Update on CJR and SHFFT programs from Medicare

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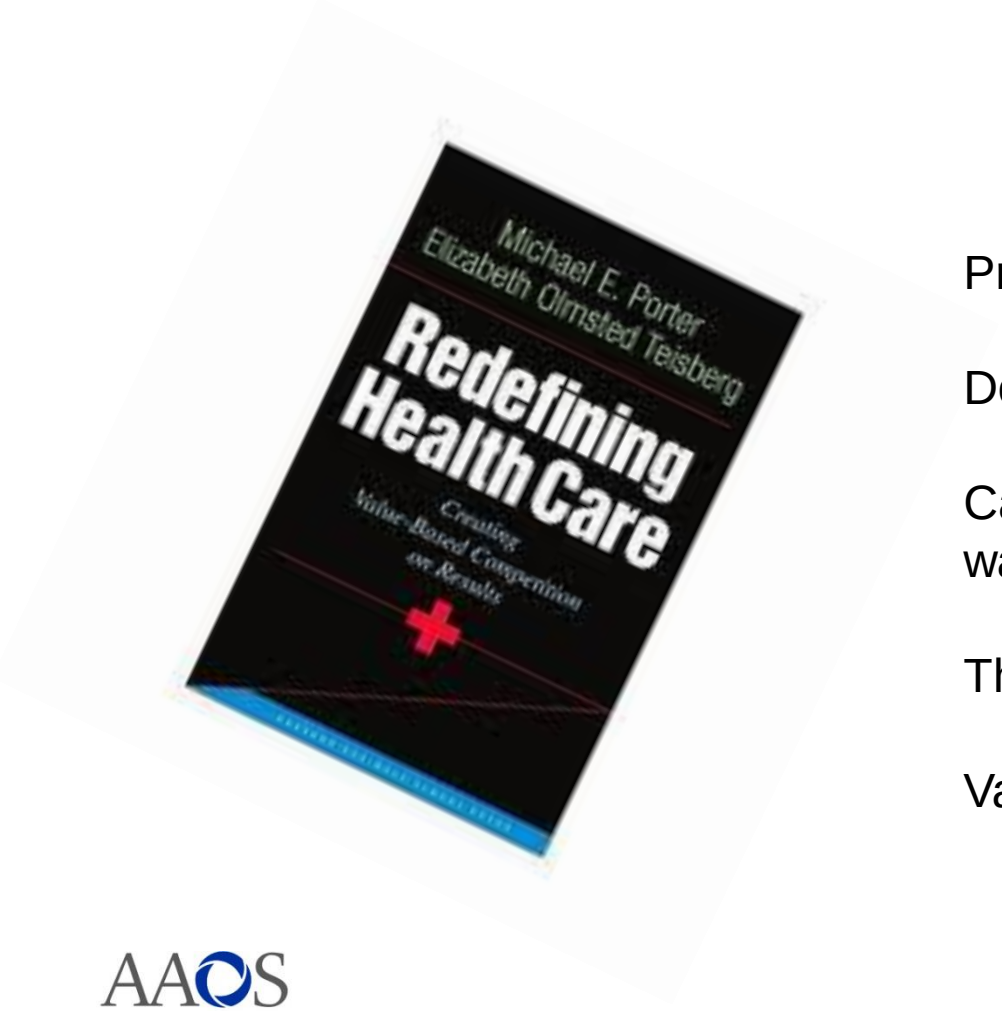
Michael Porter- Value Based Care Delivery, Annals of Surgery 2008



Principals:

Define Value as a Goal

Care should be Organized around the way value is created

There is a need to measure value

Value= Outcome/Cost

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Berwick, IHI and the Triple Aim

- 2008 “The Triple Aim: Care, Health, And Cost”: Health Affairs, Vol 27 #3

- 1. Improve the Experience of Care
- 2. Improve the Health of Populations
- 3. Reduce per capita Costs of Health Care

- “we will need new financing and competitive dynamics”

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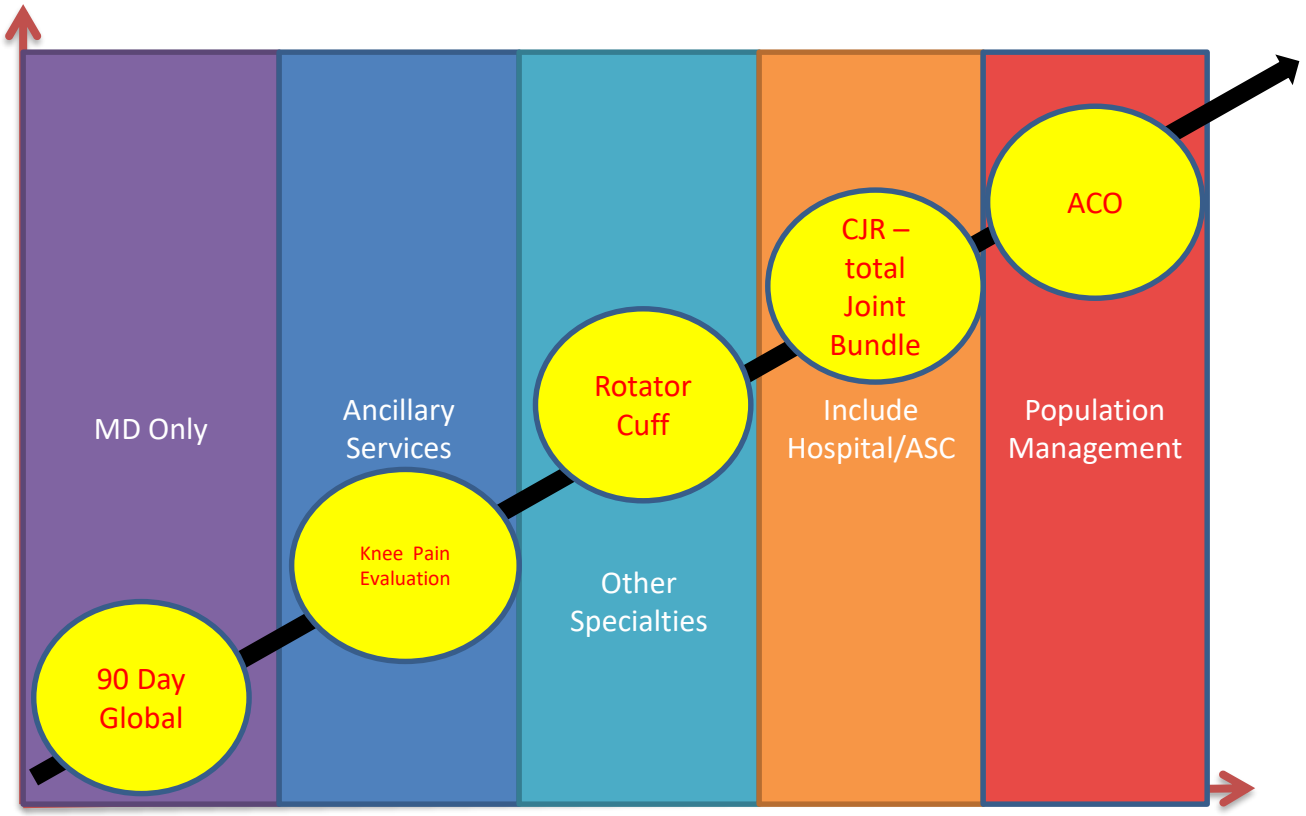
Medicare Payments

- "Large Variations in Medicare Payments for Surgery Highlight Savings Potential from Bundled Payment Programs", Health Affairs, November 2011, Vol 30 # 11, David Miller, et al

- Medicare episode payments for certain inpatient procedures varied by 49-130 percent
- Post discharge care accounted for a large proportion of variation in payments, as did discretionary physician services
- It can be argued that strong incentives exist for CMS expand or refine its bundled payment policies include spending for home health

Risk and Complexity



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CJR Proposed Rule Key Points

- Hospital Initiator (owner) of Bundle
- Mandatory in 67 markets (1/3rd of all markets in USA)
- Retrospective Payment Design
- Quality Thresholds
- Financial Options/Gainsharing with physicians and "collaborators"
- April 1, 2016 start

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Components of the Model

- Triggered by MS-DRG 469 or 470
- Includes hemiarthroplasty for hip fx, Total Ankle Arthroplasty, Primary THR, TKR
- Services in the bundle include hospital services, all physician services, post-acute care, PT.
- *ALL In hospital & post acute expenses (for 90 days)*

Retrospective Payment Design

- If the hospital meets quality thresholds *and* the total spending is less than the calculated (and discounted) "target price" the hospital eligible for "**reconciliation** payment" from Medicare
- If the total spend is greater than the "target price," the hospital must **repay** Medicare

Mandatory In 67 Markets

- “MSA”: Metropolitan Statistical Area
- 2 stage stratified randomization to determine areas
- Need for inclusion of entire market
- Represents about 1/3 of THA/TKA in the country

Quality Thresholds

- *Hospital* required to report on 2 quality measures:
  - Hosp Level Risk Standardized Complication Rate Following Elective Primary THA and/or TKA
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Pt Reported Outcome Measures

- Voluntary collection of PROMs
- May prove burdensome to measure; estimated about $75/pt to administer
- Cover the cost by reducing year 1 “discount” from 2% to 1.7%

Quality Payments

- 50% Complication Measure
- 40% HCAPS
- 10% Voluntary PRO program

- Overall 0-100 score developed

Quality Payments

- 10% Below Acceptable: No Quality or Target Payments
- 12% Acceptable: No Quality Bonus, yes target payment
- 64% Good 1% quality bonus, yes target payment
- 14% Excellent 1.5% Quality Bonus, yes target payment

How Can Hospitals Manage?

- Cherry Picking or Lemon Dropping
- Individual case management
- Proper systems/processes
  - Registries
  - Managing the entire care continuum
  - Careful co-management by hospital and doctor

Infrastructure Needs

- Quality Measurement
- Care Management
- Contracts & Relationships with SNF & Home Health
- Collaborative Environment
- Cost Monitoring

More Implications

- Must have an infrastructure to gather quality data
- Must meet meaningful use
- Must be able to work cooperatively with other stakeholders
- Need to lead the process in order to maximize revenue

Key Areas of Concern

- Risk Adjustment - Including Socioeconomic
- Small Practice Issues
- Infrastructure Needs
- Possible success strategies
- Inability to contract on in hospital issues
- Measure Development
- QDCR function
- Medicare Data

SHFFT MODEL

- Same structure as CJR
- Covers hip fracture treated by ORIF, Rod, or Screws

Delay

- Final Rule on SHFFT –
  - Start Date Delay until Oct 1, 2017
- Assessment of CJR
  - Delayed until May 20, 2017

Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- **In future performance years**, we anticipate that the following models will be Advanced APMs:

Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)	New Voluntary Bundled Payment Model
Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)	Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
ACO Track 1+	

This can often lead to higher costs and more difficult experiences for patients

ILLUSTRATIVE

TODAY'S TJR BILLINGS New York Area	
Initial inpatient stay	$14,500
Part B / Physician fees	$2,800
SNF stay (14 days)	$10,000
ER & Readmission (2 days)	$5,000
SNF stay (3 days)	$2,200
Home health (8 visits)	$1,600
TOTAL BILLINGS	**$36,100**
Target price	**$30,000**
RAW PENALTY	**$6,100**

WELL-EXECUTED TJR BUNDLE New York Area	
Initial inpatient stay	$14,500
Physician fees	$2,800
SNF stay (8 days)	$5,800
Home health (12 visits)	$2,400
TOTAL BILLINGS	**$25,500**
Target Price	**$30,000**
RAW BONUS	**$4,500**

Summary