Comprehensive Care for Joint Replacement (CJR)

David Roberts
Population Health Executive

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“CMS has set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.”

Sylvia Mathews Burwell
Secretary of HHS
Outline

• Proposed mandatory bundled payment program
  • All hospitals in specific metropolitan areas must participate

• CJR is only scoped to impact MS-DRGs 469 and 470
  • Lower extremity joint replacements/reattachments (e.g. knee replacement)

• Begins April 1, 2016 and runs through December 31, 2020

• Bundled payments paid retrospectively

• Two sided risk model
  • Financial targets are set based on local and regional experience
  • Hospitals can share in the savings, or
  • Hospitals may have to pay back overpayments based on target prices
Episode Definition

Begins with admission to an eligible hospital for a LEJR
- MS-DRG 469 is major joint replacement or reattachment with MCC
- MS-DRG 470 is major joint replacement or reattachment without MCC

Includes most Medicare Part A or B 90 days post discharge
- A few exceptions are listed related to certain chronic conditions
- Exceptions are the same as for BPCI LEJR
- A list of exclusions by ICD-9 (will be updated to ICD-10) can be found here

An episode will be excluded if:
- A patient is admitted to another hospital for MS-DRG 469 or 470
- A patient dies during the hospitalization
- A patient initiates an LEJR episode under BPCI Models 1, 2, 3, 4
Division 4 Mandatory Participation

- Bates County Memorial Hospital
- Saint Luke’s Cushing Hospital
- Miami County Medical Center
- Susan B. Allen Memorial Hospital
- Truman Medical Center Lakewood
- Cameron Regional Medical Center
- Truman Medical Center-Hospital Hill
- Via Christi Hospital Wichita St. Teresa, Inc.
- Lee’s Summit Medical Center
- Saint Luke’s Northland Hospital
- Saint Luke’s Hospital of Kansas City
- SSM Health St. Joseph Health Center
- Belton Regional Medical Center
- Providence Medical Center
- Kansas Spine & Specialty Hospital, LLC
- SSM Health St. Joseph Hospital West
- Mercy Hospital Jefferson
- St. Joseph Medical Center
- Newton Medical Center
- Overland Park Regional Medical Center
- St. Mary’s Medical Center
- SSM Health St. Mary’s Health Center
- Saint Luke’s East Lee’s Summit Hospital
- Mercy Hospital Washington
- Menorah Medical Center
- Sanford Medical Center Bismarck
- SSM Health St. Clare Health Center
- Liberty Hospital
- Des Peres Hospital
- SoutheastHEALTH
- Kansas Medical Center, LLC
- Barnes-Jewish West County Hospital
- St. Francis Health Center, Inc.
- Centerpoint Medical Center
- Olathe Medical Center
- University of Kansas Hospital
- Kansas City Orthopaedic Institute
- Saint Luke’s South Hospital
- Via Christi Hospitals Wichita, Inc.
- Saint Francis Medical Center
- Shawnee Mission Medical Center
- Wesley Medical Center
- Bryan Medical Center
- Lincoln Surgical Hospital
- University of Missouri Health Care
- St. Luke’s Hospital
- Mercy Hospital St. Louis
- Stormont-Vail Healthcare
- St. Alexius Medical Center
- St. Anthony’s Medical Center
- SSM Health Depaul Health Center
- North Kansas City Hospital
- Boone Hospital Center
### Two Sided Risk Model

<table>
<thead>
<tr>
<th>The anchor hospital bears full responsibility for the episode cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can enter into cost agreements</td>
</tr>
<tr>
<td>Can offer beneficiary agreements</td>
</tr>
</tbody>
</table>

**CJR Bundled Payment is a retrospective calculation**

<table>
<thead>
<tr>
<th>A comparison of net costs to net target costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation occurs Q2 following year, and again a year later</td>
</tr>
</tbody>
</table>

**2017 will be the first year of downside risk**

**Risk will be phased in with a discount in target price in 2017 and 2018**

**Mandatory CQMs must be successfully submitted to receive a reconciliation payment**
Eligibility

- Short term acute care hospitals paid under the IPPS
- Hospitals in Maryland are excluded
- Hospitals participating in BPCI Models 1, 2, or 4 are excluded

Hospitals are included based on their location in a Metropolitan Statistical Area (MSA) as defined by OMB at a county level:

- This requires that the MSA have an urban core population of at least 50,000
- List of affected MSAs and counties can be found here
<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Episodes beginning on or after April 1, 2016</td>
<td>Episodes that end on or before Dec 31, 2016</td>
</tr>
<tr>
<td>2017</td>
<td>Episodes that end on or after January 1, 2017</td>
<td>Episodes that end on or before December 31, 2017</td>
</tr>
<tr>
<td>2018</td>
<td>Episodes that end on or after January 1, 2018</td>
<td>Episodes that end on or before December 31, 2018</td>
</tr>
<tr>
<td>2019</td>
<td>Episodes that end on or after January 1, 2019</td>
<td>Episodes that end on or before December 31, 2019</td>
</tr>
<tr>
<td>2020</td>
<td>Episodes that end on or after January 1, 2020</td>
<td>Episodes that end on or before December 31, 2020</td>
</tr>
</tbody>
</table>
Risk Limits (Stop-Loss/Stop-Gain)

**Stop-Loss to protect hospitals in repayment amount**
- Stop-Loss for 2017 is 5%
- Stop-Loss for 2018 is 10%
- Stop-Loss for 2019-2020 is 20%
- \[ \text{Stop-Loss} = 20\% \times (\text{target price} \times \# \text{ of MS-DRG episodes}) \]

**CMS Stop-Gain of 20%**
- Stop-gain for 2016-2017 is 5%
- Stop-gain for 2018 is 10%
- Stop-gain for 2019-2020 is 20%
- \[ \text{Stop-Gain} = 20\% \times (\text{target price} \times \# \text{ of MS-DRG episodes}) \]

**SCHs, MDHs, RRCs**
- Have a stop-loss of 3% in 2017 and
- Have a 5% in 2018-2020
Target Episode Prices

- Target prices will be created for each MS-DRG
- Target prices will be provided before each reporting period
- There will be 8 target prices 2016 and 2019-2020 (16 for 2017 & 2018)
- Target price created for January through September and for October through December
- Regional and hospital specific episode prices are capped at 2 standard deviations over the mean
Target Price Considerations

Target Prices include the following considerations:

- 3 years historical data
- Application of payment systems (IPPS, PFS, OPPS, etc)
- A discount target prices
- Blend of regional and hospital specific claims
- Wage normalization
- Pooling and weighting of MS-DRG 469 and 470
Quality Measures

2 mandatory CQMs

• Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550)
• HCAHPS Survey measure.

“Voluntary” Measure

• Patient Reported Outcomes following elective primary THA or TKA measure of both
• Successful submission = reduction of discount in target price

Total Composite Score of 20 Possible

• Composite score based on national percentile ranking of each hospital for CQMs
• Must score above “Below Acceptable” to share in savings
# Quality Scores Assigned

<table>
<thead>
<tr>
<th>Percentile</th>
<th>THA/TKA RSCR</th>
<th>HCAHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 90th</td>
<td>10 points</td>
<td>8 points</td>
</tr>
<tr>
<td>≥ 80th and &lt; 90th</td>
<td>9.25 points</td>
<td>7.40 points</td>
</tr>
<tr>
<td>≥ 70th and &lt; 80th</td>
<td>8.5 points</td>
<td>6.8 points</td>
</tr>
<tr>
<td>≥ 60th and &lt; 70th</td>
<td>7.75 points</td>
<td>6.2 points</td>
</tr>
<tr>
<td>≥ 50th and &lt; 60th</td>
<td>7 points</td>
<td>5.6 points</td>
</tr>
<tr>
<td>≥ 40th and &lt; 50th</td>
<td>6.25 points</td>
<td>5 points</td>
</tr>
<tr>
<td>≥ 30th and &lt; 40th</td>
<td>5.5 points</td>
<td>4.4 points</td>
</tr>
<tr>
<td>&lt; 30th</td>
<td>0 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>
Quality Composite Scoring

- THA/TKA Risk Standardized Complication Rate 30 days post discharge – 10 points
- HCAHPS – 8 points
- Voluntary Patient Reported Outcome – 2 points

20 Total available points

- 0-4 is **Below Acceptable** = No Change in Discount/No Shared Savings
- 4-6 is **Acceptable** = No change in discount
- 6-13.2 is **Good** = 1% reduction in discount
- 13.2-20 is **Excellent** = 1.5% reduction in discount
Cost Sharing Agreements

Hospitals can enter into Cost Sharing Agreements

- Cannot be a loan or require referrals for business
- Hospital must retain responsibility for 50% of total cost
- No CJR Collaborator can take on more than 25%
- Hospital is responsible for enforcement of participants
Value of Collaboration Agreements

- Align the continuum of care through the episode
- Create coordinated data sharing
- Structure episode wide care plans
- Leverage other bundle or risk contracts
- Share risk/reward
- Strengthen lines of communication
Beneficiary Incentives

Hospitals can provide beneficiary incentives

- Incentive must be closely tied to and advance a clinical goal
- Incentive cannot induce a beneficiary to choose a specific hospital or provider
- Incentives are capped at $1,000
- The hospital must retain ownership of any incentive over $100

- You still cannot pay for referrals
- Incentives must be in kind, not cash
Enforcement Mechanisms

- A warning letter
- Corrective Action Plan (drafted by the hospital)
- Forfeiture of reconciliation payments
- Increase of 25% in recoupment payments
- Termination from the program
Waiver of Certain Medicare Requirements

Waiver of “incident to” requirement.

- Allows provision of in home services up to 9 times during episode
- Requires use of special G Code

Telemedicine Waivers

- Waiver of geographic site and originating site requirements
- Requires use of special G Codes

SNF 3 day inpatient stay requirements

- Must go to a SNF with at least 3 stars in CMS’s quality rating system
- Information must be provided to beneficiary
Hospitals can request data

- Claims data at a hospital specific or regional level are available
- Claims data available at beneficiary level, or aggregate level
- 3 years worth of data
Beneficiary Notice

Notice must contain

- Information/Education on CJR and services
- Retention of freedom of choice
- Explain patient access to records through portal or blue button
- Advise beneficiaries that protections remain in place and give them 1-800 number

Must be provided by:

- Hospitals need to provide notification on admission
- Physicians in a sharing agreement need to provide information on the CJR program when surgery decision is made

EHRs may be used to retain documentation that notification was provided

CMS will provide model notices, but these do not have to be used
Risk Limits (Stop-Loss/Stop-Gain)

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Target rates are calculated Local/regional mix

- Years 1 & 2 2/3 /1/3
- Year 3 1/3 / 2/3
- Years 4 & 5 0 /1.0
### Rough Analysis 469 & 470

- **Primary source American Hospital Directory**
- **Acute is estimated to be 52% of episode**
- **Dollars are for current year and not based on the 3 year development**
- **Case Mix and Complication Rates are well within 1 standard deviation for Division 4**

<table>
<thead>
<tr>
<th>Category</th>
<th>Division 4</th>
<th>Example</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Episodes</td>
<td>12,733</td>
<td>279</td>
<td>22-819</td>
</tr>
<tr>
<td>Total Days</td>
<td>42,702</td>
<td>1032</td>
<td></td>
</tr>
<tr>
<td>ALOS (weighted)</td>
<td>3.35</td>
<td>3.70</td>
<td>2.4-5.3</td>
</tr>
<tr>
<td><strong>Total Hospital Payment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Hospital Payment/episode</td>
<td>$13,500</td>
<td>$12,377</td>
<td>$11-$22K</td>
</tr>
<tr>
<td>Estimated Episode Revenue</td>
<td>$25,962</td>
<td>$23,802</td>
<td></td>
</tr>
<tr>
<td>Average Case Mix</td>
<td>2.2000</td>
<td>2.2342</td>
<td>2.1463-2.3854</td>
</tr>
<tr>
<td>Average Complication Rate</td>
<td>7.45%</td>
<td>6.80%</td>
<td></td>
</tr>
<tr>
<td>Average Readmission Penalties</td>
<td>0.51%</td>
<td>0.08%</td>
<td></td>
</tr>
</tbody>
</table>
Questions?