CJR 101: Initial Target Prices and Baseline Data Comprehensive Care for Joint Replacement (CJR) Webinar

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PRESENTATION

Claire Schreiber: *Inaudible…*We will provide you with a set of those slides at the conclusion of the webinar. And a second reminder is that after we go through the presentation we will take questions and so if you have questions please feel free to chat them through the Q&A function and we will take questions from the participants in that fashion after the end of the webinar. So we'll go through the slides, we'll take a very brief break to gather some of the questions and then we will start answering questions.

So very briefly, the agenda for today's webinar is as follows: we will first discuss very briefly how to request and receive data. So hospitals should have received this information from CMS and if they have not already, we will discuss how you can get that information. We are also going to talk briefly about the different reports that are now available on the CJR data portal including the Target Price Reports, the Historical Summary File and the Specifications and Layout files. Then we will talk about the target prices. So we will review what files are available and what they look like and then also have a discussion about how those target prices were calculated. So with that I'll turn it over to Sherrie Wilcox to get us started.

Sherrie Wilcox: Thank you, Claire. Good afternoon everyone. This is Sherrie Wilcox and today I will very briefly review how to request your data and what to expect when you receive your data. Please note that the initial target prices, your summary data, and your beneficiary line level claims data are now available for CJR hospitals. In order to receive this data, you must be sure to request it by completing the Data Request and Attestation Form, which I will refer to as the data request form for the rest of this presentation. This form was provided in the welcome materials sent to the hospitals' designated points of contact. If your hospital needs another copy of this form or has not received one, you can email us at CJRSupport@cms.hhs.gov. After returning your completed CJR data request form to CMS, hospitals will receive an email with instructions on how to sign up for the CJR data portal, which is where the hospitals will be able to download their requested data, and I will be showing a screenshot of what that actual data portal looks like in a couple slides. Please note that the data points of contact designated on each hospital form are available to access the portal. So these data points of contact will then be able to approve secondary users to access their data. This process is explained in the data portal instruction email that you will be receiving after returning your signed and completed data request form. Also note that there is one data request form per hospital. So if you are overseeing multiple hospitals then you must submit one data request form for each hospital.

In this section, I will discuss what to expect when you have access to the data portal and how to understand your file layouts once you actually receive your data. After completing your data request form and receiving approval from CMS to access your data, you will then have access to the data portal. This is a screenshot of the Download tab on the data portal. As you can see, once you enter either your CCN or organization name, the site provides easy access allowing you to download data that you have requested by clicking the Download button. Note that the data portal instructions will again be sent to you via email after you submit that data request form, so I'm not going to thoroughly discuss it in this webinar.

When you get into the data portal, you will see that there are multiple files available, which may vary slightly from hospital to hospital depending on the data you have requested. The files included are a README file that's in PDF format and will present an overview of the CJR episodes and how the target prices were calculated. You will receive your hospital target prices for April through September of 2016, and you may receive historical claims data or historical claims summary data depending on what you have requested. And finally, you will find a file layout that explains all of the variables and the data.

It's important to note that in order to open your data files, you will need to open a zipped file, which can be done by using any standard unzipped software such as WinZip or SecureZIP and in many cases you can actually just double click on that downloaded .ZIP file and the unzipped software will automatically populate. So once the file is unzipped and opened, you then need to rename your file by adding the .csv extension to the file name, allowing the data to be opened in Excel. If you would like to open your data in Notepad or some other text file, then you can add the .txt to the file name instead of the .csv.

The Target Price Report includes eight variables, your CMS Certification Number or CCN, your hospital name, the U.S. Census Region number, which can also be found in figure 3 of the Final Rule, which is on page 73349. You'll find the MS-DRG of either 469, which includes major complications or comorbidities or MS-DRG 470, which excludes major complications or comorbidities, the fracture status, your hospital target price for that specific episode, and then variables to indicate whether or not your hospital has either no history of the type of episode or low volume of the type of episode. Note that if you have no history or low volume of an episode type then you will receive 100 percent regional pricing for that episode type.

So here is a sample of what the Target Price Report may look like for your hospital. As you can see there's a column for each variable and the data is below, one row for each episode type. The screen is a little small but you will be able to download a PDF version of this presentation for your convenience. This will basically be the general layout for your data and all the different data files that we will talk about today.

There are several historical claims files within the historical raw claims .ZIP file. Presented here is an overview of the types of historical claims files that are represented in the data set. As you can see, the .ZIP file will contain 12 historical claims files providing information on CJR episode summaries, excluded CJR episode summaries, claims data for inpatient, outpatient, home health, SNF, Part B, durable medical equipment, hospice, as well as diagnosis and procedural codes from claims, enrollment information and dual eligibility information. And I will not go into detail for each of these different files and you will actually receive a README file and claims layout file to help you navigate through these data.

As we move forward, you will continue to be able to see how your files may look when you receive them and get an idea of the data file landscape, how to merge files and gain an understanding of important variables that you should review if and when you chose to look through the larger claims files. So this particular slide presents specific variables within the claims data and there are three that I'd like to point out specifically, standardized episode amount which presents the dollar amount that represents the standardized episode payment included in

the episode spending. Then there's COSTINC which is a variable that is either zero or one indicating whether or not a specific claim amount is included in the episode, where zero indicates that specific claim was not included in the episode and one indicating that there was a specific claim included in the episode. Then there is prorated, which indicates whether or not the claim amount is prorated and then again uses these zeros and ones to indicate whether or not the claim was prorated. So we wanted to call out these particular variables because unlike the raw claims variables provided, these variables are those that we created to construct the total episode spending.

On this slide you can see a sample of the claims file layout. So this is the inpatient header claims file or the IPHDR which contains the main part of the claim versus the DTL or detailed line item file, which provides that additional information on the procedures or the VAL (value file), which provides additional information related to add-on payments. Note that the files contain more columns than the screenshot is able to capture but we wanted to make sure that we were able to provide you an example of a viewable screenshot so we didn't include all the specific variables. Again, as a quick reminder, in order to open your data files you will need to rename the file by adding the .csv or .txt extension to the file name.

This slide presents a review of how to merge the historical claims data that were outlined in slide nine. So it is possible to link some of the CJR baseline files and the method that you use really depends on the files to be merged. For example, if you want to see if a beneficiary is dual-eligible or check their Medicare enrollment status around the time of the episode, you would want to merge episodes to enrollment. However, there are different merge variables for other linkages. So if you want to merge episodes into claims you can merge by using the EPI_ID variable. If you want to merge episodes to enrollment you can merge the files by using the GEO_BENE_SK variable. And another reason to merge is really to pull the data together in the claim header and revenue level information. For example, outpatient (or OP) claims have header and revenue center information and the claims can be merged using five variables listed under the second main bullet that is on the slide, including the EPI_ID, GEO_BENE_SK and those other variables that are listed there. And finally again I want to reiterate you will receive a key that really explains all of these variables so that you are able to navigate through the data.

This slide presents the general contents of the historical summary claims file that can be downloaded from the portal. The file contains descriptive statistics on the hospital and regional levels. And note that if you are a low-volume hospital, which is defined as having fewer than 20 CJR episodes in total across the three historical years of data used to calculate the episode target price, then your hospital will receive 100 percent regional historical episode payments. And for hospitals that have undergone a recent merger, consolidation, spin off, or other reorganization that resulted in a new hospital entity without three full years of historical claims data, they will use hospital-specific historical episode payments determined using the historical episode payments attributed to their predecessor.

This slide again is similar to slide nine in that it is an overview of the file content and layout for the hospital summary files. So there are multiple variables that are listed here that your hospital can expect to receive and view when opening your hospital summary file layout, including the target prices for your hospital, the number of episodes for DRG fracture combinations, the total

episode spending during the historical period, and other useful summary data specific to your hospital.

So now I would like to turn it over to Bryan Perez from Mathematica Policy Research (or MPR) to discuss target prices as well as methodology used to calculate these target prices.

Bryan Perez: Thank you so much, Sherrie. The target prices available in the portal are the first of two target price reports your hospital will receive for Performance Year 1. Because target prices incorporate changes to Medicare payment systems such as the DRG base rate specified in IPPS rules, CMS will send a new set of target prices for episodes occurring later in the performance year. At the time of each report, all CJR participants will receive four target prices, one for each DRG fracture combination regardless of whether your hospital had any historical episodes for one of those categories. Target prices for Performance Year 1 are available today. These target prices are applicable to episodes that start between April 1, 2016 and September 30, 2016. In September 2016, target prices will be available for Performance Year 1 episodes that start October 1, 2016 and end December 31, 2016.

The target prices are based on historical episodes at your hospital and for other hospitals in your region. All target prices in performance years will use historical episodes spanning the three-year period. In Performance Years 1 and 2, target prices will use historical episodes starting between January 1, 2012 and December 31, 2014 and ending before March 31, 2015. If you requested historical claims and summary files, you will be able to take a detailed look at the historical episodes that determine your target prices. You will receive updated target prices over time, which reflect changes to Medicare payment systems. You can expect a new set of target prices in September. These target prices will use the same historical episodes and therefore the historical claims and summary files will not change.

When reviewing your historical claims, you might notice that two payment amounts are listed: allowed charges and standardized allowed charges. Allowed charges are the actual payment Medicare makes to providers and your final target prices and reconciliation amounts will reflect allowed payments. We use standardized payments to calculate target prices to remove the effect of incentive programs. This is important because programs like Meaningful Use, Value-based Purchasing, or the Hospital-Acquired Condition Programs could influence target prices and the reconciliation amount. As a last step in our calculations, we translate standardized payments into allowed or actual payments by reintroducing geographic wage factors. We would also like to mention to hospitals that are or will be analyzing the data that is currently available on the portal that we have received some questions regarding replicating results using the hospital and regional mean. To clarify, it is difficult to replicate the target prices this way and this would only result in an approximate price because the results would not be trended. Use of several national parameters, such as the update factors and the national duals rate, inhibits a complete replication of target prices.

The next section gives an overview of the technical methods used to calculate target prices. Although we send you information on historical claims, you cannot fully replicate your target prices from this information alone. However, the historical claims and summaries are useful and we hope this overview gives you a big picture idea of how your price is generated.

To recapitulate, you can find your Performance Year 1 target prices, historical claims, and historical claims summaries on the portal. As a reminder, these files contain sensitive and confidential information. Please do not email these files and please be sure to store them securely. If you want to understand the information in these files, the first place to look is the file layout documentation, which is available within each .ZIP file. But if you want to understand the gory details on how target prices are calculated you'd look in the README file. This section is a condensed explanation of the specifications in the README file. We focus primarily on the information in the target price specifications but we do allude to the information in the episode definition and update factor specifications.

Three input data files were used to calculate the target prices. The first is the national episode summary file. This file contains all episodes anchored by DRGs 469 and 470 from 2012 to 2014 for all acute care hospitals—not just CJR participants. For each episode, the file includes information on the episode's start and end date as well as the total spending amounts. The creation of this file is described in the episode definition specifications included in the README file. The next input is update factors. The update factors are used to trend the historical episode payments to the performance year. This is conceptually similar to inflation like the consumer price index whereby dollar value is adjusted. If you want to understand the methods to calculate update factors, we have a separate specification report for this included in the README file as well. The last data file that was used to calculate target prices was the wage index file, which is a hospital-level file with wage indices. This information is obtained from the IPPS Final Rule published by CMS in the impact file.

So this slide describes the seven steps to calculate target prices at a high level. Before I give this description however, I would like to go ahead and skip ahead to the next slide, which is a flow chart that visually describes and represents the process.

As a reminder, we begin with a national episode summary file. The flow chart starts on the upper top left-hand corner. The target prices calculation begins with the national episode summary file, one of the data inputs that was mentioned before. After we trend, cap, anchor, and pool (the first four steps down the left-hand side), we end up with a hospital- and regional-level historical average. So these four steps are part of the calculation to prepare historical episodes to take an average. Now if you look at the bottom row, you will see that we start with hospital- or regional-level average episode payments. By the time we move to the right column, we have a blended amount, which is labeled as "blended hospital payments," meaning we now have one episode amount for each hospital. If you start on the bottom right and move up, we turn each hospital's blended hospital payment into four target prices. Now let's go back to the previous slide to describe what's exactly happening at each step.

We begin with the national episode summary file. The first step is trending. Trending moves all episode payments to 2014 dollars like an inflation factor. Next we remove high-cost outlier payments. This is to reduce the influence of particularly expensive episodes on target prices. The next step is pooling. Pooling is the process of averaging all of the hospital's episode payments into one amount by taking an average. The pooled amount represents the average episode payment at your hospital for DRG 470 without fracture. This pooled amount is then trended to 2016. This is where update factors come into play. Again, this is similar to inflation

conceptually. Now at this point we have one average for each hospital and one for each region. Similar to combining and mixing ingredients for a cake, blending is done to combine these two amounts. At the end of this step, we have one blended historical episode payment amount for each CJR participant hospital. Next, we reintroduce wage factors. This is done to translate standardize payments back to real or actual dollars. And finally we calculate the four target prices, one for each DRG-fracture combination. This final step actually has two parts. First, we reduce the blended payment by three percent. This is called the discount. Then the last step is to split the blended average into four different payments. This is done by using a national anchor factor that was calculated at an earlier stage. Think of the anchor factor like a DRG weight—it represents the relative difference in price for episodes in different DRG-fracture combinations. The target prices you see in your portal represent the calculations from the last step of this process.

And that's the end of our presentation. We will now answer your questions. Please submit your questions using the chat function on WebEx. As a reminder, we will send everyone the slides and a transcript of this webinar within a week.

Claire Schreiber: Thanks, Bryan. This is Claire Schreiber with CMMI again. Just a reminder to everyone please feel free to submit your questions via the chat Q&A function. We are going to take just a few minutes to gather some of those questions and then we will come back on the line and start answering them.

Q&A SECTION

Claire Schreiber: This is Claire Schreiber with the Innovation Center again. We are going to start answering some of the questions. So, we received a number of questions from participants in the webinar about how long it takes to receive data from the time that they submit their request form or request access to the portal, how long it takes to receive approval, how long it takes to receive the data, how to get the data, and how to get the instructions. So Sarah Mioduski is going to address that.

Sarah Mioduski: Thanks, Claire. So it takes about a week for our team to do some QC on the data forms and make sure all of it is completed correctly. Then we will be in contact with the two data points of contact indicated on that form and then they will be receiving the instructions. The instructions come in two emails and if we receive any bounce back because the point of contact was not able to receive it, we will be sending a follow up email in a PDF form. At that point, if we receive another bounce back, we will be in contact with your hospital to find a different avenue for your points of contact to get the instructions. Please remember that the specific names indicated on the form as your data points of contact are the only people from the hospital that are able to be the primary users to request the data. Once those two data points of contact go into the portal and receive access, they then can approve secondary users—as Sherrie said previously in the webinar—to get access to your data. You originally are only able to have the two data points of contact that you indicated on your form to request the data. Also we know there are some issues with the Experian check. If someone fails the Experian check, there is a manual process and we are going through that avenue right now to figure out how to get the people access and

we will be in contact with you. Also if you were rejected when you applied for the portal, we do understand that it does not give you the reason. Please email us to let us know why you were rejected and we will look into that issue. Also we have a number of questions from people who have submitted their data forms and they did not receive the instructions to date. You also can email us and we will look into those issues as well. Please just provide your CCN when emailing us.

Claire Schreiber: And just as a reminder, the email address is CJRSupport@cms.hhs.gov. So we have a few questions about target prices in particular so I'm going to turn it over to Bryan Perez at Mathematica to address those. The first is we received a couple of questions from participants about why they might not be able to exactly replicate their target price and then questions just seeking a little bit more clarity about what the update factors represent. So I will turn it over to Mathematica to answer that.

Bryan Perez: Thanks, I will actually turn it over to Alex who will be able to explain this in greater detail.

Alex Bohl: Thanks everyone. The first question is "Why can we not replicate target prices from the information provided?" So even if you start with the claims data that we sent and condensed it down and you were able to calculate the episode amount, you cannot first of all, trend your payments in the baseline period to 2014 dollars. That's because we used national growth factors and we have not provided the national growth factors. The second reason is that even if you are able to trend, what ends up happening is you also have to apply update factors to move 2014 payments to 2016. Again, we do not provide update factors. So those are the two main issues and the reason why you cannot replicate those is because you are not able to trend or calculate update factors because either of those require information on all hospitals nationally or information specific to your hospital.

One thing I will also say is that we provide a summary that shows the descriptive statistics on episode payments in the historical period. We will provide information on the mean, median, etc., and we will do that for the hospital and the region. The issue is that you cannot just use those numbers to calculate the target prices as well. The reason being those numbers represent standardized payments. Because those standardized payments are not allowed charges you would have to reintroduce the wage factor.

The second piece is that in addition the way that the pooling historical average is calculated is different than the straight average. This is defined in the specs and the Final Rule. So these are different quantities than what we provide. The hospital and regional summaries are really descriptive statistics to show the variation in historical episode spending at your hospital and it could provide some basic description information on the types of services that were used and go into those episode spending calculations. Claire, does that answer everything?

Claire Schreiber: I think so, thanks Alex. That was very helpful. We have a few other questions we will address. We've gotten a couple of questions about what the low-volume threshold means and in particular what the 20 cases apply to, whether it's just one of the DRGs or both or how that's determined. Sherrie Wilcox is going to address that.

Sherrie Wilcox: Thank you, Claire. So a low-volume hospital is defined as a hospital with fewer than 20 CJR episodes in total within both 469 or 470 across the whole three years of historical data used to calculate the episode target price. So if you have fewer than 20 episodes during that whole period, then you will fall into this category and your hospital will receive 100 percent regional historical episode payments.

Claire Schreiber: Thanks, Sherrie. We have gotten a couple of other questions about when the quarterly data will begin to be available. So not just the 2012 through 2014 baseline data that was used for the initial target prices but the ongoing claims data that participant hospitals will be receiving on a quarterly basis throughout the model. Hospitals should expect to start receiving that later in 2016. So once the model performance period has begun they wouldn't start receiving the quarterly data until several months after that. And we will be communicating about an exact date at that time but that data would really represent episodes or potential episodes that have occurred under the model and the performance year starts April 1, 2016.

Another question that we received is with regard to the data portal is about secondary users of the data and Sarah Mioduski is going to address that. We have gotten questions about how a secondary user would request access, whether or not there's a separate DUA process needed for that, questions of that nature. So I will turn it over to Sarah to address that.

Sarah Mioduski: Thanks, Claire. The two points of contact that you indicated on your Data Request and Attestation Form are the primary points of contact that are able to be approved in the system. Those two contacts can then approve secondary users for your organization. As indicated in the form, they need to be HIPAA-covered business associates in order to be able to access the data. You are considered a standard user when you email the data form in and have it on the form. This is how we indicate whether or not the name matches up with the person that is applying in the portal. So that's why I said previously that we want to make sure that the people in your organization that are applying for access to the portal are the same people indicated on the form. You do not need to resubmit another DUA if you want additional access for your secondary users. That is all done throughout the portal and that's kind of the whole basis for doing it through the portal and having the one DUA is to provide the hospitals with a more smooth transition of sharing their data with their business associates.

Claire Schreiber: And Sarah, can you clarify another question on what people should do if their data point of contact changes during the model at any point? How should they communicate that to us?

Sarah Mioduski: Sure, so what you will need to do is resubmit the Data Request and Attestation Form with your new points of contact indicated on that form and just email us letting us know that that is the most updated copy if you have previously submitted the form. I do apologize; I just want to clarify something. When the two points of contact apply for access, they are considered the data PPOCs. That is the role that they use and then any secondary users would use the standard user role. So I do apologize; I misspoke previously. Again, that is for the data portal. The two points of contact indicated on the form are considered data PPOCs and any secondary users that your organization wants to have access for data they are considered a standard user and that is the role they should use in the portal when applying for access.

Claire Schreiber: Thanks, Sarah. We have another question for the Mathematica team and it refers to something in the claims. Several people are asking, "What is the common data point that ties claims to a patient?" So a question about kind of how to use their data and I will turn it over to Alex and Bryan to answer that.

Alex Bohl: Thanks, Claire. First of all, the claims we are using and the variables that we are reporting come directly from CMS data systems. So if you're familiar with the CMS CCW or IDR, a lot of these data variable names will be familiar and we are trying to report as many variables as possible that seem relevant to these calculations. But to get to the question about how to identify an individual, there's a variable called GEO_BENE_SK or BENE_SK, sometimes it's named differently but in general that is the variable used to identify an individual person. Now if you want to link enrollment data, we provide something called the BENE dual file. If you want to link that to episodes you can link directly with the GEO_BENE_SK or the BENE_SK field. But if you want to link episodes to claims, then you need to link by the episode ID.

Claire Schreiber: Thanks, Alex. This is Claire Schreiber again with the Innovation Center and I am going to turn it back over to Sarah Mioduski to further clarify some of the data portal issues. We have continued to get a number of questions and also just to address, we've continued to get some more questions about the timing between submitting the form and approval. So if you could just address that as well.

Sarah Mioduski: In regards to the timing, it takes about a week to QC the form and make sure all the required information is correct and to get back to the points of contact listed on the form. At that point, you should be receiving instructions. They will be coming in two emails back to back. Due to the file size we have to send two emails.

To address the secondary users of data, in the instructions—and I believe it's the number three PowerPoint titled "CJR Portal 508" on slide 10—we address how there are CJR primary points of contact. So we have, "If you are one of the two hospital representatives or data points of contact that are listed on the CJR Data Request and Attestation Form that you are included in your hospital orientation materials, you are considered the CJR primary point of contact and that is going to be your role when you are requesting data in the CJR portal. If you then want to have secondary users of your data, you can then send those instructions to those users." And as it explains in the same PowerPoint, "Their role will be a CJR standard user, which means if you are not listed on the form and you are requesting data for a CJR participant hospital. At that point, CJR prime point of contact will have the ability to approve or deny that standard user." So a person that is requesting data for a certain CCN, the two data points of contact associated with that CCN will have the ability to approve them so their secondary user can get the data.

Claire Schreiber: Thank you, Sarah. We are also receiving a number of questions about the quality measures. First, I just want to clarify that we will be having separate webinars about the quality measures, including the patient reported outcomes data. So there were a few questions about that.

There were also a couple of questions about when hospitals will receive their composite quality score and because the composite quality score will be calculated for a time period that includes the model performance period, they will not receive their quality performance under the model until the completion of the first model performance year. So again, we will be reaching out with additional information about the quality measures and the composite quality score, as well as the patient reported outcomes data. I just wanted to clarify that the hospitals would get their composite quality score for 2016—so their performance under the model from April until December 2016—and that will be included in their reconciliation in 2017. So it's not necessarily data that they will be provided prior to the start of the model because it is related to their performance under the model.

With that said, there is information in the Final Rule and in other documents about how their composite quality score could possibly effect their performance under the model. And so we would just encourage folks to look at those documents on the model website, and also we will be having more targeted webinars in the future.

We are going to take another couple of minutes or so to gather the final questions. We just encourage people to send in any final questions you may have and anything we may not get to on this webinar. First of all, a number of things—particularly policy questions answered in the CJR Final Rule or we would also like to point people to the model website on the CMS Innovation Center website. The Comprehensive Care for Joint Replacement model website includes several documents that provide shortened versions of some of the policies that can help to answer some of your questions. In addition, if you have further questions that we didn't get to in the webinar, you can email CJRSupport@cms.hhs.gov. In addition, that is also the web address to be used for questions about the data portal, the Data Request and Attestation Form, and things of that nature. So we will take just a quick break and come back and answer the final questions.

We are still receiving a number of questions related to technical issues with the data portal so we just want to clarify that if you have a particular question please send it in an email to CJRSupport@cms.hhs.gov and we can address them that way. We want to thank everyone for participating in the webinar today. Just a couple final reminders: the first is the participants will receive a copy of the slides so those will be made available. Sarah do you want to end with additional information about the portal as a reminder?

Sarah Mioduski: As a reminder, if there are any changes to your data request form please resubmit that by emailing us at CJRSupport@cms.hhs.gov. Again, if there are any questions regarding technical issues, you can call the help desk number that is in the instruction manual or just email our help desk. We appreciate your patience with us as we get through these technical issues.

Claire Schreiber: And we just also wanted to end by noting that there will be a survey distributed at the end of this webinar so please take a few minutes and fill out the survey. We are interested in knowing what was helpful and what further topics you might want to know more about with regards to the data. We really appreciate everyone's participation.