Bundled Payment Best Practices Web Conference Series

How to Make CJR a Success — Implementing a Winning Strategy

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FOLEY
FOLEY & LARDNER LLP

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General Overview

- Comprehensive Care for Joint Replacement ("CCJR") Model
- Acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity
- Mandatory Participation of roughly 800 hospitals in 67 MSAs
- Program begins April 1, 2016
- 5 year program

Reconciliation Payment Model

- Retrospective, two-sided risk model with hospitals bearing financial responsibility
  - Providers and suppliers continue to be paid via Medicare FFS
  - At the end of the performance year, actual episode spending will be compared to the episode target prices.
- Reconciliation payments will be phased-in and capped (stop-gain):
  - Years 1 and 2: Capped at 5%
  - Year 3: Capped at 10%
  - Years 4-5: Capped at 20%
- Hospital responsibility to repay Medicare will be phased-in and capped (stoploss):
  - Year 1: No responsibility to repay Medicare
  - Year 2: Capped at 5% of target prices
  - Year 3: Capped at 10% of target prices
  - Years 4 and 5: Capped at 20% of target prices
- Additional protection for rural, sole community (SCH), Medicare dependent (MDH), and rural referral center (RRC) hospitals with stop-loss of 3% for Year 2 and 5% for Years 3-5.

Establishing Target Prices

- Each participant hospital will have its own target prices set by CMS based on 3 years of historical data
- 3% discount to serve as Medicare's savings
- Based on a blend of hospital-specific and regional episode data transitioning to regional pricing by the 4th year.

Program Waivers: SNF

- CJR model waives the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization beginning in performance year 2.
- Beneficiaries discharged pursuant to the waiver must be transferred to SNFs rated 3-stars or higher for at least 7 of the previous 12 months on the CMS Nursing Home Compare website.
- Beneficiaries must NOT be discharged prematurely to SNFs, and they must be able to exercise their freedom of choice without patient steering.

Program Waivers: Home Visits

- For CJR post-discharge home visits, CMS waives the "incident to" direct supervision rule for physician services.
- Allows clinical staff of a physician or non physician practitioner to furnish a visit in the beneficiary's home under the general supervision of a physician.
- Permitted only for beneficiaries who do not qualify for Medicare coverage of home health services.
- Waiver allows a maximum of 9 visits during the episode, billed under the Physician Fee Schedule using a HCPCS code created specifically for the model.

Program Waivers: Telehealth

- CJR model waives the geographic site requirement for any service on the Medicare-approved telehealth list and the originating site requirement only to permit telehealth visits to originate in the beneficiary's home or place of residence
- Telehealth visits under the waiver cannot be a substitute for in-person home health services paid under the home health prospective payment system
- Requires all telehealth services to be furnished in accordance with all other Medicare coverage and payment criteria except that payment for the special home health visits under the model will be paid at a special rate
- The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary's home

Floors and Caps

- Per calendar year, total alignment payments to a hospital cannot exceed 50 % of hospital repayment amount to CMS. Hospital required to retain 50% of downside.
- 25% cap per collaborator outside of the above.
- Not tied to volume or value but quality of care.
- Cap of 50% of gainsharing payment to PGP or physician (compared to total PFS)
- Internal cost saving must be only hospital actual, verifiable and not "paper" savings realized from care redesign undertaken by hospital. (i.e. saving must be realized by hospital not collaborator).

Hospital Requirements: PAC Requirements

- Written agreement.
- Hospital must develop a written set of policies for selecting providers/ supplies.
- Criteria must be based on quality not volume or value.
- For PGPs, PGP must contribute to care redesign and be clinically involved in CJR beneficiaries' care (e.g. care coordination, design of care)
- Agreement must tie provider compliance plan to CJR.
- Hospitals can assign various percentages of gainsharing to different collaborators.

CJR: FRAUD & ABUSE WAIVERS

- Three Waivers:
  1. Waiver for Distribution of Gainsharing Payments and Payment for Alignment Payments Under Sharing Arrangement ("Gainsharing and Alignment Payment Waiver")
  2. Waiver for Distribution Payments from a Physician Group Practice to a Practice Collaboration Agent ("PGP to Collaboration Agent Waiver")
  3. Waiver for Patient Engagement Incentives Provided by Participant Hospitals to Medicare Beneficiaries in Episodes ("Patient Engagement Waivers")

GAINSHARING AND ALIGNMENT PAYMENT WAIVER

- Following Six Requirements Must be Met
  1. Requirements of 42 CFR 510.500 Must be Met. These include:
     - Sharing Arrangement Meeting Requirements be Signed
     - Hospital Must Update its Compliance Plan for Sharing Arrangement
     - Hospital has Policies to Select Providers and Suppliers of CJR Collaborators
  2. Requirements of 42 CFR 510.405 (Beneficiary Choice and Beneficiary Notice) Must be Met
  3. Hospital May Not Add Conditions, Limitations or Restrictions Other than Those Required or Permitted in CJR Rule

GAINSHARING AND ALIGNMENT PAYMENT WAIVER (cont.)

4. Criteria for Selecting a Provider/Supplier as a CJR Collaborator Must Include Criteria Related to Quality to be Delivered by Collaborators During an Episode (and Collaborator Agrees to Quality Criteria)
5. Collaborator Must Meet Quality Criteria for Calendar Year for Which Gainsharing Payment is Determined, and Criteria Must be Related to Episode and be in Sharing Agreement
6. The Methodology for Determining Gainsharing Payments Must be Based, at Least in Part, on Those Criteria

Comprehensive Care for Joint Replacement (CJR) Webinar

June 16, 2016

remedy partners

What Does Remedy Do?

Remedy Partners empowers health care providers to develop and operate patient-centric episode of care payment programs leading to improved clinical outcomes, lower costs and increased patient satisfaction.

+ Remedy and its provider partners achieve these results through:
  - Workflow optimization
  - Advanced analytics
  - Technology tools
  - Patient-centric care coordination
  - Downstream Partnerships
  - Aligning financial incentives

+ Remedy provides a suite of tools, resources, and a deep bench of expertise to meet these goals

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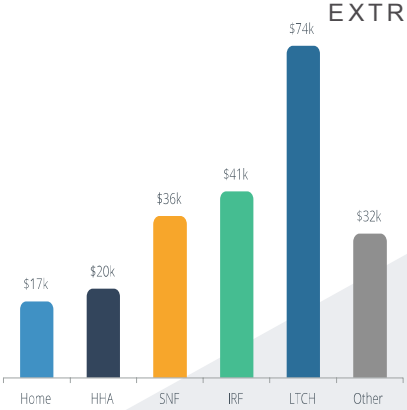
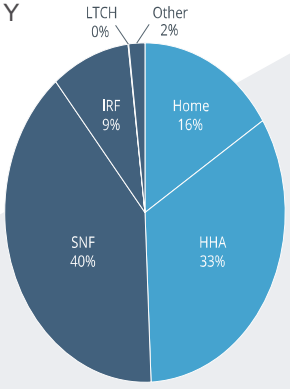
Breakdown of Episodic Costs

MAJOR JOINT REPLACEMENT OF THE LOWER EXTREMITY



Average Episode Cost by First Site of Discharge



Percent of Episodes by First Site of Discharge

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Source: Time Period Oct 2013-Mar 2014 (Claims Version 093014)-All Remedy Partners Phase I Providers (600+)

Success

Succeeding in CJR begins with understanding your claims data.

Episodes	Adj. Historic
Discharge to Home w/ Ltd. Services	0.8%
Discharge to Home w/ Home Health	11.2%
Discharge to SNF	78.1%
Discharge to Inpatient Rehabilitation	9.7%
Discharge to LTCH	0.0%
Discharge to Other Sites	0.2%
Episodes with a Readmission	12.8%
Readmissions per Episode	0.15
SNF Days	22.2

Major joint replacement of the lower extremity	2013Q4 Adj Baseline Avg
Total Episode Cost	$32,861
Anchor Inpatient	$12,726
Anchor Part B	$2,462
Anchor Durable Medical Equipment	$8
Skilled Nursing Facility	$9,650
Inpatient Rehabilitation Facility	$1,314
Long-Term Care Hospital	$57
Home Health	$1,989
Outpatient	$631
Post-Anchor Inpatient	$1,197
Post-Anchor Part B	$2,674
Post-Anchor Durable Medical Equipment	$154

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Source: Medicare Claims Data 2000-2012; Remedy Analysis

Provider Variation

Episodes	SURGEON A	SURGEON B
Discharge to Home w/ Ltd. Services	1.7%	66.7%
Discharge to Home w/ Home Health	18.8%	0.0%
Discharge to SNF	53.4%	33.3%
Discharge to Inpatient Rehabilitation	24.0%	0.0%
Discharge to LTCH	0.4%	0.0%
Discharge to Other Sites	1.7%	0.0%
Episodes with a Readmission	23.2%	0.0%
Readmissions per Episode	0.32	0.00
SNF Days	28.4	34.0

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Source: Medicare Claims Data 2000-2012; Remedy Analysis

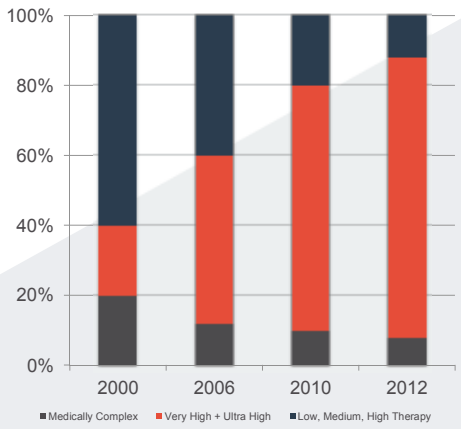
RUG Rates – Miami Dade County

Rehab plus extensive services

- RUX = $766.67
- RHX = $618.25
- RLX = $498.06

Rehab

- RUC = $581.23
- RHC = $434.49
- RLA = $239.12



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Source: Medicare Claims Data 2000-2012; Remedy Analysis

Post-Acute Variation

Identify variation in post-acute providers and partner accordingly

Quartile	SNF Facilities	Avg. Episode Cost	Avg. Readmission Rate
1 (Top)	35	$16,987	30.6%
2	35	$22,210	38.6%
3	34	$25,497	45.2%
4 (Bottom)	34	$31,417	59.5%

Source: 2010-11 Medicare LDS claims data; Remedy Analysis. Seattle, WA market

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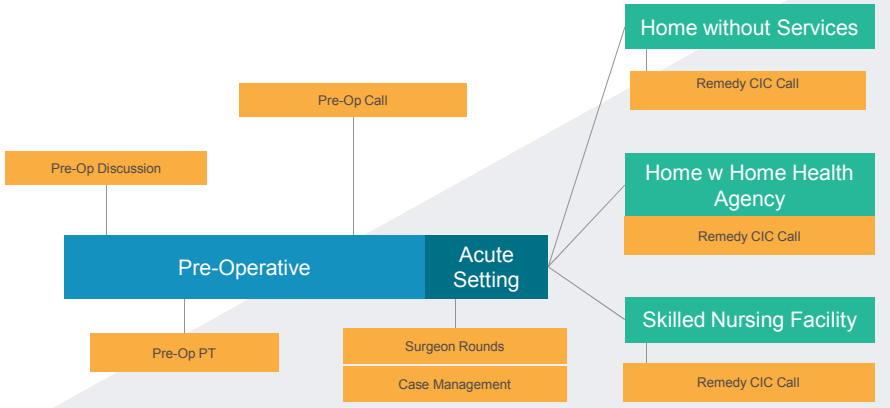
Care Redesign

Care redesign increases coordination and decreases costs without significantly disrupting your current processes



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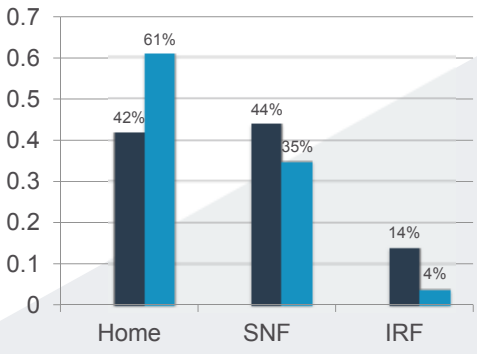
CIC=Care Innovation Center (call center)

Experience

Remedy has more experience than anyone with helping healthcare providers effectively navigate and succeed in bundled payments



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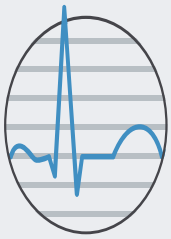
What We Offer

Data Analytics

Evaluating, developing and operating episode payment programs requires sophisticated analytics. Remedy has assembled a team of statisticians, actuaries and clinicians to deliver the clinical and financial insights necessary to design successful bundled payment programs.

- Features
  - Manage Data Flows
  - Predictive Analytics and Machine Learning
  - Regional and Targeted Benchmarking
  - Process and Performance Reporting
  - Reconciliations



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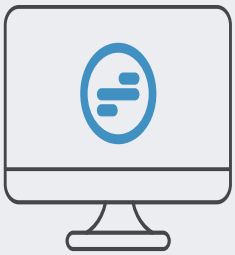
What We Offer

Episode Connect

Our proprietary suite of software applications is a powerful care coordination tool delivered via web and mobile apps. It's the 'Connective tissue' between program managers, nurses, physicians, patients and family that makes a bundled payment program successful.

- Features
  - Multi-Channel Communications
  - Intuitive Workflow Tools
  - Care Plans, Protocols and Guidelines
  - Clinical Analytics and Performance Reports
  - Multiple User Portals
  - Clinical Data Aggregation
  - Rapid Patient Identification
  - Assessment and Engagement Tools



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What We Offer

Care Coordination

Remedy's comprehensive Care Coordination Program is an integration of proven strategies and easy-to-use tools to help assure a patient's successful recovery from a hospitalization.

+ Features
  - Condition-Specific Care Plans
  - Role Specific Training Programs
  - Advances Transition Planning
  - Live Phone Support
  - Patient/Family Resources and Guidance
  - Patient Progress Tracking
  - National Performance Network of SNFs, HHAs and Community Service

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CONTACT US FOR MORE INFORMATION

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Q&A Session