Comprehensive Care for Joint Replacement Payment Model For Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

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Comprehensive Care for Joint Replacement Payment Model For Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

A collaborative effort brought to you by

Harmony University
The Provider Unit of
Harmony Healthcare International, Inc. (HHI)
&

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aegis therapies

Comprehensive Care for Joint Replacement Payment Model For Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

October 2015
Mark Besch

Comprehensive Care for Joint Replacement (CCJR)

- Proposed bundled payment model
- There are 430,000 TJRs in DRG 469 and 470 per year costing Medicare $7 billion per year
- TJRs are 5% of all acute hospital discharges
- Proposed rule released July 9, 2015; comment period open until September 8.
- Implementation proposed to begin January, 2016

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CCJR – Summary of Key Provisions

- With few exceptions, participation would be mandatory. Unlike all existing bundled payment models
- 5-year program that would apply to all acute care hospitals furnishing the services in 75 selected MSAs

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CCJR – Summary of Key Provisions

- Involves two DRG groups:
  - 469 major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)
  - 470 major joint replacement or reattachment of lower extremity without MCC
- Episode initiated with admission to hospitals for lower extremity joint replacement (LEJR) procedure assigned to DRG 469 or 470

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CCJR – Summary of Key Provisions

- Episode ends 90 days after discharge from the acute care hospital and includes the acute hospital claim costs
- Episode includes LEJR procedure, inpatient stay and all related care covered under Medicare Parts A and B within 90 days after discharge including hospital care, post-acute care and physician services.
- Beneficiaries would be automatically included in the model

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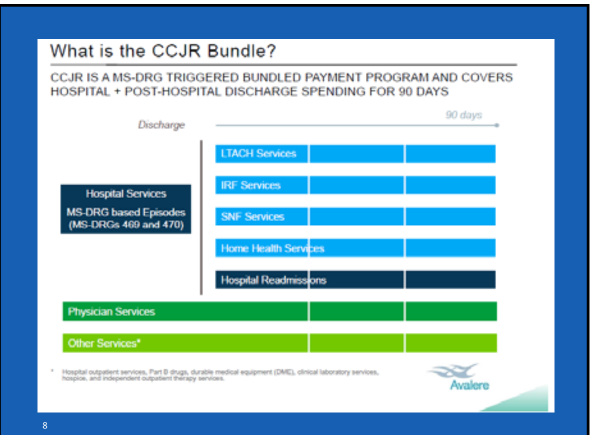

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CCJR – Summary of Key Provisions

- Participant hospitals in selected markets would be episode initiators and bear financial risk (risk-bearing entity is called "collaborator")
- Risk bearers cannot be non-Medicare providers (companies such as Remedy Partners, naviHealth and Signature Medical)
- Retrospective annual reconciliation against a target price. Upside opportunity for years 1-5; downside risk only for performance years 2-5.
- Both upside gain and downside risk are limited
- Target prices will reflect a blend of regional and individual hospital data; Medicare takes 2% discount off the target prices as their savings

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CCJR – Summary of Key Provisions

- Payment eligibility dependent of performance on three hospital-based quality measures
  1. Complication measure
  2. Readmission measure
  3. Patient experience survey measure
- Waivers related to SNFs and physicians will be available
- Gainsharing agreements with PAC providers are allowed, within limits

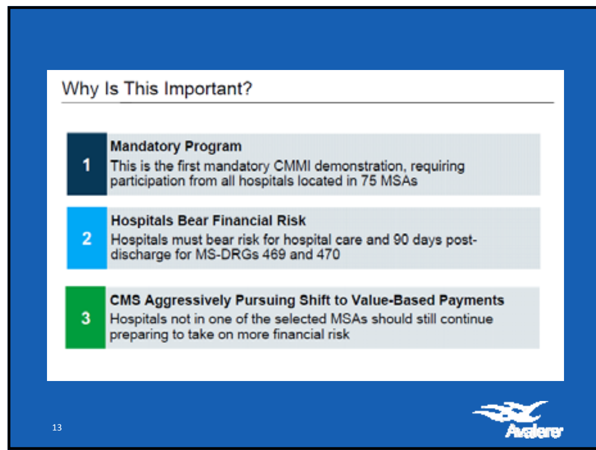
Quality Measures

The CCJR program will implement quality performance standards that must be met for the hospitals to receive reconciliation payments.

Quality Measure	Weight in Composite Quality Score
Hospital-level 30 day, all-cause readmission following elective primary THA and/or TKA	20%
Hospital-level complication rate (RSCR) following elective primary THA and/or TKA	40%
HCAHPS survey	30%
Voluntary THA/TKA data submission on patient-reported outcome measure	10%

CCJR – Summary of Key Provisions

- Beneficiary protections
  - Retain the right to obtain care from any qualified Medicare provider
  - Cannot opt out
  - Hospitals must provide written information
- Beneficiary exclusions
  - Medicare Advantage members
  - ESRD
  - Medicare is secondary payer


Why Is This Important?
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Mandatory Program
This is the first mandatory CMMI demonstration, requiring participation from all hospitals located in 75 MSAs
2
Hospitals Bear Financial Risk
Hospitals must bear risk for hospital care and 90 days post-discharge for MS-DRGs 469 and 470
3
CMS Aggressively Pursuing Shift to Value-Based Payments
Hospitals not in one of the selected MSAs should still continue preparing to take on more financial risk
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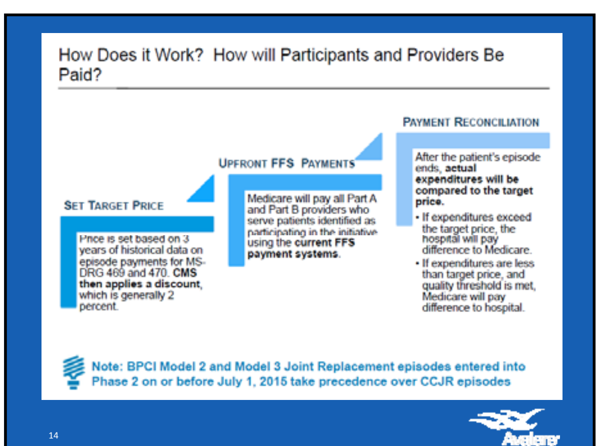
How Does it Work? How will Participants and Providers Be Paid?
SET TARGET PRICE
Price is set based on 3 years of historical data on episode payments for MS-DRG 469 and 470. CMS then applies a discount, which is generally 2 percent.
UPFRONT FFS PAYMENTS
Medicare will pay all Part A and Part B providers who serve patients identified as participating in the initiative using the current FFS payment systems.
PAYMENT RECONCILIATION
After the patient's episode ends, actual expenditures will be compared to the target price.
• If expenditures exceed the target price, the hospital will pay difference to Medicare.
• If expenditures are less than target price, and quality threshold is met, Medicare will pay difference to hospital.
Note: BPCI Model 2 and Model 3 Joint Replacement episodes entered into Phase 2 on or before July 1, 2015 take precedence over CCJR episodes
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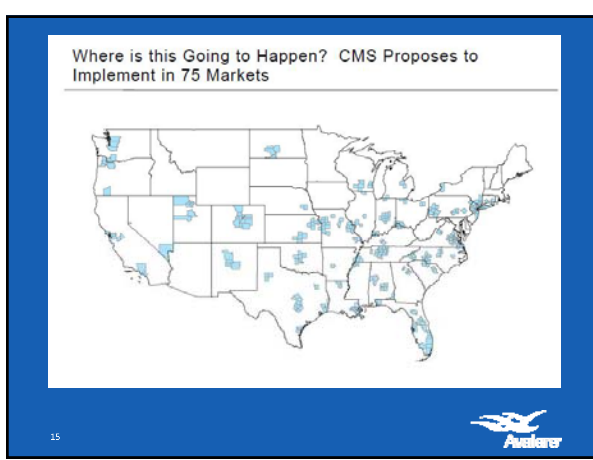
Where is this Going to Happen? CMS Proposes to Implement in 75 Markets
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75 MSAs

MSA	MSA Title	Counties
10420	Akron, OH	Portage County, Summit County
10740	Albuquerque, NM	Bernalillo County, Sandoval County, Torrance County, Valencia County
11700	Asheville, NC	Buncombe County, Haywood County, Henderson County, Madison County
12020	Athens-Clarke County, GA	Clarke County, Madison County, Oconee County, Oglethorpe County
12420	Austin-Round Rock, TX	Bastrop County, Caldwell County, Hays County, Travis County, Williamson County
13140	Beaumont-Port Arthur, TX	Hardin County, Jefferson County, Newton County, Orange County
13900	Bismarck, ND	Burleigh County, Morton County, Oliver County, Sioux County
14500	Boulder, CO	Boulder County
15380	Buffalo-Cheektowaga-Niagara Falls, NY	Erie County, Niagara County
16020	Cape Girardeau, MO-IL	Alexander County, Bollinger County, Cape Girardeau County
16180	Carson City, NV	Carson City
16740	Charlotte-Concord-Gastonia, NC-SC	Cabarrus County, Gaston County, Iredell County, Lincoln County, Mecklenburg County, Rowan County, Union County, Chester County, Lancaster County, York County

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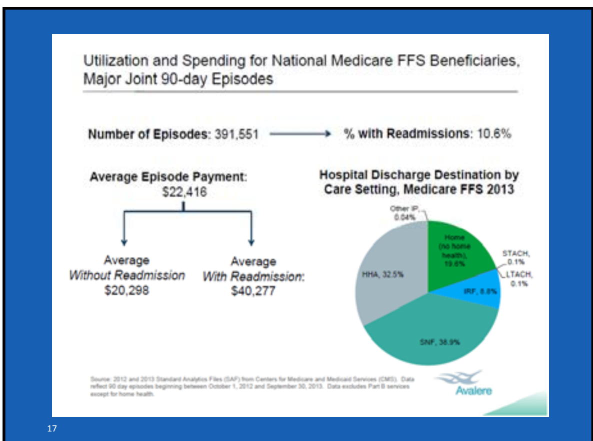

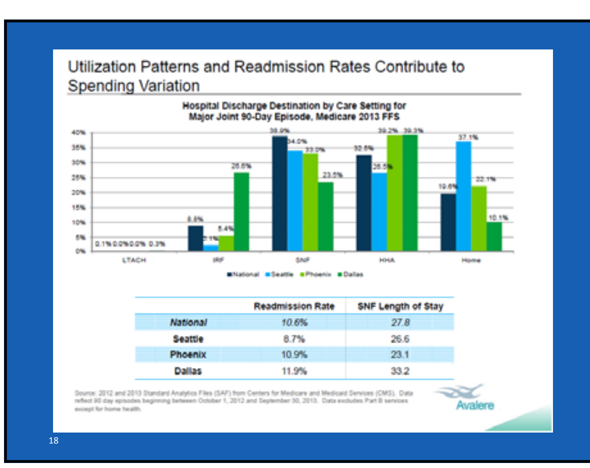

	Readmission Rate	SNF Length of Stay
National	*10.6%*	*27.8*
Seattle	8.7%	26.6
Phoenix	10.9%	23.1
Dallas	11.9%	33.2

Keys to Success

Define the Opportunity	• Meet with hospitals to understand their approach under CCJR • Analyze utilization data to understand trends and areas for improvement
Understand Market Dynamics	• Identify other providers that can impact outcomes (90 day episode) • Develop partnership opportunities
Develop Solutions	• High performance product lines • Clinical integration and transition of care programs • Outcomes measurement & management

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What You Need to Understand

- Current market dynamics and your position in the marketplace
- Current potential opportunity this presents based on hospital size and volume in joint replacements
- Your key metrics (Medicare LOS, readmit %, 5-star score, average SNF episode cost, etc.)
- Hospital/Physician point of view
- Competition
- Partnership potential

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What Can You Leverage?

- Any bundled payment experience in Model 3 and Model 2
- Clinical pathways
- Any ACO experience
- Care redesign approaches and the use of accelerating systems to process patients through more rapidly
- Attending M.D.s connected with the hospital collaborator
- Outcomes reports
- IT experience and capabilities (e.g., 90-day tracker)

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Clinical Pathways

Aegis Therapies Bundled Payment TKA Clinical Pathway - SNF

Ranges listed are estimates. Actual patient performance may vary based on PLOF and discharge environment					
	Day 1-2 post SNF admission	Days 3-5	Days 6-8	Days 8-10	Days 11-14
Physical Therapy					
Assessment	Vitals, edema, pain, range of motion, balance, strength, mobility/transfers, WB status	Vitals, edema, pain, range of motion, balance, strength, mobility/transfers, WB status, observe for any signs of infection or DVT Complete home environment assessment	Vitals, edema, pain, range of motion, balance, strength, mobility/transfers, WB status, observe for any signs of infection or DVT	Vitals, edema, pain, range of motion, balance, strength, mobility/transfers, WB status, observe for any signs of infection or DVT	Vitals, edema, pain, range of motion, balance, strength, mobility/transfers, WB status, observe for any signs of infection or DVT Complete on-site home assessment if needed
Intervention					
Pain mgt	Ice; consider e-stim or TENS as needed	Ice; consider e-stim or TENS as needed	Ice; consider e-stim or TENS as needed	Ice; consider e-stim or TENS as needed	Ice; consider e-stim or TENS as needed
Mobility	Transfer training, gait training	Transfer training, gait training, instruct and practice steps and stairs, instruct and practice car transfers	Transfer training, gait training, practice stairs and car transfers; progress to gait on uneven surfaces	Advance transfers and gait training; practice stairs and car transfers	Transfer training as needed, gait training, move to indep for stairs and car transfers; progress gait to community distances, uneven surfaces and crowded environments

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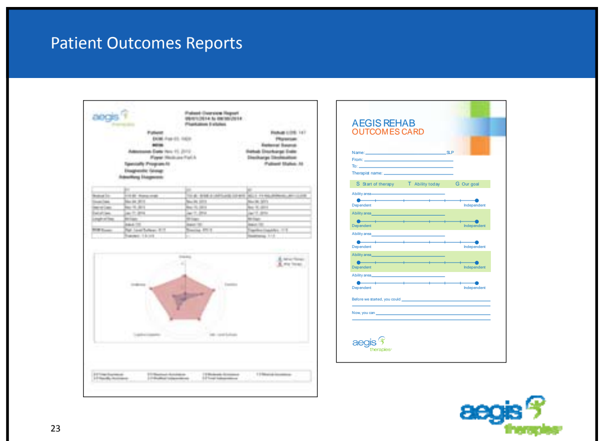
Patient Outcomes Reports



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What Is Financial Success in CCJR?

- Increased volume as measured by admission
- 3-day stay waivers can bring incremental volume – 3-star and above facilities
- Opportunity to accept risk-gain share dollars are voluntary (new money is available in reducing readmissions)
- Demonstrate strong transitions of care to reduce readmissions
- Support eagerly the hospital quality measures

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Next Steps/Needs

- Begin Communication with hospitals
- Assess readiness for care redesign strategies
- Develop operational plan/model that incorporates the use of care coordination and communication strategies with the hospital
- Consider risk-bearing capabilities
- How will you demonstrate value?

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Next Steps/Needs

Questions?

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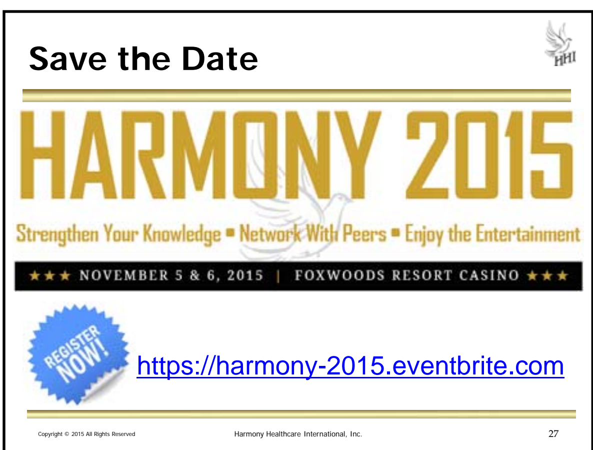

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