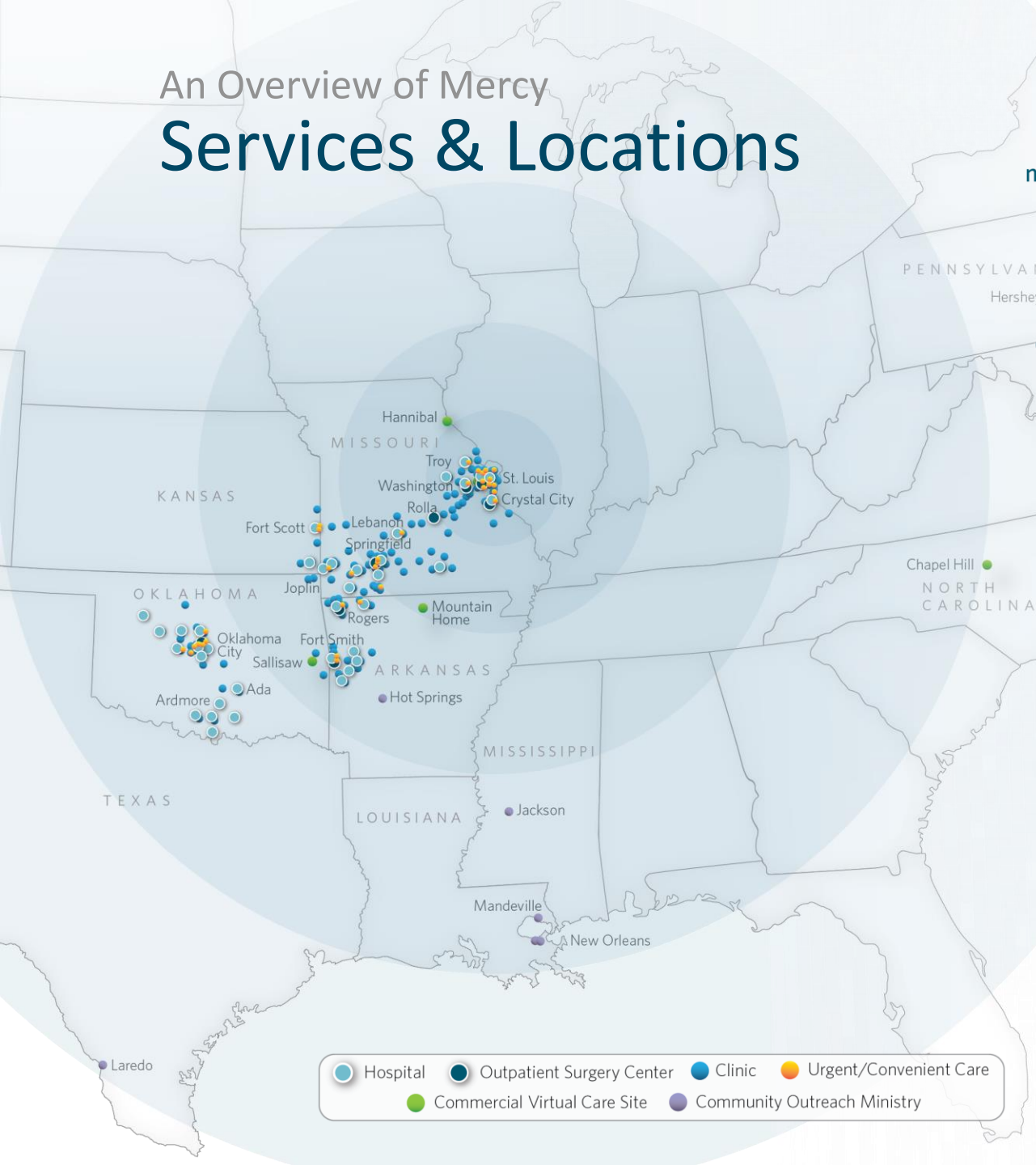
Comprehensive Care for Joint Replacement (CJR)

Mercy | *Your life is our life's work.*

The Leadership Institute
May 17, 2017

An Overview of Mercy

Services & Locations



Headquartered in St. Louis with a multi-state footprint, Mercy is the 5th largest Catholic health system in the US.

Outreach ministries in Arkansas, Louisiana, Mississippi and Texas.

Opened the first of its kind virtual care center.

Serving millions each year.

1827
founded

43
hospitals

350
outpatient facilities

3,500
integrated providers[1]

40,000
co-workers

>$5B
revenue

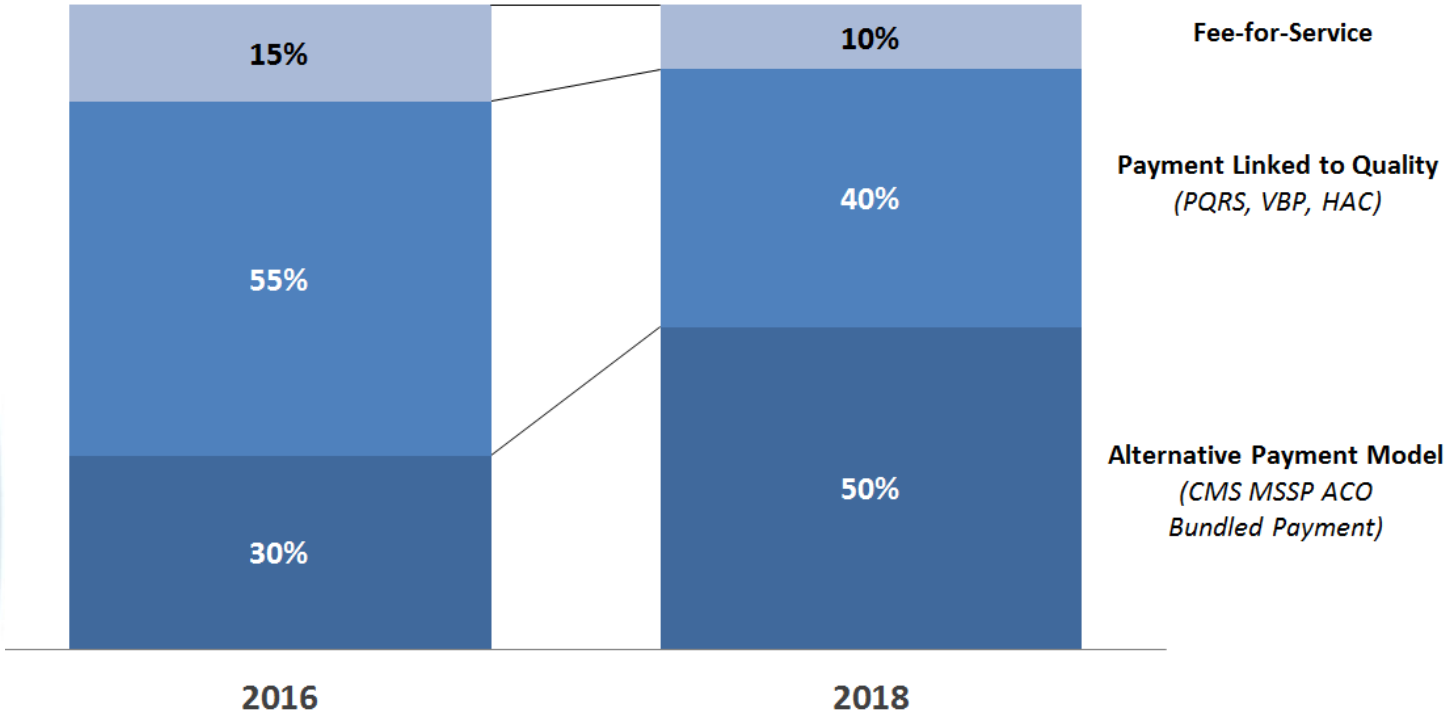
Top 5
best performing large health system[2]

1 Physicians & advanced practice clinicians
2 Truven Health 15 Top Health Systems 2016

Mercy

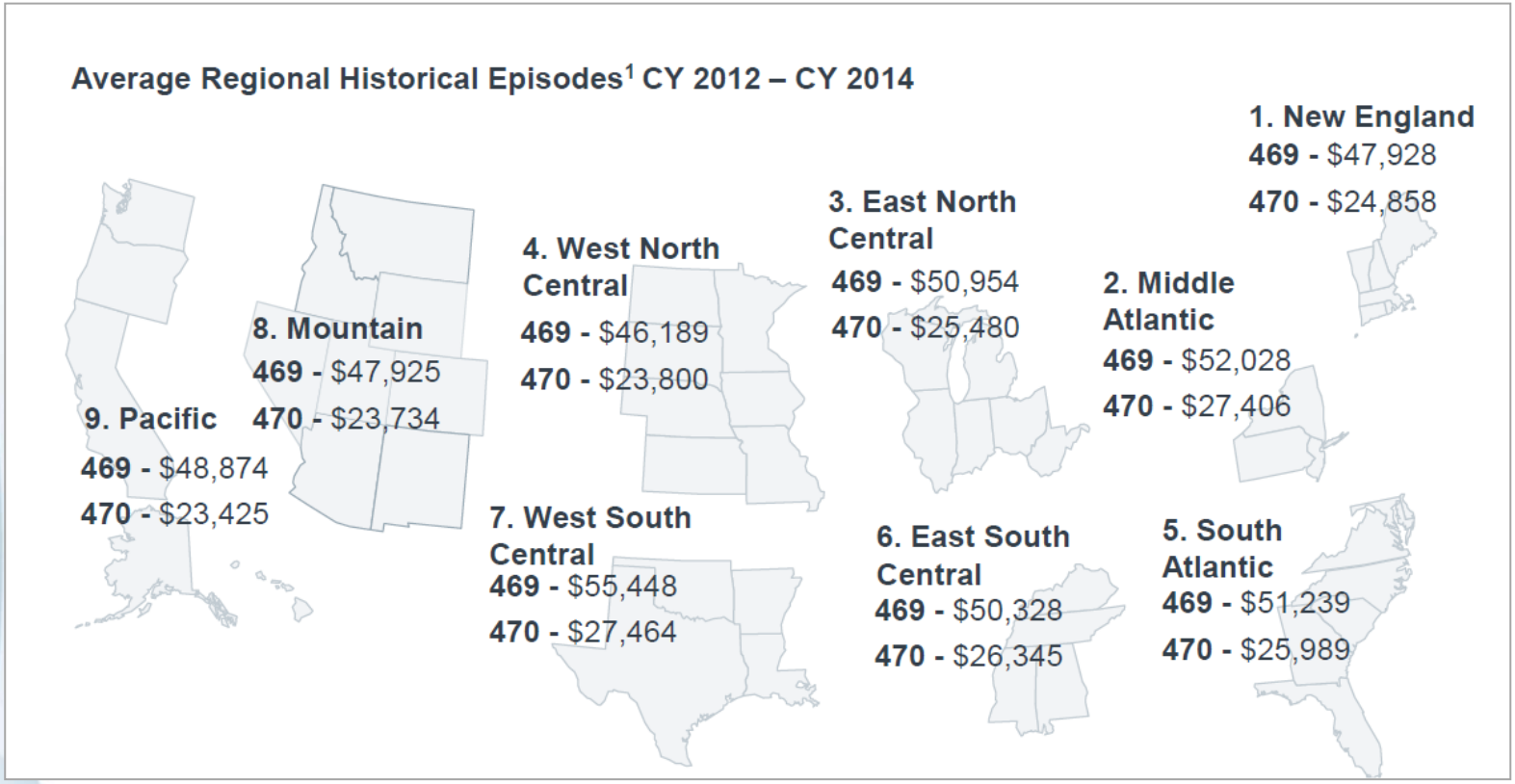
TRUVEN HEALTH ANALYTICS 15 TOP HEALTH SYSTEMS 2016

Why is CMS doing this?



CMS goal for 2018 is to have 90% of Medicare payments linked to quality

Why is CMS doing this? (cont.)



Estimated CJR program will generate $30M in savings for CMS

1. Displayed figures do not reflect removal of special payment provisions outside of IPPS (VBP, HAC, Readmissions, DSH, IME etc.), nor include risk adjustment for hip fractures http://innovation.cms.gov/initiatives/ccjr/

CJR Program Design

Mercy

Participants

- Hospitals in the program
  - IPPS hospitals in 67 different metropolitan statistical areas
- Patients in the program
  - Medicare fee-for-service with DRG 469 or 470
- Patients excluded from the program
  - Medicare Advantage
  - ESRD
  - Patients part of CMS Bundled Payment for Care Improvement (BPCI) Model 1, risk-bearing Model 2 and 4 for joint replacement

Timeline of the Program

Episode Definition

- Starts at the hospital admission[1] *regardless of surgeon*
  - DRG 469: Major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)
  - DRG 470: Major joint replacement or reattachment of lower extremity without MCC
- Ends 90-days post discharge from hospital
  - Services that are beyond the 90-days are prorated
  - Episode must end within the performance year to be counted within the performance year
    - Example: Performance year 1 only included episodes that ended on or before December 31, 2017

1. Includes services normally bundled into the IPPS within the 72-hour rule such as diagnostic services and non-diagnostic outpatient services related to the admission provided by the admitting hospital

Services in the Episode

All services paid under Medicare Part A and Part B

Included Services	Excluded Services
• Physicians' services • Inpatient hospitalization (including readmissions with some exceptions) • Inpatient Psychiatric Facility (IPF) • Long-term care hospital (LTCH) • Inpatient rehabilitation facility (IRF) • Skilled nursing facility (SNF) • Home health agency (HHA) • Hospital outpatient services • Independent outpatient therapy services • Clinical laboratory services • Durable medical equipment (DME) • Part B drugs • Hospice	• Certain inpatient admissions based on MS-DRG • Certain Part B services based on ICD-10 diagnosis codes • Services and clotting factors for hemophilia • Inpatient new technology payments • Outpatient transitional pass-through payments for devices

Payment

- Retrospective payment methodology
  - ***All services bill and receive reimbursement via current Medicare fee schedule***
  - At completion of a performance year, actual claim spending is compared against the episode target price
- Performance Years
  - Year 1: April 1, 2016 through December 31, 2016
  - Years 2-5: January 1 through December 31 for years 2017 through 2020
- Two-sided risk model
  - Reconciliation payment if actual spending is less than the target and quality requirements satisfied
  - Repayment if actual spending is greater than the target
  - *No downside risk in performance year 1*
  - Phased-in downside risk in performance year 2
  - Full downside risk in performance years 3 through 5

Target Price

- Each DRG (469, 470) to has its own target price
- Target price based on 3 years of historical data, updated every other year
  - Year 1 and 2: January 1, 2012- December 31, 2014
  - Years 3 and 4: January 1, 2014 and December 31, 2016
  - Year 5: January 1, 2016 and December 31, 2018
- Trend historical data to the most recent year
  - National trend factor applied to historical episode payments
  - Inflate 2 oldest years of historical episode payments to the most recent year using changes in national CJR episode payments
  - Apply national trend factors for each combination of MS-DRG anchor and hip fracture status
- Historical episode payments trended forward using ongoing payment updates
  - Calculate separate target prices for January 1- September 30 and October 1- December 31

Target Price (cont.)

- Include 3% discount factor
- Begin as a combination of hospital-specific and regional (US census region) historical payments and transition to regional-only rates

Target Rates	Year 1	Year 2	Year 3	Year 4	Year 5
Hospital specific episode data	66.6%	66.6%	33.3%	0%	0%
Regional specific episode data	33.3%	33.3%	66.6%	100%	100%

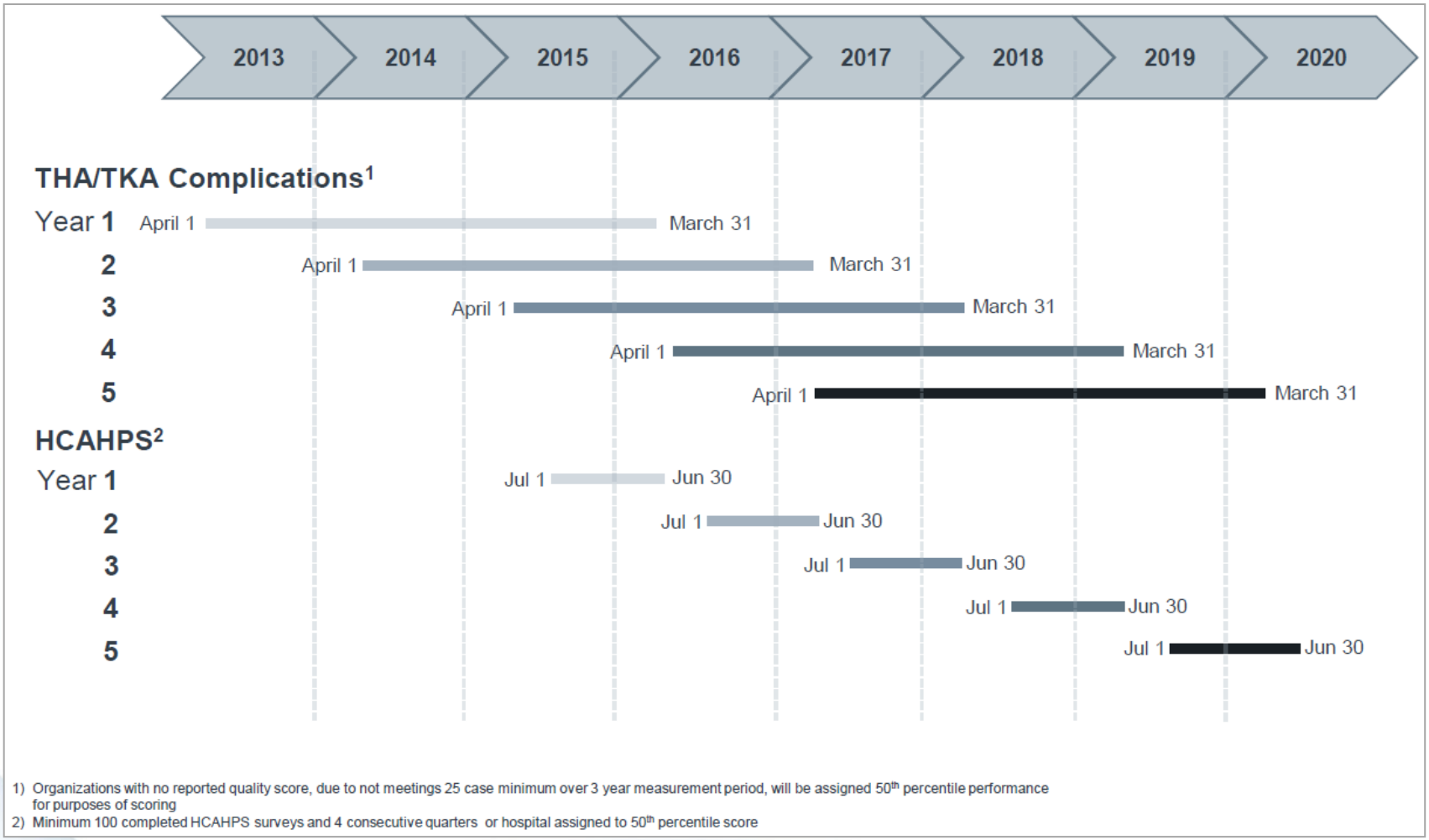
Quality Measures - Mandatory

- Two mandatory quality measures for the program
  - Hospital-level **risk standardized complication rate** following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)
    - 3-year rolling performance period
    - *year 1 will use THA/TKA Complications Rate for time period of April 1, 2013 - March 31, 2016*
  - **HCAHPS** survey measures
    - Summary score
    - 4 consecutive quarters of data
    - Not specific to patients with THA or TKA
    - *CJR year 1 will use HCAHPS for time period of July 1, 2015 - June 30, 2016*

Quality Measures - Optional

- Optional quality measure of Patient Reported Outcomes (PRO)
- PRO's include questions on symptoms, stiffness, pain, function, and quality of life
- Submission of data = success
  - Must meet specific elements and patient thresholds per year
    - 50% of THA/TKA patients or at least 50 patients in Year 1
    - 80% of THA/TKA patients or at least 200 patients in Years 4 and 5
- Successful submission can increase overall quality composite score

Quality Measure Timeline



1) Organizations with no reported quality score, due to not meetings 25 case minimum over 3 year measurement period, will be assigned 50th percentile performance for purposes of scoring
2) Minimum 100 completed HCAHPS surveys and 4 consecutive quarters or hospital assigned to 50th percentile score

Source: Advisory Board

Quality Measure Timeline (cont.)

- Patient-Reported Outcomes (PRO) for performance year 1 required only submission of pre-operative survey data
- Starting with performance year 2, hospitals will be required to submit pre *and* post-operative survey data
- Example: PRO submission requirement for PY2 (CY 2017)
  - Submit *post*-operative survey data for procedures performed between July 1, 2016 through August 31, 2016

    and

  - Submit *pre*-operative survey data for procedures performed between September 1, 2016 through June 30, 2017

Impact of Quality Measures

- Points are assigned based on percentile rank of quality measures
- A hospital receives points for the PRO measure by meeting the reporting threshold and submitting the data to CMS
- Quality Composite Score is calculated based on total points from the three quality measures with 20 points being the highest possible score

Percentile Rank	Points for THA/TKA Complications (+1 for improvement)*	Points for HCAHPS Survey (+0.8 for improvement)*	Points for Submitting PRO Data	Quality Composite Score
≥90th	10	8	2	*Total Number of Points from Three Quality Measures*
≥80th and <90th	9.25	7.4		
≥70th and <80th	8.5	6.8		
≥60th and <70th	7.75	6.2		
≥50th and <60th	7	5.6		
≥40th and <50th	6.25	5		
≥30th and <40th	5.5	4.4		
<30th	0	0		

** Improvement points awarded for substantial improvement (at least 3 deciles) from prior measurement period performance.*

Impact of Quality Measures (cont.)

- Quality Composite Score is used to determine the Quality Category and drives a hospital's Reconciliation (gain share) or Repayment for each performance year (PY)
- Effective discount percentage is the percentage difference in actual to target price per episode that must be first met before Reconciliation or Repayment occurs

Quality Composite Score Range (out of 20)	Quality Category	Eligible for Reconciliation Payment	Effective Discount % for Reconciliation Payment	Effective Discount % for Repayment Amount
>13.2	Excellent	Yes	1.5%	PY1: N/A* PY 2, 3: 0.5% PY 4, 5: 1.5%
≥ 6 and <13.2	Good	Yes	2%	PY1: N/A PY 2, 3: 1% PY 4, 5: 2%
≥ 4 and <6	Acceptable	Yes	3%	PY1: N/A* PY 2, 3: 2% PY 4, 5: 3%
<4	Below Acceptable	*No*	3%	PY1: N/A* PY 2, 3: 2% PY 4, 5: 3%

Reconciliation

- Reconciliation amount is the difference between actual and target expenditure calculated after each period
- Initial reconciliation 2 months after end of performance year; second calculation to address claims run-out and overlaps one year later
  - Year 1: Episodes ending December 31, 2016; reconciliation payment or repayment by the end of calendar Q2 2017, second calculation adjustment by calendar Q2 2018
- Reconciliation payments are capped (stop-gain)

Years 1,2	Capped at 5% of target
Year 3	Capped at 10% of target
Years 4,5	Capped at 20% of target

Repayment

- Hospital repayments are capped (stop-loss protection)
  - Year 1: No repayment (upside only)
  - Year 2: Capped at 5% of target
  - Year 3: Capped at 10% of target
  - Years 4 and 5: Capped at 20% of target
- Starting performance year 2:
  - Monitor 30-day post-episode spending on all Part A & B services to determine if it is 3 standard deviations above the regional average to prevent shifting of care outside window
    - If 3 standard deviations above, hospital must repay beyond that up to the stop loss

SHFFT Program

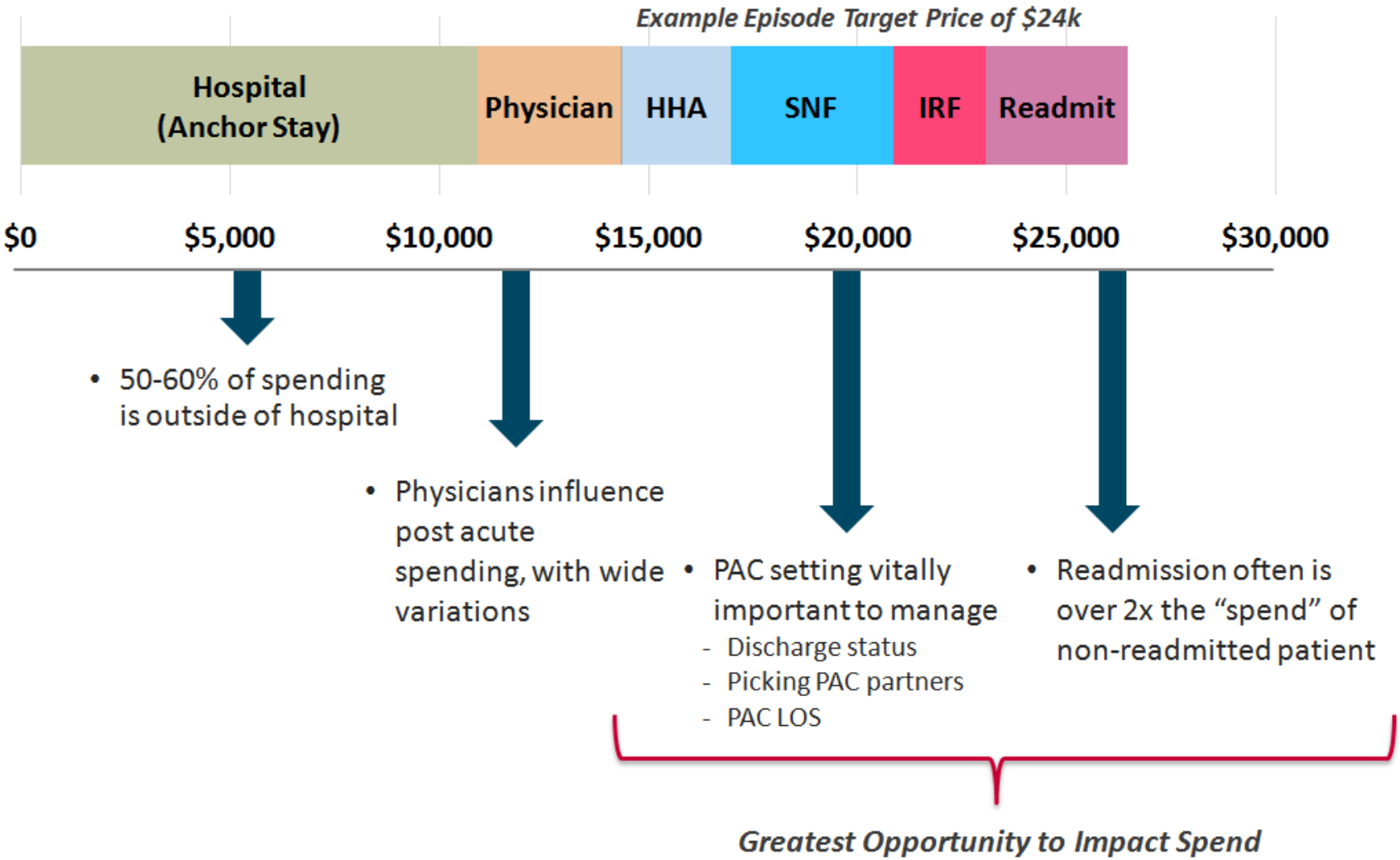
- Surgical Hip and Femur Fracture Treatment (SHFFT)
- CMS proposed program patterned after CJR to include MS-DRGs 480, 481 and 482 (hip and femur procedures)
- Model would impact IPPS hospitals within the same 67 MSAs[1] as the CJR program
- Applies only to Medicare fee-for-service patients
- Originally was to be implemented July 1, 2017 with end date of December 31, 2021
- Now delayed until at least October 2017 with potential to be delayed until January 2018

1. Metropolitan statistical areas (MSAs)

Drivers of Success

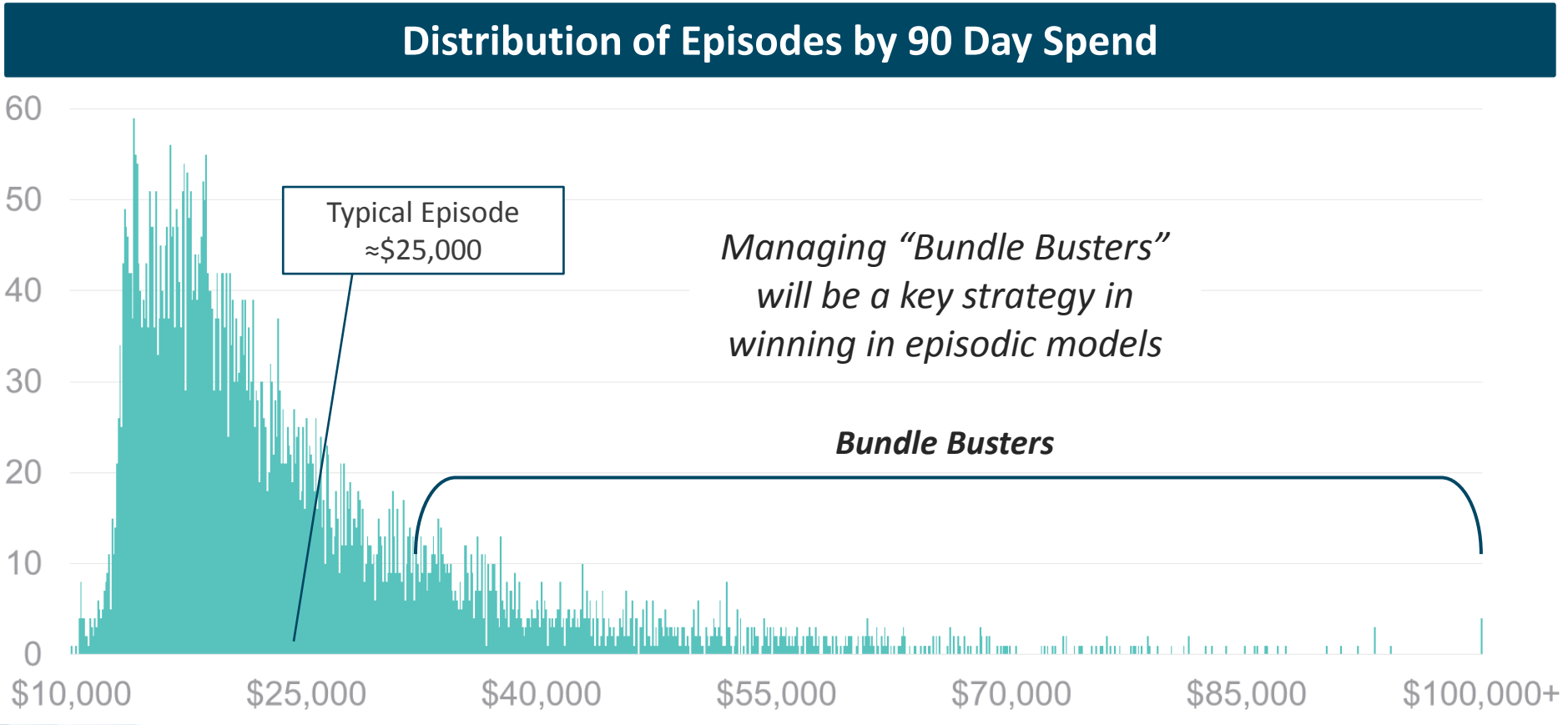
Mercy

Post-Acute Care and Readmissions



Source: DHG healthcare

Managing “Bundle Busters”



Source: DHG healthcare

Additional Drivers

- Leadership, accountability and organizational structure
- Strong understanding of the program
- Physician engagement and leadership
- Management of post-acute care and partnerships
- Nurse navigator(s)/care manager(s) to coordinate and manage care of patients through continuum
- Development of a clinical pathway
- Leverage claims data
- Focus on improving quality measures

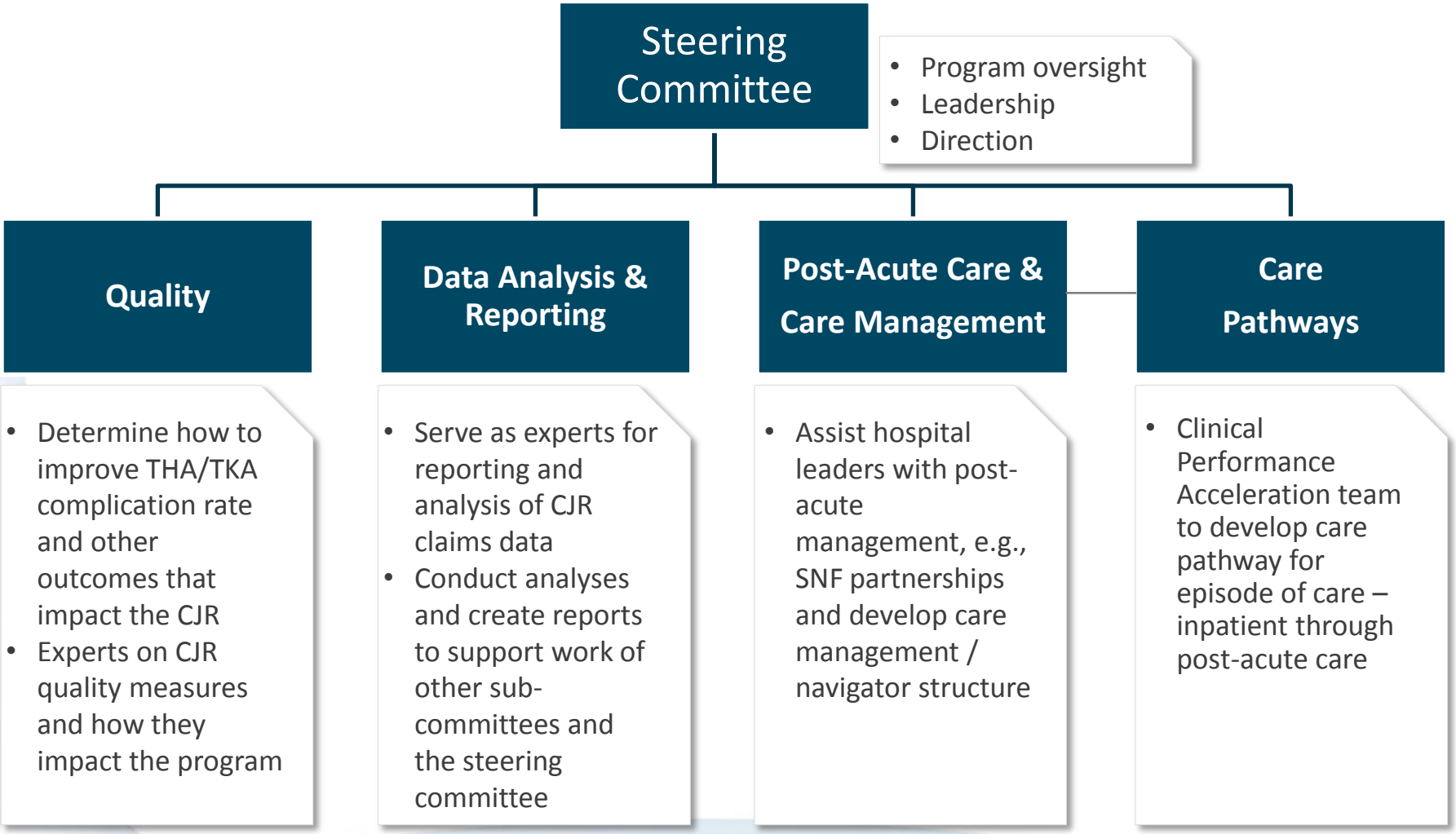
Mercy's Approach

Mercy

Background

- Started in 2016 with a Steering Committee comprised of many representatives from multiple departments across Mercy
- Engaged consultant to assist with claims data analysis and reporting
- Established sub-committees to drive work within Mercy communities
- Identified hospital leaders for each hospital participating in the CJR program
- Developing episodic clinical pathway for THA/TKA

Structure


Steering Committee
• Program oversight
• Leadership
• Direction
Quality
• Determine how to improve THA/TKA complication rate and other outcomes that impact the CJR
• Experts on CJR quality measures and how they impact the program
Data Analysis & Reporting
• Serve as experts for reporting and analysis of CJR claims data
• Conduct analyses and create reports to support work of other sub-committees and the steering committee
Post-Acute Care & Care Management
• Assist hospital leaders with post-acute management, e.g., SNF partnerships and develop care management / navigator structure
Care Pathways
• Clinical Performance Acceleration team to develop care pathway for episode of care – inpatient through post-acute care

Quality

- Mercy Quality and Safety creates a THA/TKA complications rate for all hospitals on a monthly basis to help identify trends
  - Distributed monthly by all payor and Medicare fee-for-service patients at least 65 years of age
  - Based on 12-months of discharges
- Report is utilized to help improve the complications rate as CMS data is claims-based, risk-standardized and based on a 3-year time period
- Existing workgroups focused on improving HCAHPS will drive quality measure improvement for CJR

Data Analysis and Reporting

- Team comprised of Finance and Quality
- Partnered with DHG for claims data analysis
- Creating standard reporting package for hospital leaders to drive work within Mercy communities
- Perform ad hoc analyses to support the work of the Steering Committee and Sub-Committees
- Determining how to incorporate claims data for the internal THA/TKA complications rate

Pathways

- Developing 90-day episode of care for THA/TKA that will be implemented throughout Mercy
- Episode encompasses inpatient and ambulatory clinical, operational and Epic workflows
  - Enhancing or building tools within Epic to support the episode
  - Working with multidisciplinary teams to ensure operational support and functionality
- Leveraging existing expertise within Mercy and sharing across the Ministry
- Exploring nurse navigator/care manager program for THA/TKA patients to help manage continuum of care

Pathways (cont.)

- Evaluating how to incorporate clinical recommendations for surgical appropriateness developed by Mercy's Orthopedic Specialty Council Total Joint Subcommittee

1. Morbid obesity (BMI >45)
2. Severe or unstable cardiovascular or respiratory disease (ASA Class IV, decompensated CHF, unstable angina, severe COPD with forced expiratory volume (FEV1) <50% or daytime oxygen requirement)
3. Severe aortic stenosis with aortic valve area <1cm2
4. Uncontrolled hypertension (preoperative SBP >200 or DBP >100)
5. Severe or unstable neurologic disease (i.e. poorly controlled seizure disorder)
6. Poorly controlled diabetes mellitus with HgbA1c >8%
7. Hepatic failure (hepatic encephalopathy as surrogate marker, MELD score for borderline cases)
8. Chronic kidney disease stage 5 or 6 (GFR <15)
9. Severe coagulopathy
10. Severe malnutrition (serum albumin <2.5)
11. Pediatric patients with history of congenital heart disease or condition associated with a difficult airway
12. Tobacco use within the past 30 days

Performance Year 1: Results for Mercy Hospitals

Mercy

Count of Episodes

Mercy Hospital	MS-DRG 469[1]	MS-DRG 470[2]
Jefferson	**1**	**7**
Oklahoma City	**10**	**120**
St. Louis	**6**	**99**
Washington	**7**	**63**

1. Major Joint Replacement or Reattachment of Lower Extremity *with* major complication or comorbidity
2. Major Joint Replacement or Reattachment of Lower Extremity *without* major complication or comorbidity

Quality Measure Performance

Mercy Hospital	THA/TKA Complications Rate			HCAHPS			Patient Reported Outcomes		Composite Quality Score	Quality Category
	Rate	Percentile	Points	Rate	Percentile	Points	Submitted	Points		
Jefferson	4.89%	0.16	0	84	19.80	0	No	0	**0**	**Below Acceptable**
Oklahoma City	2.67%	55.81	7	85.67	40.30	5	Yes	2	**14**	**Excellent**
St. Louis	2.12%	91.87	10	86.78	59.28	5.6	No	0	**15.6**	**Excellent**
Washington	2.02%	94.67	10	87.39	69.95	6.8	No	0	**16.8**	**Excellent**

THA/TKA Complications Rate		HCAHPS	
Percentile Range	Assigned Points	Percentile Range	Assigned Points
≥ 0.90	10	≥ 0.90	8
< 0.90 and ≥ 0.80	9.25	< 0.90 and ≥ 0.80	7.4
< 0.80 and ≥ 0.70	8.5	< 0.80 and ≥ 0.70	6.8
< 0.70 and ≥ 0.60	7.75	< 0.70 and ≥ 0.60	6.2
< 0.60 and ≥ 0.50	7	< 0.60 and ≥ 0.50	5.6
< 0.50 and ≥ 0.40	6.25	< 0.50 and ≥ 0.40	5
< 0.40 and ≥ 0.30	5.5	< 0.40 and ≥ 0.30	4.4
< 0.30	0	< 0.30	0

Composite Quality Score	Quality Category	Discount Factor	Eligible for Reconciliation Payment
> 13.2	Excellent	1.50%	Yes
≤ 13.2 and ≥ 6.0	Good	2%	Yes
< 6.0 and ≥ 4.0	Acceptable	3%	Yes
< 4.0	Below Acceptable	3%	No

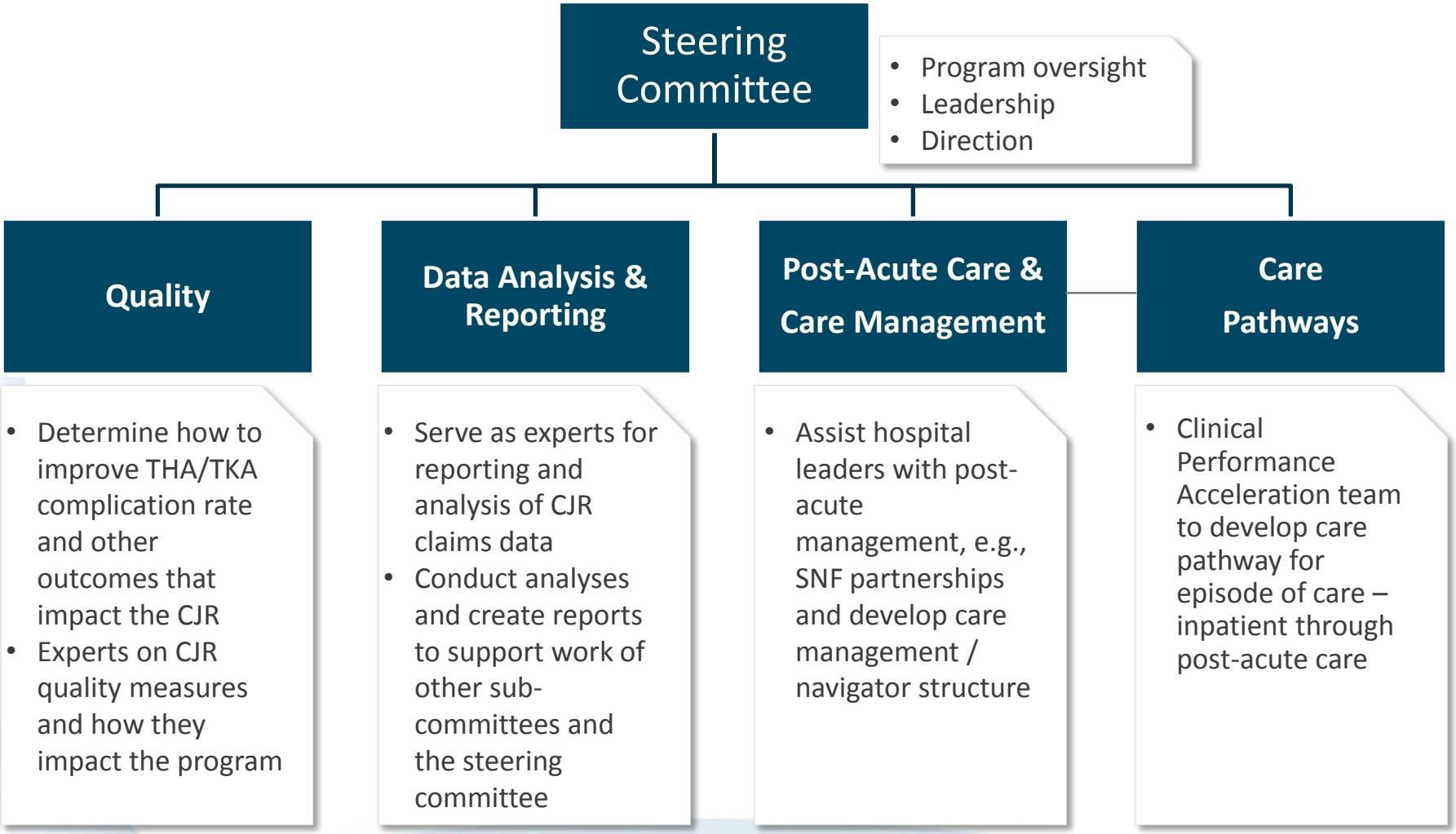
Financial Performance

Mercy Hospital	Target Episode Spend	Actual Episode Spend	Initial Reconciliation *or* Repayment Amount[1]	Total Stop Loss *or* Stop Gain Amount	Quality Category	Eligible for Reconciliation Payment	Reconciliation Payment Amount[2]
Jefferson	$230,605.71	$183,292.58	$47,313.13	$11,530.29	Below Acceptable	No	**$0.00[3]**
Oklahoma City	$3,412,088.42	$3,792,998.53	($380,910.11)	($170,604.42)	Excellent	No	**$0.00[4]**
St. Louis	$2,347,861.37	$2,272,823.07	$75,038.30	$117,393.07	Excellent	Yes	**$75,038.30**
Washington	$1,609,799.38	$1,583,165.69	$26,633.69	$80,489.97	Excellent	Yes	**$26,633.69**
Mercy Total							**$101,671.99**

Notes

1. Represents reconciliation/repayment amounts before Stop-Loss/Gain limits applied. Negative amounts indicate hypothetical repayment amounts because hospitals are not subject to downside risk in performance year (PY) 1.
2. PY1 of the CJR program is upside only; no downside risk or repayment. Downside risk applies to PY 2,3,4,5.
3. Jefferson is ineligible for reconciliation payment due to quality category of Below Acceptable.
4. If PY 1 involved downside risk, Oklahoma City would have a repayment amount of ($170,604.42).

Structure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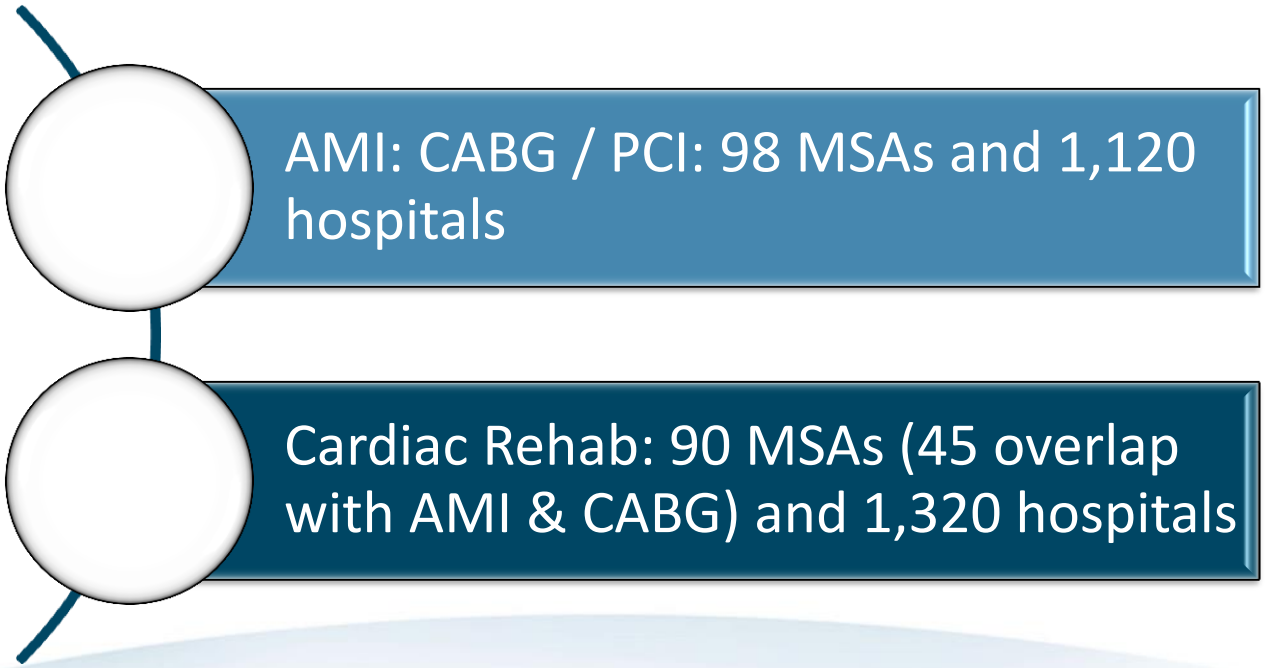
Cardiac Episodic Payment Model (EPM)

Background – What is Cardiac EPM?

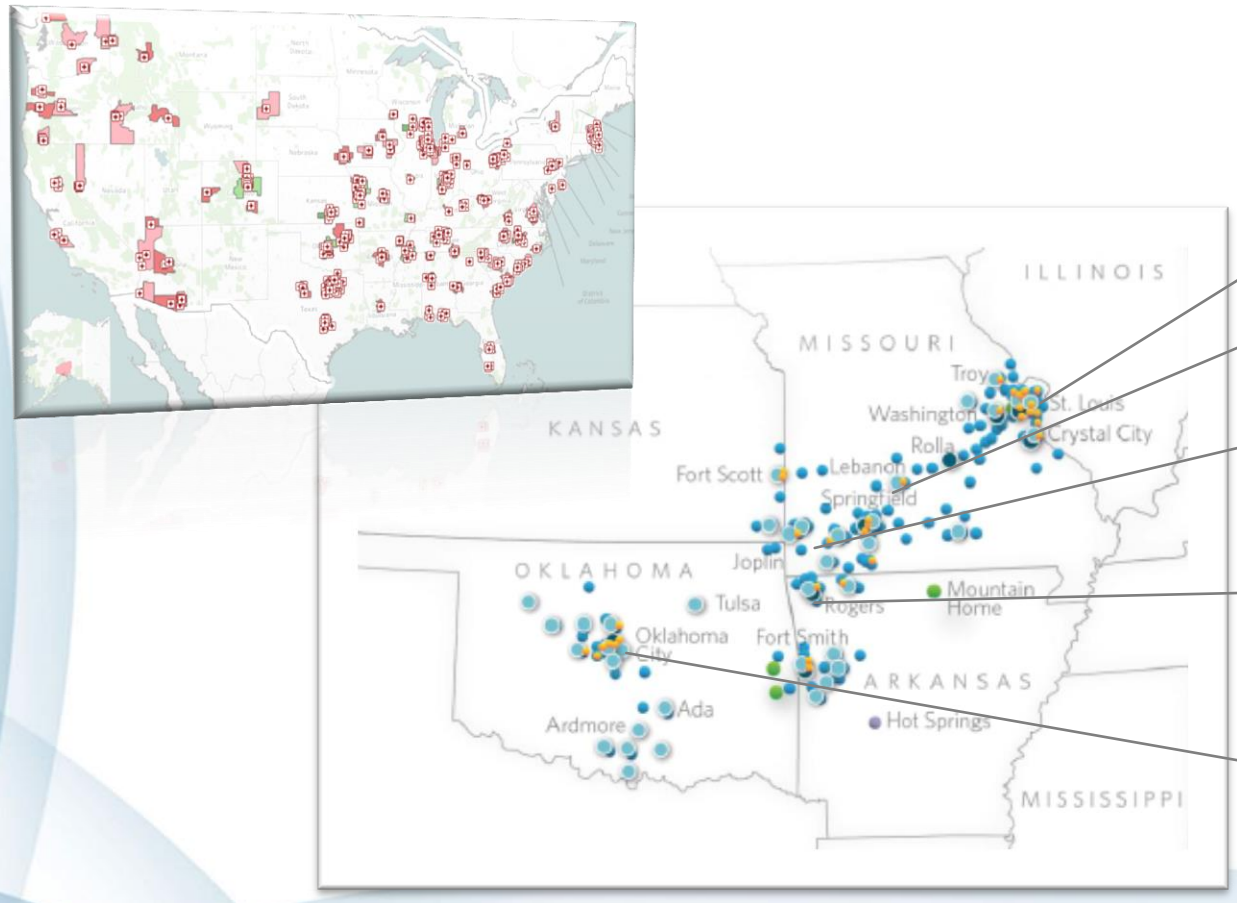
Cardiac Episodic Payment Model

- 5 – year demonstration running from July 1, 2017 – December 31, 2021
  - *Postponed start date to October 1, 2017.*
- Estimated savings of $15 - 20 million



Cardiac EPM Participants – Who's "In"?

- The new cardiac bundles impact nearly 900 acute hospitals in 98 metro areas.



St. Louis, MO
Cardiac Rehab

Springfield, MO:
Cardiac Rehab

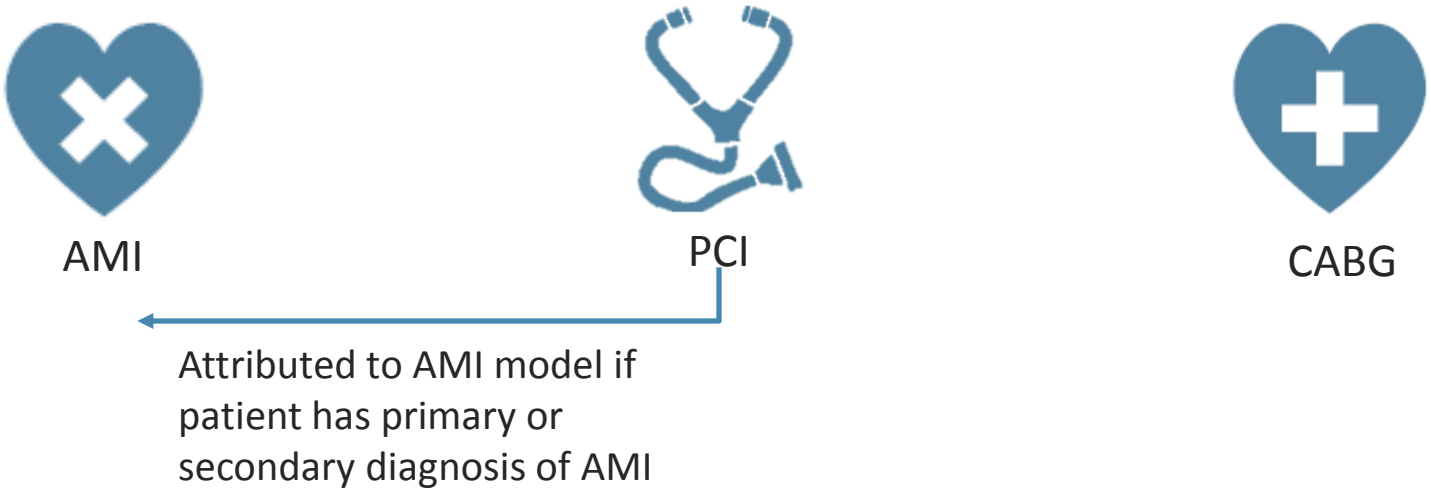
Joplin, MO:
Cardiac EPM &
Cardiac Rehab

Fayetteville – Springdale – Rogers, AR:
Cardiac Rehab

Oklahoma City, OK:
Cardiac EPM &
Cardiac Rehab

What's Included?

- Specific hospitalizations included in cardiac bundles are:
  - Acute myocardial infarction (AMI – DRGs 280-282);
  - Percutaneous coronary intervention (PCI – DRGs 246 – 251) when AMI is the primary or secondary diagnosis for the hospitalization; and
  - Coronary artery bypass graft



Which Patients Are Included?

Included

- Traditional Medicare

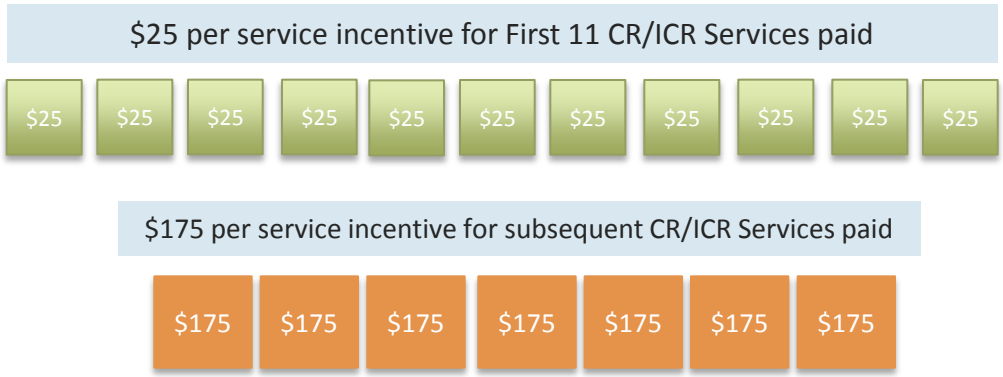
Excluded

- Medicare Advantage
- Medicaid
- Commercial
- Other

Cardiac bundles impact only Traditional Medicare patients not other payer types.

Cardiac Rehab Incentive

- Medicare program incenting cardiac rehab on select patients
- Impacts all Mercy Communities



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