CJR Model Final Performance Year 3 (PY3) and Initial Performance Year 4 (PY4) Reconciliation[i]

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Alicia Goroski: Welcome to the CJR Model Final Performance Year 3 (PY3) and Initial Performance Year 4 (PY4) pre-recorded webinar. We acknowledge that this is a challenging time for the entire healthcare system and we thank you for your time and attention. We are grateful for your dedication and ongoing efforts. This is Alicia Goroski with the CJR Learning System Team, and I would now like to briefly review the agenda. Following a brief review of the logistics we will move into announcements followed by the appeals process, payment and repayment, PY3 and PY4 reconciliation updates, data and reports, and then we will review a sample report demonstration. Followed by a reconciliation review, and we will wrap things up with reminders and next steps.

I would like to review instructions for enlarging the slides. In order to enlarge the presentation window, which contains the slides and will also be where the demonstration of the sample report occurs, you just need to hover your cursor to the top of the slide, and then you should see four outward facing arrows in the upper right-hand corner of the slides. Click on to those for outward facing arrows and the presentation will expand to your full screen, for a better viewing experience. To return to the original view, you will again hover your cursor to the top of the screen, and at this point you will see four inward facing arrows, click on these to restore to the original view.

There are several resources, including a sample CJR reconciliation report, available for download during this event as well. You will find the resources, and the small box entitled event resources, on the right-hand side of your screen. In order to download the resources, click onto each resource and then click the download file(s) button. If you have any issues downloading these files, they are also available on the CJR Connect site, or you can email LS-CJR@Lewin.com and we can get them to you.

At this point I would like to introduce and turn the webinar over to Dayna Gallagher from Mathematica. Dayna will be our main presenter today.

Dayna Gallagher: Thank you. I would like to start today's webinar off with a few announcements. First, the 2020 reconciliation report was made available on the CJR data portal as of June 10th, 2020. Last year's 2019 reconciliation report, is available separately in the CJR file 1 zip folder on the data portal. Second, having completed final reconciliation, performance year three episodes will no longer appear in your monthly data feed, in the CJR data portal. Final Performance Year 3 Episode data will be available in the reconciliation claim data zip folder. If you have any questions about today's webinar material, please address them to the CJR support email, CJRSupport@cms.hhs.gov.

Now we will look at the timeline of logistics, the CJR reconciliation appeals process. Which is outlined in section 310 of the final rule. We are discussing this topic up front as there have been some changes to the process, to provide additional flexibility for hospitals during the COVID-19 pandemic. Note, that this is the last appeals opportunity for performance year three episodes.

For your appeal to be considered you need to submit a completed calculation error form. For hospitals required to repay Medicare, the deadline to submit a calculation error form is October 7th, 2020, at 11:59 p.m. eastern time, 120 calendar days from the reconciliation report issuance date. For hospitals eligible for reconciliation payments, the deadline to submit a calculation error form is July 24th, 2020, at 11:59 p.m. eastern time, which is 45 calendar days from the reconciliation report issuance date.

Hospitals eligible for reconciliation payments, may also request an extension of the appeals period to 120 calendar days. To do this, email CJRReconciliation@cms.hhs.gov. Specify that you are requesting an extended appeals period for the performance year 3 final and performance year 4 initial reconciliation report and please include your hospital name and CCN. The deadline to submit the request is July 24th, 2020, at 11:59 p.m., eastern time. This approach allows for all participant hospitals to maintain their existing appeal rights, and avoid delays in payments to hospitals eligible for payment, unless they request extra time. And it extends the appeals timeline for those hospitals facing repayment obligations, or who have requested more time to appeal the calculation of the reconciliation payment. If a calculation error form is not submitted within the 45-day or 120-day period, the CJR reconciliation report is deemed final.

A few logistical reminders. Completed calculation error forms must be emailed to CJRReconciliation@cms.hhs.gov. Only participant hospitals can submit appeals, not consultants or contractors. Appeals are limited to episodes in performance years three and four, and participants can use one form to appeal multiple calculation errors within a performance year. But appeals for different years must be on separate forms. Note that the appeals process is for financial and methodological concerns and is not intended for feedback on the model design or scope.

No personally identifiable information or personal health information is needed on the calculation form. However, if you feel the need to send PII or PHI for an appeal, please upload the calculation error form to the data portal. If you do so, notify CMS of your upload via the reconciliation appeals inbox. The calculation error form and instructions will have additional guidance on how to upload PII and PHI. On this slide, we have outlined the types of calculation errors that can be submitted, including the inclusion or exclusion of Medicare beneficiaries or episodes in the baseline or performance period, inclusion or exclusion of specific claims within episode spending in the baseline period or performance period, reconciliation amount calculation errors and the application or use of composite scores during reconciliation or in determining the performance decile.

This flow chart shows an overview of the appeal process. The top half of the flowchart is for the first level of appeals. If a participant hospital agrees with the reconciliation report, or no calculation error form is submitted within 45 or 120 calendar days of the reconciliation report issuance, then the determination is deemed final. If a participant submits a calculation error form within 45 or 120 calendar days, CMS should respond within 30 calendar days. CMS does reserve the right to an extension of the 30 calendar day period, upon written notice to the participant. On the bottom half, you see the second appeal level. Participants may submit a request for reconsideration, within 10 calendar days of receiving CMS's written response. If no request is received, then payment or repayment proceeds. If a request for reconsideration is received, CMS will schedule a review within 15 days and will respond in about 60 calendar days. The written determination will be final, and payment or repayment will proceed. As a reminder, these are calendar days rather than business days. And that is all we have on appeals.

In the next few slides, we will be discussing payment and repayment. As a reminder on terminology, we will use payment to refer to your hospital receiving a payment, as a result of reconciliation, and repayment, to refer to your hospital receiving a demands letter for amounts owed to CMS.

For hospitals who are expecting a payment and are not appealing the reconciliation report, you can anticipate receiving payments around late August or early September. For hospitals who are receiving a payment and are appealing the reconciliation results, within the 45 calendar day appeals period, you can anticipate receiving payments in late October or early November. For hospitals who are receiving a

payment and are appealing the reconciliation results within the 120-day calendar appeals period, you can anticipate receiving payments in early January 2021.

Banking details and contact information must be up to date to ensure payments are received, and repayments don't accrue interest. These need to be correct in the Medicare Provider Enrollment, Chain and Ownership System (or PECOS). Please note that payments are sent to the account where your Medicare payments typically arrive.

For hospitals expecting payment, National Government Services, not the regular Medicare Administrative Contractor, will be facilitating the reconciliation process via USBank. The first addenda line on the EFT remit is displayed on the line under the second bullet point. There will be one payment, with separate addenda lines showing which Medicare Trust Funds were drawn from. The total payment will reflect the sum of the Part A and Part B lines.

For those who owe a repayment amount, your hospital will receive a demand letter in the mail that will detail how to submit payment. However, if you want to submit payment sooner, you can refer to the instructions included either in the email that notifies you of the availability of the reconciliation report or the notice section of the reconciliation report itself.

If you receive a payment that is less than the amount in the reconciliation report, it is due to an outstanding debt or unpaid interest on the previous performance year. The outstanding amount will be netted against your reconciliation payment. For example, if you owe $5,000 for performance year 3, and your reconciliation report says you are set to receive a $100,000 payment, you will receive a reduced total of $95,000.

Now, let's get into the performance year 3 final and performance year 4 initial reconciliation updates.

The 2020 reconciliation report and claims data files use claims processed and uploaded into the CMS integrated repository, or IDR, as of March 1st, 2020. Performance year 3 includes episodes that ended during 2018. This means that some performance year 3 episodes may have started in late 2017. Similarly, performance year 4 includes episodes that ended during calendar year 2019. Again, this means that some episodes will have begun in late 2018.

Each performance year undergoes two reconciliations: an initial reconciliation two months after the performance year and a final reconciliation 14 months after the performance year. This year’s performance year 3 final reconciliation adjusts the initial reconciliation payments made in 2019, adjusting for final claims run out, individual claim and overall episode cancellation, increases in post-episode spending, ACO overlap, and BPCI overlap using final BPCI episode data. In performance year 3, reconciliation payments will be limited to a gain or loss of 10% of the target spending for most hospitals, and 5% for rural hospitals, Medicare dependent hospitals, and sole community hospitals. Hospitals subject to repayment for performance year 3 will have a reduced discount factor based on their quality performance. We will get into the details of how that is calculated later.

There are three updates for performance year 4 initial. The limitation on stop loss and gain increases to 20%, and remains at 5% for rural and otherwise eligible hospitals. The repayment discount factor is now equal to the quality discount factor, so there is no additional discount percentage if you are responsible for repayment for performance year 4 episode spending. Episodes excluded for BPCI overlap will be

identified using final BPCI episode data, rather than the claims based exclusion approach used in previous initial reconciliations.

Now, we will review the data and reports available on the CJR data portal. Participants will be receiving several updated files on the data portal, including the reconciliation claims zip file, containing claims and beneficiary data for performance years 3 and 4 episodes. You will also receive the reconciliation reports zip file, containing the performance year 4 reconciliation report HTML file, which will contain your calculated reconciliation amounts and quality scores for performance years 3 and 4. It also contains the reconciliation amount CSV file, which shows your reconciliation amount and other summary statistics; the hospital reconciliation summary CSV file, which provides a summary of spending for each DRG fracture and episode period combination; Quality Measure or QM CSV file with detailed information on the quality measure data used to calculate the composite quality score; and finally a calculation error or CE form, with instructions on how to submit an appeal. As we previously mentioned, the archived 2019 reconciliation report is on the data portal under CJR File 1.zip. And finally, the ReadMe zip file, which includes updated file specifications, an updated data dictionary, quality measures decile cutoffs, and a log of changes that describes the reconciliation technical changes.

Now we will do a live walk-through of the report. As a reminder, in order to enlarge the presentation window, just hover your cursor over the top of the slide and click on the for outward facing arrows, in the upper right-hand corner of the slides. To return to the original view, you will again hover your cursor toward the top of the screen, and click on the for and would facing arrows. So here we see an example report, at the top of this you will see a navigation panel, that you can use to jump to sections in your report. You will also see the notice, which provides some background information. Next, you will find the overall reconciliation payment, or repayment amount, with information on how this number was calculated. Below that, you will find the overall summary, which includes both performance year 4, initial reconciliation and performance year three, final reconciliation. The initial report date is the day your reconciliation report was made available. This establishes the start for the appeals period. The payment eligible category will show whether your hospital is eligible for a payment. Hospitals with a below acceptable composite quality score will not be eligible for payment. Next, is the financial performance section. Which provides a breakdown of reconciliation payment and repayment calculations overall, and by year. Then, we move into a section describing the adjustments to the reconciliation amount, that are made at the hospital level. That includes quality performance and improvement, post episode spending, loss and gain limitations, ACO recoupment, and finally an adjustment for extreme and uncontrollable circumstances that will be applied for certain episodes. The report concludes with the appeals section that describes how to submit a calculation error form. One final note, if you wish to print this document out for your records or review, we recommend that you print it in landscape view. And with that, we will return to the slides.

For those of you who might be new to CJR could use a refresher, we will now provide an overview of reconciliation. Reconciliation amounts are calculated using the methods described in the 42 C.F.R. Sections 510 and 512, in the slides we've included the links to the relevant CJR final rules. Regulations and notices can also be found on https://innovation.CMS.gov/Initiatives/CJR. On this slide we review why episodes may be excluded, examples of exclusions are beneficiaries who are covered by nontraditional Medicare health plans, such as Medicare advantage, beneficiaries who are admitted for another anchor stay, beneficiaries who are being covered for a lower extremity joint replacement under BPCI, though CJR takes precedence over the newer model, BPCI Advanced. And finally, beneficiaries in next GEN or SSP track 3 whose episodes began after July 1st, 2017. For more comprehensive information on episode exclusion criteria you can look at the episode definition specifications and the DROPREASON

variables in the data dictionary. Both of those can be downloaded from the data portal in the README zip folder. Information is also available in 510.205 and 510.210 of the regulatory text in the final rule. This slide reviews the episode level adjustments of that are applied to reconciliation. First, non-claims based payments or NCBPs, which include claims from other CMMI models such as CPC+ will be incorporated into episode spending. Per-beneficiary per-month payments from models, including the oncology care model, and the Medicare Care Choices model will be excluded from episode spending. Episode payments will be capped for episodes beginning or occurring during an emergency period and or in an area of extreme and uncontrollable circumstances. DRGs may also be changed to prevent hospital acquired conditions from being recorded as complications. And all episode spending adjustments described in further detail in the episode definition specifications. On this slide we review target prices. Target prices are created for participant hospitals in advance of each performance year. Target prices are delivered to participants at least two times per year, to account for Medicare payment updates. They apply based on the anchor stay admission date and assume a 3% discount for quality. In your target price file on the data portal, you can reference the episode period variable to find the applicable target price. During reconciliation, we adjust the target price discount factor to account for quality. If, based on your composite quality scores, your hospital falls into a higher-quality category, you will receive a smaller discount percentage. This means that you will either receive larger payments, or need to make smaller repayments. A cross walk of composite quality scores and applicable discount factors can be found in table 5 of the reconciliation report. The quality adjusted target price, applies the same wage factors from the perspective target prices. This uses IPPS impact file, that was available when the priest active target prices were created.

So, now we will go a bit more into detail about how we determine your hospitals composite quality score. Your composite quality score is your quality measure performance points plus your improvement points, plus points for PRO submission. Quality performance measure points are based on your hospitals quality measure results, and are assigned based on your performance percentile. You can see your results on table 6 and 7 of the reconciliation report. Please note that CMS assigns hospitals without reportable quality measures to the 50th percentile. And this year, we have included additional information on quality measure performance points, percentiles, and results directly in your reconciliation report. However, detailed information on quality measurement can also be found in the QM file that is delivered with your report.

On this slide, we have included the weight that is given to the two quality measures, THA and TKA complications measure which is weighted at 50%, with a max of 10 points. And the HCAHPS survey measures which are weighted 40% with a max of 8 points. The THA TKA voluntary PRO and limited risk variable data submission has a 10% weight where 2 points are given just for successful submission. Quality improvement points can be earned if the quality performance on a measure increases from the previous year by at least 2 deciles.

On this slide you can see how a hospital's composite quality scores impact the discount factor. As you are comparing quality adjusted target spending with actual episode spending, it is important to remember that is in performance year three there were two different discount factors that may be affecting calculations. One is if you received a reconciliation payment, and another if your hospital is subject to repayment. In performance year four, those numbers are the same. Note that any hospitals with below acceptable composite scores will not be eligible for payment.

On this slide you can see how the stop gain and loss limits have changed over the performance years. Highlighted in red are the stop gain and stop loss limits for performance years three and four. Which are

10% and 20% respectively. On the far right we have included the 5% protected stop loss limit which applies to rural hospitals, rural referral centers, Medicare dependent hospitals, and sole community hospitals. The stop gain loss percentages that we see in performance year four will stay constant through performance year five.

Your reconciliation payment or repayment, will include the net payment reconciliation amount, or NPRA, which is the difference between your hospital's spending and quality adjusted target price. This will include the application of the high-cost threshold, and stop loss and stop gain limits. The NPRA also includes adjustments for performance year three final reconciliation, and any post-episode spending, shared savings with ACO models and payment eligibility based on quality performance. This includes if an overpayment was made during the initial performance three reconciliation, where the initial net payment amount is greater than the final net payment amount. For example, if your performance year three initial net payment amount was $1,000 greater than your performance year three final net payment amount, the overpayment difference of $1,000, would be subtracted from your 2020 reconciliation payment. Finally, reconciliation amounts will be expressed in real dollars, with wage factors reintroduced.

So, looking ahead, performance year four final reconciliation will occur in summer 2021. Keep in mind that final reconciliation has the potential to change your performance year four reconciliation amount, that you will receive this year. As we discussed for performance year three, final reconciliation will adjust for episodes that need to be added or removed, changes in episode spending, post-episode spending and ACO recoupment. Any changes will be reflected in the 2021 reconciliation report.

And now I will hand it back over to Alicia to wrap us up.

Alicia Goroski: Thank you Dayna, I will now review a few final reminders and next steps. You should have received a notification via email, or on the CJR Connect site, about the availability of the CJR participant monitoring reports, performance year five update as a pre-recorded webinar. If you did not receive this notification, you can find the link to this recording and the web links area of this webinar, which is in the upper right-hand corner.

You can access this recording on CJR Connect, or by emailing LS-CJR@Lewin.com and we will send you the link. This recording, including all materials and resources are available on this CJR Connect site, if you do not have a CJR Connect account and would like to receive one, you may request one by going to the website URL listed on slide 39, or clicking it in the upper right hand corner of the web links area, and click on the new user tab. You can also click directly on the link, in the web links area on the right hand side of your screen. A recent change to CJR Connect policy means that users who have not been active within 60 days or more, will have their accounts suspended. So in order to avoid suspension we encourage you to log in at least once every 60 days. If your CJR Connect has been suspended, and you would like to regain access, please follow the instructions that you see on slide 39. You may either email or call the CMMI Connect helpdesk, and be sure to include your name, organization, and CCN.

As a final reminder, please send any follow-up questions from this event, or regarding your data, to CJRSupport@cms.hhs.gov. Please follow the appeals process, if you are inquiring about a reconciliation episode, and if your organization has made any recent changes to your points of contact for the CJR model, please email those to CJR support as well, and include the changes and your CCN. Finally, I would like to encourage you to please take a few minutes to respond to the post-event survey, it should pop up shortly, or you may click on the link in the upper right-hand corner of your screen today. I would like

to thank Dayna, again, for this informative presentation on the final PY three and initial PY four reconciliation report. Thank you again for your time and attention to view this, as well as your dedication and ongoing efforts during this challenging time. This concludes this recording.

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[i] *Please note that this transcript is designed to help organizations implement the CJR model. The Center for Medicare & Medicaid Services (CMS), its employees, agents, and staff assume no responsibility for any errors or omissions in the content of this transcript. CMS makes no guarantees of completeness, accuracy, or reliability for any data contained or not contained herein. CMS shall not be held liable for any use of the information described and/or contained herein and assumes no responsibility for anyone's use of the information. This transcript does not serve as advice provided by CMS. CMS and the Department of Health and Human Services Office of the Inspector General have not verified this transcript as compliant with Title 42 CFR Part 510. Although every reasonable effort has been made to assure the accuracy of the information, the ultimate responsibility for compliance with the regulations associated with the CJR model lies with the provider of services.*