 months after the end of the first performance year.
- First reconciliation will be revised 12 months later to ensure all claims run-out is captured
- Same process for years 2 through 5

CJR Payment Waivers

- CMS waives the "incident to" rule to for physician services
  - Allows CJR beneficiaries who do not qualify for home health services to receive up to 9 post-discharge home visits during an episode
- CMS waives the geographic site requirement for telehealth services and the originating site requirement for telehealth services to originate in the beneficiary's home or place of residence
- CMS would waive SNF 3-Day Stay Rule beginning in Year 2
  - Beneficiaries must be transferred to SNF rated 3 stars or better, but retain their full choice of providers

CJR Policies NOT Waived

- 60 % rule and 3 hour rule for IRF
- Home health homebound rule
- Patient Steering

CJR Data Sharing

- CMS will share beneficiary Part A and B claims for the duration of the episode in
  - Summary format,
  - Raw claims line feeds, or
  - Both summary and raw claims
- Data would be available for the hospital's baseline period and on a **quarterly basis** during a hospital's performance period
- CMS would also share aggregate regional claims data for MS-DRG 469 and 470 (with and w/out hip fracture)
- In order to get CMS data, you must have an identified contact within your hospital to receive the data use agreement

Overview of CMS and OIG Waivers for CJR Program

Background

- No waivers of any fraud and abuse authorities were included in either proposed or final CJR rule.
- On 11/16/15, CMS and OIG jointly issued notice waiving certain federal fraud and abuse laws for purposes of testing the model.
  - https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html

Summary

1. Waiver for distribution of Gainsharing Payments and Alignment Payments under a Sharing Arrangement between a participant hospital and a CJR Collaborator (“Payments Waiver”)
2. Waiver for Distribution Payments from a Physician Group Practice (PGP) to a Practice Collaboration Agent (“Physician Group Waiver”)
3. Waiver for patient engagement incentives provided by participant hospitals to Medicare beneficiaries during the episodes (“PEI Waiver”)

Summary (cont.)

- **Each waiver protects only those arrangements that meet all of the specified conditions.**
  - Not applicable outside the CJR
  - No retrospective protection
- Apply only to federal Stark, AKS, and CMP laws specified in the Notice for each waiver
- No special action required to utilize waivers

Summary (cont.)

- Waivers not needed to the extent the arrangement:
  - Does not implicate the specific fraud and abuse law;
  - Implicates the law but fits within an existing exception/safe harbor; or
  - Otherwise complies with the law.

Payments Waiver

- Applies to application of Stark and AKS
- Protects:
  - Gainsharing Payments from Participant Hospital to a CJR Collaborator; and
  - Alignment Payments from CJR Collaborator to Participant Hospital.
- Does not protect:
  - Payments in the form of in-kind items or services

Payments Waiver (cont.)

- Does not protect other financial arrangements even if of comparable value to the Gainsharing or Alignment Payments
- Collaborator Agreement must satisfy all requirements of the Rule relating to financial arrangements (§510.500) and beneficiary choice and notification (§510.405)

Payments Waiver (cont.)

- Hospital may not add conditions, limitations, or restrictions other than those required or permitted by Rule or this waiver
- CJR Collaborator quality requirements
- Methodology for determining Gainsharing Payments must be based, at least in part, on criteria related to and inclusive of the quality of care to be delivered to beneficiary during an Episode.

Physician Group Waiver

- Applies to application of Stark and AKS
- Protects Distribution Payments from a physician group practice (§510.505) that is a CJR Collaborator to a Practice Collaboration Agent who is entitled to receive such distribution under §510.505

Physician Group Waiver (cont.)

- All requirements for Distribution Arrangements as set forth in CJR Final Rule are met
- Distribution Payments are derived solely from Gainsharing Payments made by a Participant Hospital to the PGP pursuant to a Sharing Arrangement under the CJR model

Physician Group Waiver (cont.)

- Distribution of Gainsharing Payments from the Participant Hospital to the PGP satisfies the requirements of the Payments Waiver described above
- Must be a written Distribution Arrangement between the PGP and the Practice Collaboration Agent setting forth the terms and conditions of the Distribution Arrangement in advance of any distribution

Physician Group Waiver (cont.)

- PGP does not add conditions, limitations, or restrictions to the Distribution Arrangement other than those required/permitted by the Final Rule or the waiver.

Patient Engagement Incentives (PEI) Waiver

- Applies to beneficiary inducements CMP law and AKS with respect to items or services provided to Medicare beneficiary in an Episode if conditions are met.
- All requirements of documentation of beneficiary incentives as set forth in the Final Rule must be met

PEI Waiver (cont.)

- A Participant Hospital may provide items or services to CJR beneficiaries provided the item or service:
  - Is provided directly by a Participant Hospital, or by an agent of the Participant Hospital under the Participant Hospital's direction and control
  - Is in-kind (no cash or cash equivalents such as gift cards; no copay waivers)

(cont.)

PEI Waiver (cont.)

- Is provided during the Episode
- Is reasonably connected to the medical care provided to the Medicare beneficiary during the Episode, is for preventative care, and advances outlined clinical goals by engaging the beneficiary in better managing his or her own health

PEI Waiver (cont.)

- The item or service is not tied to the receipt of items or services outside the Episode
- All requirements of beneficiary choice and notification set forth in the CJR Rule are met
- Participant Hospital must maintain for 10 years contemporaneous documentation of incentives valued at >$25

PEI Waiver (cont.)

- Items and services involving technology
  - May not exceed $1,000 in retail value
  - Those exceeding $100 must remain the property of the hospital and be retrieved by the hospital after the episode
- Costs of incentives must not be shifted to another federal health care program
- Incentives must not be promoted

Compliance Issues

- Requirements of CJR Rule are complicated, and qualifying for waiver protection may be challenging.
  - Required Disclosures and Beneficiary Notices are burdensome. Failure to handle correctly = ineligibility for waiver(s)
  - Collaborator Agreements are complicated. If not done right = ineligibility for waiver(s).

Compliance Issues (cont.)

- No waiver available for other federal laws (antitrust, tax, etc.). Proceed with caution to insure compliance.
- CMS has no authority to preempt application of state laws to CJR program. Thus, California's regulatory schemes still apply.

California Laws

- Corporate practice of medicine prohibition
  - Prohibits lay entities (such as hospitals) from owning or controlling the practice of medicine
  - May be violated if the lay entity exerts an impermissible level of control over a physician's medical judgment or holds itself out as providing, or bills for the provision of physician services

California Laws (cont.)

- Adoption and imposition of clinical guidelines
- CA Anti-Kickback Laws (B&P §650, H&S §445): prohibits payments for patient referrals.
  - No assurance that the activities/financial arrangements contemplated by CJR model (gainsharing, shared savings) even if protected by federal waiver, will comply

California Law (cont.)

- CA Physician Ownership and Referral Act (B&P §650.01, Labor Code §139.3): prohibits referrals by physician for certain services to entities in which the physicians have a financial interest
- California antitrust laws

Overview of CHA DataSuite Analysis

Data Sources

- Medicare Standard Analytics Files, 2012-2014
  - IP, OP, Home Health, SNF, Rehab and Hospice
  - DME, Physician and other Part B service (5% national sample extrapolated)

- Anchor admission in first 7 months of 2014
  - Ex: Anchor Discharge is 8/6/14

    90-Day Episode Ends on 11/3/14

    HH starts 11/3/14 would end on 1/2/15

Definitions

- **Episode:** All Medicare fee-for-service covered services provided during an anchor admission and 90 days after discharge from the anchor stay. Excluded from the episode are Direct Graduate Medical Education and Part D services. Beneficiaries eligible for End Stage Renal Disease coverage, those not enrolled in Part B, those enrolled in Medicare Advantage plans and those who die during the 90-day episode period are excluded.
- **Payments:** Payments made by Medicare, to any provider or the beneficiary, for a Medicare-covered service.

Report Description

- DRG 469: *Major Joint Replacement or Reattachment of Lower Extremity with Major Complications and Comorbidities*
- DRG 470: *Major Joint Replacement or Reattachment of Lower Extremity without Major Complications and Comorbidities*
- Compares each hospital's average Medicare spending per episode to the regional average and to an estimate of the year 1 target price
- Episodes for hip fractures have separate target prices

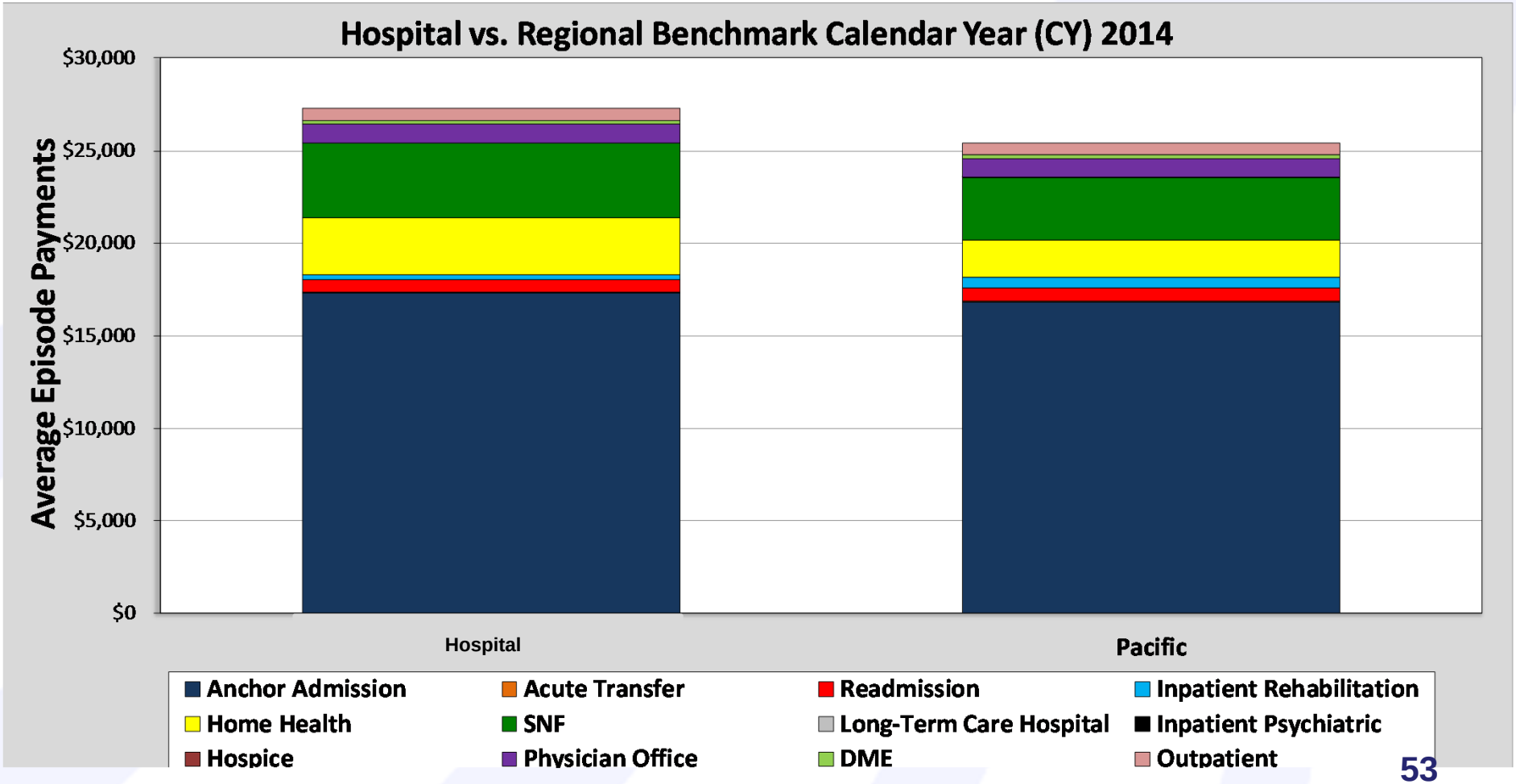
Average 90-Day Episode Payments

Estimated Calendar Year (CY) 2014 CJR Performance

	DRG 469		DRG 470		
	Without Hip Fracture Episodes	Hip Fracture Episodes	Without Hip Fracture Episodes	Hip Fracture Episodes	Total
Hospital Average CYs 2012-2014 Baseline @ CY 2014 Dollars (adjusted to reflect national weights)	$44,197	$62,685	$26,061	$47,029	
Regional Average CYs 2012-2014 Baseline @ CY 2014 Dollars (adjusted to reflect national weights)	$42,300	$59,994	$24,942	$45,010	
Blended Average (2/3 Hospital, 1/3 Regional)[+]	$43,565	$61,788	$25,688	$46,356	
Estimated CY 2014 Target Price (Blended Average *.97)	$42,258	$59,934	$24,917	$44,965	
CY 2014 Hospital Volume [++]	15		634	65	
CY 2014 Hospital Average Episode Payment	$34,375	$58,036	$25,761	$45,868	
CY 2014 Total Hospital Episode Payments	$515,625		$16,332,474	$2,981,420	$20,409,879
CY 2014 Total Estimated Target Price	$633,870		$15,797,378	$2,922,725	$19,953,313
CY 2014 Hospital Performance	$118,245	$18,980	-$535,096	-$58,695	-$456,566
% Gain/(Loss)	22.9%	3.3%	-3.3%	-2.0%	-2.2%

Average 90-Day Episode Payments

DRG 470: Major Joint Replacement or Reattachment of Lower Extremity w/o MCC Without Hip Fracture (634 total episodes)



Average 90-Day Episode Payments

MS - DRG Description		Hospital				Pacific			
	# of CY 2014 Episodes *	634				38,868			
	Average CY 2014 Total Payment	$27,283				$25,414			
	Episode Component/Service Type	Average Number of Claims per Episode	Average Payment Per Claim	Average Payment per Episode	% of Average Episode Payment	Average Number of Claims per Episode	Average Payment Per Claim	Average Payment per Episode	% of Average Episode Payment
470 - Major Joint Replacement or Reattachment of Lower Extremity w/o MCC (Without Hip Fracture)	Anchor Admission	1.0	$17,325	$17,325	64%	1.0	$16,837	$16,837	66%
	Acute Transfer	0.0	$4,703	$13	0%	0.0	$12,894	$9	0%
	Readmission	0.1	$10,058	$707	3%	0.1	$10,115	$739	3%
	Inpatient Rehabilitation	0.0	$16,866	$228	1%	0.0	$15,527	$588	2%
	Home Health	0.9	$3,319	$3,095	11%	0.6	$3,112	$1,993	8%
	SNF	0.5	$7,554	$4,042	15%	0.5	$7,125	$3,380	13%
	Long-Term Care Hospital	0.0	$0	$0	0%	0.0	$39,481	$30	0%
	Inpatient Psychiatric	0.0	$0	$0	0%	0.0	$7,025	$6	0%
	Hospice	0.0	$0	$0	0%	0.0	$3,079	$2	0%
	Physician Office	3.8	$274	$1,033	4%	2.6	$378	$998	4%
	Durable Medical Equipment	1.0	$198	$202	1%	1.0	$200	$202	1%
	Outpatient	1.5	$420	$639	2%	1.9	$324	$630	2%

Acute Hospital Considerations

To be successful, acute hospitals will need to monitor and influence post-acute care utilization

- Refer to lower-cost PAC care where appropriate
- To avoid readmissions and maximize outcome, ensure access to appropriate level of PAC
- *Establish effective partnerships with PAC providers at all levels*
- Provide patients “informed choice”
- Address functional status and ADLs

PAC Provider Considerations

To succeed in CJR, PAC providers will need to partner with acute care hospitals to manage resource use

- ***IRFs*** will be challenged to demonstrate value and cost effectiveness
  - Under current design, IRFs cannot reduce overall cost to episode (case rate)
  - IRF may want to focus on higher acuity/more complex patients
- ***SNFs*** can reduce episode cost by managing RUGs achievement and length of stay
- ***HHAs*** who can handle patients at higher levels of acuity may be able to support earlier transition to lower cost home setting.

Acute and PAC Considerations

Providers at all levels of care will benefit from:

- Review of current referral processes and PAC utilization
- Communication among and between participating providers
  - Acute hospital
  - MD
  - PAC providers - both within and outside the organization
- Consider changes to current pathways/practices

Next Steps

1. CMS needs two hospital employee contacts for every participant hospital, regardless if you are currently providing the service or not.

Email cjrsupport@cms.hhs.gov or cjr@cms.hhs.gov

2. CHA will post every Friday the list of hospitals that CMS shares with us have not responded with contact names to http://www.calhospital.org/resource/cjr-model-final-rule-resources
3. Orientation packet, FAQ and DUA will be sent to those contacts. Fill out the DUA with two DATA contacts. Send to cjrsupport@cms.hhs.gov

Next Steps

5. Request all data available to you
6. CMS is setting up an online portal for you to create user names and passwords. Data will be downloadable from that site. Instruction manuals and YouTube Videos in the works.
7. CMS Goal – distribution of data in late January
8. CMS setting up a collaboration site where hospitals can share information, best practices, continuous learning
9. CMS to conduct a needs assessment of CJR hospitals in March

What to expect and tips for success

- This is a new program, it will experience hiccups
- Trust but verify!
- Stay engaged with CMS and CHA
- CMS has authority to make changes through sub regulatory guidance (e.g. episode definitions)
- **This program WILL experience hiccups**
- Revisit program contacts as needed
  - CMS asked for two, you can give them 4

CHA commitments

- Keep you informed
- Watch for any changes in CHA news
  - CHA CJR Distribution List
- Raise policy issues of concern with CMS
- Identify additional opportunities for education and collaboration
- Solicit your input and advice for how CHA and the Regional Associations can support your efforts
  - Please fill out our evaluation!

Discussion

- Enter your question/comment into the Q and A box.
- Evaluations will be sent via email. Please share your thoughts with us!

THANK YOU FOR PARTICIPATING

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