Comprehensive Care for Joint Replacement Model - Background

The Comprehensive Care for Joint Replacement Model ("CJR") is a payment model for episodes of care related to knee and hip replacements under Medicare. This five-year model began April 1, 2016 in 67 geographic areas.

Acute care hospital patients are categorized by Medicare Severity Diagnostic-Related Groups ("MS-DRGs"); the CJR model covers two MS-DRGs:

MS-DRG 469	Major joint replacement or reattachment of lower extremity with major complications or comorbidities (These comorbidities are specific to acute care hospitals and are defined differently than IRFs' comorbidities.)
MS-DRG 470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities (These comorbidities are specific to acute care hospitals and are defined differently than IRFs' comorbidities.)

IRF patients are categorized by Rehabilitation Impairment Categories ("RICs"); CJR model patients are a subset of two RICs:

RIC 07	Lower extremity fractures (~30% are MS-DRG 469 and 470)
RIC 08	Lower extremity joint replacements (~75% are MS-DRG 469 and 470)

Since the implementation of the 60% Rule, the relative amount of RIC 07 patients treated in HealthSouth IRFs has declined moderately while the amount of RIC 08 patients treated has declined significantly.

RIC	% of HealthSouth Medicare Discharges					
	2005	2007	2009	2011	2013	2015
Total RIC 07(Fractures)	13.1%	14.8%	13.6%	11.6%	10.2%	9.8%
Total RIC 08 (Replacements)	17.9%	11.8%	9.0%	7.6%	6.7%	5.5%

Source: https://innovation.cms.gov/initiatives/cjr

CJR Model - How Does It Work?

Begins with an admission to an acute care hospital for a patient who is ultimately discharged under MS-DRG 469 or 470.





Patients are discharged to a post-acute care provider or to home self-care.

There is no downside risk in year one. Repayment responsibility will be phased in during year two.

Acute care hospitals are accountable for expenditures and quality of care for entire "episode." Episode = hospitalization + 90 days post discharge

POST-ACUTE CARE PROVIDERS



RETROSPECTIVE RECONCILIATION PERFORMED BY CMS

At the end of each performance year, actual spending for each episode is compared to each acute care hospital's target price.

If episode spending < target price, acute care hospital receives additional payment from Medicare*.
If episode spending > target price, acute care hospital returns a portion of the Medicare episode payment.

All providers are paid under the usual Medicare payment system rules and procedures.

Acute care hospitals receive separate episode target prices each year reflecting the differences in spending for each MS-DRG. Target prices:

- ✓ are based on three years of historical data;
- ✓ include a 3% discount* vs. expected episode spending; and
- ✓ incorporate a blend of historical, hospital-specific spending and regional spending for CJR episodes, with the regional component of the blend increasing over time.

Years 1 and 2 = 2/3 hospital-specific; 1/3 regional	Year 3 = 1/3 hospital-specific; 2/3 regional	Years 4 and 5 = 100% regional

Source: CMS
*Subject to quality of care attainment

CJR Model - How Does It Work? - Collaborators

Risk Sharing is Allowed in CJR with "Collaborators"

Acute care hospitals participating in CJR may choose to engage in risk-sharing financial arrangements with other care providers for CJR episodes. A provider participating in these risk-sharing arrangements with a CJR acute care hospital is deemed a "collaborator."

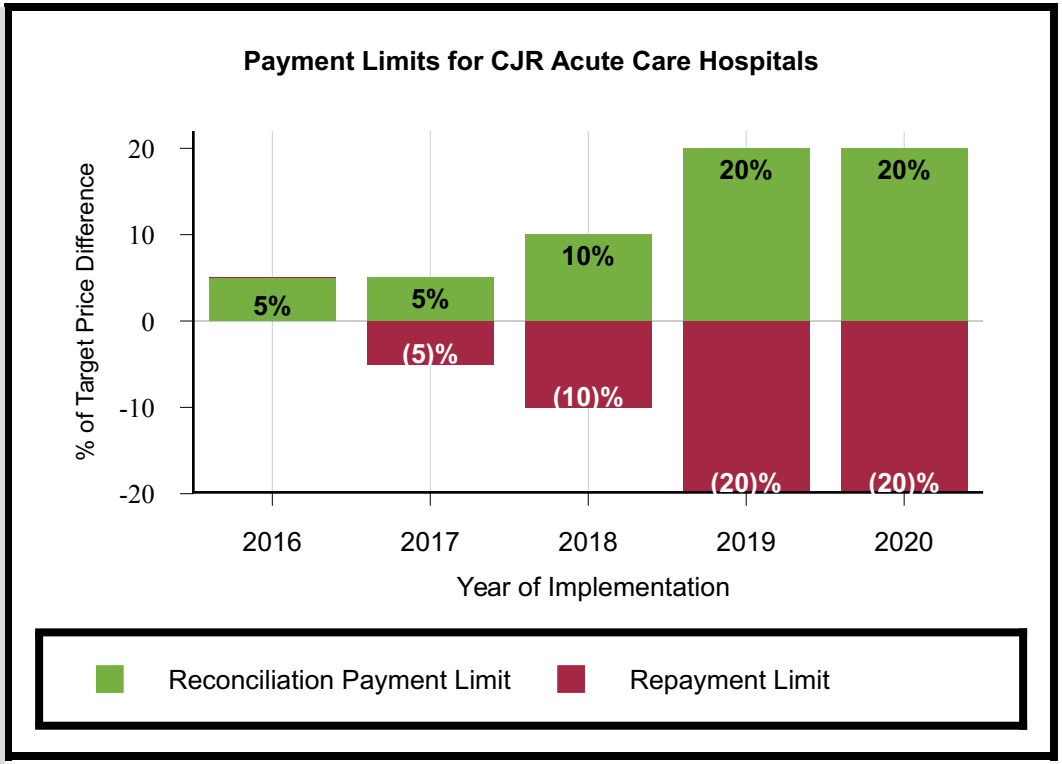
There are eight types of providers eligible to be CJR Collaborators, including IRFs and home health agencies.

CJR acute care hospitals must establish eligibility criteria for Collaborators to meet, including quality of care criteria.

Gain sharing payments must be actually and proportionally related to the care of beneficiaries in a CJR episode.

No one Collaborator may make an alignment payment greater than 25% of the CJR acute care hospital's repayment amount. In aggregate, a CJR acute care hospital may not collect alignment payments for more than 50% of its repayment amount.

There is no ceiling on the portion of the reconciliation payments received by a hospital from Medicare that the hospital may distribute to non-physician Collaborators.



The corridors for risk sharing phase-in over time.

Source: DHG Healthcare and CMS

CJR Model - What's the Potential Impact to HealthSouth?

HealthSouth Discharges in CJR Markets
Fractures
~580 discharges
Replacements
~1,450 discharges
Σ = ~2,030 Discharges, or ~2.1% of Total HLS Medicare Discharges (~1.5% of Total HLS Discharges)

90-Day Episode Spend	
Fractures	
HLS cost ≤ SNF cost	HLS cost > SNF cost
~400 discharges	~180 discharges
Replacements	
HLS cost ≤ SNF cost	HLS cost > SNF cost
~200 discharges	~1,250 discharges

~30% of HealthSouth's fractures and ~40% of HealthSouth's replacements have complicating comorbidities* that require the intensity of care delivered in an IRF.

	Fractures (average revenue per discharge of ~$19,300)	Replacements (average revenue per discharge of ~$14,400)
Total CJR discharges	~580	~1,450
CJR discharges with HLS cost ≤ SNF cost	(~400)	(~200)
Discharges with complicating comorbidities	(~50)	(~500)
Residual CJR discharges	~130	~750

Source: 2014 Medicare claims data

* Complicating comorbidities include conditions such as diabetes, morbid obesity, and congestive heart failure.

CJR Model - HealthSouth's Strategies

Opportunities Outweigh the Risks

Increase the number of CJR discharges in all markets where HealthSouth has a cost advantage

- ✓ Present the empirical data to referral sources
- ✓ Further improve advantage by reducing acute care transfers and discharges to SNFs through tools such as predictive modeling

Increase the number of Encompass home health CJR episodes

- ✓ Lower length of stay or bypass SNFs and go directly to Encompass home health
- ✓ Increase clinical collaboration efforts between HealthSouth's IRFs and Encompass

Average revenue per episode of ~$3,300

Serve as a collaborator

- ✓ Enhance value proposition to CJR acute care hospitals by engaging in risk-sharing financial arrangements
  - Individually negotiated with each acute care hospital based on circumstances in each market
  - Risk capped at 25% of acute care hospital's repayment amount

Improve value proposition for CJR discharges in markets in which HealthSouth does not currently have a cost advantage

- ✓ Import best practices from other HealthSouth IRFs
- ✓ Reduce acute-care transfers and discharges to SNFs through tools such as predictive modeling
- ✓ Increase clinical collaboration between HealthSouth's IRFs and Encompass

Increase the number of stroke discharges in all markets

- ✓ New guidelines for adult stroke rehabilitation and recovery favoring IRFs over SNFs released by the American Heart Association and the American Stroke Association
- ✓ 100 of HealthSouth's IRFs hold The Joint Commission's Disease-Specific Care Certification in Stroke Rehabilitation.

Average revenue per discharge of ~$22,700

Independent Research Concludes IRFs are a Better Rehabilitation Option than SNFs

AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery

A Guideline for Healthcare Professionals From the American Heart Association / American Stroke Association

Purpose—The aim of this guideline is to provide a synopsis of best clinical practices in the rehabilitative care of adults recovering from stroke.

Methods—Writing group n … vious work in relevant topic areas and were a … Scientific Statement Oversight Committee ar… vant articles on adults using computerized sear… thin the context of the AHA framework and is … d supplementary AHA methods of classifying th… erwent extensive AHA internal ar… roke Council Leadership review, and Scientific Statements Oversight Committee review b… val by the AH… sustained and… and

Results—St… his or he… other caregiver… and occupati… ge pathologists… kers, and other… nation among t… ness and efficie… underlie this en… ated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.

"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility. While in an inpatient rehabilitation facility, a patient participates in at least three hours of rehabilitation a day from physical therapists, occupational therapists, and speech therapists. Nurses are continuously available and doctors typically visit daily."*

"If the hospital suggests sending your loved one to a skilled nursing facility after a stroke, advocate for the patient to go to an inpatient rehabilitation facility instead…"*

"The studies that have compared outcomes in hospitalized stroke patients first discharged to an IRF, a SNF, or a nursing home have generally shown that IRF patients have higher rates of return to community living and greater functional recovery, whereas patients discharged to a SNF or a nursing home have higher rehospitalization rates and substantially poorer survival."**

* AHA/ASA press release, "In-patient rehab recommended over nursing homes for stroke rehab," issued May 4, 2016 (newsroom.heart.org)

** "Guidelines for Adult Stroke Rehabilitation and Recovery," issued May 2016 (stroke.ahajournals.org)