Surgical Hip and Femur Fracture Treatment Model

Provider and Technical Fact Sheet

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) announced regulations regarding the Surgical Hip and Femur Fracture Treatment (SHFFT) model in the Advancing Care Coordination through Episode Payment Models final rule. The final rule finalizes three Episode Payment Models (EPMs) and a Cardiac Rehabilitation Incentive Payment Model and includes some modifications to the Comprehensive Care for Joint Replacement (CJR) Model. The rule also creates an advanced APM track option for each of the 3 EPMs and the CJR Model.

This final rule implements a new payment model for Part A and B items and services provided to Medicare fee-for-service beneficiaries under the authority of Section 1115A of the Social Security Act. Acute care hospitals in certain selected geographic areas will participate in retrospective episode payments for items and services that are related to SHFFT and recovery, beginning with a hospitalization for SHFFT and extending for 90 days following hospital discharge. The Model furthers CMS' goal of improving the efficiency and quality of care for Medicare beneficiaries with SHFFT, a common and serious condition, and encourages hospitals, physicians, and post-acute care providers to work together to improve the coordination of care from the initial hospitalization through recovery.

The first performance period will begin on July 1, 2017. The SHFFT Model will continue for 5 years, ending on or about December 31, 2021.

Overall Model Design

The SHFFT Model holds participant hospitals financially accountable for the quality and cost of a SHFFT Model episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. A SHFFT episode is defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that eventually results in a discharge paid under Medicare Severity-Disease Related Group (MS-DRG) 480 (Hip and femur procedures except major joint with major complication or comorbidity - CC), MS-DRG 481 (Hip and femur procedures except major joint with complication or comorbidity - MCC), or MS-DRG 482 (Hip and femur procedures except major joint without CC or MCC).

The episode of care continues for 90 days following discharge. Part A and Part B services related to the SHFFT Model episode are included in the episode. For each performance year of this model, CMS will set Medicare episode quality-adjusted target prices for each participant hospital that include payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who have SHFFT surgery at that hospital. Quality-adjusted target prices will initially be set based on a blend of provider-specific and census-region historical claims data for beneficiaries hospitalized for SHFFT, and gradually transition to being set based on census-region pricing only. All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. Following the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) will be compared to the Medicare quality-adjusted target price for the participant hospital where the beneficiary had the SHFFT surgery. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

Major Policy Changes from the Proposed Rule to the Final Rule

There are several major policy changes from the proposed rule to the final rule. The major rule changes are bulleted below.

- *Implementation of downside risk:* In our final rule, we finalized a policy which allows SHFFT Model participants to voluntarily accept downside risk beginning in performance year 2 on January 1, 2018. For participants who do not elect early downside risk, downside risk will begin with episodes ending in performance year 3 on January 1, 2019.
- *Stop-loss/Stop-gain limits:* In the proposed rule, we had proposed a stop-loss limit of 5% in performance year 2 during the single quarter of downside risk, 5% in performance year 2, 10% in performance year 3, and 20% in performance years 4 and 5 for participating hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals, which had lower stop-loss limits. As specified above, we have changed our policy to allow SHFFT Model participants to elect optional downside risk in the beginning of performance year 2. Participants not electing early downside risk will have required downside risk beginning in performance year 3. We have altered our stop-loss and stop-gain limits to reflect this policy. Specifically, the stop-loss limits are 5% in in performance year 2 (for voluntary downside risk),5%,in performance year 3, 10% in performance year 4, and 20% in performance year 5, with lower limits for certain hospitals. We also have finalized stop-gain limits which mirror the stop-loss limits. Specifically, the stop-gain limit for all participants in performance years 1, 2, 3, 4, and 5 will be 5%, 5%, 5%, 10% and 20%, respectively.
- *Adjustments for hospitals with a low volume of episodes:* In response to comments, we are implementing a policy for hospitals determined to have a low volume of historical

episodes under a model—"volume protection hospitals." Specifically, hospitals with a historical volume of EPM episodes at or below the 10th percentile of the number of hospital-specific historical EPM episodes for hospitals located in the MSAs eligible for selection into that specific EPM will have the same protections as rural hospitals, sole community hospitals, Medicare Dependent Hospitals, and rural referral centers (RRCs). These stop-loss limits will be 3% in performance years 2 (if they voluntarily accept early downside risk) and 3, and 5% in performance years 4 and 5.

General Model Overview

Participants

The SHFFT Model will be implemented in 67 geographic areas, defined by metropolitan statistical areas (MSAs). The 67 geographic MSAs participating in the SHFFT Model are the same 67 MSAs that are currently participating in the CJR Model. MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection. Eligible MSAs, which were used for MSA selection in the CJR Model, must have had at least 400 eligible (not included in the Bundled Payments for Care Improvement (BPCI) initiative) CJR cases between July 2013 and June 2014, and no more than 50 percent of otherwise qualifying CJR procedures occurring in a Maryland hospital, hospital participating in BPCI, or receiving post-acute care services at a skilled nursing facility (SNF) or home health agency (HHA) participating in BPCI. The MSAs were selected by stratified random sampling for CJR. The 67 MSAs selected can be found on our website: https://innovation.cms.gov/initiatives/epm.

Participant hospitals in these selected geographic areas are all acute care hospitals paid under the IPPS that are not concurrently participating in Model 1 or Models 2 or 4 of the BPCI initiative for SHFFT episodes.

Approximately 865 hospitals are required to participate in the SHFFT Model. The number of hospitals that actually participate in the SHFFT Model will be dependent on performance within the Model, subject to BPCI participation and whether a given hospital discharges Medicare beneficiaries under SHFFT Model-eligible MS-DRGs during SHFFT Model performance years. The list of hospitals required to participate in the SHFFT Model can be found on our website at https://innovation.cms.gov/initiatives/epm. Full implementation of the Model in selected geographic areas, rather than only in organizations volunteering to participate in the Model, yields more valid and reliable study results.

Episode definition

The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 480, 481, or 482 and ends 90 days post-discharge in order

to cover the complete period of recovery for beneficiaries. The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions. The following categories of items and services are included in the episodes: physicians' services; inpatient hospital services (including hospital readmissions); inpatient psychiatric facility (IPF) services; long-term care hospital (LTCH) services; inpatient rehabilitation facility (IRF) services; skilled nursing facility (SNF) services; home health agency (HHA) services; hospital outpatient services; outpatient therapy services; clinical laboratory services; durable medical equipment (DME); Part B drugs; hospice; and some per beneficiary per month (PBPM) care management payments under models tested under Section 1115A of the Social Security Act. Unrelated services are excluded from the episode. Unrelated services are for acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of SHFFT surgery; and chronic conditions that are generally not affected by SHFFT surgery or care during the 90-day post-discharge period. The complete list of exclusions can be found on our website at https://innovation.cms.gov/initiatives/epm, accompanied by the list of excluded MS-DRGs for readmissions and ICD-10-CM diagnosis codes for Part B services.

Pricing and payment

The SHFFT Model is a retrospective episode payment model. CMS will provide participant hospitals with Medicare episode prices, called quality-adjusted target prices, prior to the start of each performance year. Quality-adjusted target prices for episodes anchored by MS-DRG 480 vs. MS-DRG 481 vs. MS-DRG 482 will be provided to participant hospitals. The quality-adjusted target price includes a discount over expected episode spending and this discount varies based on the composite quality score earned by hospitals across the SHFFT quality measures. This quality-adjusted target price will incorporate a blend of historical hospital-specific spending and regional spending for SHFFT Model episodes, with the regional component of the blend increasing over time. All providers and suppliers furnishing SHFFT Model episodes of care to beneficiaries throughout the year will be paid under existing Medicare payment systems.

Following completion of a SHFFT Model performance year, participant hospitals that achieve SHFFT Model actual episode spending below the quality-adjusted target price and achieve an acceptable or better composite quality score will be eligible to earn a reconciliation payment from Medicare for the difference between the quality-adjusted target price and the actual episode spending, up to a specified cap. We are finalizing a policy for no repayment responsibility in performance years 1 and 2 of the Model for providers not opting for an early start for downside risk in January of 2018. Providers who do opt for voluntary downside risk in performance year 2 will be at risk for repayment in performance year 2. We are also finalizing a policy to apply a reduced discount percentage for repayment responsibility in performance years 3 and 4 in order to phase in financial responsibility for spending during SHFFT Model episodes throughout the Model performance years. We are also finalizing parallel stop-loss and stop-gain limits, which

both protect hospitals from excess financial risk while limiting gains proportional to the potential downside risk.

All hospital participants that achieve SHFFT Model actual spending below the quality-adjusted target price and achieve an acceptable or better composite quality score will be eligible to earn up to 5 percent of their quality-adjusted target price in performance years 1, 2 and 3, 10 percent in performance year 4, and 20 percent in performance year 5. Hospitals with SHFFT Model episode spending that exceeds the target price will be financially responsible for the difference to Medicare up to a specified repayment limit. We have finalized stop-loss limits of 5 percent in performance year 2 (for participants that elect voluntary early downside risk), 5 percent in performance year 3, 10 percent in performance year 4 and 20 percent in performance year 5 for participant hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, sole community hospitals and certain volume-protection hospitals. We are finalizing the stop-loss limit for these hospitals at 3 percent in performance years 2 and 3, and 5 percent in performance years 4 and 5. We believe that our stop-loss and stop-gain limits provide proportionately similar protections to CMS and hospital participants, as well as ensure beneficiaries have access to high quality care under the Models. We believe it is appropriate that as participant hospitals increase their financial responsibility, they can similarly increase their opportunity for additional payments under this model. We also believe that these changes will both facilitate participants' ability to be successful under this model and allow for a more gradual transition to financial responsibility under the Model.

Additional flexibilities for participant hospitals and collaborating providers and suppliers

The Model waives certain existing payment system requirements to assist participant hospitals in caring for beneficiaries in the most efficient, convenient setting, to encourage timely, accessible care, and to facilitate improved communication and treatment adherence. These include: allowing payment for certain physician visits to a beneficiary in his or her home via telehealth and allowing payment for certain types of physician-directed home visits for non-homebound beneficiaries. In addition, a participant hospital may wish to enter into certain financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain in-kind patient engagement incentives to advance the clinical goals of their care, under certain conditions.

Quality and the pay-for-performance methodology

The SHFFT Model has the potential to improve quality in four ways. First, the Model adopts a quality first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price. Second, higher episode quality, considering both performance and improvement, may lead a hospital to have the opportunity for greater financial rewards given the level of actual spending based on the hospital's composite quality score, a summary score reflecting hospital performance and improvement on the following two measures:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF#1550); and
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF#0166).

The composite quality score also takes into consideration a hospital's submission of THA/TKA patient-reported outcomes and limited risk variable voluntary data.

Third, in addition to quality performance requirements, the Model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments.

Fourth, CMS provides additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals with relevant spending and utilization data; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of care; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

More information on quality in the pay-for-performance methodology can be found on our website at https://innovation.cms.gov/initiatives/epm.

Beneficiary benefits and protections

Beneficiaries retain their freedom of choice to choose services and providers. Physicians and hospitals are expected to continue to meet current standards required by the Medicare program. All existing safeguards to protect beneficiaries and patients remain in place. If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800- MEDICARE or contact his or her state's Quality Improvement Organization by going to http://www.qioprogram.org/contact-zones. The establishment of an Alternative Payment Models Beneficiary Ombudsman will also ensure monitoring of the Models and fielding inquiries from beneficiaries if needed. The final rule also describes additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services.

Interaction with other models and programs

Hospitals participating in other CMS models or programs such as the Shared Savings Program and other Accountable Care Organization (ACO) initiatives are included in the SHFFT Model if they are located in a selected MSA. Beneficiaries included in SHFFT Model episode under the SHFFT Model may also be assigned to an ACO, in which case CMS will attribute savings achieved during a SHFFT Model episode to the SHFFT Model participant, and include SHFFT Model reconciliation payments for ACO-aligned beneficiaries as ACO expenditures. Episodes initiated by beneficiaries who are prospectively aligned to certain two-sided risk shared savings programs such as the Next Generation ACO will be excluded from the SHFFT Model.

Innovation Center

The SHFFT Model has been designed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by Section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models to reduce CMS program expenditures and preserve or enhance the quality of care for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. The Innovation Center's mission is to take locally-driven approaches – approaches from doctors and other health care partners providing care to patients every day – and give them platform to scale through a very collaborative and highly transparent process.

The Advancing Care Coordination through Episode Payment Models can be viewed at https://www.federalregister.gov/public-inspection/current starting December 20, 2016.

For **more information** about the SHFFT Model, go to https://innovation.cms.gov/initiatives/shfft-model

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