Centers for Medicare & Medicaid Services Finalizes New Comprehensive Care for Joint Replacement Payment Model

November 19, 2015

Effective April 1, 2016, acute care hospitals located in 67 geographic areas will be subject to the new mandatory payment model for lower extremity joint replacement ("LEJR") services. Under the new Comprehensive Care for Joint Replacement ("CJR") payment model, the Department of Health and Human Services ("HHS") places the participating hospitals at risk for the quality and cost of care related to LEJR.

Hospitals Included in CJR

All hospitals reimbursed under the inpatient prospective payment system ("IPPS") and located in one of 67 geographic areas selected by the Centers for Medicare & Medicaid Services ("CMS") will be required to participate in the CJR. The geographic areas are defined by a metropolitan service area ("MSA") and include all hospitals within the boundaries of the MSA. The hospital's location is determined based on the address associated with the CCN for the hospital. Hospital participation will include hospitals within the MSA on April 1, 2016 and will not change if the MSA is adjusted during the performance periods. The MSAs selected for participation include Kansas City, Topeka (Kansas), Wichita (Kansas), St. Louis, Denver, and Los Angeles. A full list of the MSAs and affected hospitals selected for inclusion in the CJR payment model is available at https://innovation.cms.gov/initiatives/cjr. A total of 789 hospitals were selected for participation in the CJR payment model.

Because the CJR payment model is mandatory for all PPS hospitals within a geographic area, any beneficiary receiving services from a CJR-participating hospital is required to participate. The CJR will only apply to patients with traditional Medicare as their primary insurance and will not include beneficiaries enrolled in Medicare Advantage plans. Participating hospitals are required to provide specific notices to the beneficiaries to educate them regarding the model and certain beneficiary rights.

Annual Reconciliation

The CJR will be tested for five performance periods from April 1, 2016 to December 31, 2020, with the first year running April 1 to December 31 and subsequent performance years based on calendar year. During a performance year, the hospital and other providers will be reimbursed for LEJR services under the usual

Medicare fee for service systems. However, at the end of each performance year, CMS will calculate a reconciliation payment based on comparison of the “Total CJR Target Price” and the actual “Episode Payments.”

Where the hospital obtained efficiencies and has Episode Payments below the Total CJR Target Price, the hospital will be entitled to an additional reconciliation payment, so long as quality measures are satisfied. Beginning in the second performance year, if a hospital’s actual Episode Payments exceed the Total CJR Target Price, the hospital will be responsible for repayment of the difference between the actual Episode Payments and the Total CJR Target Price. The amount of potential repayment will be capped at a set percentage of the Total CJR Target Price, with the percentage cap increasing each performance year.

Definition of a LEJR Episode Payment

For purposes of the CJR, LEJR services are defined as hospital services reimbursed under the IPPS utilizing either MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC). The LEJR “Episode” for which a hospital is responsible begins with the admission of a Medicare beneficiary for a service that is assigned to MS-DRG 469 or 470 under IPPS and continues for 90 days post-discharge. The Episode Payment includes all services provided to the beneficiary and reimbursed under Medicare Part A or Part B during this time period related to the LEJR procedure.

Episode Payment determination may include payments for physician services, inpatient and outpatient hospital services, inpatient psychiatric facility services, long term care hospital services, inpatient rehabilitation services, skilled nursing facility services, home health services, outpatient therapy services, clinical laboratory services, durable medical equipment, Part B drugs, and hospice services related to the LEJR. The Episode Payment will exclude services that report certain MS-DRG or ICD-10-CM codes as a principal diagnosis, available at https://innovation.cms.gov/initiatives/cjr. This list was tested in previous bundled payment initiatives and is intended to exclude chronic conditions that are generally not affected by the LEJR procedure or post-surgical care (such as removal of the prostate) and acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of LEJR surgery (such as appendectomy).

Determination of the CJR Target Price

The Total CJR Target Price will be a sum of the CJR Target Prices for each Episode of LEJR services the hospital provides during the performance period. To account for changes in fee schedule and clinical risk factors, each hospital will have a set of CJR Target Prices established. Separate CJR Target Prices will be set based on whether the service is provided January 1 to September 30 or October 1 to December 31 of

the performance year to adjust for changes in the Medicare fee schedules. The CJR Target Price will be risk adjusted based on use of MS-DRG 469 or 470 and the patient's hip fracture status. Further, separate CJR Target Prices will be set based on whether or not the hospital successfully reports the voluntary patient-reported outcome measure.

The rates for each CJR Target Price would be determined based on three years historical Medicare payment data, updated every two years. The historical data will be a blending of individual hospital data with regional data.

Quality Measures

If, at the end of a performance year, a hospital's Episode Payment is less than the Total CJR Target Price, the hospital is entitled to a reconciliation payment, adjusted based on the quality category to which the hospital is assigned for that performance year. Hospitals participating in the CJR payment model will be assigned a composite quality score based on quality performance and improvement on the total hip arthroplasty (THA)/total knee arthroplasty (TKA) complications measure (NQF #1550) and the HCAHPS Survey measure (NQF #0116), as well as submission of THA/TKA voluntary patient reported outcomes and limited risk variable data. The composite quality score will then be used to place the hospital in one of four quality categories for each performance year, "Below Acceptable," "Acceptable," "Good," and "Excellent." Hospitals in higher quality categories will be entitled to a greater percentage of the reconciliation payment.

Fraud and Abuse Waivers

In implementing the CJR, HHS recognized that hospitals may be able to achieve greater efficiency and quality through collaboration with other entities who participate in the provision of care during an LEJR Episode. HHS, therefore, provides waivers of certain fraud and abuse requirements to the participating hospitals so that they can enter into financial arrangements with collaborating providers to share the risk related to the reconciliation payment. Like any fraud and abuse exception or safe harbor, the CJR waivers include specific requirements that must be satisfied for the collaboration arrangement to qualify. These requirements include, but are not limited to: execution of collaboration agreements prior to the provision of services; development of hospital policies and procedures related to the collaboration; establishment of the methodology to divide the gainsharing payments, which must include quality criteria and cannot be based on the volume or value of referrals; and public notification on the hospital's website of all entities with whom the hospital collaborates.

HHS also provides limited waivers to the hospitals to: 1) incentivize patients to adhere to a drug regimen or care plan, reduce readmissions and complications, or manage chronic diseases that could be affected by a LEJR procedure; 2) allow home health services without satisfying "incident to" requirements; 3) create new

G codes to report tele-health services provided related to the CJR payment model; and 4) waive the three-day hospitalization requirement for a patient to qualify for skilled nursing services in certain facilities.

Summary

Hospitals and other healthcare providers who participate in the care provided to Medicare beneficiaries who undergo a LEJR and are located in one of the 67 MSAs selected to participate in the CJR payment model should assess their ability to manage costs and maximize quality related to these procedures. Collaboration agreements among providers should be carefully structured to satisfy the requirements of the fraud and abuse waivers. To the extent possible, necessary preparations should be in place by April 1, 2016.

Hospitals and healthcare providers desiring additional information should contact their Lathrop Gage attorney or any of the attorneys listed above.