Current Initiatives

- Medicare Value Based Purchasing
- Medicaid Reform
- Performance based pay
- Quality metrics
- New-Performance Measures
- Publically Reported Data

New Payment Model Expectations

- Medicare Value Based Purchasing
- Medicaid Reform
- Performance based pay
- Quality metrics
- New-Performance Measures
- Publically Reported Data
Bundled Payment

- Single payment for an array of services that may include multiple providers and multiple settings within an episode of care
- Traditional Medicare
- Traditional state-managed FFS Medicaid
- Private payers in Commercial insurance or managed Medicare or Medicaid
- Diagnosis Related Grouping (DRG) used for hospital reimbursement. Multiple other model designs exist.

Mandatory Bundle

- Began April 1st - First mandatory APM
- Five year demonstration program
- 90 day episode bundle including hospital stay
- Mandatory for approximately 800 hospitals in 67 locations (MSA)
- Acute Care bears financial risk
  - 90 days post DC
  - MS – DRG's 469 and 470 (Major lower joint replacement)
- Shared Savings
  - Tied directly to specified quality measure performance targets
- Hospitals and Physicians have finalized data
  - Partnerships
  - Referrals
  - Networks – drive referrals to lower cost settings
  - Clinical systems
- $7 billion market for Medicare joint replacement cost in 2014
- Projected Savings to Medicare - $153 million

Comprehensive Care for Joint Replacement (CJR)

“Starting April 1, 2016, 67 areas of the country will participate in a CMS-mandated bundled payment model.

- The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for Medicare beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements.

- This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.” - CMS
The most common inpatient surgery for Medicare beneficiaries
- In 2014, there were more than 400,000 procedures
- In 2014, Medicare spent $7 billion for the hospitalizations alone
- Quality and costs of care still vary greatly among providers
  - Infections, implant failures can be 3 X higher at some hospitals
  - $16,500 to $33,000 for surgery, hospital, & recovery across geographic areas

Can require lengthy recovery and rehabilitation periods
- In 2014, Medicare spent $7 billion for the hospitalizations alone
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**Total Joint Replacement Spend Breakdown**

- Infections: 7%
- Readmission: 4%
- Hospital: 56%
- Pre-operative: 3%
- Other Consults: 1%
- Post Hospital (PAC, DME, Medication): 29%

http://federalregister.gov/a/2015-29438

The Centers for Medicare & Medicaid Services have implemented a new Medicare Part A and B payment model under section 1115A of the Social Security Act, called the Comprehensive Care for Joint Replacement (CJR) model (formerly using the acronym CCJR), in which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity (LEJR).

**CJR Model: Final Rule**

- Proposd CJR rule published September 8, 2015
- Comment period for CJR rule ended November 16, 2015
- CMS finalized CJR regulations April 1, 2016
- First performance period will begin July 9, 2015
- Comment period for CJR rules ended November 16, 2015
- CMS finalized CJR regulations April 1, 2016
- First performance period will begin July 9, 2015

**CJR Goal**

- Hospitals
- Physicians, HHA, SNF, & Others
- Coordinated Care for Beneficiaries

**Affordable Care Act Goals**

- Better Care
- Better Health
- Lower Cost
Medicare Goals

Medicare fee-for-service payments made via alternative payment models:

- 30% by 2016
- 50% by 2018

Reach the Goal Through Hospitals

1. Hospital held financially accountable for the quality and cost of the CJR episode of care
2. MS-DRG 469: Major joint replacement or reattachment of lower extremity with major complications or comorbidities
3. MS-DRG 470: Major joint replacement or reattachment of lower extremity without major complications or comorbidities
4. Episode of care continues for 90 days following discharge

Episode Definition

- Admission to a participating hospital and ultimately discharged under MS-DRG 469 or 470
- 90 days post discharge

Exclusions

- 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 postsurgical care
- Excluded MS-DRGs and ICD-10-CM diagnosis codes

Hospital Partners

- Bundled Items & Services
  - Physicians
  - Inpatient hospital admissions & re-admissions
  - Inpatient psychiatric facilities
  - PAC: LTCH, IRF, SNF, HHA
  - Outpatient therapy
  - Clinical labs
  - DME
  - Part B drugs
  - Hospice
  - Some care management payments

Model: 67 MSAs, ~ 800 Hospitals

https://innovation.cms.gov/initiatives/cjr

Comprehensive Care for Joint Replacement (CCJR) Initiative Locations
Actual Wisconsin Hospitals

<table>
<thead>
<tr>
<th>Madison</th>
<th>Milwaukee</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Monroe Clinic</td>
<td>Waukesha Memorial Hospital</td>
</tr>
<tr>
<td>Divine Savior Healthcare</td>
<td>Columbia Center, St. Mary’s Hospital</td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td>Milwaukee, St. Mary’s Hospital Ozaukee</td>
</tr>
<tr>
<td>University of Wisconsin Hospitals and Clinics Authority</td>
<td>Aurora Medical Centers, Washington County, St. Luke’s, West Allis</td>
</tr>
</tbody>
</table>

CMS Regions for Target Pricing

- MS-DRG 469 and MDS-DRG 470
- With Hip Fx vs. Without Hip Fx
- Blend
  - Hospital-specific historical spending
  - Regional spending for LEJR episodes
    - Regional component increases over time
- All providers will be paid throughout the year under existing Medicare payment systems

Target Prices

- MS-DRG 469 and MDS-DRG 470

  - With Hip Fx vs. Without Hip Fx

  - Blend
    - Hospital-specific historical spending
    - Regional spending for LEJR episodes
      - Regional component increases over time

  - All providers will be paid throughout the year under existing Medicare payment systems

Retrospective Bundled Payments

- MS-DRG Reimbursement to Hospital
- Actual Spending Analyzed by CMS at End of Each Program Year
- Additional Payment to Hospital or Refund to CMS

Hospital Incentives

- Year 3
  - Actual Spending Below Target Price + Quality = Up to 10% of target price

- Years 1 & 2
  - Actual Spending Below Target Price + Quality = Up to 5% of target price

- Years 4 & 5
  - Actual Spending Below Target Price + Quality = Up to 20% of target price
Hospital Disincentives

- Year 1
  - No responsibility to repay Medicare

- Year 2
  - Capped at 5% of target price

- Years 4 & 5
  - Capped at 20% of target price

- Year 3
  - Capped at 10% of target price

Non-Compliance Measures

- Warning Letter
- Expulsion
- Plan of Correction
- Increase Repayment Amount
- Reduce or Remove Incentives

Quality and Pay-for-Performance

- Quality First
  - Minimal level of episode quality before receiving reconciliation payments when spending is below target

- Performance and Improvement
  - Hospital-Level Risk-Standardized Complication Rate for THA &/or TKA (NQF#1550)
  - Hospital Consumer Survey (NQF#0166)

- Avoidance of Expensive and Harmful Events
  - Goals for all hospitals

Tools

- Relevant spending & utilization data
- Waiving some Medicare requirements
- Sharing best practices

BPCI and CJR

Exhibit 1: Summary of BPCI and CJR Provisions

- Participation: Voluntary
- Geography: National
- Duration: 5 years
- Episode: 48 type episodes
- Episode Length: 36/60/90 days
- CMS Discount: 2-3%
- Reconciliation: Quarterly
- Risk adjustment: MS-DRG only
- Maximum gain: 20%
- Maximum loss: 20%
- Quality: Monitored
- NPIA: Net payment reconciliation amount

Source: American Hospital Association
http://www.aha.org/content/16/issbrief-bundledpmt.pdf

Beneficiary Benefits & Protections

- Additional monitoring of claims data
- Retain freedom of choice
- Existing safeguards remain in place

Additional “Flexibilities”

- Waivers
- Telehealth Visits
- Home Visits for Non-Homebound
- Collaborations
SNF Waiver

3 Day Rule Waived
- Following anchor hospitalization
- Begins in Year 2

3 Star or Higher SNF
- 7 of the previous 12 months

Discharges
- No premature discharges to SNF
- Beneficiaries must be able to exercise freedom of choice

Implications for Stakeholders

Hospitals – accountability and risk
Physicians – coordination of outcomes with acute, decrease variation, evidenced based care and best practice
IRF – shift to lower cost settings, care complexity
PAC – networks, care paths, delivery patterns
SNF – ALOS, efficient, high quality, less costly care
HHA –benefit from being lower cost provider, essential to bundle savings
Payer – keeping close eye on success of CJR

Beneficiary Notifications

- Beneficiary Notifications
- This CMS-issued notification form is not modifiable by any entity or individual unless otherwise indicated in the form.
- Please see § 510.405 of the Comprehensive Care for Joint Replacement Final Rule for all requirements surrounding beneficiary notification.
- In order to aid monitoring and compliance efforts, CMS recommends all CJR hospitals and their collaborators maintain a list of beneficiaries that receive these notification documents.
Centers for Medicare & Medicaid Services

**Comprehensive Care for Joint Replacement Model**

Post-acute care provider/supplier Notification Letter

[Post-acute care provider name] has entered into a financial arrangement with [Hospital name] for participation in the Comprehensive Care for Joint Replacement (CJR) model. Through this arrangement, [Hospital name] may share payments received from Medicare as a result of reduced episode of care spending and hospital internal cost savings with [Post-acute care provider]. [Hospital name] may also share financial accountability for increased episode of care spending with [Post-acute care provider].

---

**Beneficiary Notifications**

Most spending variations are in the PAC setting

IRFs are the most expensive PAC setting

Readmissions are the most significant cost driver

SNF length of stay is a significant cost driver

Measures for recovery or outcomes don’t exist or are unclear

Bundled payments provide opportunities for non-conventional strategies

Know your value

---

**Spending Variations**

This is about Medicare spending, not internal costs; therefore, the acute inpatient payment component of the bundle is always the same.

Hospitals must evaluate the efficacy of physicians’ post-acute care plans and work to reduce Medicare spending in PAC settings.

The most successful CJR hospitals will reduce the incidence and magnitude of institutional PAC.

---

**IRFs Are Expensive**

DataGen Healthcare Analytics 2015
**Data and Outcomes**

- Hospitals understand
  - Most significant opportunity to increase gain or decrease loss occurs in PAC setting
  - Average of 45% of all episode payments occur after the anchor DC
- Biggest variable –
  - READMISSIONS
  - ALOS PAC
  - Intensity of rehabilitation
- Alignment with providers who demonstrate ability to efficiently provide high quality care

**SNF Lengths of Stay (LOS)**

SNFs are the only PAC setting paid on a per diem basis by Medicare Part A.

There are 2 expense drivers for SNF care:
- Length of Stay and Case Mix.

Even small LOS reductions can help reduce Medicare spending (and SNF revenue).

**Readmissions Are Expensive**

Readmission rate for joint replacements is generally low; however, Medicare payments for the episode are doubled when a patient is readmitted.

Why?

Major joint readmissions tend to be for revisions or surgical complications, after which the PAC work generally starts all over.

**SNF QMs**

- In April 2016, CMS will begin posting data for six new quality measures (QMs) on Nursing Home Compare:
  1. Percentage of long-stay residents who received an antianxiety or antihypertensive medication (MDS-based)
  2. Percentage of short-stay residents who were successfully discharged to the community (Claims-based)
  3. Percentage of short-stay residents who had an outpatient emergency department visit (Claims-based)
  4. Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)
  5. Percentage of short-stay residents who made improvements in function (MDS-based)
  6. Percentage of long-stay residents who received an antianxiety or antihypertensive medication (MDS-based)

**Recovery and Outcome Measures**

No rigorous, comparative standards for benchmarking; only anecdotal evidence.

CJR data will provide data.

New SNF QMs will provide data as well!

**Opportunities**

- Care Coordination
- Telehealth
- Home Delivered Meals
- Transportation for Shopping, Outpatient Therapy

Potential episode savings generated by providing the services may cover the costs!
Knowing your value is the key to success!

How do you compare to your competition and to best practices? Without this information, PAC providers are at risk!

“Low Spend” Providers have an advantage.

“High Spend” Providers will have to justify the higher cost or rectify it.

For the CMS bundled payment system to work, hospitals will need to recruit high-quality post-acute care partners.

- Decrease SNF LOS
- Skip a SNF
- Build a SNF
- Partner with a SNF
  - Increase MD Continuity
  - Demand Value SNF Competencies from selected SNFs
  - Scalability
- Increase HHA integration
- Narrow networks

Whew...

- Not in my marketplace?
- Think again!
- CJR is the beginning
- Change operations and approach to care now
What Do You Need To Know?

- 5 Star Rating
- Quality Measures
- Customer Satisfaction
- Costs of Care
- Hospitalization Rate
- Other Data?
- Other Care Models

Strategies for Success

- Assess Readiness
- Data and Technology
- Capabilities and Competencies
- Partner and Collaboration

Becoming a valued partner

- Document your delivery of care and services:
  - Quality services
    - Satisfaction survey (LTSS and PAC – separate)
    - Overall ranking – 5 star and SNF performance measure
    - Readmission
    - ALOS per disease state
    - TCOC
    - HCC
    - Clinical practices – evidenced based
    - Care transition/care coordination

Val Prop - Create

- "A business or marketing statement that communicates why a consumer should buy a product or use a service. This statement should convince a potential consumer that one particular product or service will add more value or better solve a problem than other similar offerings."

- Create a Business Case – tell your story
- Service Delivery
- Staffing Model
- Specialties
- QAPI
- Key metrics
- Cost containment
- Communication
- Partnerships

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Val Prop</th>
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</thead>
<tbody>
<tr>
<td>Market Demand and Size</td>
<td>What do we offer</td>
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<tr>
<td>Our Differentiator</td>
<td>Benefits to our services</td>
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<tr>
<td>Values and Expectations</td>
<td></td>
</tr>
<tr>
<td>Competition</td>
<td>Position in Market – Message</td>
</tr>
</tbody>
</table>

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Leadership

- **Change agent** – drive change through “collective” creativity
- **Refine and shape the culture**
  - (listen, appreciation and optimism)
- **Embrace the challenge**
  - Lead creativity and innovation
- **Acknowledge the essentials that should not change**
- **Think BIG! Look to the “road” ahead**
- **Energetic and Passionate** – the fuel for change

Thank You

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