CJR Model Performance Year 4 (PY4) Evaluation Results[i]

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>> Hello and welcome to this pre-recorded webinar on the CJR model performance year for evaluation results. Audio for this event is available only through your device speaker. The agenda for this webinar includes a logistics review, speaker introduction and a presentation on the CJR model for peer evaluation results. One of the key takeaways as well as results . we will wrap things up with a few announcements and reminders.

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To download a single file, select that file and click on the downward facing arrow. A pop-up window will open up allowing you to save the document. If you prefer to download all resources at once, click on the three dots and select download all . Resources in today's event include the evaluation annual report, as well as the appendices, and the findings at a glance . We have also included the latest release of the CJR toolkit , version 3.0. you can download the slides from today's event as well is the text alternative. >> Now I would like to introduce today's webinar presenter. Dr. Jessica McNeely is the evaluation contacting officer representative at the CMS innovation Center. Jessica . >> Let me start off with thinking, thanking everybody for entering the CJR evaluation , core findings sharing with these participants of the webinar.

I will cover the main findings from the fourth annual CJR report . This report was recently posted on the CMS website and presents findings from the first for performance years. For those on or after April 21, 2015, ended by December 31, 2019. >> Before we dive into the results I want to start off with describing which hospitals are part of the evaluation report. At the start of performance year three, a number of MSA's were scaled-back from the 67 originally randomly selected MSA's. 34 MSA's with the high average , highest average scores. Hospitals averaging slow volume or rural were no longer required . However we did have a note one time opportunity to opt into the model. We saw the majority of hospitals that fell into this category did not continue participation. Similarly hospitals that were located in the other 33 MSA's were also given a one time opportunity to opt into the model,
and as the other group, a large majority of hospitals choosing not to continue in the model.

So this report largely focuses on the 395 mandatory hospitals in the 34 mandatory MSA's that were continuously required to participate for the entire model. These hospitals and CJR hospitals. The report provides information on opt in and not opt in hospitals and the 33 volunteer MSAs where hospitals could elect to continue operating in the CJR model . Just to note the analyses presented in the report do not include 15 hospitals located in MSAs designated as low-volume or rural, who chose to opt into the model. Due to the limited participation in the group, generating impact estimates is more likely to lead to unreliable acronym.

So jumping in to the high level. Giving you the Birdseye view before I get into details. Overall the CJR model continues to be up promising approach for reducing episode payments. Hospitals in the

model learned very early on that the reducing institutional payments was by focusing the efforts on reducing institutional post-acute care use. Looking at the breakdown on the net savings to see that the majority of savings from the model came from the mandatory CJR hospitals . One of the primary goals of the model was to improve care coordination across the care pathway. During the evaluation we conducted many site visits and hospital interviews, interviews with surgeons, NIST and Karen coordinations did approve, improve across .

We did a series of analyses to investigate the impact of health equity. For the most part we are seeing a neutral impact or no differences between.

And last I did want to highlight a new finding in the report, that we have not seen in the past . we are seeing early indications that fracture patients may be experiencing worse functional recovery. >> Here I am showing a figure of the payment trends for both the CJR groups. This is the line and the dashed line. The care was enough for the role making, and as shown here in the right, the time between the proposed rule and when the final role was accepted in the model started. You can see with the dark blue line, a sharp decline in the group prior to the start of the model. And then lines that we heard from hospitals, many said they started planning and implementing changes prior to the start of the model. And now the actual reduction. On the left, we are showing the proportion of patients , decreased by a little over 28% , resulting in a decrease of $593. And first of, sniffs, we do see significant decrease in the number of days in a SNF. So the patient's in a SNF spent on average 2.6 fewer days . The SNF reduction led to a reduction of $843 per episode. And last, we saw an increase in home health use of 20.5%. And increasing use however did not lead to an increase in home health. >> I want to shift the focus to discussing the net result. Before diving into the numbers , I wanted to go over some basic definitions. We derive the net savings from the impact estimate for reductions , we are calling here gross savings. And then we subtract the reconciliation payment. And the full reconciliation amount includes money paid out to participants, and also the repayment from participants. And the evaluation, we did not include the cost to run the model in the net savings calculation. So starting out with the model wide estimate. We saw a 251.8 million dollar gross reduction in payments. After accounting for reconciliation payments, we found the net savings of $21.4 million. While significant,

positive, this number is not significantly significant.

Next I will break down what is included in the model wide estimate.

So here we have the estimate for mandatory hospital. As a reminder, these are hospitals located in the 34 highest costs MSAs. We have $202 million in gross savings, and after accounting for the $126.1 million in reconciliation payments, we get a net savings of $76 million. This estimate is not statistically significant. It's actually different from last year where the net savings was significant. The differences largely due to the change in the policy that allows for outpatient knee surgery. We found future hospitals spend the about 10% fewer patient per outpatient. When we account for the difference the impact is no longer significant. This trend is likely to continue throughout the performing year. >> Moving to the hospitals in the lower cost, voluntary areas. Those hospitals that chose to continue in the model, are the Austin hospitals. They have saved a significant gross savings of 37.1 million dollars. And after subtracting the $81.6 million in reconciliation payments, we found significant let , net loss of $44.5 million. >> And for the hospitals in the voluntary MSAs that did not opt in, these numbers are for the two years in the CJR model. They achieved a significant gross savings of $12.7 million. After accounting for the reconciliation payments, we found a net loss of $1 million. But because of the wide confidence interval, we could not, loss that significant. So summarizing all of the savings generated from the CJR model came from the managed hospitals

commendatory hospitals. It's important to point out, in the lower cost areas that were already efficient, these hospitals were still able to reduce payments. While the reductions did not lead the net savings, I think it shows even in areas that are more efficient, there is still opportunity for savings. >> One of the primary goals of the CJR model is to encourage greater coronation across hospitals, surgeons and post-acute care facilities. After many site visits and interviews we discovered communication and coordination have improved across the care pathway. Hospitals are engaging with surgeons, care providers in a new way. And there's lots of different ways they're doing that. Some are still doing meetings, data sharing's, and most of them with patient follow-ups. Some hospitals have referred care network . Often we find hospitals set the tone for these conversations and the care activities. We heard from surgeons and hospitals providing guidance related to modifiable doctors. Not only guidelines for patients with uncontrolled diabetes, open seas, obesity and smoking. And the SNF's that participated reported they changed LEJR care in response to the hospitals request. Hospitals advise SNF's to provide information about patients during their stay and reduce the adjust the frequency and timing of physical therapy. Providing physical therapy earlier and more often. >> Shifting the focus to impact on quality, we sought overall measures of quality care improved or maintained. So both unplanned readmission rate and complication rate for LEJR episodes improved. And emergency department visits and mortality were maintained. These results are identical to what we found in the third annual report. >> For the first time in the evaluation, were seeing early spines , early signs that fracture patients may have worse recovery. The two times a year we surveyed, patients that CJR hospitals, the surveys are sent out towards the end of the 90 day episode. During the last two surveys we discovered three of the functional recovery measures, patients recorded worse recovery. Specifically for CJR patients, they reported less improvement from rising from sitting, standing, and using the toilet. To put this finding in the context, this is roughly 3 to 6 more CJR patients out of 100, indicating a decline in functional status from before the fracture, relative to the control group. So we are continuing to monitor fracture patients to get a deeper understanding of this finding. >> So this is the first time we've investigated the impact on the model and health equity. We looked at a number of different outcomes for average payment , quality, in terms of quality using both claims measures and on location survey. We looked at three groups, Black or African-American, patients , both on Medicaid and Medicare. A proxy for lower socioeconomic status, and black or African-American annual status. We focused on these because they have been shown in the literature to have historically worst healthcare outcomes. So far we have not detected any differences across the group. We did find some positive differences . For this group we sought reduction in episode payments, and it was a little over $1000 higher for black or African-American patients related to white. And then cut the necessary services were being cut leading to a lesser quality, we would be concerned. Looking at quality we have not seen changes, and improvement in a few of the measures. It resulted in a .41 percentage point larger reduction in all cause mortality for black and African-American patients relative to white. And black or African-American patients recorded that they were more satisfied than white respondents to the extent which providers listen to their preferences.

At this point were interpreting these results with great caution. We do not have results on patient access. If the CJR model is resulting in restricted access for black or African-American patients, these results might be more of a result of Haitian election, rather than group care. We are currently looking into this possibility. Keep your eye out for the future.

Switching gears to hospital performance. We been interested in understanding what factors are associated with reconciliation payments . For the mandatory hospitals we found higher-quality

performance, higher LEJR volume, not-for-profit status, and less complex patient populations received higher mean and PRA per episode.

So looking across time,
hospitals are more financially successful in performance your number two, when the target praises hardly waited to historical payments . >> So we went through a lot of information. Let me take a few minutes to review the takeaways before we end. First we saw in the hospitals and the model learned early on that reducing episode payments was to focus efforts on reducing institution care use. And hospital started reducing payments even before the official start of the model. We also so that the majority of savings in the model came from the mandatory CJR hospitals. While the hospital in the lower cost voluntary areas were able to significantly reduce cost , after accounting for the reconciliation payments we saw net losses. The overall model net savings, which is a positive, was not specifically significant. One of the primary goals of the model being care coordination, we saw lots of evidence for that. On the ground from the site visits and during interviews. It is clear that communication and coordination did approve, improve across hospitals and surgeons and care facilities . A preliminary finding on the impact of the model and health equity is neutral, with a few differences between. Were continuing to investigate this topic further and will be exploring the impact on patient access. And glass, were seeing some early indications that fracture patients may be expensing more functional recovery and work continuing to moderate or this finding to understand more about what is contributing to this.

So thank you again everyone for your attention and participation in the CJR model. The CJR model is consistently positive impact, due to your dedication to patient care. >>

Thank you so much for that detailed and informative visitation, Jessica. Now we have a few announcements and reminders, before we wrap up this webinar. If you have any questions related to this presentation, or the evaluation report, please send those via email to . If you have any point of contacts regarding the CJR model, send those as well to CJR support, and request an attestation form . And finally to request a CJR connect account, you can navigate to the website listed on slide 22 . It is also the first web link on the upper right-hand corner of your screen . you can click on that. Once you are there, click on the new user registration . Finally, we invite you to take a few moments to complete the postevent survey for this pre-recorded webinar. It should pop up automatically on your screen. Thank you so much and have a great rest of your day.

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>> [Event concluded]

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