Determining PAC Networks with Medicare's New CJR Program

As seen in Healthcare Informatics.

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Hospitals participating in Medicare's mandatory new Comprehensive Care for Joint Replacement (**CJR**) reimbursement model need to develop a high-quality preferred post-acute care (PAC) network to which they can discharge high-risk CJR patients. Hospitals can do so either independently or by using an external consultant. The PAC must, per CMS, have a minimum 3-star rating or reimbursement will be negatively impacted.

By developing a PAC preferred provider network based on objective criteria and supported by collaborative agreements, hospitals can more readily create effective two-way communication between their care coordinators and PAC teams. Two-way communication is critical to managing post-acute care problems rapidly and efficiently. Keep in mind that patient participation in CJR is voluntary, and fee-for-service (FFS) Medicare patients can select a PAC provider that is not on the acute providers' preferred list. The challenge is when patients want to select a PAC organization with less than a 3-star rating.

Recommendations to successfully maximize PAC network relationships include:

1. **Develop multidisciplinary work groups**, including physicians, to create aligned preoperative (pre-habilitation, joint camp support or similar programs), acute stay and discharge care guidelines. The acute care facility's existing lower extremity joint replacement (LEJR) guidelines should include documentation of a functional assessment

score, identification of high-risk patients, and hand-off and/or post-discharge care management policies for patients who are discharged to a PAC.

2. **Identify senior leader and medical staff champions** to lead the bundled payment initiatives (CJR, cardiac, etc.). These leaders are responsible for the overall success of the shift toward managing care in the acute and post-acute care environments, as well as for communicating regularly with staff, providers and clinical leaders.

3. **Create standard protocols for educating and communicating with CJR patients**, prior to surgery and while they are an inpatient, as well as upon discharge, in order to gain better patient cooperation and compliance.

4. **Utilize evidence-based practices,** such as functional assessments, to support first PAC placement recommendations (as these have a significant impact on episode costs).

5. **Assess the hospital's ability to manage patients in the PAC environment**, including electronic (shared EMR, etc.), telephonic or on-site oversight, to ensure adherence to care plans.

6. **Develop a meaningful PAC scorecard that includes outcome and process measures.** The scorecard should allow both the acute and post-acute provider to measure their performance against stated metrics.

7. **Use objective criteria to select preferred PAC network providers** (published quality scores, adverse events, utilization data, staffing ratios and safety scores, etc.) and conduct on-site tours of each preferred provider.

8. **Formulate preferred PAC networks** that include high-quality PAC providers including SNFs, home health agencies, and other providers (IRFs, etc.). Invite post-acute providers to a kick-off meeting and review your organization's PAC strategy including the development of a preferred PAC provider network.

9. **Form cooperative agreements with preferred PAC providers** to delineate shared goals and ensure that goals and two-way communication tools are in place (exchanging PHI requires that PAC providers adhere to HIPAA requirements). Develop and agree upon a PAC scorecard.

10. **Ensure PAC adherence to post-acute care plans** as part of the cooperative agreement, which includes the PAC reporting any variance from care plans to the acute provider.

11. **Develop PAC patient monitoring tools and processes**, such as an integrated EMR tool that provides a concise discharge summary that can be sent to the PAC provider, a universal transfer form, and/or patient tracking software.

Acute care providers, except for those that have already been involved in CMS' bundled payment programs or other risk-bearing arrangements, generally have not created internal competencies for managing patients throughout the 90-day post-discharge period. Under CJR, acute providers are responsible for the entire episode, including all PAC costs, quality outcomes and patient satisfaction results. Developing the skills, expertise, and care

model takes time and adds complexity to the acute providers' delivery model.

The CJR payment formula uses a method that weights the overall quality and patient satisfaction scores of acute care providers to determine their reimbursement for CJR patients. Acute care providers with low quality and/or patient satisfaction scores will be penalized by incurring a higher payment discount rate. Both patient satisfaction ratings and quality outcomes can be affected by the patient's post-acute care experience.

Creating a network of preferred PAC providers will help ensure that patients discharged to these entities will receive quality care, and that these organizations will readily communicate with the acute provider regarding the patient's care. With ongoing communication and the frequent exchange of information, the organizations can work more closely as a team to support improved patient outcomes and satisfaction.

Review CJR Data and Metrics

For more than a decade, CMS has required providers to report quality (core measures) and patient satisfaction ratings (HCAHPS) through its standardized data collection process. In addition, most hospitals have developed correlating quality and patient satisfaction scorecards to monitor quality and patient satisfaction rates on a real-time basis. By measuring what truly matters to your organization, you can more effectively increase your organization's focus on execution and results.

What kind of data should you be reviewing? Consider basing your analysis on the following acute and post-acute care metrics to create a recurring scorecard of your performance and progress:

• **Acute Care Metrics**

• Functional assessment (e.g., mobility, self-care capabilities, activities of daily living) at admission and prior to discharge to determine appropriate first PAC setting (assessment score included in EMR)

• First PAC selection adherence rate

• Surgical complication rate (required by CMS)

• Patient satisfaction (required by CMS)

• Bundled payment performance (target price to actual spending)

• **Post-Acute Care Metrics-by PAC**

• Readmission rate

• Functional assessment scores at admission and at discharge

• Expected versus actual PAC length of stay (care plan adherence rate)

• Patient satisfaction scores (provided by PAC provider)

• PAC spending per episode

Future Steps

Once you've reviewed and fulfilled your initial action steps relative to CJR, you can begin developing a roadmap and work plan around performance improvement goals (as revealed by your CJR evaluation and analysis). These performance improvement goals typically revolve around:

• Ambulatory, acute and post-acute care plan documentation

• Clinical and administrative roles, tasks and/or responsibilities

• Communication planning and execution, including among internal and external providers and patients

• Critical care risks and issue management processes

By identifying and segmenting your continuous quality improvement goals into achievable sub-sets (instead of a single, massive "CJR improvement effort"), you reduce the likelihood of internal challenges and increase your chances of quality improvement success. You also pave the way toward achieving other, similar quality improvement efforts in the future.

Through these steps, you are well on your way toward complying with the new CJR initiative. Just as importantly, you are preparing your organization long-term for a wave of other bundled payment initiatives, such as the mandatory cardiac bundled payment program that CMS announced in July 2016.

