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PY6 Reconciliation Overview

Comprehensive Care for Joint Replacement Model

November 20, 2023

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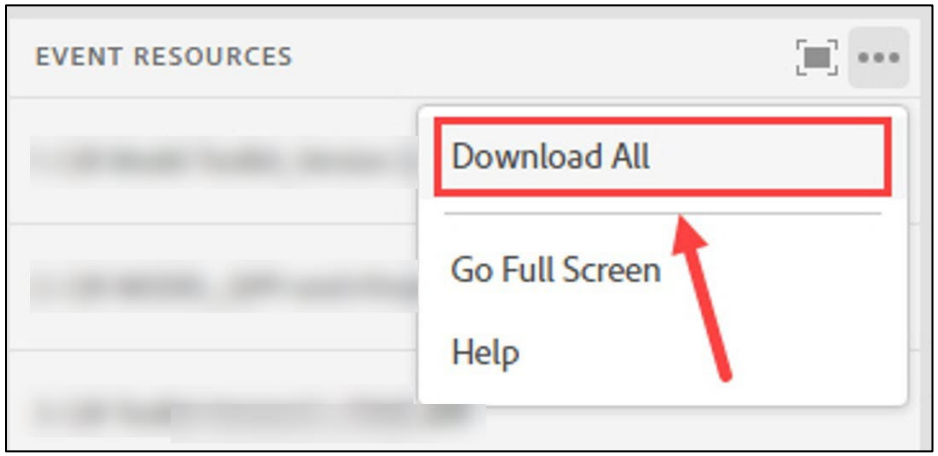

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Agenda

1. Announcements
2. Payment and Repayment
3. Reconciliation Review and Updates
4. Data and Reports
5. Appeals Process
6. Reconciliation Review

Announcements

- PY6 Reconciliation Report available on the CJR Data Portal as of November 7, 2023
  - PY5.2 Final Reconciliation Report available separately
- Monthly data feed no longer includes Performance Year (PY) 6 episodes as a result of PY6 reconciliation
- Send questions regarding today's webinar materials to CJRSupport@cms.hhs.gov

Updates for PY6 Reconciliation

- PY6 reconciliation incorporates methodology changes for the three-year extension of the CJR model
- PY6 has one reconciliation, rather than an initial and final reconciliation
  - For PY6-8, reconciliations will be referred to by PY, rather than calendar year in which reconciliation occurs
- Payments/repayments and appeals for PY6 reconciliation occur separately from PY5.2 final reconciliation

CJR Regulations

- Reconciliation amounts calculated according to methods described in 42 C.F.R. §§510, 512
  - Published in the CJR Original Final Rule
  - Revised in the EPM Final Rule enacting minor modifications, the CJR/EPM Voluntary Participation and other changes Final Rule, the April 2020 COVID-19 Interim Final Rule with Comment Period (IFC), the November 2020 COVID-19 IFC, and the **May 2021 CJR Model Three-Year Extension, Episode Definition and Pricing Changes Final Rule**
- Regulations and notices can also be found on https://innovation.cms.gov/initiatives/CJR

Payment and Repayment

Payment Timing

- Approximate timing of payment delivery
  - February 2024 for those not appealing
  - May 2024 for those appealing

Your Information

- Must be correct in Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
  - Banking details
  - Contact person name and address
- Ensures payments are received and repayments don’t accrue unnecessary interest

Payment

- An independent payment contractor, National Government Services (NGS), facilitates the reconciliation process
  - Payments are made via USBank
  - Not regular Medicare Administrative Contractor (MAC)
- The first addenda line on the EFT remit will show:

  `*ZZ*CMMI IPC NGS  *ZZ*USBANK`
- One payment with separate addenda lines showing which Medicare Trust Funds were drawn from:

  `CMS-CJR-A`

  `CMS-CJR-B`
- Total payment will reflect the sum of the CMS-CJR-A (Part A) and CMS-CJR-B (Part B) lines

Repayment

- If you owe a repayment:
  - You will receive a demand letter at your hospital's mailing address of record that will include information on how to submit payment
- If you wish to pay the amount due prior to receiving the demand letter repayment, instructions will be included in:
  - The email notification of the availability of the reconciliation reports, and
  - The reconciliation report itself

Payment Offset

- You may receive a payment less than the amount shown in your reconciliation report
  - Due to an outstanding CJR model debt or unpaid interest from a previous PY, either from your CCN or another CCN that shares the same TIN
  - Due to a current CJR model repayment owed by a CCN that shares the same TIN
  - Outstanding amount is netted against the reconciliation payment
- For example:

PY6 reconciliation payment amount	$30,000
PY5.2 final outstanding debt/interest	-$5,000
EFT remit	$25,000

Reconciliation Review and Updates

Reconciliation Review and Updates

1. Reconciliation Parameters
2. Episode Definitions and Adjustments
3. Target Prices
4. Net Payment Reconciliation Amount Adjustments

PY6 Reconciliation Parameters

Update: Included Episodes and Target Prices

- Episodes that ended October 1, 2021 – December 31, 2022
- Episodes starting from 7/4/2021 – 10/3/2022 receive the same set of PY6 target prices
  - A small number of episodes use target prices from Performance Year Subset 5.2 (episodes with start dates prior to July 4, 2021)
  - Episodes are assigned to an episode period in the report (indicating applicable target prices and wage factors) based on episode start date

Update: Single Reconciliation

- For PY6-8, episodes only go through **one reconciliation**
  - PY6 reconciliation uses claims processed into the CMS IDR as of **July 1, 2023,** six months after the close of the performance year
- This differs from PY1-5, which had both initial and final reconciliation for each performance year
- As a result, the reconciliation payment/ repayment in the report is final – there will not be a second reconciliation next year

Episode Definitions and Adjustments

Update: Inclusion of Outpatient Episodes

- Beginning with PY6, the CJR model includes outpatient lower extremity joint replacement (LEJR) procedures
  - Outpatient anchor procedures are identified using HCPCS codes 27447 (TKA) or 27130 (THA)
  - The 90-day post-discharge period for outpatient episodes includes the day of the anchor procedure
- Outpatient episodes are assigned to the same prospective target prices as inpatient episodes with similar characteristics

Update: Inclusion of Outpatient Episodes

- Outpatient episodes and inpatient episodes are assigned to an “episode type” based on anchor DRG/HCPCS code and fracture status
- Some episode types include both inpatient and outpatient episodes, but are **referred to by the inpatient DRG**
- Episodes with the same episode type and period receive the same prospective regional target price
  - Prospective target prices are then adjusted at the episode level at reconciliation

Update: Inclusion of Outpatient Episodes

Episode Type	Episodes included, by anchor procedure
DRG 469	• **Inpatient episodes** with **DRG 469** (Total hip/knee/ankle arthroplasty (THA/TKA/TAA) without fracture and with major complication or comorbidity (MCC))
DRG 470	• **Inpatient episodes** with **DRG 470** (THA/TKA without fracture and without MCC) • **Outpatient episodes** with **HCPCS 27447** (TKA) • **Outpatient episodes** with **HCPCS 27130** (THA) without fracture
DRG 521	• **Inpatient episodes** with **DRG 521** (THA with fracture and with MCC)
DRG 522	• **Inpatient episodes** with **DRG 522** (THA with fracture and without MCC) • **Outpatient episodes** with **HCPCS 27130** (THA) **with fracture**

Review: Excluded Episodes

- Three examples of excluded episodes:
  - Beneficiary covered by Medicare health plans that are not "traditional" fee-for-service, including Medicare Advantage and other plans
  - Beneficiary date of death during the episode
  - Readmitted for another anchor stay
- For more details see:
  - Episode Definition Specifications and the DROPREASON variable in the Data Dictionary
  - EPIEXC file in PY6 Reconciliation Claims Data.zip, containing excluded episodes and applicable DROPREASON(s)
  - § 510.205: Beneficiary inclusion criteria
  - § 510.210: Determination of the episode

Review: Episode-level Adjustments

- The following adjustments will be made to total episode cost:
  - Capping episode payments at the target price for episodes that occur during an emergency or that include a claim with a COVID-19 diagnosis
  - Capping episode payments at the high-cost threshold
  - Adjustments for suspension of sequestration
- Inpatient payment reflects Medicare DRG payment adjustment for hospital acquired conditions
- For more info, see the Episode Definition Specifications in the README zip file

Update: High-cost Episode Cap

- For PY6-8, high-cost episode spending is capped at the 99th percentile
  - This differs from PY1-5, for which high-cost episodes were capped at two standard deviations above the regional mean
- This cap is calculated separately for each region and episode type combination

Update: Adjustments for Sequestration

- Medicare sequestration was suspended or partially suspended from May 2020 to July 2022
  - Sequestration is the automatic 2% payment reduction in Medicare payments
- Episode spending and target prices are adjusted during reconciliation based on episode start date to reflect the full or partial suspension of sequestration

Episode start date	Adjustment to standardized payment amounts and target prices
May 1, 2020 – March 31, 2022	2% sequestration reduction removed
April 1, 2022 – June 30, 2022	Sequestration reduction adjusted to 1%
On or after July 1, 2022	No adjustment to sequestration (standard 2% reduction applies)

Target Prices

Review: Prospective Target Prices

- CMS establishes episode target prices for participant hospitals each performance year
- Prospective target prices:
  - Apply based on anchor procedure date
  - Assume a 3% discount for quality
- Prospective target prices are posted publicly on the CMS website prior to reconciliation*
- For applicable prospective target prices, reference EPISODE_PERIOD_TP (or anchor begin date)

*Target prices for performance year subset 5.2 (applied to episodes with start dates prior to July 4, 2021) are also provided with wage factors incorporated on the CJR data portal

Update: Adjustments to Target Prices

- At reconciliation, PY6-8 prospective target prices are adjusted for:
  - Beneficiary-level risk adjustment factors*
  - Normalization factor*
  - Market trend factor*
  - Geographic wage factors
  - Quality performance
- For adjusted reconciliation target prices, see RECON_TP in the RECON_EPI csv file

*Not applied to target prices for performance year subset 5.2 (applied to PY6 episodes with start dates prior to July 4, 2021)

Update: Beneficiary-Level Risk Adjustment Factors

- Adjust target prices at the episode level to account for patient-driven episode expenditure variation within episode types
- Uses three factors:
  - CJR hierarchical condition category (HCC) count
  - Dual-eligibility
  - Age bracket
- Risk adjustment multipliers are calculated prospectively and posted on the CMS website

Update: Beneficiary-Level Risk Adjustment Factors

- CJR HCC count
  - Based on patient's total number of clinical conditions, as determined by a patient's number of CMS Hierarchical Condition Categories (CMS-HCC)
  - HCC conditions are identified by CMS based on a beneficiary's Medicare claims data during the CY of the episode start date, across providers and settings
  - Brackets are 0, 1, 2, 3, and 4+ HCCs
- Dual-eligibility
  - Based on patient's eligibility for full Medicaid benefits on the first day of the episode
- Age bracket
  - Based on patient's age on the first day of the episode
  - Brackets are age <65, 65-74, 75-84, and 85+

Update: Normalization Factor

- Applied at the national level so that risk adjustment does not result in an increase or decrease to the national average target price
- Calculated as:

$$\frac{national\ mean\ target\ price}{national\ mean\ \boldsymbol{risk-adjusted}\ target\ price}$$

- Single value across all episode types and regions

Update: Market Trend Factor

- Adjusts target prices at reconciliation to adjust for regional spending trends
- Calculated as:

$$\frac{average\ cost\ for\ \boldsymbol{performance\ year}\ episodes}{average\ historical\ cost\ for\ \boldsymbol{target\ price\ base\ year}\ episodes}$$

- This is calculated separately for each region and episode type combination

Update: Quality Performance

- Prospective target prices include a standard 3% discount, which can be reduced or eliminated based on quality performance
  - Higher performance ➔ smaller discount ➔ higher target price ➔ higher reconciliation payments or lower repayments
- In PY6-8, CMS provides hospitals with a **greater reduction in the discount factor for good (1.5%) and excellent (3%) performance**
- Hospitals with below acceptable performance are not eligible for reconciliation payments

Review: Quality Performance Points

- Quality measure performance points + improvement points + PRO submission points = Composite Quality Score (CQS)
- Quality measure performance points are based on quality measure results
  - Points are assigned based on performance percentile
- CMS assigns hospitals without reportable quality measure values to the 50th percentile
- PRO data for PY6 is based on an eligible THA/TKA procedure window between 7/1/2021 and 6/30/2022
- For detailed information, refer to the QM file

Review: CQS Points

Quality Performance	Weight (%)	Max Points
THA/TKA Complications measure (NQF #1550)	50	10.0
HCAHPS Survey measure (NQF #0166)	40	8.0
THA/TKA voluntary PRO and limited risk variable data submission	10	2.0

Quality Improvement	Max Points
THA/TKA Complications measure (NQF #1550)	1.0
HCAHPS Survey measure (NQF #0166)	0.8

Review: CQS Ranges & Discount Factors

CQS	Quality category	PY6 discount factor	Reconciliation payment eligible
> 15.0	Excellent	0% ⬇	Yes
≤ 15.0 and ≥ 6.9	Good	1.5% ⬇	Yes
< 6.9 and ≥ 5.0	Acceptable	3%	Yes
< 5.0	Below Acceptable	3% (repayment only)	No

Net Payment Reconciliation Amount (NPRA) Adjustments

Review: Reconciliation NPRA Calculation

- Your NPRA is the:
  - Difference between adjusted episode spending and the reconciliation target price
  - With adjustments (if applicable) for:
    - Stop-loss/gain limits
    - Excess post-episode spending
    - Payment eligibility (hospitals with 'Below Acceptable' quality not eligible for payment)
- Reconciliation amounts are expressed in real dollars (wage factors included)

Review: Loss and Gain Limitations

- Loss and gain limitations prevent the NPRA for each performance year from exceeding a stated percentage of the target spending
- **Stop-loss:** Reconciliation repayments limited to **20%** of total target spending
- **Stop-gain:** Reconciliation payments limited to **20%** of total target spending

Review: Excess Post-Episode Spending

- Post-episode spending includes Medicare Part A/B claims for services in the 30 days after an episode ends
- If average post-episode spending exceeds three standard deviations above the regional average, this is considered “excess post-episode spending”
- The excess amount is subtracted from the NPRA

Update: ACO Recoupment

- The Accountable Care Organization (ACO) shared savings adjustment used in PY1-5 will no longer be applied at reconciliation
  - Previously referred to in the reconciliation report as “ACO recoupment”, this reduced the reconciliation payment amount or increased the repayment amount by the amount of the hospital's discount percentage that is paid to an ACO as shared savings
  - This applied to a small percentage of hospitals
- However, PY6-8 still excludes certain episodes that overlap with select ACO models
  - Excludes beneficiaries *prospectively* assigned to:
    - A Shared Savings Program ACO in the ENHANCED track

Recap of PY6 Updates

- Single reconciliation for each PY
- Inclusion of outpatient episodes
- Change in high-cost episode cap
- Adjustments for suspension of sequestration
- New adjustments to prospective target prices at reconciliation
- Greater quality adjustments for good and excellent performance
- No ACO recoupment

Data and Reports

Files on the Data Portal

File	Contains
Reconciliation Claims Data.zip	Claims and beneficiary data for PY6 episodes, using run-out dates for reconciliation
Reconciliation Reports.zip	Reconciliation HTML report, summary data files, quality measure summary file, and calculation error (CE) form and instructions
PRO Hospital-Specific Report.zip	Hospital-Specific Report (HSR) providing detailed measure results for hospitals that did not successfully submit Patient Reported Outcomes (PRO) data
README & Data Dictionary.zip	Specifications and data dictionary, quality measure deciles, and log of changes

- PY5.2 Final Reconciliation Report zip folder available in Archived Reconciliation Reports file

New RECON_EPI file

- PY6 Reconciliation Reports folder includes a new episode-level csv file: **RECON_EPI**
- RECON_EPI shows episode spending, target price adjustment factors, and reconciliation target prices for each episode
- See the CJR Data Dictionary in the README zip file for more information

PY6 Reconciliation Report

Report Demo

(screen share)

Appeals Process

Submitting an Appeal

- To dispute payments matters, hospitals must submit a notice of calculation error (CE) within 45 calendar days of reconciliation report issuance date
  - DUE: December 21, 2023 11:59 pm ET
  - CE form must be emailed to CJRreconciliation@cms.hhs.gov
  - Only hospitals may submit appeals
- Limited to PY6 episodes only
- Note that there is no administrative or judicial review for topics such as model design or scope (see 42 CFR §510.310(d))

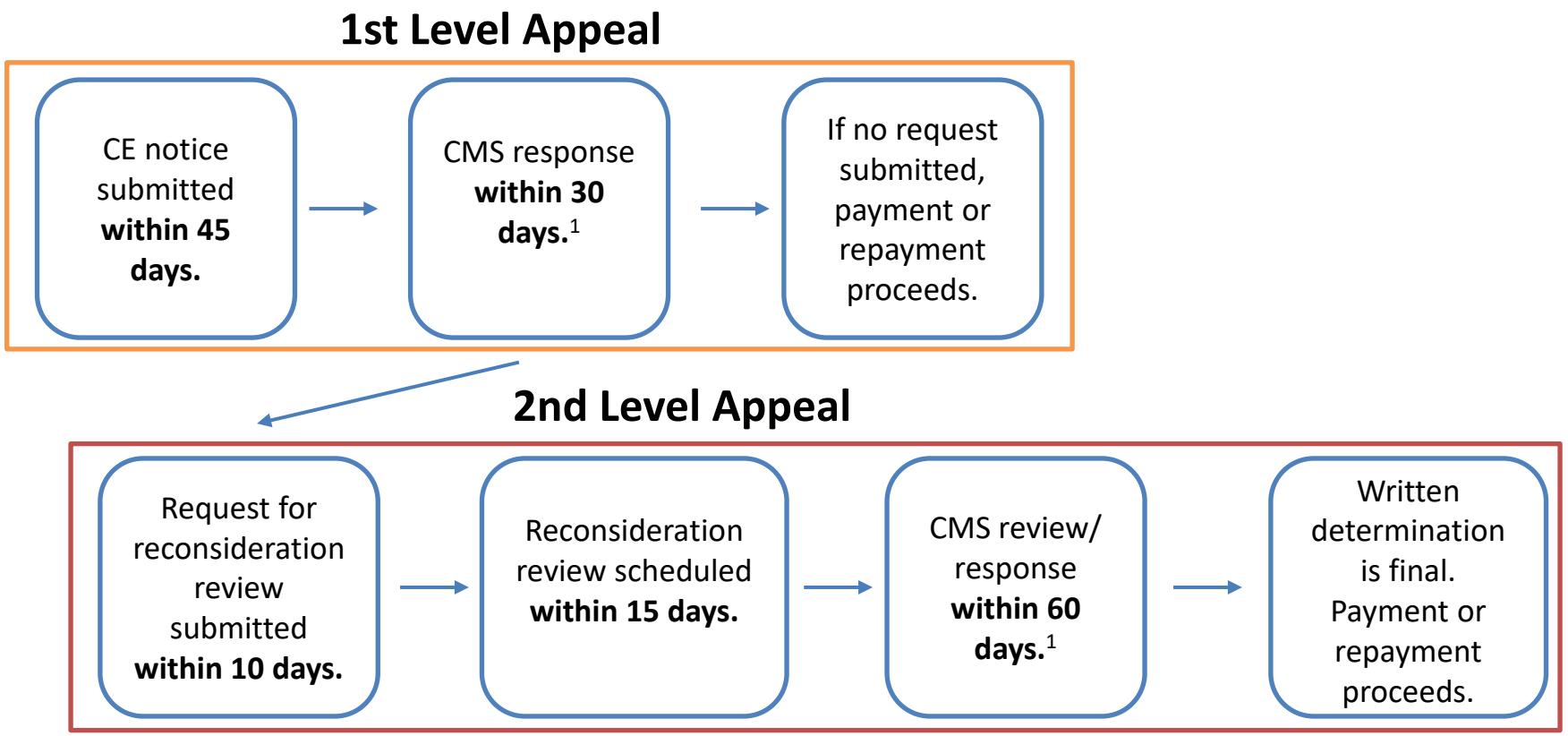
Sending PII/PHI

- Need to send PII or PHI?
  - Upload notice of calculation error (CE) form or other documentation with PII/PHI to the CJR Data Portal
  - Email notification of upload to CJRreconciliation@cms.hhs.gov
  - See CE Form Instructions in CJR Data Portal for additional instructions

Types of Calculation Errors

- Including or excluding Medicare beneficiaries or episodes in the baseline or performance year
- Including or excluding specific claims within episode spending in the baseline or performance year
- Reconciliation amount calculation error
- Applying or using the composite quality score (CQS) during reconciliation or in determining the performance decile

Submitting an Appeal



[1]CMS reserves the right to extend the review period upon notice.

Reminder for PY6 appeals

- As PY6 will undergo a single reconciliation, this is the only opportunity to submit appeals for this performance year

Reminder

- Send questions regarding today's webinar materials or an aspect of your reconciliation report to CJRSupport@cms.hhs.gov

- Inquiring about a reconciliation episode? Follow the appeals process

Thank you for joining us.

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Thank you for joining.

You will be able to view the OnDemand Recording on CMMI Connect.