PUBLICATION

Key Ingredients of CMS' Proposed Comprehensive Care for Joint Replacement Model [Ober|Kaler]

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On July 14, 2015, CMS released a proposed rule [PDF] regarding a new, alternative payment model: the Comprehensive Care for Joint Replacement (CCJR) program.

Modeled in large part on the Bundled Payments for Care Improvement (BPCI) Model 2 program, as proposed, CCJR will mandate that certain acute care hospitals accept a bundled payment, to be paid retrospectively, for a 90 day "episode of care" surrounding lower extremity joint replacement (LEJR) – i.e., hip and knee replacements. CMS intends to test CCJR for five performance years, beginning January 1, 2016, and ending December 31, 2020.

This new alternative payment model is intended to align with the Secretary's goal of increasingly paying for value and outcomes, not volume. Indeed, the LEJR procedures that are the focus of the CCJR model embody the very health spending patterns that CMS is attempting to tackle: high expenditure, high utilization procedures for which there is significant variation in spending across the country.

As support for its proposal, CMS is relying on demonstration authority established by Section 1115A of the Social Security Act (42 U.S.C. § 1315a), the same authority relied upon by CMS to test the BPCI initiative. **Comments are due September 8, 2015**.

Key ingredients of the proposed rule include the following:

1. **Mandatory participation for all hospitals located in select geographic areas (subject to exceptions):** CMS is proposing that all hospitals paid under IPPS and physically located in certain selected geographic areas must participate in the CCJR model, *unless* the hospital is already an "episode initiator" in the BPCI Model 2 program for an LEJR episode. Hospitals that are an "episode initiator' for LEJR episodes under BPCI Model 2 are excluded from CCJR participation. (Also note, due to the fact that only hospitals paid under IPPS will participate, this excludes all critical access hospitals and Maryland hospitals, although CMS indicated that Maryland hospitals may be interested in CCJR upon the expiration of the Maryland All-Payer Model).
2. **The selected geographic areas are based upon MSAs:** CMS is proposing to determine which hospitals will participate in CCJR based upon Metropolitan Statistical Areas (MSAs). A list of proposed participating MSAs is available here [PDF] (80 Fed Reg 41198, 41212 (July 14, 2015)). Note that MSAs "dominated by" BPCI Models 1, 2, 3, or 4 (i.e., more than 50 percent of otherwise qualifying proposed CCJR episodes are impacted) are excluded.
3. **Participating hospitals will be held financially accountable for a 90 day episode of care:** The episode of care will begin upon admission by a Medicare beneficiary to a participating hospital for an LEJR procedure that is assigned to MS-DRG 469 or MS-DRG 470, and will extend 90 days after the date the beneficiary is discharged from the participating hospital. Thus, the episode of care will include the LEJR procedure, inpatient stay, and all "related care" covered under Medicare Parts A and B, within the 90 days after discharge. Examples of care deemed unrelated to the LEJR episode include, but is not limited to, drugs paid outside of the MS-DRG (specifically hemophilia clotting factors) and IPPS new technology add-on payments for drugs, technologies, and services.

4. **The (retrospective) bundled payment model:** Participating hospitals will initially be paid by Medicare in accordance with their usual fee-for-service (FFS) payment system. However, on an annual basis, CMS will *retrospectively* assess participating hospitals' financial performance for each episode of care. That is, for a given performance year, CMS will compare the hospital's actual Medicare fee-for-service (FFS) claims furnished to CCJR beneficiaries across each 90 day episode of care (i.e., the actual episode payment), as compared to a CMS "target price." If a participating hospital's actual episode payment is *less* than CMS' target price for that year, the participating hospital may be eligible to receive a "reconciliation payment" from CMS (subject to meeting certain quality requirements). If, in performance years two through five, a participant's hospital's actual episode payment is greater than CMS' target price, a participating hospital will be financially liable to CMS for such "Medicare repayment amounts." Note that, as proposed, a participating hospital will not be at financial risk for any Medicare repayment amount during the first performance year of CCJR.
5. **Quality matters:** In order to be eligible to receive a reconciliation payment from CMS in the first instance, a participating hospital must first meet certain quality standards related to: (a) hospital-level, 30 day readmission rates following elective total hip arthroplasty (THA) and/or total knee arthroplasty (TKA); (b) hospital-level complication rates following elective primary THA and/or TKA; and (c) HCAHPS survey results. Of note, CMS is also financially incentivizing participating hospitals to submit data for certain patient-reported outcome measures related to THA and TKA.
6. **CCJR collaborators:** While not a model requirement, CMS is actively encouraging participating hospitals to partner with community providers (CCJR collaborators) to jointly engage in care redesign and potentially share in any financial risk and/or reward. Specifically, participating hospitals can choose to enter into certain financial arrangements with CCJR collaborators, in which the parties may share in upside risk (Gainsharing Payments) and/or downside risk (Alignment Payments). Eligible CCJR collaborators include skilled nursing facilities (SNFs), home health agencies (HHAs), long term care hospitals (LTCHs), inpatient rehabilitation facility (IRFs), physician group practices, physicians, non-physician practitioners and outpatient therapy providers.
7. **Participant agreement:** Prior to sharing any Gainsharing Payment or receiving an Alignment Payment, participating hospitals and CCJR collaborators must enter into a written agreement (Participant Agreement). This Participant Agreement must specify, among other requirements, certain limitations on the manner in which Gainsharing Payments may be distributed, specific HHS and participant hospital audit rights, and certain additional compliance requirements imposed on both the Participant Hospital and the CCJR collaborator.
8. **The upside-gainsharing payments:** Gainsharing Payments from a participating hospital to a CCJR collaborator may be comprised of only two sources of savings realized as a result of participation in the CCJR model: (a) reconciliation payments, i.e., the amount a participating hospital may save as a result of having an actual episode payment amount for a given performance year be less than the CMS target price; and (b) internal cost savings, i.e., the cost savings realized by the hospital as a result of certain care redesign activities related to the CCJR episodes of care. Of import, Gainsharing Payments are capped for individual physicians, non-physician practitioners, and physician practice groups.
9. **The downside-alignment payments:** Alignment Payments allow for CCJR collaborators to share in the downside risk with a participating hospital. Thus, in the event a participating hospital owes money to CMS (i.e., the Medicare repayment amount), the CCJR collaborator can contribute to the total amount due to CMS. Notwithstanding the foregoing, CCJR collaborators are limited in the amount that they can contribute – only up to 50 percent of the participating hospital's total Medicare repayment amount.
10. **Beneficiary incentives:** CMS proposes that participating hospitals consider providing certain items and services to beneficiaries during the episode of care in order to help the hospital achieve the underlying goals of the CCJR. Thus, the services must be reasonably connected to the beneficiaries care, and must be a preventive care item or service or an item or service that advances a clinical goal

for the beneficiary. The items or services should be designed to increase the beneficiary's engagement in the management of his or her own healthcare, adhere to a treatment or drug regimen, adhere to follow-up care plan, reduce admissions and complications, or to facilitate the management of a chronic disease or condition that might be affected by the procedure. The permissibility of beneficiary incentives to encourage patient engagement is limited to hospitals. CMS considered but declined to extend the policy on beneficiary incentives to other providers and suppliers participating in CCJR as collaborators, noting that the hospital is better positioned to coordinate beneficiary care.

11. **Fraud and abuse waivers:** The inclusion of certain fraud and abuse waivers has been essential to the success and implementation of the various BPCI programs. That said, no specific fraud and abuse waivers related to the civil monetary penalty law, the Anti-kickback statute, or the physician self-referral law were proposed by CMS. CMS noted only that the Secretary will "consider whether waivers of certain fraud and abuse laws are necessary to test the CCJR model as the model develops." It is anticipated that such waivers will be promulgated separately by the Department of Health and Human Services, Office of Inspector General.
12. **Payment policy waivers:** CMS is proposing three payment policy waivers. First, to facilitate increased patient access to home care and enhanced utilization of non-physician practitioners, CMS seeks to waive the "incident to" requirement for post-discharge home visits. This will allow for a CCJR beneficiary who does not qualify for home health services to receive post-discharge home visits from a licensed clinician under the general supervision of a physician. Second, and in recognition of the fact that the CCJR model may allow participating hospitals to realize increased efficiencies, CMS intends to waive the "SNF 3-day rule," such that hospitals may discharge CCJR beneficiaries to a SNF in less than three days, where medically indicated and appropriate. As participating hospitals will only be financially liable beginning in year two of the model, so too will this waiver only be available beginning in performance year two. Third, CMS is proposing to waive the geographic site requirement for telehealth billing services, in addition to the originating site requirements when telehealth services are being furnished in a CCJR's beneficiary home or place of residence during the episode.
13. **Model overlap:** In the proposed rule, CMS acknowledged that CCJR will inevitably overlap with other alternative payment models, like BPCI and Medicare shared savings programs. Solutions proposed by CMS include a "trumping" mechanism for the BPCI program (e.g., within BPCI Model 2, BPCI LEJR episodes of care will trump CCJR LEJR episodes of care) and adding in an additional reconciliation period to account for any overlap with the Medicare Shared Savings Program.
14. **Documentations requirements:** Similar to the audit and document retention requirements included under other payment demonstration models, CMS proposes a ten year documentation retention requirement. The ten year period is determined by looking to the timeframe calculated from the last date of participation in the CCJR or the date of completion of any audit, evaluation, inspection, or investigation — whichever is latest. Nothing in the proposed rule limits or restricts the OIG's audit authority.

Ober|Kaler's Comments

If finalized, the proposed CCJR model would represent a significant change in Medicare payment policy. While certainly not the first CMS model to encourage providers to transition to value-based payment methodologies, it appears that it is the first to mandate provider participation.

CMS is encouraging comments. In particular, hospitals participating in the BPCI Model 2 program, as well as Maryland hospitals, may wish to consider commenting on the CCJR model, as CCJR may present an opportunity to speak to their experiences and possibly gain clarification on either the BPCI or CCJR payment model.

The success of the CCJR program will require coordination among health care providers at least equal to, or more than, the coordination typically found in the BPCI initiative. Additionally, a hospital's financial success in the CCJR program may ultimately rely on whether Medicare beneficiaries choose to receive care from collaborators aligned with the CCJR hospital or to receive care from health care providers who have no incentive to accomplish the CCJR program's goals.