What is CJR? Basic Overview and Refresher

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PRESENTATION

Moderator: Thank you for joining us today for the CMS Innovation Center's webinar, "What is CJR? Basic Overview and Refresher," hosted by the CJR program team. If you have questions during today's webinar, please submit them through the Q&A feature, and we will address them following the presentation. To submit a question, click on the "Q&A" button located at the top of your screen, enter your question in the text box, and click "Send." Participant phone lines will remain muted during the webinar. Please note that the default audio connection is through your computer. If you are unable to connect through your computer, please use the toll number provided in the confirmation email you received upon registering. After the conclusion of the presentation, you will be asked to participate in a short survey regarding today's webinar. We would appreciate you taking a moment to complete the survey. Thank you again for joining us. I will now turn it over to Claire Schreiber from the Innovation Center.

Ellen Lukens: …Centers for Medicare and Medicaid Services Webinar on the Comprehensive Care for Join Replacement Model, otherwise known as CJR. I'm Ellen Lukens, the Division Director for specialty patient models, and I'm joined today by my colleague Claire Schreiber who's the team lead for the CJR model. The purpose of today's webinar is to provide a basic overview and refresher of the CJR program and to provide some detail on how you can access your hospital's data if you haven't already done so.

The slide presentation will take about 30 minutes and will be followed by Q&A. Please note that the slides will be sent within a week to webinar participants. Again, the purpose of today's webinar is to really help participants understand the CJR model at a high level. And this webinar really reflects the feedback we received from several participants following our last webinar who wanted a more basic and high-level overview. So please do complete the information request at the end of this webinar as we do use those as well as topics and questions to our inbox and help desk to prioritize our educational initiatives.

In terms of the outline of today's presentation, which you have up now, we'll start with a brief description of upcoming educational opportunities. We'll then go through an overview of the CJR program followed by a description of beneficiary notification requirements. We'll then shift to how hospitals can request and receive their data and resources for CJR hospitals. So we'll start with upcoming webinars.

As you will see on slide three, we have four webinars planned for early March. And again these webinars reflect your feedback on topics of interest such as patient reported outcomes data, the quality measures and composite score, and specific program parameters such as waivers and financial arrangements. We've also included a webinar highlighting key program characteristics for March 15th, and that will really cover what you need to know for the model starts April 1. Please note on the bottom that we have sent the webinar registration links to every hospital with a CJR contact. Every hospital in CJR needs to provide CMS with two primary points of contact. We've received them from most hospitals but there are still a few out there. So if you have not sent those in, please do, because we use those as points of contact for ongoing communication.

CJR Model: Description

So we'll start today with an overview of the CJR Model. The CJR Model will start up April 1, 2016. The model will last for five years, that is through December 2020. Note that since we are starting in April, the first performance period is actually not a full year, it is nine months. So it will be episodes beginning and ending between April 1, 2016, through December 31, 2016. CJR is an episode-based payment model for lower extremity joint replacements. What this means is that the hospital will be held financially accountable for the entire episode of care cost. And the cost is from a Medicare perspective, so it's really for Medicare payments. CJR episodes include patients that are hospitalized for MS-DRG 469 or 470. Hospitals are financially responsible for almost all Part A and Part B services for the hospitalization and the care 90 days post discharge. The episode period then is the hospitalization plus the 90 days after discharge.

The CJR model will be implemented in 67 MSAs. In these MSAs, all acute care hospitals paid under the inpatient prospective payment system will participate except those that are already participating in a bundled payment model through the Bundled Payments for Care Improvement initiative, and that's a separate initiative within CMMI. There are approximately 800 hospitals required to participate in the CJR model. The full list of hospitals is available through the link included on this slide or on the CMMI website. In the comments from the proposed rule, many of you noted that LEJR patients with fractures differ substantially in terms of episode costs from elective LEJR patients. We did modify the structure of the payment so that episode costs for fracture patients would be calculated separately from elective patients. So both types of patients are included, but they will have different target prices.

CJR Model: Financial

Speaking of target prices, let's shift to focus on how this will work from a financial perspective. We've received several questions on this so we just want to review it again. CMS will continue to pay all providers during the episode on a fee-for-service basis. This actual fee-for-service spending will be compared against a prospective target price. Hospitals will note what this prospective target price is before the performance year. If the hospital episode spending is higher than the target price, then the hospital will be responsible for the difference. If the spending is lower than the target price, then the hospital will be eligible for a reconciliation payment. So again, an episode will be triggered by an inpatient hospital stay with MS-DRG 469 or 470. All services for those patients will continue to be paid on a fee-for-service basis for the duration of the episode as they would be paid under traditional fee-for-service.

After a performance year, CMS will aggregate all the beneficiaries' claims for the hospitalization as well as any claim activity for 90 days post-discharge, and based on that, CMS will calculate the actual episode payments for LEJR patients. That actual episode payment will be compared against a target price through a process we call reconciliation. The target price is based on historical spending, and we will go into the target price in more detail on the next slide. If the actual payments exceed the target price at reconciliation, the hospital will be responsible for

paying Medicare the difference between the target and actual episode spending. If the target price is greater than the actual episode payment, hospitals will be eligible to earn a reconciliation payment.

CJR Model: Target Prices

So let's just talk a little bit more about target prices. But before I go into that, I did want to underscore that there is no downside risk in Year 1. So that period of time we talked about that's starting April 1, there is no downside risk. So if the hospital spending is actually higher than the target price they will not be responsible in Year 1 for reimbursing Medicare. So CMS, again, will be tracking hospital performance on an annual basis, and if your spending is lower than the target price you will be eligible for a reconciliation payment.

Okay, so now for a deeper dive on target prices. As we discussed previously, target prices will be set separately for episodes with hip fractures versus episodes without hip fractures. The target prices are based on three years of historical data. So Medicare aggregated all episodes to calculate the average episode price over the three-year period. Medicare also updates those episode payments with trend factors to reflect increases in payments. The model includes savings to Medicare, which is a reduction of 3%, and that is a discount off the target price. The target price as you see in the table, and I know this has caused some confusion, is a blend of the hospital-specific episode spending and the regional spending. So the hospital-specific is based on your spending experience, and the regional spending is based on each of the nine census divisions. What this means is that regional spending is based on lower extremity joint replacement episodes for all the CJR hospitals in the region. So for example, all CJR hospitals in New England, episode spending would be averaged to calculate the regional portion. For the first two years the target price is based more heavily on the hospital's historical spending. So it's going to be based much more on your historical experience. The hospital-specific portion of the price is ⅔ and the regional is ⅓ for the first two years. In Year 3 that shifts to ⅓ hospital-specific and ⅔ regional, and by Year 4 the target price is fully regional. This means that by Year 4 all hospitals within a census division, for example Pacific, will have the same target price.

CJR Model: Quality

Quality plays a critical role in the CJR model. The CJR model includes two quality measures and an opportunity for hospitals to submit data to support the development of a hospital-level patient reported outcome measure. As discussed earlier, there will be two webinars on quality coming up, which will have much more detailed information on each of the measures and also the quality composite score. The two measures are hospital level standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty, and that's obviously an existing measure, as well as the HCAHPS survey measure.

Again, hospitals will also have the opportunity to submit voluntary patient reported outcomes and limited risk variable data. On March 10th and 17th, again we will hold webinars to discuss

details about the quality measures included in the model and how they relate to hospitals' performance under the model. Again this is really in response to feedback we received in the last several webinars asking for more detail around quality reporting and the quality composite score. Again, more details to come, but in short we just wanted to underscore two things about the quality component of the CJR model on this webinar. The two required quality measures, the complications measure and the HCAHPS survey measure, are already included in other CMS quality reporting programs. So CJR hospitals will not need to engage in additional quality reporting in order to comply with this aspect of the model.

The voluntary patient reported outcomes data will use a separate reporting process, and we will outline in the webinar on that topic how you will be able to do that, but please note that the data submission is not required. CJR does incorporate a pay-for-performance methodology. What this means is that performance on the two required quality measures may adjust a hospital's financial results under the model. We will discuss this is more detail in the quality presentations, but in general the pay-for-performance methodology will benefit hospitals at reconciliation. With that, I will turn it over to my colleague, Claire Schreiber.

Claire Schreiber: Thank you Ellen. This is Claire Schreiber, the team lead for the CJR model. So I'm going to briefly discuss the beneficiary notification requirement for the CJR model, how to request and receive the data and target prices, and some additional resources for CJR hospitals.

CJR Model Requirements: Beneficiary Notification

Hospitals in the model are required to notify beneficiaries about their participation in the model. What this mean is that hospitals and their collaborators must ensure that the beneficiaries receiving lower extremity joint replacements are aware that they're being furnished care at a hospital that is participating in the CJR model, and the purpose of this notification is to promote transparency and patient education about any potential financial relationships between CJR hospitals and their collaborators. CMS will be providing all CJR hospitals with the required beneficiary notification documents, and this will include notification documents that will satisfy the requirement that hospitals, physician collaborators, and post-acute care providers and collaborators notify beneficiaries about the model. Please note that these forms will be provided by CMS and they are not modifiable. So that means the forms that we provide the hospitals and physician group practices as well as PAC providers should use that exact form that CMS provides. The notification materials will be to the primary points of contact at each CJR hospital, and in addition we will discuss in more detail the notification materials and requirements on the March 15th webinar that focuses on getting ready for April 1st. CMS will provide all CJR hospitals with the notification materials prior to that date, and as I said before those will be sent to the primary points of contact at each hospital.

Please also note that the hospitals will be required to provide beneficiaries with the following in addition to the required notification letter that CMS will provide: a list of all available post-acute care providers in their area, and also discharge planning notice of potential financial liability. So

for example, if a beneficiary will be discharged to a skilled nursing facility with a less than three-day patient stay and the skilled nursing facility does not meet the quality requirements for utilization of the SNF three-day stay waiver that will be available starting in Year 2 of the CJR model, the hospital will be required to provide the beneficiary with notice of potential financial liability. And as I said before, we will go into more detailed on the notification materials and requirements on the March 15th webinar, and the hospitals in the model will have those materials prior to that. And again, we will not be providing hospitals with required templates or materials for the discharge planning notice or the list of all available post-acute care providers.

Requesting and Receiving Data

So I'll now spend some time reviewing the process for requesting and receiving historical claims data and target prices. As a reminder, hospitals in the model can request to receive three years of baseline episode data as well as ongoing quarterly data throughout the model. Hospitals can choose between summary-level data, line-level data, or both. The first step in this process is for hospitals to complete the CJR Data Request and Attestation Form. Hospitals that have not yet done so should complete this form and email the completed form to our support email, which is CJRSupport@cms.hhs.gov. I will repeat that again and just note that is also the email that points of contact at hospitals should use for not only sending the data forms to CMS but also requesting the data form if you need it to be resent again. So that's CJRSupport@cms.hhs.gov.

We ask that hospitals provide two data points of contact on the form. And these should really be individuals who will be responsible for gaining access to the CJR data portal, downloading the initial data files, and approving any secondary users such as business associates, if applicable. Upon receipt of the completed form, our team will provide detailed instructions for accessing the CJR data portal. The data portal now contains historical episode claims data and prospective target prices for the first performance year for those hospitals that have completed and submitted the data form, and many hospitals have already begun accessing this data. It is very important that all hospitals in the model request access to the data portal even if they don't believe they will be utilizing the line-level or the raw claims data. The data portal is used to communicate other personal information such as the prospective target prices, and it will also be used for the reconciliation reports beginning in 2017.

Data Portal

This slide shows a snapshot of what the data portal looks like today. As you can see the hospital has four files available here in the portal and is able to download them directly from the site.

Available on the Portal Today

So this next slide describes the types of files or materials that are now available on the portal: the historical aggregate or summary claim, the historical raw or line-level claims, the target price report, and a README file that contains instructions and specifications documents for the calculations. Please note that this depends on which files are requested by a hospital as the minimum necessary data for healthcare operations. For example, some hospitals requested summary data only on their Data Request and Attestation Form, and for those hospitals they will receive their target prices and the summary data only, not the line level raw claims data. So what's available in the portal for each hospital depends on what they have requested on the Data Request and Attestation Form. And I'll also just note, because we've received a number of questions about this, if a hospital has already submitted a form and already begun to access data, should they need to change to who their data points of contact are or if they would like to make a different request, for example, request the summary data if they have not yet requested that, then they can fill out a new form and resubmit it to us at CJRSupport@cms.hhs.gov, and we can update those data points of contact and also the type of data available to those hospitals.

In addition, as new resources are available to the CJR hospitals in the future, such as quarterly data, updated target prices for future performance years, and reconciliation forms in 2017, those will also be housed on the portal. A final note on what's available on the portal today: Note that the target prices, historical raw claims, and the summary claim files must be renamed to have a ".csv" at the end in order to open them in Excel. In addition, in response to the feedback we received during the last webinar and from other inquiries from our hospitals, we are also adding additional resources to the data portal in order to help hospitals more fully understand their target prices and data. In the coming weeks we will provide additional data points such as the update factors and the trend factors used to calculate target prices, and alongside that data we will also provide some additional instructions and specifications documents on how to utilize those data points to really understand the information that we are providing on the portal. When this is available, we will notify all the CJR hospitals who have access to the data portal that this additional information is now available.

Resources for CJR Hospitals

Finally, I'm going to briefly go over some additional resources that are available to CJR hospitals. First, the comprehensive care for joint replacement final rule is available on the Federal Register website. The final rule is a rather lengthy document; however, it is the best resource for all details about the policies in the model. For example, the target pricing methodology, the requirements for beneficiary notification, other background information on model features, such as the types of data available to participants, the quality measures, the methodology for the composite quality score.

Second, CMS will be hosting an internal website for CJR hospitals only, and this site will be available to hospitals by March 1st and will feature all of the past webinar materials, the

notification materials, and many other background materials. It will also be a space where the hospitals can reach out to CMS or get additional information about the model.

Third, the CMMI public website—so the website that is available today with information about the CJR model—also has background, frequently asked questions documents, a list of hospitals in the model that is updated on a regular basis, and many other resources.

And finally, please feel free to reach out to our support team using the email on the slide, CJRSupport@cms.hhs.gov, and that's for data request inquiries, so data forms, requesting the data forms, questions about the model, anything that relates to hospitals in the model. Please use that email address, and that is the quickest way to get a hold of our team.

So at this time we encourage you to submit some question over the Q&A chat function, and we will now take a short break, and then we will address those questions.

Q&A SECTION

Ellen Lukens: Hi this is Ellen Lukens, and we are sort of going to divide them up into categories of questions: one related to signing up for the webinars on the portal, and then Claire Schreiber is going to address along with some other colleagues some of the more detailed policy questions. Several of you noted that when you actually tried to register for the webinar some of you were asked to provide a password; we will go back and look at that again. We understood that was a problem a couple of weeks ago, and we also understood that it was resolved, but if it continues to be an issue we will certainly look into that. There is no passcode, so if that's happening that's an error on our part. So we will go in and try and correct that, the webinar. So you should just be able to log in without a specific passcode to register for those webinars. And I'm going to turn over to our colleague Mike who will just answer some of the portal questions that have come through.

Mike McCormick: Hey; how's it going? I'm Mike McCormick from the CJR model team, and I'm just going to talk about a few questions we've been having about the actual data portal. First, to reiterate, like Claire said, if you are able to access your files but are unable to open specific files, once you download them and open them up, it should happen automatically to be unzipped using your computer's WinZip software, but once they are opened there's multiple files that if you double-click it will ask you for a specific program to use. Instead of doing that, if you just rename them with a ".csv" extension, each file you will be able to open them up in Excel. That's the first thing, and then in general we know this has been a cumbersome process. Many of our participants have made it through and have access to their data. We know some people are still stuck in the process a little bit. Please send your questions to us, and we are doing our best to answer them. If there's an Experian issue, we know a few people are stuck in the Experian process and we're working diligently with our contractors and with Experian to get that resolved. We'll hopefully have something this week or the next few weeks, and we apologize for that. If people are still unable to access the actual CJR data portal, if you could send a screenshot to the address on your screen it would help us know where you are in the process, and if you do actually have access to Innovation Center and have been approved for the actual CJR

application and you are looking for your organization in the drop-down and you're not seeing it, if it says it's loading or if nothing's there, if you could just log out, give it a little bit and try again that's been resolving the issue for many of our participants.

Claire Schreiber: This is Claire Schreiber with CMMI, and I wanted to add something to some questions we've been getting about the data portal and the hospitals in the model. So we've received a number of inquiries both today on the webinar and also through our support team email about hospitals that are currently participating in the Bundle Payments for Care Improvement initiative and whether they can receive the CJR data and how to do so. So because we are only able to give the episode data to hospitals that are actually in the model, we are not able to give this data to hospitals that are currently in BPCI regardless of what their future intentions may be. So at the point at which a hospital would no longer be in BBCI and then they would be in CJR, then they would be able to request their data; however, we have received a few requests from hospitals that are requesting the data, but we don't have any kind of knowledge that they will not be in BPCI anymore and would be in CJR, so we just wanted to clarify that. The data is only available for facilities that are in CJR. We've received also a number of requests about secondary data users, and Mike will address kind of broadly what the process is for that is.

Mike McCormick: Yes. When you turn in your CJR Data Request and Attestation Form, it gives a place for two CJR data primary points of contact for each CCN, and those are the ones that initially receive the instructions and sign up for the portal and get approved by us and are able to access the data, but then there's questions about secondary users, additional users at the hospitals that would like data access, or even some consultants or other business associates, and per the CJR Data Request and Attestation Form, you are allowed to share the data with business associates as best defined under HIPAA as long as they are using the data for operational use and healthcare operations that we also describe in the attestation form, and to do this they would just follow the same instructions that you followed to get to the CJR part except when it gets to the point of requesting a CJR application. They select "secondary users" instead of "primary points of contact," and instead of us approving them, the two CJR data portal points of contact that have already been approved by us will approve them. You just need to make sure that under HIPAA you have all the proper agreements in place, and we're putting that on the actual hospitals to approve and grant access to secondary users.

Claire Schreiber: Thanks Mike. We've also had a few requests on the webinar to clarify if a hospital that is paid under the IPPS located in one of the MSAs but does not do hip or knee replacement, if that hospital will be required to participate in the model. And we want to clarify that while we understand not all hospitals do these procedures, based on the requirements of the model that an acute care hospital paid under the IPPS and in one of the geographic areas selected, that hospital would technically be a participant in the model, and so it is important that we do receive a point of contact for that hospital in the event they do perform a hip or knee replacement or another procedure that falls under MS-DRG 469 or 470, we do know that there are a small percentage of procedures that are not hip or knee replacements and they do still fall into 469 or 470 so they would be included in the model. So just to reiterate that a hospital that does not do these procedures but otherwise meets the requirements of the model would be technically required to participate in the model. So we are asking that those hospitals provide us

with a point of contact; they may sign up for the data portal as well. They would have a target price, which would be fully regional if they don't have enough episodes in the historical period, and we are also going to provide the required materials for the notification materials to those hospitals as well so they are able to comply with the requirements of the model should they have an episode.

We've had a few questions about whether baseline quality data is included in the baseline data that's on the data portal, and my colleague David O'Reilly will address that question.

David O'Reilly: Okay; hello. Again, we've had questions about the baseline quality data, and that won't come into effect, effecting the discount rate, until the first reconciliation period. So it won't be entirely replicable, but hospitals can go to Hospital Compare for a pretty close estimate. However, if we do have additional data that we can share for approximating that baseline, we will share those with the hospitals.

Claire Schreiber: Thanks, David. So we have a couple of other questions about the data forms and what happens if there's a hospital system with more than just one hospital, does the hospital need to provide multiple request forms, and Mike McCormick will talk about that.

Mike McCormick: Yes; so to answer Claire's question, if you are a hospital system, we realize there are many out there that have the same data points of contact for multiple CCNs that are participating in CJR, and yes, you will need to turn in a separate form for each individual CJR hospital.

Claire Schreiber: Thanks, Mike. We have a couple of questions about the interaction between BPCI and the CJR model and in particular what happens when there's a physician group practice that is participating in BPCI for lower extremity joint replacement clinical episodes and they are furnishing procedures at a hospital that is included in CJR. So it's a bit of a complicated question, and there's a couple of parts to it. The first piece is that in that case, the BPCI episode would have precedence, and what that means is that at the time of reconciliation that would not be a CJR episode. There's some discussion of this in the final rule, but essentially it means that if a hospital is located in a CJR MSA, any of their episodes that would not be a BPCI episode will be included in the CJR model. So we recognize that at some hospitals there may be a physician group practice that's participating in BPCI, and in that case those episodes would remain BPCI episodes, and the remainder of the episodes that are assigned 469 or 470 at that hospital would be in CJR. There's a similar precedence rule, as we say, for Model 3 of BPCI, so that could also be for the physician group practices or post-acute care facilities. So I think the best place to get information on this is in the final rule. You can also email us for further clarification on that. However, in response to the questions on the webinar, so what would happen in that case, the answer is that those BPCI episodes would remain BPCI episodes, and the remaining episodes would be CJR episodes.

We have a few questions about the financial methodology and the pricing methodology. The first question we've received from a few folks on the webinar is whether the discount percentage is 2% or 3%. So the discount percentage is 3%. That's the discount percentage used to calculate the prospective target price. However, at reconciliation there's a potential for a slightly different

effective discount percentage due to the composite quality score, and the first thing I will say is that we will be discussing that in much more detail in our webinar on the quality methodology, and the second point is for those hospitals that do qualify for reconciliation payments, so they meet the minimum composite quality score, that slight change to the effective discount percentage at reconciliation would actually benefit the hospital. So there's a possibility based on the composite quality score for a hospital to have a slightly lower discount percentage, and that would make their reconciliation results a bit better due to quality. So in some, the prospective target prices do incorporate a 3% discount across the board, and we will be discussing later in the quality webinars exactly how that may or may not change based on performance under the model.

In addition, we have a few questions about the downside risk in the model, the mention of when there is or is not downside risk, and we just want to clarify that the first performance year for the model will be episodes that begin April 1, 2016, and end by December 31, 2016, so that is the first performance year for the model, and those are the episodes for which there would be no downside risk or for which the hospitals that may have exceeded their target price in episode spending would not be required to make a payment to Medicare for the difference.

We have a question about how to get information about BPCI providers, and I will turn that over to David O'Reilly.

David O'Reilly: Okay. There is a list of BPCI participants on the CMMI website, and the name of that file is the "BPCI Analytic File," and again that's on the CMMI website.

Claire Schreiber: Thanks, David.

Ellen Lukens: We have several questions about portal access, Experian, very specific individual cases about things going on, so we will follow up on those cases on a one-by-one basis rather than doing it on the webinar today.

Claire Schreiber: We have a couple of questions as to how hospitals will know which SNFs would qualify for the three-day stay waiver. So a couple of things here, the first is that we just want to clarify that that Medicare program waiver will not effect until performance year two of the model. However, prior to the performance year, we will be publishing a list of skilled nursing facilities that would meet that quality requirement. We will be publishing that on the CMS website, so that will be information that is available to hospitals prior to the period of time in which they could utilize the waiver. And there's also other publicly available quality data on skilled nursing facilities as well as home health agencies, and we've received a couple of questions about that, so we just wanted to point folks to those publicly available compare websites; however, for the purposes of the model, that list will be on the website as well.

Mike McCormick: Okay. We're not seeing too many more new questions, so we're just going to kind of finish with this: If you do have more specific one-on-one questions regarding the data portal, we'd like to obviously answer as many questions as we can on here, but we will need some additional information, so if you could write to our email box at CJRSupport@cms.hhs.gov. Be sure to include where you are in the process, if you know a screenshot and also the CCN of the participant hospital in which you're working with, and also

again, these slides will be emailed out to everyone on the distribution list for this webinar later this week. So you will be able to review them there. Thank you for participating today, and again, just let us know if you have any questions through the inbox.

Claire Schreiber: Thanks, everyone.