ADVANCED PAYMENT MODELS: CJR

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Partner
SHIFTING FROM VOLUME TO VALUE

2016

85%

30%

All Medicare FFS

FFS Linked to quality

Alternative payment models

2018

90%

50%

Bundled Payment Popularity

Participants in CMMI Payment Models

Source: CMMI Website
PREPARING FOR BUNDLED PAYMENTS

- From 67 MSAs to ALL MSAs
- From hips and knees to:
  - COPD
  - CHF
  - AMI
  - Pneumonia
42 CFR PART 510 [CMS-5516-P]

- **60-day public commenting period** on proposal ended Sept 8th
- Numerous comments
- Effective April 1, 2016
- Key Changes
  - 2% to 3% discount
  - New targets for fractures
  - 67 MSAs
  - 3 month delay
  - Stop loss reduced
  - Quality measures
Episodes are triggered by hospitalizations of eligible Medicare FFS 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**
- **All Part A and Part B services**, with the exception of certain excluded services that are clinically unrelated to the episode
EPISODE DEFINITION: SERVICES

**Included**
- Physician services
- IP hospitalization (including readmissions)
- IP Psych Facility
- LTCH
- IRF
- SNF
- Home Health
- Hospital OP services
- Independent OP therapy
- Clinical lab
- DME
- Part B drugs
- Hospice

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

- Providers and suppliers continue to be paid via Medicare FFS
- In Year 2, actual episode spending will be compared to episode target prices
  - If in aggregate target prices are greater than spending, hospital may receive reconciliation payment
  - If in aggregate target prices are less than spending, hospitals would be responsible for making a payment to Medicare
CMS intends to establish target prices for each participant hospital prior to start of each performance period. Includes 3% discount to serve as Medicare’s savings. Based on blend of hospital-specific and regional episode data, transitioning to regional pricing. Essentially competing against yourself in the beginning.
REGIONAL HISTORICAL CJR PAYMENTS

<table>
<thead>
<tr>
<th>Region</th>
<th>DRG 469</th>
<th>DRG 470</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>$47,928</td>
<td>$24,858</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>$52,028</td>
<td>$27,406</td>
</tr>
<tr>
<td>East North Central</td>
<td>$50,954</td>
<td>$25,480</td>
</tr>
<tr>
<td>West North Central</td>
<td>$46,189</td>
<td>$23,800</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$51,239</td>
<td>$25,989</td>
</tr>
<tr>
<td>East South Central</td>
<td>$50,328</td>
<td>$26,145</td>
</tr>
<tr>
<td>West South Central</td>
<td>$55,448</td>
<td>$27,464</td>
</tr>
<tr>
<td>Mountain</td>
<td>$47,925</td>
<td>$23,734</td>
</tr>
<tr>
<td>Pacific</td>
<td>$48,874</td>
<td>$23,425</td>
</tr>
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</table>
TARGET PRICE CALCULATION

Regional Average: $27,464
Sample Hospital: $22,456 +/- ?
Target Year 1 & 2: $20,000

Wage Index
DSH
IME

$27,464 + $22,456 = $50,000

$50,000 < $20,000

1/3 + 2/3 = $20,000

TARGET PRICE CALCULATION
UPSIDE AND DOWNSIDE FINANCIAL MODELING

0-20% Stop Loss

$9,500,000 Example Reconciliation Target

5-20% Stop Gain

$7,300,000

359 Total Episodes

Episode # 324 of 359

$63,460

$53,516 (2X SD)

$25,989

<table>
<thead>
<tr>
<th>Year</th>
<th>Stop Loss</th>
<th>Stop Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>3</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>4</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

$9,500,000
PAYMENT AND PRICING: LINK TO QUALITY

Minimum threshold for 2 quality metrics

- Hospital Level Risk Standardized Complication Rate following elective hip and knee arthroplasty
- HCAHP
- 3 decile improvement
- Voluntary Total Hip & Total Knee Arthroplasty (THA/TKA) data submission of patient reported outcomes
## QUALITY POINTS

<table>
<thead>
<tr>
<th>Decile Improvement</th>
<th>THA/TKA Complications</th>
<th>HCAHPS Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 90th</td>
<td>10.00</td>
<td>8.00</td>
</tr>
<tr>
<td>≥ 80th and &lt; 90th</td>
<td>9.25</td>
<td>7.40</td>
</tr>
<tr>
<td>≥ 70th and &lt; 80th</td>
<td>8.50</td>
<td>6.80</td>
</tr>
<tr>
<td>≥ 60th and &lt; 70th</td>
<td>7.75</td>
<td>6.20</td>
</tr>
<tr>
<td>≥ 50th and &lt; 60th</td>
<td>7.00</td>
<td>5.60</td>
</tr>
<tr>
<td>≥ 40th and &lt; 50th</td>
<td>6.25</td>
<td>5.00</td>
</tr>
<tr>
<td>≥ 30th and &lt; 40th</td>
<td>5.50</td>
<td>4.40</td>
</tr>
<tr>
<td>&lt;30th</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>3 Decile Improvement</td>
<td>1.00</td>
<td>0.80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THA/TKA Voluntary PRO and Limited Risk Variable Data</th>
<th>HCAHPS Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2.00</td>
</tr>
<tr>
<td>No</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Total Points**

14.1

- **Poor**: < 6.0
  - 3% discount
- **Good**: 6.0 – 13.2
  - 2% discount
- **Excellent**: >13.2
  - 1.5% discount
Consistent with applicable law, participating hospitals might have certain financial arrangements with Collaborators to support their efforts to improve quality and reduce costs.

Collaborators may include:

- Physician and non-physician practitioners
- Home health agencies
- SNF
- LTCH
- Physician group practices
- IRF
- Inpatient and Outpatient PTs and OTs
CJR SELECTION CRITERIA

Develop written selection criteria for CJR Collaborators

- Selection criteria for CJR Collaborators must relate to the 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 the volume or value of referrals
## Development of CJR Collaborator Agreements

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Internal Cost Savings Process</th>
<th>Engaging Collaborators</th>
<th>Ongoing Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal: Determine entities to approach as collaborators</strong>&lt;br&gt;Understand Collaborator Agreements&lt;br&gt;Satisfy written selection criteria requirements&lt;br&gt;Identify specific collaboration goals&lt;br&gt;Analyze available information &amp; data to identify and select Collaborators&lt;br&gt;Identify basic financial sharing methodologies</td>
<td><strong>Goal: Determine specific ICS parameters in Sharing Arrangements</strong>&lt;br&gt;Identify incentive goals – implant cost savings, OR Efficiency etc.&lt;br&gt;Analyze available data for each goal – Decision Support, EHR&lt;br&gt;Develop internal cost savings methodologies in compliance with CJR&lt;br&gt;Select Quality Performance Metrics &amp; analyze potential outcomes</td>
<td><strong>Goal: Approach potential Collaborators and finalized arrangement parameters</strong>&lt;br&gt;CJR Rule Education, Collaborator Agreements and Parameters of Agreements&lt;br&gt;Provide scenario analyses based on levels of success&lt;br&gt;Get collaborators comfortable with data &amp; process&lt;br&gt;Negotiate terms and parameters of Agreements (Financial &amp; Quality)&lt;br&gt;Identify related alignment opportunities&lt;br&gt;Document sharing arrangements with negotiated parameters</td>
<td><strong>Goal: Develop reporting mechanisms and monitor compliance of calculation</strong>&lt;br&gt;Determine specific procedures to perform related to the calculation&lt;br&gt;Monitor performance of procedures&lt;br&gt;Identify data anomalies&lt;br&gt;Share progress with Collaborators&lt;br&gt;Develop and implement control procedures for calculations</td>
</tr>
</tbody>
</table>

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*experienced by BKD LLP*
FINANCIAL ARRANGEMENTS: RISK SHARING

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

- CMS would continue to make **reconciliation payments and recoupments solely with the hospital**.
- The hospital would be responsible for **paying/recouping** from its collaborators.

CMS will limit the hospital’s sharing of risk to 50% of the total repayment amount to CMS.

Hospitals can’t share more than 25% of the risk with any one CJR Collaborator.
Skilled Nursing Facility
- CJR would waive the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization beginning in Year 2
- Patients must be transferred to SNFs rated 3-stars or higher
- Beneficiaries must not be discharged prematurely to SNFs

Home Visits
- CJR would waive the “incident to” rule for physician services
- Allows the licensed clinical staff of a physician to furnish a home visit in the patient’s home
- Permitted only for patients who do not qualify for Medicare coverage of home health services
- Maximum of 9 visits using a new HCPCS code

Telehealth
- Waives the geographic site requirement and the originating site requirement to permit visits originating in the patient’s home or place of residence
- Cannot be a substitute for in-person home health services
- Must be furnished in accordance with all other Medicare coverage and payment criteria
OTHER ITEMS

Beneficiary protection

- Providers and suppliers would be required to notify patients of the payment model.
- Patient’s access to care would not be impacted by the CJR model.
  - Copays would not change
  - Patient provider relationships would be maintained
  - Patients retain entitlement to Medicare covered services

Monitoring

- CMS will monitor compliance with the model requirements
- CMS will monitor potential risks
  - Increasing profitability by delaying care
  - Decreasing costs by avoiding medically indicated care
  - Avoiding high cost patients
GOVERNANCE AND OVERSIGHT

Steering Committee

- Prehab
- Acute
- Finance
- IT
- Transitions PAC
DATA ANALYTICS

SOLUTIONS OVERVIEW

UPSIDE & DOWNSIDE MODELING
When entering into outcome-based reimbursement, it’s crucial to thoroughly understand potential risks and rewards as well as best- and worst-case scenarios. BKD can use your data to model the CCRJ program, offering insight into the risk landscape.

LONGITUDINAL VIEW OF PROVIDER SPENDING
It’s essential to visualize Medicare payments across an entire care episode. Post-acute payments often outweigh inpatient payments and produce unfavorable outcomes against a target price. Forward-thinking providers can redesign care pathways to realize significant savings. BKD can analyze provider payments across an episode and benchmark trends that help lead to effective care pathways.

USING DATA TO REDESIGN CARE
A deep dive into your organization’s Medicare LEJR payments is critical for success—ones can’t manage what one doesn’t measure. BKD has the data set CMS will use to implement and reconcile MEJR payments. Our forensic data analytics team can provide a comprehensive picture of MEJR risks and opportunities. BKD can help identify volumetric and financial data and understand complex patient and provider trends such as avoidable complications.

COLLABORATORS, QUALITY & GAINSHARE
CMS has granted providers a unique opportunity to create alignment through gainsharing. BKD can help you find potential gainsharing opportunities. Our data-driven approach can help you evaluate which providers offer the highest probability for low-cost, high-quality outcomes. BKD can suggest the ways your organization can participate in the CCRJ program upside opportunities.
DATA ANALYTICS

Patients

Physicians

Post-Acute Providers

Risk Stratification

1

2

Experience Support

Experience BKD LLP
CPAs & Advisors
In 2013, Hospital discharged a total of **356 lower extremity joint replacement (LEJR)** episodes. Understanding the distribution of DRGs within the CJR program is significant because of the wide variance of cost, resources, and care pathways. With the recent implementation of ICD-10, it will be critical for providers to review coding sensitivity. For example, an outlier episode in DRG 470 (without MCC*) could have been more appropriately coded as a more complex DRG 469 (with MCC).

<table>
<thead>
<tr>
<th>DRG 470</th>
<th>DRG 469</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>342</strong></td>
<td><strong>14</strong></td>
</tr>
<tr>
<td>EPISODES</td>
<td>EPISODES</td>
</tr>
</tbody>
</table>

* Major complications or comorbidities
In addition to being Medicare’s first mandatory bundled payment program, CJR is the first to introduce regional pricing targets for hospitals. This structure could create financial challenges for some hospitals. According to a recent AAMC analysis, some lower-volume teaching hospitals’ average payments ranged from approximately 205 percent greater than the regional average to 39 percent below the average. Benchmarking episode performance against other hospitals in the region will help provide insight into target price calculation. It is also important to note that the CJR final rule created separate target prices for trauma episodes of DRG 469 and 470.
Longitudinal Payment Comparison

Regional and peer hospitals often indicate controllable variances. Post-acute settings with a high coefficient of variation are a great place to start focusing care redesign efforts.
LONGITUDINAL VIEW OF PROVIDER PAYMENTS

Evaluating the distribution of episode payments between acute and post-acute settings is an essential component of care redesign. Because Hospital will continue to receive fee-for-service DRG payments for each of their discharged LEJR episodes, the emphasis on payment reduction will come from increased collaboration with the post-acute care providers.

**Distribution of Medicare Payments**

<table>
<thead>
<tr>
<th>DRG 469</th>
<th>55.6% INPATIENT</th>
<th>POST-ACUTE 44.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$218,196 total Medicare payments</td>
<td>$174,354 total Medicare payments</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRG 470</th>
<th>52.7% INPATIENT</th>
<th>POST-ACUTE 47.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,984,372 total Medicare payments</td>
<td>$2,679,151 total Medicare payments</td>
<td></td>
</tr>
</tbody>
</table>

Other payments distribution:
- HOSPICE: 17.27%
- HH: 6.3%
- SNF: 18.59%
- OP: 10.06%
- IRF: 23.8%
- READM.: 1.1%
OUTLIER VISUALIZATION

Visualizing the distribution of outlier episodes at Hospital can offer a unique perspective on risk identification.

The graph to the right plots each of the 342 episodes of DRG 470 and 14 episodes of DRG 469 with respect to total Medicare payments. Analyzing and understanding the drivers of outliers can help mitigate unfavorable outcomes in the future.

PATIENT EPISODE

- **AGE:** 86
- **RACE:** Caucasian
- **GENDER:** Female
- **PROCEDURE:** Partial hip
- **COMORBIDITIES:** Hypertension, Diabetes
- **ANCHOR STAY:** $11,577
- **IP REHABILITATION:** $16,120
- **SKILLED NURSING:** $21,060
- **IP READMISSION:** $14,075
- **OUTPATIENT:** $463
DRG 470
Post Acute Utilization

- Home Health: 71%
- Skilled Nursing: 17%
- Other: 10%
- Hospice: 2%

CARE PATHWAY VALUATION

- $15,226
- $9,213
- $2,787
LONGITUDINAL VIEW OF PROVIDER PAYMENTS

POST-ACUTE PAYMENT ANALYSIS

Skilled nursing services are often an essential component for patients who undergo LEJR episodes. Identifying high-value providers who supply appropriate levels of care can have a significant impact on overall episode payments. Working with collaborators to overcome fee-for-service barriers, such as extended lengths of stay (LOS) and RUG rates, associated with high-intensity therapy will be a challenging yet necessary process.

Top 5 SNFs by Volume

<table>
<thead>
<tr>
<th>SNF</th>
<th>Episodes</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF 1</td>
<td>24</td>
<td>$9,810</td>
</tr>
<tr>
<td>SNF 2</td>
<td>22</td>
<td>$17,686</td>
</tr>
<tr>
<td>SNF 3</td>
<td>11</td>
<td>$7,186</td>
</tr>
<tr>
<td>SNF 4</td>
<td>7</td>
<td>$16,537</td>
</tr>
<tr>
<td>SNF 5</td>
<td>5</td>
<td>$9,690</td>
</tr>
</tbody>
</table>

QUICK FACTS: DRG 470

- 18 Number of SNF utilized
- $23,920 Average Episode payment if SNF is first discharge
- $10,056 Average SNF payment
- 23.06 Average LOS

QUICK FACTS: DRG 469

- 4 Number of SNF utilized
- $38,596 Average Episode payment if SNF is first discharge
- $15,032 Average SNF payment
- 48.50 Average LOS
Financial Impact of Readmissions

Potentially avoidable complications for patients include events such as ED visits and readmissions. These are key drivers of variation in Medicare payments that can result in losses upon episode reconciliation against a fixed target price.

<table>
<thead>
<tr>
<th>Episodes with Readmissions</th>
<th>Episodes without Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>326</td>
</tr>
<tr>
<td>Number of DRG 470 &amp; DRG 469 episodes</td>
<td>Number of DRG 470 &amp; DRG 469 episodes</td>
</tr>
<tr>
<td>11</td>
<td>89</td>
</tr>
<tr>
<td>Percent of DRG 470 &amp; DRG 469 episodes</td>
<td>Percent of DRG 470 &amp; DRG 469 episodes</td>
</tr>
<tr>
<td>$35,293</td>
<td>$17,702</td>
</tr>
<tr>
<td>Average episode payment DRG 470</td>
<td>Average episode payment DRG 470</td>
</tr>
<tr>
<td>$44,192</td>
<td>$30,826</td>
</tr>
<tr>
<td>Average episode payment DRG 469</td>
<td>Average episode payment DRG 469</td>
</tr>
</tbody>
</table>
Using Data to Manage Risk

**Episode Count**

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Count</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>85</td>
<td>$19,339</td>
</tr>
<tr>
<td>Dr. B</td>
<td>50</td>
<td>$19,943</td>
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<tr>
<td>Dr. C</td>
<td>37</td>
<td>$21,348</td>
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<td>Dr. D</td>
<td>32</td>
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<td>Dr. E</td>
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<td>Dr. F</td>
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<td>Dr. G</td>
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<td>Dr. H</td>
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<tr>
<td>Dr. I</td>
<td>2</td>
<td>$32,481</td>
</tr>
<tr>
<td>Dr. J</td>
<td>1</td>
<td>$29,875</td>
</tr>
</tbody>
</table>

**Physician Drivers**

Physicians play a significant role in the financial management of LEJR episodes. The inpatient care they provide, as well as the discharge and post-op care orders they write, set the tone for clinical and financial outcomes. Leveraging the data to identify best practices can help clinicians support new care plans and standing orders to help offset outlier episodes. Variances in episode payments are strongly linked to patient acuity and biometrics as well as post-acute providers. Aligning these variables will provide evidence-based guidelines for enhanced care.
Physician Episode Composition

Care pathways direct the composition of episode payments. Working with physicians to identify best practice pathways is an essential step in an outcomes-based environment that can lead to improved clinical and financial results. By leveraging claims data from full episodes of care, the patient variables underlying treatment plans can be distinguished and addressed with clarity.
MONITORING PROGRESS

1. Monthly progress reports
2. Key metrics dashboard
3. Data Custodian
4. Target price calculation
5. Reconciliation