Comprehensive Care for Joint Replacement (CJR) Readiness Kit
CMS Announces Shift From Volume To Value

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, HHS Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move Medicare payments toward providers based on the quality, rather than volume, of medical care they deliver.

Traditional, or fee-for-service, Medicare payments to quality or value will begin in 2016, and by 2018, Medicare payments tied to quality or value will be 90 percent. These payment models will shift the focus of Medicare payments from volume to value, rewarding providers and systems that deliver high-quality care.

The goal of these payment models is to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

“Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today’s announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely,” Secretary Burwell said. “We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement.”

“We’re all partners in this effort focused on a shared goal. Ultimately, this is about improving the health of each person by making the best use of our resources for patient good. We’re on board, and we’re committed to changing how we pay for and deliver care to achieve better health,” Douglas E. Henley, M.D., executive vice president and chief executive officer of the American Academy of Family Physicians said.
Top Things To Know About CJR Final Rule

• CJR is for bundled payment for lower extremity joint replacement (LEJR) DRG 469, 470.

• CJR will start on April 1, 2016, and run for 5 years through December 31, 2021. Downside risk starts on January 1, 2017.

• The CJR program is mandatory in 67 Metropolitan Service Areas (MSAs).

• The CJR mandatory bundle only applies to Medicare Fee-For-Service (FFS) beneficiaries.

• The bundle places the responsibility of the total price of in-patient episodes and 90-days post-discharge with the hospital.

• Each hospital will have a unique target price, which is set by a combination of a hospital's blended, regional, and historical episode spending data with a discount factor of 3%.

• Reconciliation is two-sided. If a hospital's costs are under the target price then the hospital gets a bonus from CMS; if it's higher, the hospital owes CMS at year end starting in 2017. Hospitals will have a chance to lower the 3% discount if they meet quality performance metrics.

• Hospitals will receive a composite score on their ability to meet quality metrics, which can reduce their discount from 3% to 1.5% in years 4 and 5.

• Voluntary Patient Reported Outcomes (PROs) will result in an additional 10% contribution to the composite score.

• Hospitals can gain share with physicians, Skilled Nursing Facilities (SNFs), Home Health, etc.

• CMS will waive certain laws and requirements to enhance care coordination and lower costs, including a waiver to incentivize hospitals to encourage patient engagement through the use of technologies or services.
Proposed Timeline For CJR

- **July 2015**: CMS announced CJR proposal
- **11/16/15**: CMS released final rule
- **4/1/16**: CJR begins
- **Years 1 & 2**: Target Price = 2/3 hospital-specific, 1/3 regional
- **Years 3**: Target Price = 1/3 hospital-specific, 2/3 regional
- **Years 4 & 5**: Target Price = 100% regional
- **Year 2 phase-in of repayment penalties**
- **Year 3**: 3 years of historical data
- **Year 4**: CMS releases 3 years of historical data
- **Year 5**: CJR begins
- **12/31/20**: Initiative ends

**Timeline:**
- **July 2015**
- **Nov. 2015**
- **April 2016**
- **2017**
- **2018**
- **2019**
- **2020**

**Notations:**
- **7/9/15**: CMS announced CJR proposal
- **11/16/15**: CMS released final rule
- **4/1/16**: CJR begins
- **Year 3**: Target Price = 1/3 hospital-specific, 2/3 regional
- **Year 4**: Target Price = 100% regional
- **Year 5**: CMS releases 3 years of historical data
- **12/31/20**: Initiative ends
Who Is Impacted?

- Hospitals located in 67 specified metropolitan statistical areas (MSAs) will be held financially responsible for the total cost of care associated with hip and knee joint replacement surgeries for traditional Medicare beneficiaries.

- Exceptions - providers in the selected geographies who are already participating in:
  - Model 1 or
  - Phase II of Models 2 or 4 of Bundled Payments for Care Improvement (BPCI)

- Hospitals selected to participate in CJR may also participate in an ACO.
CMS Regions For Target Price

- CMS will average the cost of procedures in 9 regions throughout the country.
- Hospitals that are poor performers in those regions stand to lose the most.
- Target price will be determined by the end of 2016 with no downside risk reconciliation next year.
How Does This Mandatory Payment Model Work?

- Eligible beneficiaries include Medicare FFS only, not Medicare Advantage.
- This is the first time that CMS is implementing a bundled payment model in which providers are required to participate.
- The accountable entity bearing financial risk is the acute care hospital where the surgery is performed.
- The responsible episode period starts on the date of admission to the acute care facility and ends 90 days after discharge.
- Calculation of payment begins after conclusion of a performance year where the actual episode payment is based on MSA claims data and is risk adjusted. A hospital's payment will be calculated based on the target price (set by end of 2016) and adjusted based on quality and post-episode spending. If the actual cost is greater than the target price, the hospital would be required to make a reconciliation payment to CMS.
- Quality measure and reporting requirements include surgical complications, patient experience, voluntary submission of patient reported outcomes, and incentives for year-over-year improvement. Minimum quality thresholds must be met before any gain sharing can be earned.

<table>
<thead>
<tr>
<th>DRG</th>
<th>Target Price</th>
<th>Episode Count</th>
<th>Target Payment Amount</th>
<th>Actual FFS Payment</th>
<th>Medicare Savings/Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>469</td>
<td>$40,000</td>
<td>20</td>
<td>$800,000</td>
<td>$1,100,000</td>
<td>($300,000)</td>
</tr>
<tr>
<td>470</td>
<td>$25,000</td>
<td>400</td>
<td>$10,000,000</td>
<td>$10,600,000</td>
<td>($600,000)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>420</td>
<td>$10,800,000</td>
<td>$11,700,000</td>
<td></td>
<td>($900,000)</td>
</tr>
</tbody>
</table>

In this example the hospital is spending above the target payment amount and will owe CMS a check at the end of the reconciliation year.

Example for illustrative purposes only.
Background On Proposed Quality Measures

Hospitals have the opportunity to cut the episode discount by 50% if they can achieve high levels of quality performance. For example, the discount can be decreased from 3.0% to 1.5% in years 4 and 5 by scoring well in areas including surgical complication rates and HCAHPS. These measures are combined into a composite quality score. CMS also provides an additional bonus for voluntary submission of PROs.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weight in Composite Quality Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-level Risk Standardized Complication Rate (RSCR) following elective primary THA and/or TKA (NQF #1550)</td>
<td>50%</td>
</tr>
<tr>
<td>HCAHPS survey (NQF #0166)</td>
<td>40%</td>
</tr>
<tr>
<td>THA/TKA PRO and limited risk variable voluntary data</td>
<td>10%</td>
</tr>
</tbody>
</table>

Based on relative rankings of surgical complication rates and HCAHPS, CJR hospitals will earn ‘points’ towards the composite quality score. Hospitals can earn 2 bonus points for voluntary submission of PROs and up to 1.8 bonus points if they achieve a 3% improvement in HCAHPS and/or surgical complication rates from the prior year.

<table>
<thead>
<tr>
<th>Performance Percentile</th>
<th>THA/TKA Complications Measure Quality Performance Score (Points)</th>
<th>HCAHPS Survey Measure Quality Performance Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;90th</td>
<td>10.00</td>
<td>8.0</td>
</tr>
<tr>
<td>&gt;= 80th and &lt;90th</td>
<td>9.25</td>
<td>7.40</td>
</tr>
<tr>
<td>&gt;= 70th and &lt;80th</td>
<td>8.5</td>
<td>6.80</td>
</tr>
<tr>
<td>&gt;= 60th and &lt;70th</td>
<td>7.75</td>
<td>6.20</td>
</tr>
<tr>
<td>&gt;= 50th and &lt;60th</td>
<td>7.00</td>
<td>5.60</td>
</tr>
<tr>
<td>&gt;= 40th and &lt;50th</td>
<td>6.25</td>
<td>5.00</td>
</tr>
<tr>
<td>&gt;= 30th and &lt;40th</td>
<td>5.50</td>
<td>4.40</td>
</tr>
<tr>
<td>&lt;30th</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Based on their composite quality scores, hospitals would be given one of four grades: “Excellent”, “Good”, “Acceptable” or “Below Acceptable.” These grades affect the hospital’s target prices for lower extremity joint replacements. Target prices increase as scores improve.
Total Joint Replacement Spend Breakdown

- Surgeon: 29%
- Readmission: 1%
- Pre-operative: 7%
- Other IP consults: 4%
- Hospital: 56%
- Post-hospital, spend may include:
  - Hospice
  - Home Health
  - SNF
  - LTCH
  - IRF
  - DME
  - Medication

Source: Accelero partner data
CMS Is Encouraging Patient Engagement

- CMS has waived anti-kickback laws and is encouraging coordinated services to be provided by hospitals to engage patients post-discharge.

- Hospitals can donate up to $1,000 per patient to physicians to be used for in-kind patient engagement services with the following conditions:
  - Incentive is provided by the hospital during the episode of care.
  - Reasonable connection exists between the technology or service and the beneficiaries’ medical care.
  - Technology or services must increase the beneficiaries’ engagement in the management of their health; adherence to a drug treatment and care plan; reduce readmission; improve management of chronic conditions that may be affected by LEJR.
  - Donation is included in the bundle price.
How HealthLoop Can Help You

● Lower Costs

- HealthLoop reduces costs by creating a patient-centric collaborative care model.
  - Connects patients pre- and post-procedure using automated and interactive HIPAA-compliant digital solutions.
  - Ensures adherence through educational content and engaging video.
  - Alerts the care team via daily check-ins if any patients are experiencing complications.
  - Creates a VIP experience for every patient with automated responses and no added work from staff members or change in work flow.
  - Provides accurate patient-reported utilization data even if a patient engages another health system for emergency visits or hospitalizations.

● Reduced Readmissions and Complications

- HealthLoop alerts the care team or implements a clinical escalation protocol if the patient is experiencing any complications or has questions that may otherwise lead to an emergency visit.
  - Patients can securely upload a photo to get more accurate care team assessment.
  - Patient responses help the care team understand the patient’s recovery state during daily check-in.

- HealthLoop can identify at-risk patients to reduce readmissions.

- HealthLoop patients experience 35% fewer readmissions.¹

How HealthLoop Can Help You

● PROs

  - Voluntary submission of THA/TKA patient-reported outcomes measures benefit hospitals by reducing the discount rate. Voluntary PROs offer a 2 point bonus on quality scores. Hospitals need to collect a 50% response rate or responses from 50 patients to be eligible.
  - HealthLoop has a turnkey solution to collect PROs.
  - HealthLoop currently collects HOOS, KOOS, PROMIS, and VR12.
  - HealthLoop has a 60% response rate with automated survey tools.¹

● HCAHPS and Our Impact

  - New CMS initiative adds HCAHPS Star Ratings to the Hospital Compare website: https://data.medicare.gov/data/hospital-compare
  - Star Ratings make it easier for consumers to understand hospital ratings, compare hospitals, and to identify excellence in healthcare quality.
  - 12 HCAHPS Star Ratings will appear on Hospital Compare. Hospitals will be able to preview HCAHPS Star Ratings in their 30-day Public Reporting Preview Report.
  - HealthLoop’s VIP patient experience translated to a 4.8% increase in HCAHPS ratings.²

¹ HealthLoop PROMs aggregate
² Customer Case Study
Continuity Of Care With HealthLoop

**HealthLoop** is today’s innovative patient engagement system that allows your hospital to identify risks and opportunities for success within this new reimbursement model.

Results:

- Measurable decrease in complication and readmission rates.
- More satisfied patients which translates to better HCAHPS scores.
- Increased collection of PROs.
- Reduced post-acute spend.

To find out what your risk is with CJR or get your Custom CJR Scorecard, [contact HealthLoop](mailto:contact@healthloop.com) or visit us at [healthloop.com/cjr-awareness/](http://healthloop.com/cjr-awareness/)
What To Do Now

1. Request three years of retrospective data for DRGs 469 & 470 to benchmark costs, complications, and HCAHPS. Click links below:
   - Wage Adjusted Episode Payment
   - Regional Historic Average

2. Review your readmissions, complications, HCAHPS scores, and your national ranking threshold.
   - [https://data.medicare.gov/data/hospital-compare](https://data.medicare.gov/data/hospital-compare)

3. To find out what your risk is with CJR or to get your Custom CJR Scorecard, [contact HealthLoop](mailto:contact@healthloop.com) or visit [healthloop.com/cjr-awareness/](http://healthloop.com/cjr-awareness/)