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CJR

Comprehensive Care for Joint Replacement Model

CJR Model Performance Year 4 (PY4) Evaluation Results

Comprehensive Care for Joint Replacement Model

September 2021

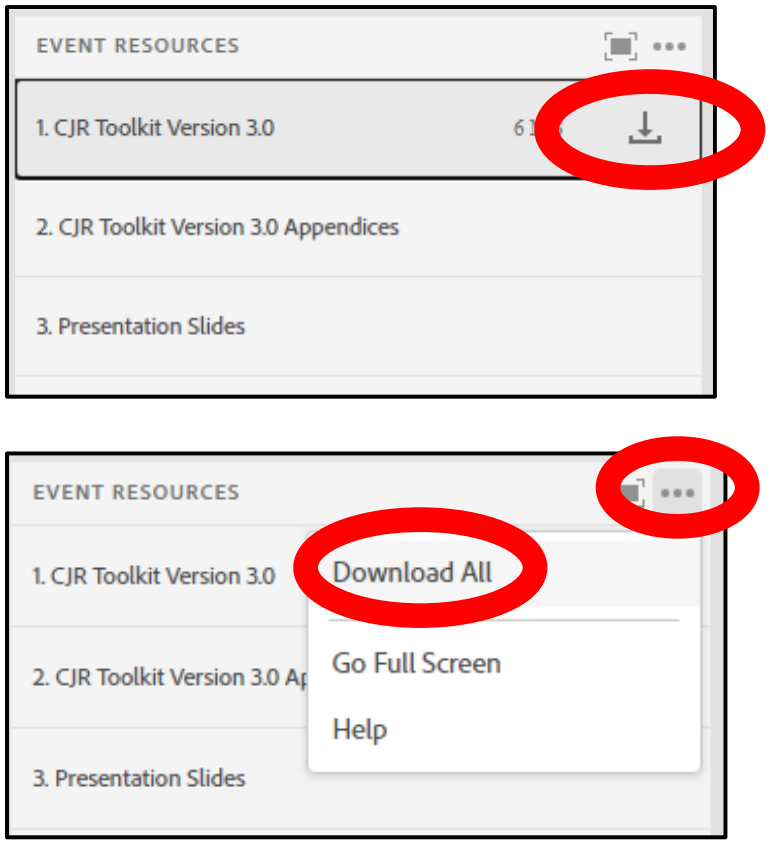
Audio is available through your device speakers

Webinar Agenda

- Welcome and Logistics
- Introduction
- CJR Model Fourth Year Evaluation Report
  - Key Takeaways
  - Results
- Announcements and Reminders

Introduction to Adobe Connect

Download Resources



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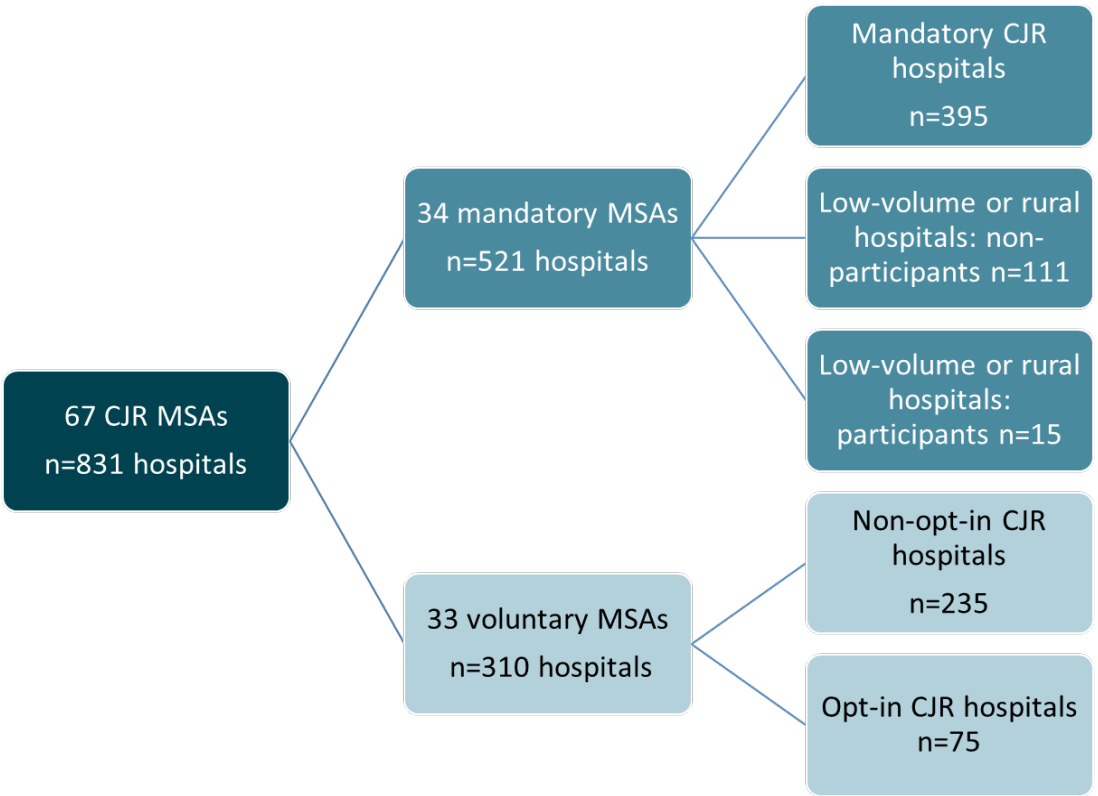
The CJR Model Fourth Year Evaluation Report

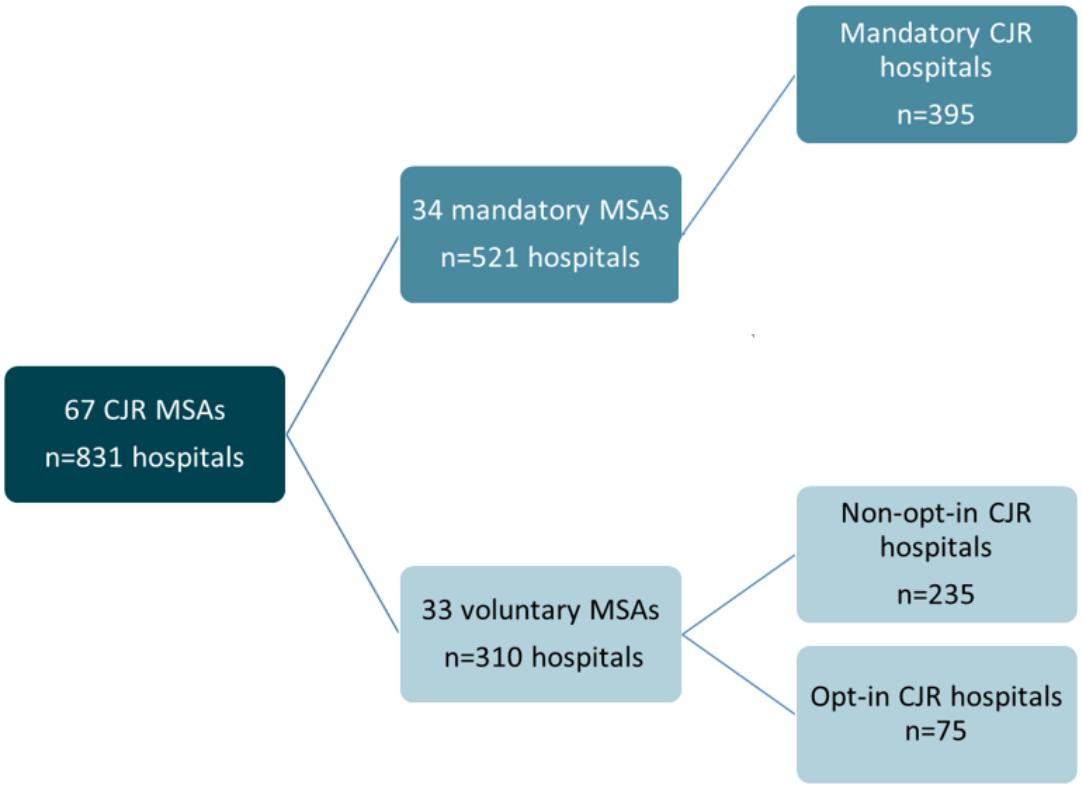
Jessica McNeely, PhD
CJR Evaluation COR
CMS Innovation Center

Starting the 3rd year of the model, participants in the 33 mid-low cost MSAs as well as low volume or rural hospitals had the choice to opt-in



This created a lot of groups!

4th Year Report Presents Cost Impacts for 3 Groups

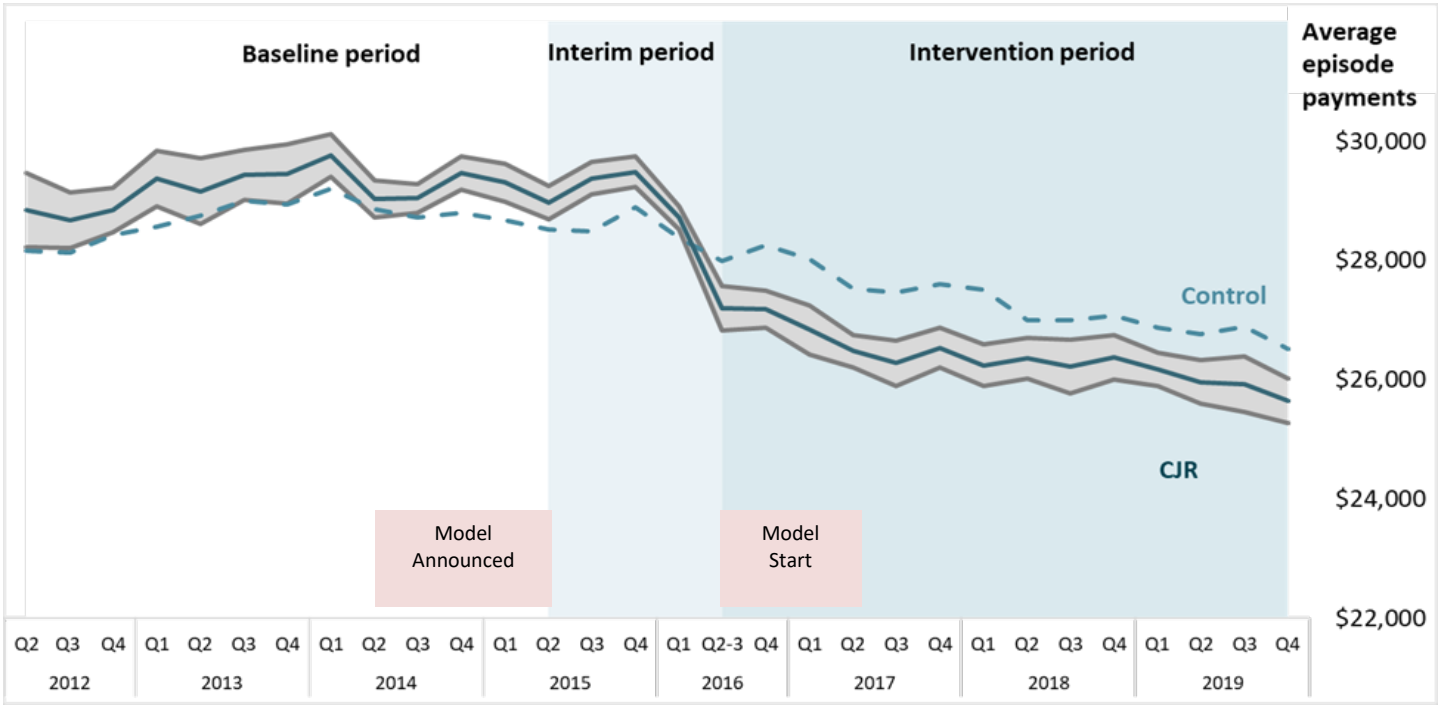


Key Takeaways

The CJR model remains a promising approach for reducing episode payments.

- Hospitals learned early that reducing institutional post-acute care was the key to reducing episode spending
- Nearly all of the savings generated from the CJR model came from mandatory hospitals
- Improved communication among the hospital, surgeons and post-acute care facilities
- Preliminary evidence suggests impact on health equity is neutral
- Early indications that fracture patients may have worse functional recovery

Hospitals learned early that reducing institutional post-acute care was the key to reducing episode spending



Note: *indicates that the impact was statistically significant,
Results shown are for mandatory CJR hospitals in the first 4 performance years
⚠ HHA spending results should be interpreted with caution, because HHA payments failed the parallel trends test and therefore we cannot conclude whether the lack of difference was due to preexisting patterns or the CJR model.

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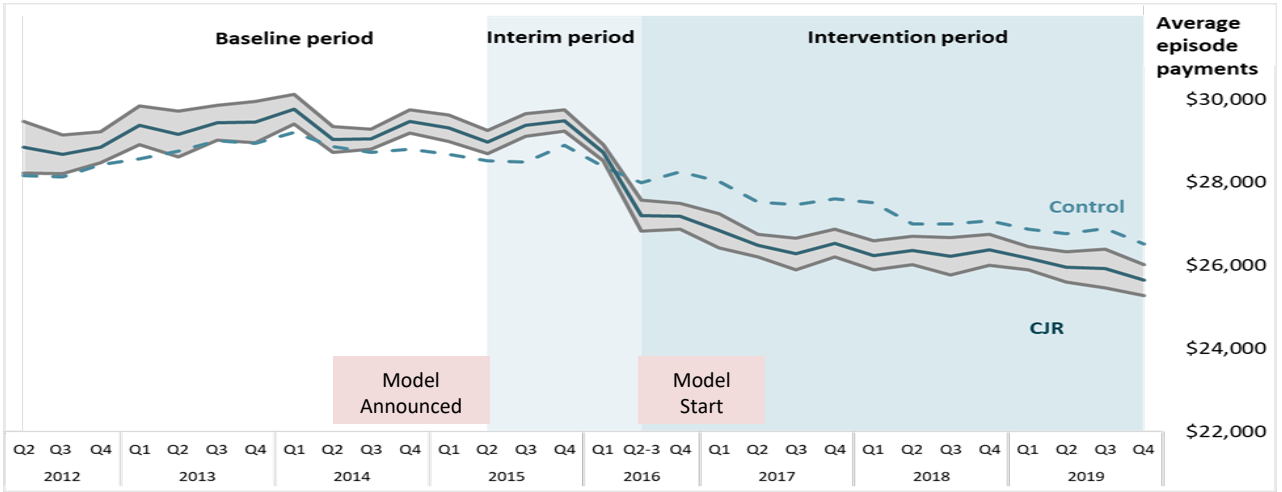

Inpatient rehabilitation facility Use ↓ **28.1%*** $593*

Skilled nursing facility Use ↓ **2.6 days*** $843*

Home health agency Use ↑ **20.5%*** $65 ⚠

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Nearly all of the savings generated from the CJR model came from mandatory hospitals (areas with higher historical costs)

Model Wide:

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Note: Figures shown in millions and small discrepancies are due to rounding. * indicates that the impact was statistically significant, rural and low volume hospitals are not included in savings estimates

Nearly all of the savings generated from the CJR model came from mandatory hospitals (areas with higher historical costs)

Model Wide:

Mandatory (Higher Cost)

Mandatory CJR hospitals reduced average episode payments, but we cannot conclude significant net savings

Mandatory hospitals: 395 hospitals, PY1-PY4

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Model Wide:

$251.8 * estimated gross savings − **$230.4** reconciliation payments = **$21.4** estimated net savings

Mandatory (Higher Cost)

Mandatory CJR hospitals reduced average episode payments, but we cannot conclude significant net savings

Mandatory hospitals: 395 hospitals, PY1-PY4

$202.0* estimated gross savings − **$126.1** reconciliation payments = **$76.0** estimated net savings

Voluntary (Lower Cost)

Hospitals in voluntary MSAs reduced payments, but contributed to Medicare losses

Opt-in hospitals: 75 hospitals, PY1-PY4

$37.1* estimated gross savings − **$81.6** reconciliation payments = **$44.5*** estimated net losses

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Voluntary (Lower Cost)

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Opt-in hospitals: 75 hospitals, PY1-PY4

$37.1* estimated gross savings − $81.6 reconciliation payments = $44.5* estimated net losses

Non-opt-in hospitals: 235 hospitals, PY1-PY2

$12.7* estimated gross savings − $22.7 reconciliation payments = $10.0 estimated net losses

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Improved communication among the hospital, surgeons, and post-acute care facilities

Interviews with hospitals, surgeons and post-acute care facilities discovered that hospitals set the tone for conversations and direction for care design activities.

Surgeons reported **hospitals provided guidelines or directives** to consider when determining whether to perform an LEJR.

Guidelines or directives often related to **modifiable health risk factors** such as uncontrolled diabetes, obesity, and patient smoking.

SNF interviewees said they **changed LEJR patient care in response to hospitals' requests.**

Hospitals advised SNFs to provide information about patients during their SNF stay, reduce SNF LOS, and adjust the frequency and timing of physical therapy.

> "Obviously **one of the biggest changes** we've seen is **length of stay pressure**, to move people along the continuum in a shorter amount of time. To that end, some of our area referral **hospitals** have even gone so far as to **provide us with guidelines for their elective joints**."
>
> – SNF Interviewee

Overall, measures of quality of care improved or were maintained

Claims-based quality measures show that the changes in post-acute care did not compromise quality of care.

Improved	Maintained
✓Unplanned readmission rate	✓Emergency department visits
✓Complication rate* (elective LEJR episodes)	✓Mortality

Early indications that fracture patients may have worse functional recovery

Patient survey results show early signs fracture patient may have worse recovery.

Patient survey results uncovered some **potential signs of worse recovery for fracture patients,** but no systematic differences with overall recovery or care management.

CJR fracture patients reported significantly less improvement in

- ✓ Rising from sitting
- ✓ Standing
- ✓ Using the toilet

This finding equates to **roughly three to six more CJR respondents out of 100 indicating decline** in functional status from before their fracture relative to comparison group.

Preliminary evidence suggests impact on health equity is neutral

Limited evidence of different impacts of the CJR model on patient subpopulations with historically worse access to care and health

There are some indications that black/African American patients have greater improvements in outcomes, but these findings should be interpreted with caution.

Greater reductions in episode payments

The reduction in episode payments was **$1,031** higher for Black/AA patients relative to white patients

Greater Improvements in Quality

The CJR model resulted in a **0.41 percentage point** larger reduction in **all-cause mortality** for Black/AA patients relative to white patients

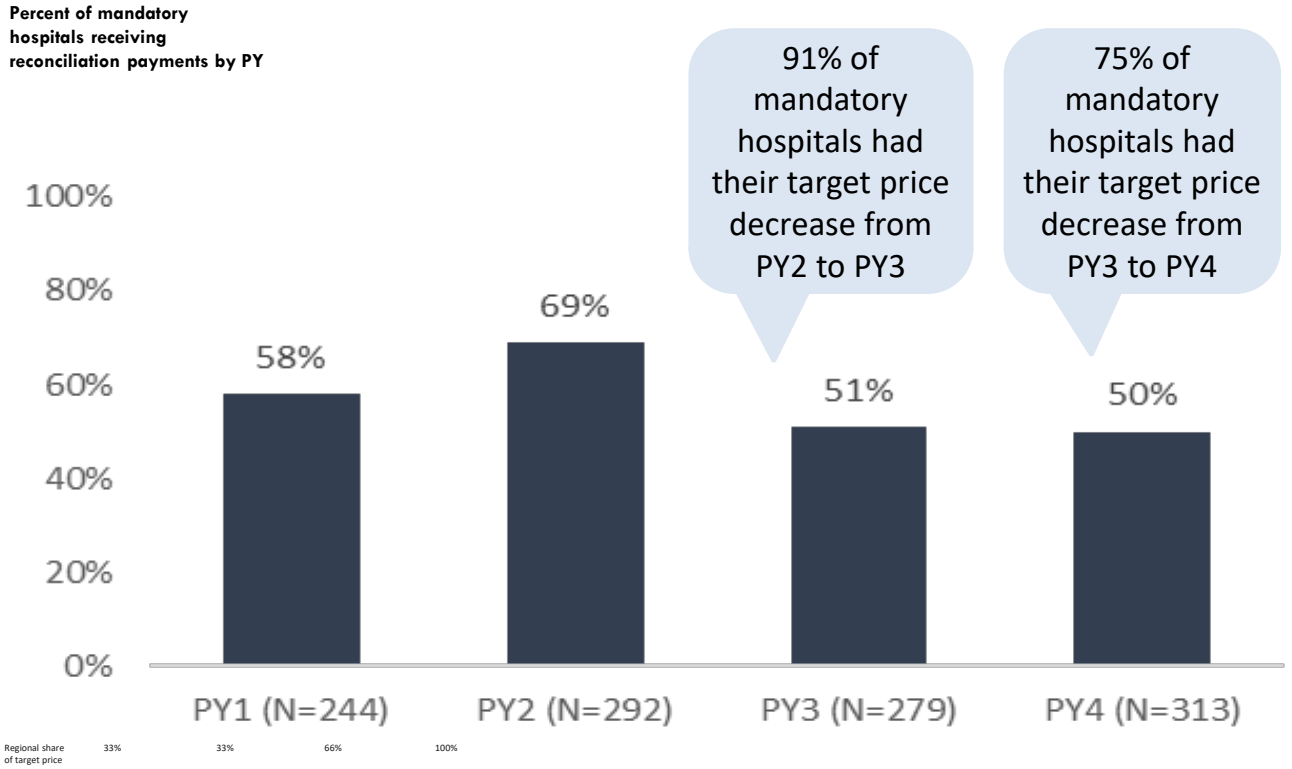
Black/AA survey respondents were **more satisfied** than white respondents in the extent to which **providers listened to their preferences**

Urge caution in interpreting these results without concurrent results on patient access.

Further work is being conducted to evaluate whether the CJR model resulted in changes in access to care for certain subpopulations, which could improve health outcome measures by exacerbating disparities in access.

Mandatory hospitals with higher quality performance, higher LEJR volume, not-for-profit status, and less complex patient populations received higher mean NPRA per episode

Hospitals were more financially successful in PY2 when the target price was heavily weighted to hospital historical payments.



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Key Takeaways

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Announcements and Reminders

Reminders

- Send any follow-up or unanswered questions from this event to CJRSupport@cms.hhs.gov.
- If your organization has made any changes to your points of contact for the CJR model, please email CJRSupport@cms.hhs.gov to request a Data Request and Attestation (DRA) form which should be submitted through the Data Portal (preferred) or through encrypted email.
- To request a CJR Connect account, go to: https://app.innovation.cms.gov/CMMIConnect/IDMLogin and click “New User Registration”.
- *Please take a few minutes to complete the Post-Event Survey.*