



Comprehensive Care for Joint Replacement



Introduction to CCJR

Webinar #1

July 15, 2015

1-2pm EDT

What is the CCJR model?

- The CCJR model would **test bundled payments for lower extremity joint replacement (LEJR)** across a broad cross-section of hospitals.
- The model would **apply to most Medicare LEJR procedures within select geographic areas** with few exceptions.
- The model would be **implemented through rule making, and the performance period would begin on January 1, 2016.**
 - The policies discussed in this presentation are **proposals subject to the notice and comment rulemaking process.**

What is the CCJR model designed to do for patients and the health system?

Better Care

- Better care for patients through more coordinated, higher quality care during and after a hip or knee replacement surgery

Smarter Spending

- Smarter spending of health care dollars by holding hospitals accountable for total episode spending, not just inpatient costs

Healthier People and Communities

- Healthier people and communities by improving coordination in health care and by connecting care across hospitals, physicians, and other health care providers

CCJR Participants

- Participants would include **Inpatient Prospective Payment System (IPPS) Hospitals in select Metropolitan Statistical Areas (MSA)** not participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payment for Care Improvement (BPCI) model for the lower extremity joint replacement clinical episode.
- **75 MSAs** were selected in a **two-step randomization** process.
 - MSAs were placed into **eight** groups based on average wage-adjusted historic LEJR episode payment quartiles and the MSA population size divided at the median.
 - MSAs were then **randomly selected within each group** using a selection percentage within each payment quartile (30% for lowest payment quartile to 45% for highest payment quartile).

Episode definition: General

- Episodes would be triggered by hospitalizations of eligible Medicare Fee-for-Service (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: Beneficiaries

- Care of Medicare beneficiaries would be 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** (eg, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations).
 - **Not** covered under a **United Mine Workers of America** health plan

Episode definition: Services

- **Included services**

- Physicians' services
- Inpatient hospitalization (including readmissions)
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Independent outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs
- Hospice

- **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

Payment and pricing: Risk structure

- **Retrospective, two-sided risk model with hospitals bearing financial responsibility**
 - Providers and suppliers continue to be paid via Medicare FFS
 - After a performance year, actual episode spending would be compared to the episode target prices
 - If in aggregate target prices are greater than actual episode spending, hospital may receive reconciliation payment
 - If in aggregate target prices are less than actual episode spending, hospitals would be responsible for making a payment to Medicare
- Responsibility for repaying Medicare begins in Year 2, with **no downside responsibility in Year 1**

Payment and pricing: Target price setting

- Target prices
 - CMS intends to establish **for each participant hospital** prior to start of applicable performance period
 - Based on **3 years of historical data**
 - Includes **discount** to serve as Medicare's savings
 - Based on **blend of hospital-specific and regional episode data** (US Census Division), transitioning to regional pricing
 - Years 1&2: 2/3 hospital-specific, 1/3 regional
 - Year 3: 1/3 hospital-specific, 2/3 regional
 - **Years 4&5: 100% regional pricing**

Payment and pricing: Link to quality

- Hospitals **must meet minimum threshold on 3 quality metrics** to be eligible for reconciliation payments:
 1. Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
 2. Hospital Level 30 day, All Cause Risk Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
 3. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
- Thresholds for performance would increase over the lifetime of the model to **incentivize continuous improvement.**
- Participant hospitals would have an **additional financial incentive** to successfully submit data on a **patient-reported functional outcome measure beginning in Year 1.**

Payments and pricing:

Risk limits and adjustments

- Episode payment would be **capped at 2 standard deviations above regional mean (high payment outlier ceiling)** for calculating target prices and for comparing actual episode payments to target prices. Payments to providers and suppliers under Medicare FFS for episode services would not be capped.
- Reconciliation payments would be capped at **20%** of target prices (**stop-gain**).
- Hospital responsibility to repay Medicare would be phased-in and capped (**stop-loss**):
 - Year 1: **No responsibility** to repay Medicare
 - Year 2: **Capped at 10%** of target prices
 - Years 3-5: **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.

Overlap with BPCI

- Hospital **participation in BPCI vs. CCJR** in selected MSAs
 - Hospitals in BPCI Model 1 or Phase II (risk-bearing phase) of BPCI Models 2 or 4 for the lower joint replacement clinical episode would remain in BPCI and not be required to participate in CCJR.
 - BPCI Phase II participants that terminate from a BPCI model for the LEJR episode and are located in an MSA that has been a selected for CCJR would be required to participate in CCJR
 - Hospitals not already in BPCI may not elect to participate in BPCI in lieu of participation in CCJR
- BPCI Model 2 and Model 3 LEJR episodes **initiated by participating physician group practices or post-acute care facilities** would take precedence over CCJR episodes.
 - CMS intends to continue the ongoing BPCI model test

Overlap with ACOs and other models

- Hospitals selected to participate in CCJR **may also participate in an ACO or other model.**
- The financial reconciliations under CCJR and other CMS models and programs would, 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 2 percent discount on CCJR episodes.

Financial Arrangements: Gainsharing

- Consistent with applicable law, participant hospitals might have certain financial arrangements with Collaborators **to support their efforts to improve quality and reduce costs.**
- **Collaborators** may include the following provider and supplier types:
 - Physician and nonphysician practitioners
 - Home health agencies
 - Skilled nursing facilities
 - Long term care hospitals
 - Physician Group Practices
 - Inpatient rehabilitation facilities
 - Inpatient and outpatient physical and occupational therapists

Financial Arrangements: Incentive Payments

- Participant hospitals might **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 CCJR episode.
- Collaborators **would be required** to engage with the hospital in its care redesign strategies and to furnish services during a CCJR episode in order to be eligible for such payments.

Financial Arrangements:

Risk sharing

- Participant hospitals **may assign various percentages of two-sided risk** to collaborators.
 - Where that is the case, CMS would continue to make **reconciliation payments and recoupments solely with the hospital**
 - The **hospital would be responsible for paying/recouping from its collaborators** according to the agreements between those entities
- CMS proposes to **limit the hospital's sharing of risk to 50% of the total repayment amount** to CMS
 - The hospital would be required to retain 50% of the downside risk
 - The hospital could not share more than 25% of its repayment responsibility with any one provider or supplier.

Beneficiary Incentives

- Consistent with applicable law, participant **hospitals might offer certain items or services to beneficiaries** during a CCJR episode.
- The items or services must, among other things:
 - Be provided to a beneficiary during a CCJR episode of care
 - Be closely related to the provision of high quality care during the episode
 - Not be more valuable than necessary
 - Not serve as an inducement to beneficiaries to seek care from the hospital or other specific suppliers or providers
- These items or services may provide advantages in aiding hospitals in following the health status and coordinating care for beneficiaries.

Financial Arrangements: Waivers

- Some financial arrangements **may implicate the federal fraud and abuse laws**
- The Secretary **may consider whether waivers of certain fraud and abuse laws are necessary** to test the CCJR model.
 - No waivers needed for arrangements that comply with the law.
 - Waivers, if any, would be promulgated separately by OIG and CMS

Program waivers: Skilled Nursing Facility

- CCJR would **waive the SNF 3-day rule** for coverage of a SNF stay following the anchor hospitalization beginning in performance year 2.
- Beneficiaries discharged pursuant to the waiver **must be transferred to SNFs rated 3-stars or higher** on the CMS Nursing Home Compare website.
- Beneficiaries **must NOT be discharged prematurely** to SNFs, and they must be able to exercise their freedom of choice without patient steering.

Program waivers: Home visits

- **CCJR would waive the “incident to” rule** for physician services.
- Allows the licensed clinical staff of a physician to **furnish a home visit in the beneficiary’s home.**
- Permitted only **for beneficiaries who do not qualify for Medicare coverage of home health services.**
- Waiver **allows a maximum of 9 visits** during the episode, billed under the Physician Fee Schedule using a HCPCS code created specifically for the model.

Program waivers: Telehealth

- **Waives the geographic site requirement** and the originating site requirement for telehealth services to permit telehealth visits to originate in **the beneficiary's home or place of residence**
- Telehealth visits under the waiver **cannot be a substitute for in-person home health services** paid under the home health prospective payment system
- Requires all **telehealth services to be furnished in accordance with all other Medicare coverage and payment criteria**
- The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary's home

Data sharing: Specifications

- CMS would 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 would share beneficiary Part A and B claims for the duration of the episode** in
 1. Summary format,
 2. Raw claims line feeds, or
 3. Both summary and raw claims
- **Data would be available** for the hospital's **baseline period** and on a **quarterly basis** during a hospital's performance period.
- CMS would also share **aggregate regional claims data** for MS-DRG 469 and 470 in the region where the participant hospital is located.

Data sharing: Privacy

- Data sharing would **fully comply with laws and regulations** pertaining to privacy.
- Affected beneficiaries would be notified and afforded the **opportunity to decline having their data shared** with a hospital.
- Beneficiaries who wish not to have their data shared can contact 1-800-Medicare to make their preference known.

Beneficiary protections:

Access to care

- Beneficiaries' **access to care would not be impacted** by the CCJR model.
 - This is a payment model that proposes to change the payment methodology for hospitals in select geographic areas.
 - Beneficiary **copayments would not change**.
 - Beneficiaries may still **select any provider of choice with no new restrictions**.
 - Beneficiaries may still **receive any Medicare covered services with no new restrictions**.
- If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800-MEDICARE or contact their state's Quality Improvement Organization by going to:
<http://www.qioprogram.org/contact-zones>.

Beneficiary protections:

Beneficiary notification

- Beneficiary notification about the CCJR model would **ensure transparency**.
 - **Providers and suppliers involved in risk sharing** with a hospital would be required to **notify beneficiaries of the payment model**
 - If there are no risk sharing arrangements, **hospitals** must notify beneficiaries of payment implications
- Beneficiary notification requirements would focus the attention of all parties on the requirement to provide all medically necessary services.

Beneficiary protections: Monitoring

- CMS **monitoring would assess compliance** with the model requirements for beneficiary protections.
- Hospitals are familiar with both bundled payment and risk-sharing and are unlikely to compromise patient care.
- Nonetheless, **CMS would monitor for potential risks** such as
 - Attempts to increase profit by delaying care
 - Attempts to decrease costs by avoiding medically indicated care
 - Attempts to avoid high cost beneficiaries
 - Evidence of compromised quality or outcomes

Compliance with requirements of participation

- Participant hospitals, and any entity or individual furnishing a service to a beneficiary during a CCJR episode, must comply with all of the **requirements of participation for the model**.
- **CMS may do one or more of the following** if a participating hospital fails to comply with any of the requirements of the CCJR model:
 1. Issue a warning letter to the participant hospital
 2. Require the participant hospital to develop a corrective action plan
 3. Reduce or remove a participant hospital's positive NPRA calculation.
 4. In extremely serious circumstances, expulsion from the model and/or other sanctions including suspension of payments or revocation from the CCJR model if indicated.

Evaluation:

Focus areas

- Evaluation of the model would assess the impact of the CCJR model on the aims of **improved care quality and efficiency as well as reduced health care costs.**
- Focus areas include
 - Payment impact
 - Utilization impact
 - Outcomes/quality
 - Referral patterns and market impact
 - Unintended consequences
 - Potential for extrapolation of results

Notice and Comment Rulemaking Process

- You can **read the proposed rule** in the Federal Register at <https://www.federalregister.gov>.
- We encourage all interested parties to submit comments **electronically** through the CMS e-Regulation website at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking> or **on paper** by following the instructions included in the proposed rule. **Submissions must be received by September 8, 2015.**
- For **more information** about the CCJR Model, go to <http://innovation.cms.gov/initiatives/ccjr/>