DRG 469 (Major joint replacement with major complications)

DRG 470 (Major joint without major complications or comorbidities)
Agenda

Analytics - Target Price (Pain or Gain)

Quality Performance

Voluntary Reporting of Patient Outcomes (PRO)

Care Coordination & Patient Case Management

1/24/2017
The proposed rule was published on July 9, 2015, with the comment period ending September 8, 2015. On **November 16, 2015**, CMS finalized the CJR regulations.

**Medicare goal is to have 30% of all Medicare FFS payments made via alternative payment models by 2016 (50% by 2018)**

In 2014, hip & knee replacements accounted for 400,000 procedures and more than $7 billion in cost (for hospitalizations alone).

Average cost from $16,500 to $33,000 for surgery, hospitalization, and recovery.

Described by Medicare as “high expenditures and high utilization”.
First performance period for the CJR model **began on April 1, 2016.**

### Table 8—Performance Years for CJR Model

<table>
<thead>
<tr>
<th>Performance year</th>
<th>Calendar year</th>
<th>Episodes included in performance year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2016</td>
<td>Episodes that start on or after April 1, 2016, and end on or before December 31, 2016.</td>
</tr>
<tr>
<td>3</td>
<td>2018</td>
<td>Episodes that end between January 1, 2018, and December 31, 2018, inclusive.</td>
</tr>
<tr>
<td>4</td>
<td>2019</td>
<td>Episodes that end between January 1, 2019, and December 31, 2019, inclusive.</td>
</tr>
<tr>
<td>5</td>
<td>2020</td>
<td>Episodes that end between January 1, 2020, and December 31, 2020, inclusive.</td>
</tr>
</tbody>
</table>
CJR Participants

Participant hospitals geographically located in the selected 67 MSAs.

Hospitals paid under Inpatient Prospective Payment System (IPPS).

Not CURRENTLY participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for Lower-Extremity Joint Replacement (LEJR) episodes.

Approximately 800 hospitals identified for mandatory participation.
CJR Participants

Retrospective, two-sided risk model with hospitals bearing financial responsibility

Only your hospital:
- Pays the penalty in Year 2 to Year 5.
- Gets assessed a quality score that is nationally published.
- Has responsibility for complications.
- Gets the opportunity for Medicare additional reconciliation payment if under the target price.
- Can facilitate obtaining the historical data.
- Has the opportunity to change patient outcomes.
Due to the public comments received, CMS did **not to finalize** its proposal to **allow beneficiaries the opportunity to decline having their data shared** at this time.

Beneficiaries retain **freedom of choice** to choose providers and services.
Care of Medicare beneficiaries is included if Medicare is the primary payer and the beneficiary is:

- Enrolled in Medicare Part A and Part B throughout the duration of the episode,
- Not eligible for Medicare on the basis of **End Stage Renal Disease**, 
- Not enrolled in a **managed care plan** (e.g., Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations), and
- Not covered under a **United Mine Workers of America** health plan

If at any time during the episode the Medicare beneficiary no longer meets all of these criteria aforementioned, the episode is canceled.
Episode of Care Definition

Episodes are triggered by hospitalizations of eligible Medicare Fee-for-Service beneficiaries discharged with diagnoses:

**MS-DRG 469:** Major joint replacement or reattachment of lower extremity with major complications or comorbidities

**MS-DRG 470:** Major joint replacement or reattachment of lower extremity without major complications or comorbidities
Episodes include:

**Hospitalization and 90 days post-discharge**

The *day of discharge* is counted as the first day of the 90-day post discharge period.

**All Part A and Part B services**, with the exception of certain excluded services that are clinically unrelated to the episode.
Episode of Care Definition

**Included services**
- Physicians' services
- Inpatient hospitalization
- Inpatient hospital readmission
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Outpatient therapy site
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs and biologicals
- Hospice
- PBPM payments under models tested under section 1115A of the Social Security Act
Episode of Care Definition

Excluded services

- Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery.

- Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care.

- The list of excluded MS-DRGs and ICD-CM diagnosis codes, including both ICD-9-CM and ICD-10-CM, is posted on the CMS Web site.

https://innovation.cms.gov/initiatives/cjr
Providers and suppliers continue to be paid via Medicare FFS. After a performance year, actual episode spending will be compared to the episode target prices:

- Actual Spending < Target Price = Reconciliation Payment to Hospital
- Actual Spending > Target Price = Repayment to CMS by Hospital

Responsibility for repaying Medicare begins in Year 2, with no downside responsibility in Year 1.

* Separate episode target prices for MS-DRGs 469 and 470
** Separate pricing methodology for hip fracture patients.

CMS will use a simple risk stratification methodology to set different target prices for patients with hip fractures within each MS-DRG 469 and 470.
DRG 469 (Major joint replacement with major complications)

DRG 470 (Major joint without major complications or comorbidities)
Hospital Episode Payment

- IRF
- SNF
- HHA
- LTCH
- Therapy
- Surgeons
In response to comments, CMS finalized:

Reconciliation payments will be phased-in and capped (stop-gain):

- Years 1 and 2: Capped at 5%
- Year 3: Capped at 10%
- Years 4-5: Capped at 20%
Repayment to Medicare (Loss)

Hospital responsibility to repay Medicare will be phased-in and capped (stop-loss):

- Year 1: No responsibility to repay Medicare
- Year 2: Capped at 5% of target prices
- Year 3: Capped at 10% of target prices
- Years 4 and 5: Capped at 20% of target prices

Additional protection for rural, sole community (SCH), Medicare dependent (MDH), and rural referral center (RRC) hospitals with stop-loss of 3% for Year 2 and 5% for Years 3-5.
Collaborators and Sharing Arrangement

Consistent with applicable law, participant hospitals may have certain financial arrangements with Collaborators to support their efforts to improve quality and reduce costs.

CJR Collaborators may include the following provider and supplier types:
- Skilled nursing facilities
- Home health agencies
- Long term care hospitals
- Inpatient rehabilitation facilities
- Physician Group Practices
- Physicians, non-physician practitioners (NPP), and providers and suppliers of outpatient therapy.

Physician Group Practices (PGP), who are CJR Collaborators, with Practice Collaboration Agents, which include:
- Physicians
- Non-Physician Practitioners
- Physical, occupational or speech therapists
CJR Collaborator Selection Criteria

Develop **written selection criteria** for CJR Collaborators

---Selection criteria for CJR Collaborators **must relate to quality of care** to be delivered
  (it can be prospective or retrospective)

Examples from CMS include:
  - Prior complication rates
  - Attending weekly care coordination meeting
  - Following specified clinical pathways
  - Contacting CJR beneficiaries frequently

---Selection criteria **cannot** be based, directly or indirectly, on volume or value of referrals.
Collaborators and Sharing Arrangement (Gain)

Participant hospitals may share with Collaborators:

- Reconciliation payments in the form of a performance-based payment.
- Internal Cost Savings realized through care redesign activities associated with services furnished to beneficiaries during a CJR episode.

Total gainsharing payment cannot exceed 50% of Medicare fee for service reimbursement for such collaborator.

Methodology for gainsharing payments
- Written policy
- Incorporate satisfying criteria related to quality of care to be delivered to CJR beneficiaries
- Cannot be based directly on volume or value of referrals
- Distributed annually via EFT
Collaborators and Sharing Arrangement (Loss)

Participant hospitals may assign various percentages of two-sided risk to collaborators.

- Where that is the case, CMS will continue to make **reconciliation payments and recoupments solely with the hospital**.

- The **hospital is responsible for payment and recoupments with its collaborators** according to the agreements between those entities.

- **CMS limits the hospital’s sharing of risk to 50% of the total repayment amount to CMS; e.g. the** hospital is required to retain 50% of the downside risk.

- The hospital is not permitted to share more than 25% of its repayment responsibility with any one provider or supplier.
CJR Gainsharing & Alignment Payments

Participant hospitals may include the following in a sharing arrangement (and nothing else)

Reconciliation Payments: payment from CMS to a CJR hospital when hospital realizes a positive Net Payment Reconciliation Amount (NPRA).

Internal Cost Savings: measurable verifiable cost savings realized through care redesign activities associated with services furnished to beneficiaries during a CJR episode.

Alignment Payments: payment from a CJR Collaborator to a participant hospital whereby participant hospital shares downside risk with CJR Collaborators.
Collaborators and Sharing Arrangement
(Agreement and Gain Sharing)

CJR requires signed written agreements with CJR Collaborators & (if applicable) also Practice Collaboration Agents of CJR Collaborators.

- Collaborator Agreement
- Distribution Agreement - (Practice Collaboration Agent); member who has entered into a distribution arrangement with the same PGP of which he or she is a member and who has not entered into a collaborator agreement with a participant hospital.
- Opportunity to receive a gainsharing payment may not be conditioned, directly or indirectly, on volume/value of referrals.

**Collaborators must contribute to care redesign

All CJR Collaborators (except for PGPs) are required to engage with hospital in its care redesign strategies and to furnish services during CJR episode.

If PGP, Practice Collaboration Agent must participate in care redesign strategies and have at least one physician/NPP that furnished services to a CJR beneficiary during applicable calendar Year.
Sharing Regulatory Compliance

--Establish board or other governing body oversight of CJR

--Update Compliance Plan to include oversight of CJR

--Maintain current and historical list of CJR Collaborators – published on participant hospital’s website

--Issue required beneficiary notifications

--Satisfy documentation requirements
   --10 year record retention

--Setup process for EFT Payments
Composite Quality: Pay-for-Performance

Hospitals are assigned a composite quality score each year based on their performance and improvement on the following 2 quality measures:

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

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

Voluntary Submission of THA/TKA patient-reported outcomes and limited risk variable data. CMS also finalized a more achievable “successful” criterion for voluntary submission of THA/TKA patient-reported outcomes and limited risk variable data.
### TABLE 4.1: QUALITY MEASURE WEIGHTS IN COMPOSITE QUALITY SCORE

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-level RSCR following elective primary THA and/or TKA Complications measure (NQF #1550)</td>
<td>50%</td>
</tr>
<tr>
<td>HCAHPS survey measure (NQF #0166)</td>
<td>40%</td>
</tr>
<tr>
<td>THA/TKA PRO and limited Risk variable Voluntary Data</td>
<td>10%</td>
</tr>
<tr>
<td>Performance Percentile</td>
<td>THA/TKA Complications measure (NQF #1550) Quality Performance Score (Points)</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>≥ 90th</td>
<td>10.00</td>
</tr>
<tr>
<td>≥ 80th and &lt;90th</td>
<td>9.25</td>
</tr>
<tr>
<td>≥ 70th and &lt;80th</td>
<td>8.50</td>
</tr>
<tr>
<td>≥ 60th and &lt;70th</td>
<td>7.75</td>
</tr>
<tr>
<td>≥ 50th and &lt;60th</td>
<td>7.00</td>
</tr>
<tr>
<td>≥ 40th and &lt;50th</td>
<td>6.25</td>
</tr>
<tr>
<td>≥ 30th and &lt;50th</td>
<td>5.50</td>
</tr>
<tr>
<td>&lt;30th</td>
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</table>
### Table 19—Performance Year 1: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced at Reconciliation

<table>
<thead>
<tr>
<th>Composite quality score</th>
<th>Quality category</th>
<th>Eligible for reconciliation payment</th>
<th>Eligible for quality incentive payment</th>
<th>Effective discount percentage for reconciliation payment (%)</th>
<th>Effective discount percentage for repayment amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4.0</td>
<td>Below Acceptable</td>
<td>No</td>
<td>No</td>
<td>3.0</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>≥4.0 and &lt;6.0</td>
<td>Acceptable</td>
<td>Yes</td>
<td>No</td>
<td>3.0</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>≥6.0 and ≤13.2</td>
<td>Good</td>
<td>Yes</td>
<td>Yes</td>
<td>2.0</td>
<td>Good</td>
</tr>
<tr>
<td>&gt;13.2</td>
<td>Excellent</td>
<td>Yes</td>
<td>Yes</td>
<td>1.5</td>
<td>No applicable.</td>
</tr>
</tbody>
</table>

### Table 20—Performance Years 2 and 3: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced at Reconciliation

<table>
<thead>
<tr>
<th>Composite quality score</th>
<th>Quality category</th>
<th>Eligible for reconciliation payment</th>
<th>Eligible for quality incentive payment</th>
<th>Effective discount percentage for reconciliation payment (%)</th>
<th>Effective discount percentage for repayment amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4.0</td>
<td>Below Acceptable</td>
<td>No</td>
<td>No</td>
<td>3.0</td>
<td>2.0</td>
</tr>
<tr>
<td>≥4.0 and &lt;6.0</td>
<td>Acceptable</td>
<td>Yes</td>
<td>Yes</td>
<td>3.0</td>
<td>2.0</td>
</tr>
<tr>
<td>≥6.0 and ≤13.2</td>
<td>Good</td>
<td>Yes</td>
<td>Yes</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>&gt;13.2</td>
<td>Excellent</td>
<td>Yes</td>
<td>Yes</td>
<td>1.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

### Table 21—Performance Years 4 and 5: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced at Reconciliation

<table>
<thead>
<tr>
<th>Composite quality score</th>
<th>Quality category</th>
<th>Eligible for reconciliation payment</th>
<th>Eligible for quality incentive payment</th>
<th>Effective discount percentage for reconciliation payment (%)</th>
<th>Effective discount percentage for repayment amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4.0</td>
<td>Below Acceptable</td>
<td>No</td>
<td>No</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>≥4.0 and &lt;6.0</td>
<td>Acceptable</td>
<td>Yes</td>
<td>Yes</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>≥6.0 and ≤13.2</td>
<td>Good</td>
<td>Yes</td>
<td>Yes</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>&gt;13.2</td>
<td>Excellent</td>
<td>Yes</td>
<td>Yes</td>
<td>1.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>
**TABLE 3.2: SUMMARY OF FINALIZED QUALITY MEASURE PERFORMANCE PERIODS BY YEAR OF THE CJR**

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
</table>
Comprehensive Care for Joint Replacement (CJR)

Voluntary Reporting of Patient Outcomes (PRO)
Voluntary Reporting Patient Outcomes

Which patients are eligible for PRO data collection?
Hospitals should ensure Medicare beneficiaries 65 years or older undergoing elective primary THA/TKA procedures complete the required PRO instruments before and after surgery.

Please note, if patients at a CJR participant hospital meet the selection criteria in Figure 1 and as specified in the CJR final rule, then the patients will be eligible for voluntary PRO and risk variable data submission, regardless of the provider’s affiliation with another CMS model (for example, the BPCI model).

First Reporting Period was due October 31, 2016
Which patients are eligible for PRO data collection?

1. Obtain surgery list for July 1 to August 31, 2016.
2. Collect required data points PRIOR to surgery for submission by October 31, 2016.
1) **Required pre- and post-operative PRO instruments:**
   - VR-12 **OR** PROMIS-Global PROMs; **AND**
   - HOOS/KOOS Jr. **OR** HOOS/KOOS subscales
     - HOOS subscales: pain, and function, daily living
     - KOOS subscales: stiffness, pain, and function, daily living

2) **Required identifiers with all (pre- and post-operative) submitted data**
   - Medicare Provider Number
   - Medicare Health Insurance Claim Number (HIC) number
   - Date of Birth

3) **Required risk variables with pre-operative submitted data only:**
   - Race and ethnicity
   - Body mass index (BMI) or height in cm and weight in kg
   - Patient-reported Health Literacy Screening (SILS2) questionnaire
   - Pre-operative use of narcotics
   - Patient-reported Pain in Non-operative Lower Extremity Joint
   - Patient-reported Back Pain (Oswestry Index question)

4) **Requested risk variables with pre-operative submitted data only:**
   - Mode of Collection
   - Date of Collection
   - Survey Respondent (if other than patient)
Table 1: Voluntary PRO Data Submission Deadlines for Given Data Elements in CJR Performance Years 1-5

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline</td>
<td>Pre-Operative Data on Model Year 1 Patients</td>
<td>Pre-Operative Data on Model Year 2 Patients</td>
<td>Pre-Operative Data on Model Year 3 Patients</td>
<td>Pre-Operative Data on Model Year 4 Patients</td>
</tr>
<tr>
<td></td>
<td>Post-Operative Data on Model Year 2 Patients</td>
<td>Post-Operative Data on Model Year 3 Patients</td>
<td>Post-Operative Data on Model Year 4 Patients</td>
<td>Post-Operative Data on Model Year 5 Patients</td>
</tr>
</tbody>
</table>

1/24/2017
When should PRO and other data elements be collected?

- **Pre-operative data:** Collect the following between 90 to 0 days prior to the eligible elective primary THA/TKA procedure:
  - 1 generic and 1 THA/TKA-specific PRO instrument plus risk variables and identifiers

- **Post-operative data:** Collect the following between 270 to 365 days after the eligible elective primary THA/TKA procedure:
  - 1 generic and 1 THA/TKA-specific PRO instrument plus identifiers

- Risk variables are collected only pre-operatively

### Table 1: Voluntary PRO Data Submission Deadlines for Given Data Elements in CJR Performance Years 1-5

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline</td>
<td>October 31, 2016</td>
<td>October 31, 2017</td>
<td>August 31, 2018</td>
<td>August 31, 2019</td>
</tr>
<tr>
<td>Data Being Submitted</td>
<td>Pre-Operative Data on Model Year 1 Patients</td>
<td>Post-Operative Data on Model Year 1 Patients</td>
<td>Post-Operative Data on Model Year 2 Patients</td>
<td>Post-Operative Data on Model Year 3 Patients</td>
</tr>
<tr>
<td></td>
<td>Pre-Operative Data on Model Year 2 Patients</td>
<td>Pre-Operative Data on Model Year 3 Patients</td>
<td>Pre-Operative Data on Model Year 4 Patients</td>
<td>Pre-Operative Data on Model Year 5 Patients</td>
</tr>
<tr>
<td>Quality Measure</td>
<td>Weight in Composite Quality Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-level RSCR following elective primary THA and/or TKA Complications measure (NQF #1550)</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCAHPS survey measure (NQF #0166)</td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THA/TKA PRO and limited Risk variable Voluntary Data</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CJR and ACO

Hospitals selected to participate in the CJR model may also participate in an ACO or other models.

The financial reconciliations under the CJR model and other CMS models and programs will, to the extent feasible, account for all Medicare Trust Fund payments for beneficiaries in those models and programs and generally ensure that Medicare saves the expected 3 percent discount on CJR episodes.
CJR Data Sharing

Data is available for the hospital’s baseline period and no less often than on a quarterly basis with the goal of as often as on a monthly basis if practicable during a hospital’s performance period.

CMS will share data with participant hospitals for hospitals to

- Evaluate their practice patterns
- Redesign care delivery pathways
- Improve care coordination

In response to a hospital’s request and in accordance with our regulations and applicable privacy laws, 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

1/24/2017
CJR Strategies

Get prepared 2017
DRG 469 (Major joint replacement with major complications)

DRG 470 (Major joint without major complications or comorbidities)
Component One – Target Price
The Pain or the Gain?
Comprehensive Care Joint Replacement (CJR) Model

Actual Episode of Care Spend for All Episodes
Medicare Target Price times number of total episodes

What’s the difference?
Repayment or Refund?

Target Price Data Analysis

✓ Why is hospital not meeting target prices? Review historical cases.
✓ Is it cost of complications, length of stay at post-acute care (PAC), daily average cost of care at PAC settings, discharge to SNF or home health instead of home care?
✓ Guarantee your Hospital meets target prices by implementing targeted plan of action based on Target Price Data Analysis.
✓ Contract & Pricing Modeling with post-acute providers.

Performance Case Studies

✓ Hospital now sends 50% of all hip and knee replacement patients home after surgery, up from 20% previously

✓ Hospital now sends 25% of all hip and knee replacement patients to home health after surgery (instead of SNF), up from 15% previously

✓ Hospital reduced SNF network from 30 to 9 with Length of Stay (LOS) dropping by more than 14 days (42 to 28 days)

✓ Hospital complications reduction by 15% by changing post-acute network utilizing historical data of infections, poor care and length of stay analysis
<table>
<thead>
<tr>
<th>Regional Average 469</th>
<th>Regional Average 470</th>
</tr>
</thead>
<tbody>
<tr>
<td>$47925.00</td>
<td>$23734.00</td>
</tr>
</tbody>
</table>

**DRG 470 National Avg Comparison**

- **Above Regional Avg - 84.62 % (11)**
- **Below Regional Avg - 15.38 % (2)**
DRG 470 Initial Discharge Status - Total Episode Payments

- HHA: 75.04% ($489,557.87)
- Home: 19.67% ($128,368.71)
- SNF: 5.28% ($34,483.67)
### Comprehensive Care for Joint Replacement (CJR)

#### Interactive Analysis

<table>
<thead>
<tr>
<th>Filters</th>
<th>Reset Filtered Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Show Complications</strong></td>
<td></td>
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<tr>
<td>No</td>
<td></td>
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<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>All Patients</td>
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<tr>
<td><strong>Patient Attribution</strong></td>
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<tr>
<td><strong>Year Of Service</strong></td>
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<td>2016</td>
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<td><strong>Deceased</strong></td>
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<td>All Patients</td>
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<td><strong>Division</strong></td>
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<td>Select Division...</td>
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<td><strong>Facility Number</strong></td>
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<td>Select Facility Number...</td>
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<td><strong>CCM Eligible</strong></td>
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<td><strong>Tin Name</strong></td>
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<td>Select Tin Name...</td>
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<td><strong>SubGroup Name</strong></td>
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<td>Select SubGroup Name...</td>
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<td><strong>NPI Number</strong></td>
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<td><strong>Surgery Facility</strong></td>
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<td>Select Surgery Facility...</td>
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<tr>
<td><strong>Surgery OON</strong></td>
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Q: When can we begin utilizing the Skilled Nursing Facility (SNF) 3-day stay waiver?

A: The SNF waiver will not be available for use until January 1, 2017. The waiver will be available for use only for episodes that initiate on or after January 1, 2017.

Q: Where can we find the list of SNFs that meet the quality requirement (3 stars or higher for 7 of the last 12 months)?

A: The list will be updated and posted quarterly on the CMS public website at https://innovation.cms.gov/initiatives/cjr.
Q: What are the guidelines for discharge planning notices and potential liability for SNF stays when a beneficiary is discharged after less than 3 days to a SNF not meeting the quality requirements?

A: Beginning in January 2017 when the SNF 3-day stay waiver is available for CJR participant hospitals, CMS will cover services furnished under the waiver when the eligibility and enrollment information available to the provider at the time the services under the waiver were furnished indicated that the beneficiary was included in the model. In cases where the hospital does not provide the discharge planning notice, the hospital would be financially liable for the SNF stay.

If a CJR participant hospital discharges a beneficiary without a qualifying 3-day stay to a SNF that does not meet the quality requirements for waiver use, the hospital must provide a discharge planning notice to the beneficiary detailing any potential financial liability for the SNF stay. Participant hospitals must provide a discharge planning notice to a beneficiary to provide written notice of potential financial liability associated with non-covered services recommended or discussed as a part of discharge planning. This must be provided no later than at the time that post-acute care is discussed or at the time of discharge, whichever occurs earlier. For example, if a participant hospital discharges a beneficiary to a SNF that would not qualify under the 3-day stay waiver, then the hospital must notify the beneficiary that he or she may be responsible for costs associated with that SNF stay, except those which would be covered by Medicare Part B during a non-covered inpatient SNF stay.

Q: When we give the beneficiaries a list of SNFs eligible for waiver use can we include their star ratings?

A: Yes, as long as there is no patient steering and the star ratings match what CMS has posted on the CJR public website. The CJR participant hospitals can also point beneficiaries to the Nursing Home Compare website, which is listed on the beneficiary notification template.
Component One – Target Price
The Pain or the Gain?
Comprehensive Care Joint Replacement (CJR) Model

Discharge Trending

✓ Patient Outcomes: IRF vs. Inpatient vs. SNF vs. Home Health vs. Self Care.
✓ Length of Stay PAC comparisons
✓ Cost of Care PAC comparisons
✓ Complication PAC comparisons

Performance Opportunity

✓ Reduce post-acute provider spend; e.g. discharge to home care instead of home health or discharge to home health instead of SNF.
✓ Build post-acute provider network based on quality performance.
✓ Find the root cause of complications and poor care in post-acute provider network.

Performance Case Studies

✓ Hospital now sends 50% of all hip and knee replacement patients home after surgery, up from 20% previously

✓ Hospital now sends 25% of all hip and knee replacement patients to home health after surgery (instead of SNF), up from 15% previously

✓ Hospital reduced SNF network from 30 to 9 with Length of Stay (LOS) dropping by more than 14 days (42 to 28 days)

✓ Hospital complications reduction by 15% by changing post-acute network utilizing historical data of infections, poor care and length of stay analysis
**Complications Trending**
- Which providers (Surgeon, SNFs, HHAs) are the root cause of patient complications
- Patient outcomes related to complications; e.g. patients not screened and eligible for surgery; patient self care not managed

**Performance Opportunity**
- Build post-acute provider network based on quality performance
- Find the root cause of complications and poor care in post-acute provider network
- Assigned Primary NPI and Surgeon Performance Accountability

**Performance Case Studies**
- Hospital now sends 50% of all hip and knee replacement patients home after surgery, up from 20% previously
- Hospital now sends 25% of all hip and knee replacement patients to home health after surgery (instead of SNF), up from 15% previously
- Hospital reduced SNF network from 30 to 9 with Length of Stay (LOS) dropping by more than 14 days (42 to 28 days)
- Hospital complications reduction by 15% by changing post-acute network utilizing historical data of infections, poor care and length of stay analysis
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Component One – Target Price
The Pain or the Gain?
Comprehensive Care Joint Replacement (CJR) Model

Comprehensive 5 Year Pricing & Contract Modeling Program
- Post-acute care provider contract models
- Bundled payment pricing models

Performance Opportunity
- Guarantee target prices with post-acute care provider contracts
- Hospital is expected to receive one payment at end of 5 year program and distribute such payment for the 90 day episode of care
- Key initiative of establishing contracts and pricing models with your network of post-acute care providers over next 5 years

Performance Case Studies
- Hospital now sends 50% of all hip and knee replacement patients home after surgery, up from 20% previously
- Hospital now sends 25% of all hip and knee replacement patients to home health after surgery (instead of SNF), up from 15% previously
- Hospital reduced SNF network from 30 to 9 with Length of Stay (LOS) dropping by more than 14 days (42 to 28 days)
- Hospital complications reduction by 15% by changing post-acute network utilizing historical data of infections, poor care and length of stay analysis
Summary CJR Performance Opportunities

- Pre-screen patients for surgery eligibility on a consistent basis.
  - Increase quality performance, reduce total episode spend and capture data for voluntary outcome reporting.
  - Ineligible patients based on pre-screening start on care plan prior to surgery.

- Patient discharge care plan on consistent basis; Home, HHA, SNF, IRF
  - Set criteria for type of discharge; e.g. Home, HHA, SNF, IRF
  - Capture data for voluntary outcome reporting

- Root cause data analysis to determine why hospital not meeting the target prices set by Medicare.
  - Avoid repayment to Medicare in Year 2 to Year 5 by strategically structuring post-acute care contracts and pricing models.

- Root cause data analysis to determine cause of complications.
  - Post-Acute Care Network Restructure

- Patient outcomes in relation to discharge location; e.g. SNF vs. Home Health vs. Self Care.
- Reduction of length of stay for post-acute care providers; e.g. SNF, IRF.
- Review HHA episode length
- Trend outcomes by surgeon
- Build post-acute provider network based on quality performance.
  - Hold post-acute providers responsible for patient complications.
Component Two – Quality Performance
The Pain or the Gain?
Comprehensive Care Joint Replacement (CJR) Model

Quality Measure Performance Tracking – NQF 1550
- Rate of complications for DRG 469 and DRG 470
- Quality Performance Scoring
- Trends in care related to complications – What is root cause of complications?
- Analysis of SNFs, IRFs, HHAs, Self-Care, etc.

5.4. Numerator Statement: The outcome for the measure is any complication (consisting of acute myocardial infarction or AMI, pneumonia, sepsis/septicemia/shock, death, surgical site bleeding, pulmonary embolism, mechanical complications and periprosthetic joint infection/wound infection) occurring during the index admission (not coded present on arrival) to 90 days post-date of the index admission. Complications are counted in the measure only if they occur during the index hospital admission or during a readmission. The complication outcome is a dichotomous (yes/no) outcome. If a patient experiences one or more of these complications in the applicable time period, the complication outcome for that patient is counted in the measure as a “yes”.

5.7. Denominator Statement: The target population for the publically reported measure includes admissions for Medicare FFS beneficiaries who are at least 65 years of age undergoing elective primary THA and/or TKA procedures.

5.10. Denominator Exclusions: This measure excludes index admissions for patients:
1) Without at least 90 days post-discharge enrollment in FFS Medicare;
2) Who were discharged against medical advice (AMA); or,
3) Who had more than two THA/TKA procedure codes during the index hospitalization.

After applying these exclusion criteria, we randomly select one index admission for patients with multiple index admissions in a calendar year. We therefore exclude the other eligible index admissions in that year.

De.1. Measure Type: Outcome
5.23. Data Source: Administrative claims
5.26. Level of Analysis: Facility
Component Three – Voluntary Patient Reported Outcomes (PRO)

Patient Case Management – Pre or Post-op

The Pain or the Gain?

Comprehensive Care Joint Replacement (CJR) Model

- Voluntary Reporting of Patient Outcomes
  - Quality Measure Incentive
  - Increase your Quality Measure Performance Score
    - Voluntary Reporting to Medicare
    - Tracking and Reporting Patient Outcomes (PRO)

- Patient Screening Tool – Surgery Eligibility

- Pre-Op Patient Engagement

- Post-Acute Care Network
  - Care Coordination after discharge
  - Manage patients post-discharge
  - Standardized Care Plans
    - SNFs, IRFs, HHAs, Self-Care
Day One – Replacement Surgery
DRG 469
DRG 470

Day One - Hospital

Day 2 and/or 3 Physical Therapy
Occupational Therapy

Day 4 Discharge to home with Home Health Agency (HHA) Care

Day 4 Discharge to SNF Rehabilitative Care

Day 4 Discharge to Home with Self Care

Day 4 Physical Therapy may continue

Day 5 to 15 Follow-up Physician Visits

Day 11 to 15 Staple incision removal

1/24/2017
Setup Patient in Care Coordination Tool upon Pre-Screening for Surgery (Day 0 to day 90 prior to surgery) & Discharge from Hospital (PRO Data Collection)

Is patient Transitional Care Management (TCM) 99495-99496 eligible
Date of Discharge plus 29 days

Is patient Chronic Care Management (CCM) 99490 Eligible?
30 days after Date of Discharge

Self Care Transition Template

Home Health Agency (HHA) Transition Template

SNF/IRF Transition Template

Patient Education & Follow-up Materials
Patient Communication Portal Access

Patient Outcomes Tracking Day 5 to Day 90

Complications & Readmissions Documentation & Intervention Templates

1/24/2017
ADVANCED APM TRACKS

Q: What are the two different Advanced APM track options for the CJR model?
A: The Track 1 option of the CJR model incorporates Advanced APM criteria to make this track of the model an Advanced APM and the APM incentive payment available for eligible clinicians. The Track 2 option of this model is an APM, but does not meet the Advanced APM criteria finalized in the Quality Payment Program final rule.

Q: Is the CJR model an Advanced Alternative Payment Model?
A: To be an Advanced APM, an APM must meet the following three criteria:

- Require participants to use certified electronic health record technology (CEHRT),
- Provide payment for covered professional services based on quality measures comparable to those used in the Merit-based Incentive Payment System (MIPS) quality performance category, and
- Require participating APM Entities to bear a more than nominal amount of financial risk.

The Track 1 option of the CJR model incorporates these criteria to make this track of the model an Advanced APM and the APM incentive payment available for eligible clinicians. The Track 2 option of this model is an APM, but does not meet the criteria to be an Advanced APM.
New & Updated Payment Models: Improve Cardiac and Joint Care and MSSP ACO 1+ Model

Join us for a webinar on Feb 03, 2017 at 2:00 PM CST.

Register now!

https://attendee.gotowebinar.com/register/4620522073455352835

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized new Innovation Center models that continue the Administration’s progress to shift Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for hospitals to deliver better care to patients at a lower cost. These models will reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery.

The announcement finalizes significant new policies that:

• Improve cardiac care: Three new payment models will support clinicians in providing care to patients who receive treatment for heart attacks, heart surgery to bypass blocked coronary arteries, or cardiac rehabilitation following a heart attack or heart surgery.

• Improve orthopedic care: One new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture, other than hip replacement. In addition, CMS is finalizing updates to the Comprehensive Care for Joint Replacement Model, which began in April 2016.

• Provides an Accountable Care Organization opportunity for small practices: The new Medicare ACO Track 1+ Model will have more limited downside risk than in Tracks 2 or 3 of the Medicare Shared Savings Program in order to encourage more practices, especially small practices, to advance to performance-based risk.

These new payment models and the updated Comprehensive Care for Joint Replacement Model give clinicians additional opportunities to qualify for a 5 percent incentive payment through the Advanced Alternative Payment Model (APM) path under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program. For the new cardiac and orthopedic payment models, clinicians may potentially earn the incentive payment beginning in performance year 2019 or potentially as early as performance year 2018 if they collaborate with participant hospitals that choose the Advanced APM path.

After registering, you will receive a confirmation email containing information about joining the webinar.

View System Requirements

1/24/2017
CJR Deep Dive

Join us for a webinar on Feb 17, 2017 at 1:00 PM CST.

Register now!

https://attendee.gotowebinar.com/register/6144226387382542595

Deep Dive overview of the Comprehensive Care Joint Replacement (CJR) program. Includes overview of 2015, 2016 and 2017 regulatory updates.

After registering, you will receive a confirmation email containing information about joining the webinar.

View System Requirements
Contact Us

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gates@healthendeavors.com