Comprehensive Care for Joint Replacement (Mandatory Bundled Payments)

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Program Overview

- ✓ Implements mandatory bundled payment program for hospitals in 67 Metropolitan Statistical Areas (MSAs)
- ✓ Applies to joint replacements with and without major complications
- ✓ Enrolls beneficiaries automatically
- ✓ Tests whether such bundles improve quality while reducing Medicare costs
- ✓ Operates for 5 performance periods beginning April 1, 2016 and ending December 31, 2020

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Applicability

- Applies to all IPPS hospitals in selected MSAs
- Exclusions include:
  - Maryland hospitals due to the All-Payer Model
  - Episodes that overlap with the Bundled Payment for Care Improvement program (BPCI) Model 2 (acute/post-acute) or 3 (post-acute care only)
- MSAs were selected based on several criteria, including sufficient load of applicable cases; low participation in BPCI; and high percentage of IPPS hospitals

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Selected MSAs

Akron, OH
Albuquerque, NM
Asheville, NC
Athens-Clarke County, GA
Austin-Round Rock, TX
Beaumont-Port Arthur, TX
Bismarck, ND
Boulder, CO
Buffalo-Cheektowaga-Niagara Falls, NY
Cape Girardeau, MO-IL
Carson City, NV
Charlotte-Concord-Gastonia, NC-SC
Cincinnati, OH-KY-IN
Colorado Springs, CO
Columbia, MO
Corpus Christi, TX
Decatur, IL
Denver-Aurora-Lakewood, CO
Dothan, AL
Durham-Chapel Hill, NC
Evansville, IN-KY
Flint, MI
Florence, SC
Fort Collins, CO
Gainesville, FL
Gainesville, GA
Greenville, NC
Harrisburg-Carlisle, PA
Hot Springs, AR
Indianapolis-Carmel-Anderson, IN
Kansas City, MO-KS
Killeen-Temple, TX
Las Vegas-Henderson-Paradise, NV
Lincoln, NE
Los Angeles-Long Beach-Anaheim, CA
Lubbock, TX
Madison, WI
Medford, OR
Memphis, TN-MS-AR
Miami-Fort Lauderdale-West Palm Beach, FL
Milwaukee-Waukesha-West Allis, WI
Modesto, CA
Monroe, LA
Montgomery, AL
Naples-Immokalee-Marco Island, FL
Nashville-Davidson--Murfreesboro--Franklin, TN
New Haven-Milford, CT
New Orleans-Metairie, LA
New York-Newark-Jersey City, NY-NJ-PA
Norwich-New London, CT
Ogden-Clearfield, UT
Oklahoma City, OK
Orlando-Kissimmee-Sanford, FL
Pensacola-Ferry Pass-Brent, FL
Pittsburgh, PA
Port St. Lucie, FL
Portland-Vancouver-Hillsboro, OR-WA
Provo-Orem, UT
Reading, PA
Richmond, VA
Rockford, IL
Saginaw, MI
San Francisco-Oakland-Hayward, CA
Seattle-Tacoma-Bellevue, WA
Sebastian-Vero Beach, FL
South Bend-Mishawaka, IN-MI
St. Louis, MO-IL
Staunton-Waynesboro, VA
Tampa-St. Petersburg-Clearwater, FL
Toledo, OH
Topeka, KS
Tuscaloosa, AL
Tyler, TX
Virginia Beach-Norfolk-Newport News, VA-NC
Wichita, KS

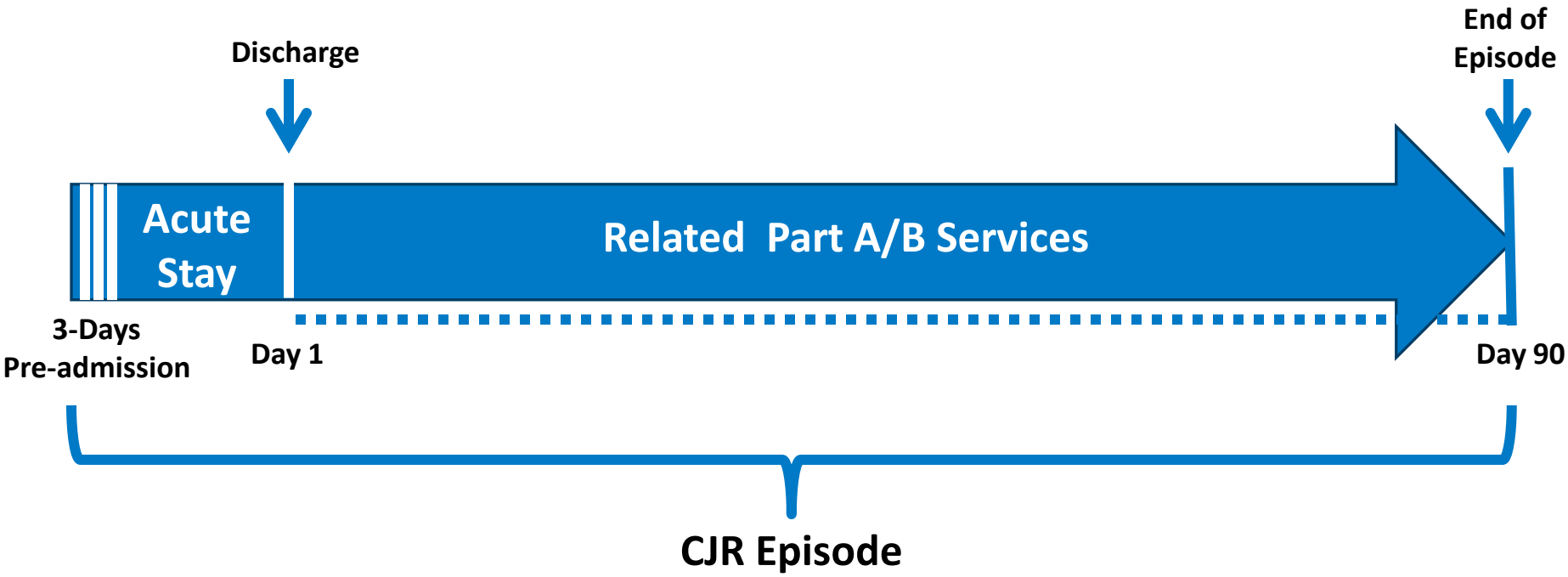
Episode Definition

- Triggered by one of two MS-DRGs:
  - **MS-DRG 469:** Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)
  - **MS-DRG 470:** Major joint replacement or reattachment of lower extremity without MCC
- Initiated by an admission to an eligible acute care hospital
- Ends 90 days after date of discharge from the hospital
- Includes:
  - Acute procedure
  - Inpatient stay
  - All related care covered under Medicare Parts A and B within 90 days of discharge, including post-acute care and hospice services

Included Related Services

- Physicians' services.
- Inpatient hospital services (including readmissions)
- Inpatient psychiatric facility services
- Long term care hospital services
- Inpatient rehab facility services
- Skilled nursing facility services
- Home health agency services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs
- Hospice

Review: Episode Definition



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Payment Waivers to Facilitate New Delivery Models

CMS finalized several waivers for payment of services not traditionally covered by the fee-for-service Medicare program, including:

- Post-discharge home visits (up to 9) for non-home health eligible patients
- Billing and payment for certain services provided in the home via telehealth
- SNF 3-Day Rule in performance years 2 through 5 only <u>if the SNF has an overall rating of three stars or better for at least 7 of the 12 preceding months</u>
- Waivers of Medicare rules to allow reconciliation payments

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Payment Model

- CMS will establish target prices for the bundle of services
- The target price will change over the life of the model from a price set predominantly on the hospital's own historic cost performance over the prior three years to a rate that is solely based on the region's historic performance
- The target price will also include a discount to drive minimum intended savings
- CMS will reconcile actual costs against the target price annually for applicable cases
- Only hospitals are financially responsible for achieving target prices

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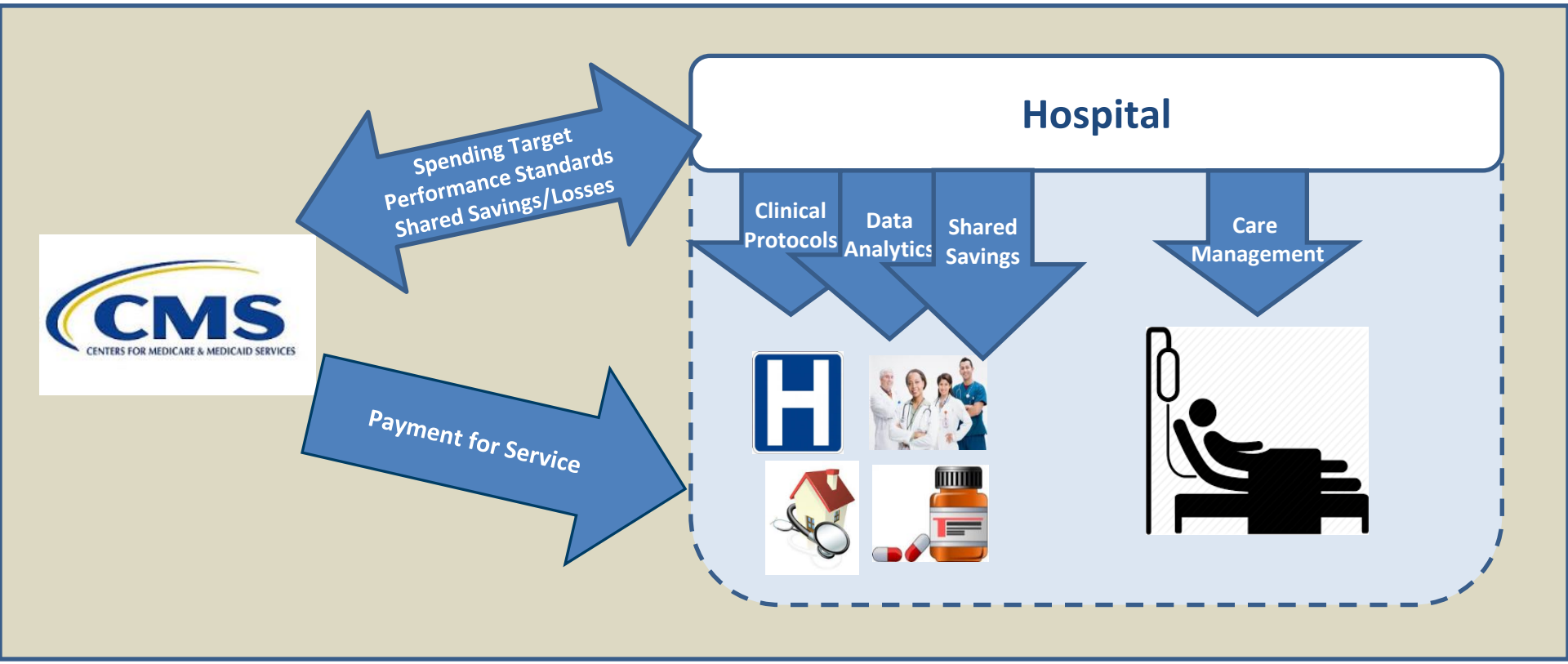
Retrospective Bundled Payment Model



Risk Model

- **Year 1:** Upside risk only
- **Year 2:** Downside risk is phased in
- **Years 3, 4, 5:** Downside risk applies; hospitals must pay back excess payments if target is not achieved
- CMS will include a stop-loss provision to prevent excessive losses for hospitals
- Eligibility for shared savings is dependent on meeting quality and financial performance targets

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Performance Metrics

- CMS will use two performance measures as part of the CJR model:
  - Hospital-level risk-standardized **complication** rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1550)
  - Hospital Consumer Assessment of Healthcare Providers and Systems (**HCAHPS**) Survey (NQF #0166)
- CMS is also seeking voluntary reporting of data to develop a new measure of a patient-reported outcome measure

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Beneficiary Benefits & Protections

- Hospitals may use incentives to encourage beneficiary compliance with the plan of care
    - Incentives must have a “reasonable connection between the item or service and the beneficiary's medical care”
- Beneficiaries retain right to obtain care from any Medicare provider
- Beneficiaries cannot opt out of the program
- Hospitals will be required to provide written information to beneficiaries about the Model

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Estimated Financial Impact

- **Year 1:** Medicare Cost: $11 million
- **Year 2:** Medicare Savings: $36 million
- **Year 3:** Medicare Savings: $71 million
- **Year 4:** Medicare Savings: $120 million
- **Year 5:** Medicare Savings: $127 million
- **Total Medicare Savings:** $343 million

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Alignment with Other VBP Models

- BPCI Models 2 and 3 will take precedence over CJR when overlap occurs
- CMS is developing a process to prevent “double-counting” of savings where multiple models are in effect for a beneficiary

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Role for Home Health & Hospice Providers

- CMS explicitly permits and encourages hospitals to enter into financial arrangements with other providers and suppliers to align the financial incentives, including home health and hospice
    - Hospitals may share in gainsharing payments or internal cost savings under a contract arrangement with another provider
- Hospitals may also choose to engage with organizations to provide operational support, including local network engagement, beneficiary outreach, care coordination and management, etc.

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Rules Around Collaborations

CMS establishes a number of rules with respect to collaboration arrangements, including but not limited to:

- Hospitals must develop and maintain a written set of policies for selecting CJR collaborators, including selection criteria
- Selection criteria must include quality of care and cannot be based directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the hospital and collaborators, and any individual or entity affiliated with a hospital or collaborator
- Collaboration agreements must be in place prior to sharing in any financial gains
- Hospitals must document all collaboration arrangements, including by publically posting them on their website
- Hospitals must conduct oversight of any gainsharing arrangements

Thank You

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