Bundled Payment Models – Comprehensive Care for Joint Replacement

Patricia “Pia” Dean

March 17, 2016

HOLLAND&HART

Roadmap for Today's Presentation

- CMS's interest in bundled payment models
- Definition of episode-based payment systems and their evolution
- Overview of the Comprehensive Care for Joint Replacement (CJR) model
- The geographic areas, hospitals, sub- acute, and post-acute care providers affected
- Stop-loss and stop-gain provisions, financial loss limitations, and appeals
- Quality measures and their effect on reimbursement rates
- Collaborator agreements and financial gain sharing arrangements

Preliminary Matter

- Presentation will be recorded and available for download at www.hhhealthlawblog.com
- If you have questions, please feel free to contact me at pdean@hollandhart.com
- If you experience technical problems during the webinar, please contact Luke Kelly at lskelly@hollandhart.com

Preliminary Matter

This presentation is similar to any other educational materials designed to provide general information on pertinent topics. The statements made as part of the presentation are provided for educational purposes only. They do not constitute legal advise and do not necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the speaker. This presentation is not intended to create an attorney-client relationship between you and Holland & Hart LLP. If you have specific questions as to the application of law to your particular activities, you should seek the advise of your legal counsel.

Why Payment Models Matter

- By every measure available, the U.S. health care system is the most expensive in the world – costing more than 2½ times the average of other developed countries.
- Accounting for ~17% of GDP, there has been tremendous focus on reducing spending.
- Experience has proved, however, that payment systems – especially those designed to reduce costs – affect provider behavior and almost every model has unintended consequences.
- Despite protestations to the contrary, study after study has shown that financial incentives have a direct correlation on the amount and type of care provided, regardless of clinical factors.

"Overall, financial incentives play a factor in patient and physician behavior regardless of specialty or area of health care. Different pay structures can change the rates of treatment given, the cost of care given, costs imposed on the system, and patient-based characteristics." Vo, A, *Working Hard or Hardly Working? The Effects of Pay Structure on Cost of Health Care Provision,* June 2013.

The Issue of Quality

- Despite the extraordinary cost of health care in the U.S., quality has continued to be an issue.
- In 2010, the Inspector General for HHS found that 80,000 patients in the Medicare program alone experienced avoidable medical errors that contributed to their deaths. When preventable errors that cause harm but not death are added to the equation, the incidence has been predicted to be as high as 40,000 errors per day.
- According to Medicare's own estimates, 1 in 7 Medicare patients will experience an "adverse" event while in the hospital, and 1 in 3 will be readmitted to the hospital within a month of discharge.

In 2009, Medicare spent an estimated $4.4 billion to care for patients who were harmed in the hospital and readmissions accounted for $26 billion in additional costs to Medicare.

Episode-Based Payment

- Prior to the passage of the ACA, the most far-reaching episode-based payment model was introduced in 1983 with the establishment of the inpatient prospective payment system (IPPS).
- Under the IPPS, hospitals are paid a fixed price, prospectively determined, for all physician and hospital charges associated with the patient's medical severity diagnosis-related group (MS-DRG).
- One of the goals of the IPPS/MS-DRG is to provide incentives for hospitals to shorten inpatient lengths of stay and reduce the number of procedures and the intensity of care provided.
  - IPPS has been at least partially effective in slowing the rate of cost increases.
  - Some studies suggest that IPPS does not significantly improve the quality of care provided.

Episode-Based Payment

- CMS conducted a series of demonstration projects to test the bundling of payment for services provided by multiple types of providers, such as hospitals and physicians, who have historically been paid under separate systems.
- These pilots have been applied to several types of episodes, including cardiac bypass, cataract surgery, and joint-replacement surgeries.

ACE Demonstration

- HHS introduced bundled payments for Medicare recipients with the Medicare Acute Care Episode (ACE) Demonstration in 2009.
  - Conducted under the authority of Section 1866C of the Social Security Act.
  - Three-year demonstration of prospective global payments for a single episode of care as an alternative approach to fee-for-service payment.
  - Limited to specific hospitals in four cities (San Antonio, Oklahoma City, Tulsa, and Denver)
  - Episode of care was defined as a combination of Part A and B services furnished to Medicare fee-for-service beneficiaries during an inpatient hospital stay for any one of a specified set of cardiac or orthopedic MS-DRGs.
- The discounted bundled payments generated an average gross savings to Medicare of $585 per episode for a total of 7.3 million across all episodes (12,501 episodes) or 3.1% of the total expected cost for these episodes.
- After accounting for some increased post-acute-care costs that were observed in two sites, Medicare estimates it saved approximately $4 million or 1.72% of the total expected Medicare spending through the ACE Demonstration.

Private Sector Efforts

- The private sector has also experimented with episode-based and bundled payment systems.
  - In 2006, the Commonwealth Fund and the Robert Wood Johnson Foundation developed the PROMETHEUS Payment model at four initial pilot sites.
    - PROMETHEUS stands for "Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-Reduction, Excellence, Understandability and Sustainability."
    - System assigns evidence-based case reimbursement rates (ECRs) to common conditions, including total joint replacement, diabetes, and depression.

Private Sector Efforts

- Also in 2006, the Geisinger Health System tested its "ProvenCare" payment model for coronary artery bypass surgery.
  - The model set a fixed price for preoperative, inpatient, and postoperative care (including re-hospitalizations), within 90 days of surgery.
  - A study of ProvenCare patients revealed that 117 patients who received their care under the model had significantly shorter lengths of stay, resulting in 5% lower hospital charges.
  - In addition, the ProvenCare patients were more likely to be discharged home and had a 10% decrease in readmissions when compared to the 137 patients who received conventional care.
  - Geisinger has added new diagnoses to its ProvenCare model, including elective coronary angioplasty, gastric bypass surgery for obesity, perinatal care, and treatment for several chronic conditions.

New Private Sector Initiatives

- In 2014, MD Anderson and UnitedHealthcare agreed on a bundled payment program for cancer patients.
  - The three-year pilot program will enroll 250 patients with cancers of the head and neck, including neoplasms of the salary glands, oral cavity, throat, and larynx who were covered by a UnitedHealthcare employer-sponsored health plan in the Houston area.
  - The yearly bundled payment amount is expected to cover almost all of the patient's cancer care including chemotherapy, imaging scans, surgery, and post-acute-care.

New Private Sector Initiatives

- UnitedHealthcare's latest project follows up on a three-year bundled payment pilot with five medical oncology practices covering 810 breast, colon, and lung cancer patients.
  - The pilot program reported medical costs that were 34% less than projections based on fee-for-service costs.
  - According to UnitedHealthcare, cancer therapy, including related drug costs, currently accounts for 11% of its total spending for healthcare.
- With one of the largest private payers investing heavily in bundled payment models and reporting savings, even if on only unlimited data, other commercial payers are likely to follow.

The Accountable Care Act

Encouraged by the cost savings of the ACE Demonstration and the inherent limitations of IPPS and other payment models, in 2010, the ACA established the Center for Medicare and Medicaid Innovation (Innovation Center) and mandated the creation of multiple programs to assess their effect on cost and quality of care.

The ACA charges the Innovation Center with "identifying, developing, assessing, supporting, and spreading new models that might reduce expenditures under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) while improving or maintaining care quality."

Bundled Payments

A payment system that covers a pre-determined episode of care involving the services of multiple providers, typically beginning with a set diagnosis and including all services provided over a specified time frame.

- Differs from fee-for-service in that the payment amount for all providers involved in the patient's care is set in advance and not affected by the number of services, procedures, or items provided.
- Differs from capitation in that capitated payment systems involve a single per capita prospective payment for all services over a fixed part of time regardless of the number of services or episodes of care provided within the designated time period.
- Moreover, since bundled payments ultimately are intended to cover services and items throughout an entire episode of care, including after the initial hospitalization ("post-acute care"), they go beyond the more limited IPPS/MS-DRG model that covers only the hospital and physician costs associated with an inpatient stay.

CMS Focus

- Bundled payment models have become a major focus of CMS.
  - Section 3032 of the ACA created the Innovation Center.
  - Section 3023 of the ACA specifically mandates the implementation of the Bundled Payments for Care Improvement (BPCI) Initiative for the purpose of testing the effects of episode-based payment approaches on "patient experience of care, outcomes, and cost of care for Medicare fee-for-service providers."

The stated goal of HHS is to have 30% of all Medicare services delivered through alternative payment models under which providers are accountable for the cost and quality of the care they deliver (e.g., ACOs and bundled payments) by 2016 and 50% by the end of 2018.

CMS's Current Bundled Payment Initiatives

- CMS is currently involved in three bundled payment initiatives:
  1. Bundled Payment for Care Improvement (BPCI) Initiative
     - Voluntary program that went into effect in 2013.
  2. Comprehensive Care for Joint Replacement (CJR) Program
     - Mandatory programs in specified geographic regions that go into effect on April 1, 2016
  3. Oncology Care Model
     - Voluntary initiative slated to be operational in Spring 2016.

Comprehensive Care for Joint Replacement Model (CJR)

- In July 2015, CMS proposed a rule (subject to notice and comment rulemaking) to implement a new Medicare Part A and B payment model under section 1115A of the Social Security Act, initially referred to as the CCJR (changed to "CJR" when the final rule was issued on November 24, 2015).
- Critically, the CJR model is mandatory in certain selected geographic areas.
- And, unlike the BPCI Initiative in which different types of entities could be the Episode Initiator (bundle-holder), in the CJR, hospitals are the only entity that can be an Episode Initiator and they bear sole responsibility for the cost and quality of the care provided.
  - CMS reasons that by putting hospitals at risk, they will have an incentive to increase care coordination, invest in infrastructure to improve quality and efficiency, and develop systems to ensure high-value post-acute care.

Lower Extremity Joint Replacement

- To understand CMS's motivation, you need look only to the numbers of lower extremity joint replacements (LEJR) performed on Medicare beneficiaries each year and the dollars involved:
  - Hip and knee replacements (although the CJR covers all lower extremity replacements and reattachments) are some of the most common surgeries for Medicare beneficiaries.
  - In in 2013, they accounted for 400,000 inpatient procedures, costing more than $7 billion for hospitalizations alone.
    - Common complications, including infections and implant failures, are almost 3 times higher at some facilities than others.
    - Costs vary widely, ranging between $16,500 to $33,000 – a difference of $6.6 trillion to the system.

Definition of Episode

- The episode is defined by the admission of an eligible Medicare beneficiary to a hospital paid under the IPPS for DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (same, without complications or comorbidities).
- The model includes all Part A and B services during the initial hospitalization and within 90 days of discharge.
- In addition to physician and inpatient hospital services, the bundle includes all services received in an inpatient psychiatric facility, long-term care hospital, inpatient rehabilitation facility, skilled nursing facility, home health agency, hospital outpatient setting, as well as independent outpatient therapy, clinical laboratory services, durable medical equipment, Part B drugs, and hospice.

Geographic Regions Required to Participate

- Critically, the CJR will be the first Innovation Center model and the only bundled payment model to date in which participation is mandatory.
- Accordingly, within each of the 67 selected geographic regions, all eligible Medicare beneficiaries, with limited exceptions, who are discharged with a MS-DRG of 469 or 470 will be included in the CJR model.

Geographic Regions

- The geographic areas for inclusion in the CJR model are determined on a stratified random sampling of certain Metropolitan Statistical Areas (MSAs) in the United States.
- The original proposed rule included 75 geographic regions (also based on MSAs) but that number was reduced to 67 in the final rule.
- A complete listing of the geographic regions included in the CJR model can be found at 80 Fed. Reg. 73,299, Table 4.
  - CMS excluded from the selection of geographic areas MSAs that met certain criteria. 42 C.F.R. §510.105(c).

Calculation of Reimbursement

- Under the CJR, all providers will continue to receive fee-for-service payments. The sum of the payments over the course of the episode are referred to as the "actual episode payment."
- At the conclusion of the episode, the actual episode payment will be reconciled against an established CJR target price with consequences if the actual episode payment is higher or lower than the target price.

Setting of Target Price

- Several factors go into the setting of target prices:
  - First, each participant hospital will have a target price based on whether the beneficiary is undergoing elective surgery or as the result of a fracture.
  - Second, CMS calculates episode target prices based on a blend of hospital-specific and regional episode expenditures. 42 C.F.R. §510.300(b)(1). (For detailed discussion see 80 Fed. Reg. 73,337-353).
    - Episode payments are capped at two standard deviations above the mean regional episode payment for both hospital-specific and regional components of the target price. 42 C.F.R. §510.300(b)(5)

Performance Years

- CMS will communicate the episode target price to participant hospitals before each performance year. 42 C.F.R. §510.300(b)(7)
- Performance Year 1 will run from April 1, 2016 through December 31, 2016. 42 C.F.R. §510.2
- Thereafter, Performance Years 2-5 will correspond to the calendar year until the model's conclusion on December 31, 2020.

Target Price

- Each participant hospital's target price incorporates a baseline 3% discount that reflects Medicare's portion of reduced expenditures from the CJR model. 42 C.F.R. §510.300(c)
- In each separate Performance Year, this discount may be affected by the two mandated quality-related scores and whether the hospital successfully submits data on a patient-reported outcomes survey.
- These scores affect:
  - (1) whether a participant hospital is eligible for a reconciliation payment;
  - (2) whether a participant hospital is eligible for a quality incentive payment; and
  - (3) the effective discount percentage for the reconciliation payment.

Reconciliation Process

- The CJR provides a series of reconciliation processes to establish final payment amounts to participant hospitals following each Performance Year.
- The reconciliation process begins 2 months after the end of each Performance Year and establishes a "net payment reconciliation amount (NPRA)." 42 C.F.R. §510.305(b).
- The NPRA essentially compares a hospital's actual episode payments to its target price multiplied by the number of episodes included in the performance year.
  - Other factors included in this calculation are increases an post-episode spending, limitations on loss, limitations on gain, and financial loss limits for certain types of hospitals. 42 C.F.R. §510.305(f).

Reconciliation Process

- For Performance Year 1, if a hospital's actual episode payments are less than the target episode price, it is eligible for a "reconciliation payment" equal to the NPRA.
- For Performance Years 2 through 5, reconciliation calculations are applied to the NPRA to determine whether a hospital is eligible for a reconciliation payment or whether it will be required to repay CMS for the amount in which its actual episode payments exceeded its target episode amount.
- CMS has instituted a phased-in repayment requirement, and accordingly, there is no repayment responsibility in Performance Year 1.

Stop-Loss and Stop-Gain

- The CJR also includes limitations on both a participant hospital's potential repayment obligation and reconciliation payment , referred to as the "stop-loss limit" and, correspondingly, the "stop-gain limit."
    - As discussed above, hospitals will not bear financial responsibility for acute episode payments greater than a ceiling set at two standard deviations above the mean regional episode payment.

Performance Year	Stop-Loss Limit (%)	Stop-Gain Limit (%)
1	There is no repayment responsibility	5
2	5	5
3	10	10
4 and 5	20	20

Stop-Loss Example

- By way of example, assume a hospital has 10 episodes triggered by MS-DRG 469 with the target price for each episode of $50,000, for a total target price of $500,000.
- If the hospital's actual spending for those 10 episodes was $650,000, the hospital's raw NPRA would be negative $150,000 ($500,000 - $650,000 = $-150,000).
- Under this scenario, starting in Performance Year 2, this hospital's raw NPRA would be capped at $50,000 (0.1 x 10 x $50,000 = $50,000), as opposed to the $150,000 that the hospital would be responsible to repay without a stop-loss limit. *See* 80 Fed Reg. 73,399.

Reconciliation Process

- On top of this reconciliation process, CMS imposes additional calculations based on several quality metrics.
- CMS assesses each participant hospital's performance on quality metrics to determine whether the participant hospital is eligible to receive a reconciliation payment for a Performance Year.
  - Before describing how quality measures affect payment, it is necessary to understand the quality measures incorporated into the CJR and their relative weight on reimbursement rates.

Quality Measures

- CMS has incorporated three quality measures into the CJR. They include:
  1. Performance on the hospital-level risk-standardized complication rate following elective primary Total Hip Arthroplasty (THA) and/or Total Ankle Arthroplasty (TKA) measure (NQF # 1550) ("THA/TKA Complications Measure);
  2. Performance on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166 ("HCAHPS Survey"); and
  3. Successful submission of the THA/TKA voluntary patient-reported outcomes and limited risk variable data ("THA/TKA Voluntary PRO and Risk Variable Data Measure").

Quality Measures

- THA/TKA Complications Measure (NQF #1550)
  - Measure is currently used in the HIQRP utilized by the BPCI Initiative.
  - Measures the rate of complications occurring after THA and/or TKA surgical procedures during the 90-day period following discharge.
- HCAHPS Survey
  - Nationalized, standardized, publicly reported survey of patients experience of hospital care.
  - Asks patients to rate their experience on 32 different aspects of their hospital experience.
- THA/TKA Voluntary PRO and Variable Risk Data
  - First measure used by CMS to assess post-operative functional outcomes.
  - Measure will be used through Performance Year 3.
  - After that, CMS plans to implement its own post-operative functional outcomes measure that it is currently developing.
  - To be eligible for increased reimbursement, hospitals must submit a substantial portion of data on this measure.

THA/TKA Voluntary PRO and Risk Variable Data

- Hospitals must submit a specified amount of requested THA/TKA Voluntary PRO and Variable Risk Data each Performance Year of the model in order to be deemed to have successfully complied with the submission requirement.

Performance Year	Percentage or Number of Primary THA/TKA Procedures	Performance Periods
1	≥50% or ≥50 total procedures	Performed between 7/1/16 and 8/31/16
2	Post-op data for ≥50% or ≥50 procedures and Pre-op data for ≥60% of ≥ 75 procedures	Performed between 7/1/16 and 8/31/16 and Performed between 9/1/16 and 6/30/17
3	Post-op data for ≥60% or ≥75 procedures and Pre-op data for ≥70% or ≥100 procedures	Performed between 9/1/16 and 6/30/17 and Performed between 7/1/17 and 6/30/18
4	Post-op data for ≥70% or ≥100 procedures and Pre-op data for ≥80% or ≥200 procedures	Performed between 7/1/17 and 6/30/18 and Performed between 7/1/18 and 6/30/19
5	Post-op data for ≥80% or ≥200 procedures and Pre-op data for ≥80% or ≥200 procedures	Performed between 7/118 and 6/3019 and Performed between 7/119 and 6/30/20

Scoring of Quality Measures and Effect on Payment

- Under the CJR, each of these three quality measures factor into the calculation of a "quality composite score.“
- The three quality measures are given the following weights:

Quality measure	Weight in composite quality score (%)
Hospital-level risk-standardized complication rate following elective THA and/or TKA measure (NQF #1550)	50
Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166)	40
THA/TKA voluntary data submission of patient reported outcomes and limited risk variable data	10

Scoring of Quality Measures and Effect on Payment

- In addition, CMS computes quality performance points for each of these quality measures based on the participant hospital's performance percentile relative to the national distribution of all hospitals performance on that measure. 42 C.F.R. §510.315(c).
  - For the THA/TKA Complications Measure, CMS assigns the participant hospital measure value to a performance percentile and then assigns quality performance points.
  - Similarly, for the HCAHPS Survey CMS assigns quality performance points based on the hospital's performance percentile.
  - In addition, a participant hospital is eligible to receive quality improvement points equal to 10% of the total available points for an individual measure if performance improves from the previous Performance Year by at least 3 deciles on the performance percentile scale.
- The table on the following page provides individual scoring for the 2 required quality measures:

Scoring of Quality Measures and Effect on Payment

Performance Percentile	THA/TKA Complications measure (NQF #1550) quality performance score (points) (one additional point available for improvement)	HCAHPS Survey measure (NQF #0166) quality performance score (points) (0.8 additional points available for improvement)
≥90th	10.00	8.00
≥80th and <90th	9.25	7.40
≥70th and <80th	8.50	6.80
≥60th and <70th	7.75	6.20
≥50th and <60th	7.00	5.60
≥40th and <50th	6.25	5.00
≥30th and <40th	5.50	4.40
<30th	0.00	0.00

Scoring of Quality Measures and Effect on Payment

- CMS may also provide incentive payments to participant hospitals depending on their composite quality score.
- These incentive payments are implemented in the form of reductions to the applicable discount rate.
  - Participant hospitals with a composite score ≤ 4.0 will be categorized as "Below Acceptable" and will not be eligible for reconciliation payment even if actual episode spending is less than the target price.
    - CMS estimates that based on current hospital quality measure performance, approximately 90% of participant hospitals would have a composite quality score of greater than or equal to 4.0 and, accordingly, would be eligible for reconciliation payments based on acceptable or better quality performance.
  - Participant hospitals with an acceptable composite quality score of >4.0 and < 6.0 will be assigned to the "Acceptable" quality category and be eligible for reconciliation payment if actual episode spending is less than the target price.

Scoring of Quality Measures and Effect on Payment

- Participant hospitals with a composite quality score of ≥ 6.0 and ≤ 13.2 will be assigned to the "Good" quality category and be eligible for quality incentive payment at reconciliation if actual episode spending is less than the target price.
- In addition, hospitals in this category will be eligible for a quality incentive payment at reconciliation that equals 1% of the participant hospital's benchmark price, thereby changing the effective discount percentage.

Scoring of Quality Measures and Effect on Payment

- Participant hospitals with a composite quality score of >13.2 will be assigned to the "Excellent" quality category and be eligible for quality incentive payment at reconciliation if actual episode spending is less than the target price.
- Hospitals in this category will also be eligible to receive a higher quality incentive payment that equals 1½ percent of the hospital's benchmark price, thereby changing the effective discount percentage included in the target price.

Scoring of Quality Measures and Effect on Payment

- This payment methodology effectively means that hospitals will either have less repayment responsibility (that is, the quality incentive payment will offset a portion of their repayment responsibility) or receive a higher payment (that is, the quality incentive payment will add to the reconciliation payment) than they would have otherwise based on a composite of actual episode spending to the target price that reflects a 3% discount.
- The tables on the next page summarize the relationship of composite quality scores to reconciliation payment eligibility and the effective discount percentage experienced at reconciliation by Performance Year.

Scoring of Quality Measures and Effect on Payment

- Performance Year 1

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	Not applicable
≥4.0 and <6.0	Acceptable	Yes	No	3.0	Not applicable
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	Not applicable
>13.2	Excellent	Yes	Yes	1.5	Not applicable

- Performance Years 2 and 3

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	3.0
≥4.0 and <6.0	Acceptable	Yes	No	3.0	3.0
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	2.0
>13.2	Excellent	Yes	Yes	1.5	1.5

- Performance Year 5

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	3.0
≥4.0 and <6.0	Acceptable	Yes	No	3.0	3.0
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	2.0
>13.2	Excellent	Yes	Yes	1.5	1.5

Financial Arrangements with Other Providers

- In an effort to facilitate collaboration between hospitals and other providers, including physicians, physician practice groups, sub- acute care facilities, post-acute care providers, and nonphysician providers, the CJR specifically allows participant hospitals to enter into "sharing arrangements" with other providers. 42 C.F.R. §510.500.
- These sharing arrangements may include agreements to share in reconciliation payments ("gainsharing") or repayment of cost overruns ("alignment payments").
- Providers entering into such financial arrangements are referred to as "CJR collaborators" and any financial arrangements to share in gains or losses must be memorialized in written "collaborator agreements."

Requirements for Sharing Arrangements

- There are several requirements for sharing arrangements:
  1. Sharing arrangements must be made only from the participant hospital to the CJR collaborator with whom the participant hospital has signed a collaborator agreement executed before care was furnished.
  2. CMS has the authority to review any sharing arrangement to ensure that it does not pose a risk to beneficiaries' access to care, freedom of choice, or quality of care.
  3. The participant hospital must have ultimate responsibility for fully complying with all provisions of the CJR model.
  4. The governing body of the participant hospital is responsible for overseeing its participation in the CJR model, its arrangements with CJR collaborators, its payment of gainsharing payments and the receipt of alignment payments, and its use of beneficiary incentives in the CJR model.
  5. Participating hospitals must develop and maintain written policies and must update its compliance program to include oversight of sharing arrangements.

Requirements for Sharing Arrangements

- In addition:
  - To be a CJR collaborator, a physician or nonphysician practitioner must not have opted out of Medicare.
  - Physician group practices that are CJR collaborators may retain all or a portion of the gainsharing payment provided that they contributed to the hospital's care redesign under the CJR model and were clinically involved in the care of the CJR beneficiaries.
  - Each sharing arrangement must comply with all relevant laws and regulations, including fraud and abuse laws and applicable payment and coverage requirements.
  - An individual's or entity's participation in a sharing arrangement must be voluntary and without penalty for nonparticipation.

Requirements for Sharing Arrangements

- The methodology for determining a collaborators receipt of reconciliation patient payments or obligation for alignment payments must be based, at least in part, on criteria related to the quality of care delivered to beneficiaries during the CJR episode and not directly on the volume or value of referrals.
- Any gainsharing payment must be derived solely from reconciliation payments, internal cost savings, or both.
- In a calendar year, the aggregate amount of all gainsharing payments distributed by a participant hospital may not exceed the amount of reconciliation payment the participant hospital receives from CMS.
- Similarly, in a calendar year, the aggregate amount of all alignment payments received by a participant hospital must not exceed 50% of the participant hospital's repayment amount.
- No alignment payments may be collected by a participant hospital if it does not owe a repayment.

Waiver of Pre-Existing Medicare Program Rules

- To further encourage collaboration between hospitals, physicians, and other providers, CMS has also waived certain Medicare program rules for providers participating in the CJR model. 42 C.F.R. §510.600.
  - CMS has waived the requirement that services and supplies must be furnished "incident to" direct physician supervision (set forth in 42 C.F.R. §410.26(b)(5)), thus allowing beneficiaries who do not otherwise qualify for home health services to receive post-discharge visits to their place of residence any time during the episode.
    - Under this provision, any service on the list of Medicare-approved telehealth services can be furnished to a CJR beneficiary, regardless of the beneficiary's geographic location.
    - CMS has also waived the requirement for a face-to-face encounter for home health certification.

Waiver of Pre-Existing Medicare Program Rules

- For episodes being tested in Performance Years 2 through 5, CMS has waived the "SNF 3-day rule."
  - Under existing Medicare rules, a beneficiary must have been in an acute-care hospital for three consecutive days in order to be eligible to be discharged to a SNF unit.
  - In an effort to encourage participant hospitals and their collaborators to redesign care for LEJR episodes across the continuum of care, the CJR waives the SNF 3-day rule, thereby allowing beneficiaries to be discharged from an acute care hospital to an SNF in less than 3 days, if clinically appropriate.

Appeals

- If a participant hospital wishes to dispute the calculation that involves a matter related to payment, reconciliation amounts, repayment amounts, or determinations associated with quality measures affecting payment, the hospital is required to provide written notice of the error, in the form and manner specified by CMS. 42 C.F.R. §510.310.
  - Unless the participant hospital provides written notice of error, the CJR reconciliation report is deemed final calendar 45 days after it is issued.
  - If CMS receives a timely notice of the calculation error, it must respond in writing within 30 calendar days to either confirm that there was an error in the calculation or verify that the calculation is correct.
    - CMS can expand this time limit upon written notice to the participant hospital.

Dispute Resolution Process

- If the participant hospital is dissatisfied with CMS's response to the notice of a calculation error, the participant hospital may request a reconsideration review.
- The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation that CMS did not accurately calculate the NPRA, the reconciliation payment, or the repayment amount.
  - Reconsideration requests must be received within 10 calendar days of the issue date of CMS's response to the notice of calculation error.

Dispute Resolution Process

- Upon timely receipt of a request for reconsideration, a CMS reconsideration official will notify the participant hospital in writing within 15 days of receiving the participant hospital's review request of the following:
  - The date, time, and location of the review.
  - The issues in dispute.
  - The review procedures.
  - The procedures (including format and deadlines) for submission of evidence.
- CMS shall take all reasonable efforts to schedule the review to occur no later than 30 days after the date of receipt of the notification.
- The provisions at 42 C.F.R. §425.804(b), (c), and (e) are applicable to reviews conducted in accordance with the reconsideration process for CJR.
- The CMS reconsideration official is to issue a written determination within 30 days of the review.
- The determination is final and binding.
- For additional information on exceptions to the process and limitations on review, *see* 42 C.F.R. 510.310 (c) and (d).

Anticipated Results

- Review of current bundled payment programs and, in particular the CJR, illustrate the extent to which the Innovation Center and CMS have thrown their weight behind this payment model.
- The final CJR rule subsumes more than 200 pages of the Federal Register in which CMS attempts to address the numerous concerns raised in over 390 comments to the proposed rule and explain its reasoning for the modifications adopted.
- This behemoth effort underscores CMS's considerable investment in the success of the bundled payment models to both reduce costs and improve (or at least maintain) the quality of care.

Anticipated Results

- The stakes for Medicare are substantial.
  - CMS reports that in 2014 there were approximately 478,000 discharges for MS-DRGs 469 and 470 nationally.
  - The estimated 90-day episode payment for LEJR procedures in 2014 was approximately $26,000.
    - Of this amount, CMS calculates that 55% was attributable to hospital inpatient services, 25% was attributable to post-acute care services (including both outpatient and in-facility care), and 20% was attributable to physician, outpatient hospital, and other spending.
  - Of the approximately 478,000 LEJR procedures in 2014, CMS estimates that about 86,000 took place in hospitals that will be mandatory participants in the CJR program.
    - This means the CJR model will include about 23% of all LEJR episodes during its pendency.

Anticipated Results

- If the model works as planned, the anticipated savings to Medicare will be $343 million over the program's five-year duration.
- CMS notes that there will also likely be a spillover effect into non-Medicare markets, or even in Medicare markets in other geographic areas.
- The following table summarizes CMS's total spending, reconciliation amounts, repayment amounts, and net reconciliation as a percentage of total episode to spend by Performance Year.

	2016	2017	2018	2019	2020	Across all 5 years of the model
Total episode spending	$1.247 billion	$2.562 billion	$2.688 billion	$2.821 billion	$2.980 billion	$12.299 billion
Net reconciliation payments	$11 billion	($36 billion)	($71 billion)	($120 billion)	($127 billion)	($343 billion)
Reconciliation amounts	$11 billion	$23 billion	$30 billion	$52 billion	$55 billion	$170 billion
Repayment amounts	Not applicable	($58 billion)	($101 billion)	($172 billion)	($182 billion)	($513 billion)
Net reconciliation as a percentage of total episode spend	0.8%	– 1.4%	– 2.6%	– 4.2%	– 4.2%	– 2.8%

Concluding Thoughts

- The Innovation Center and CMS are heavily invested in value-based payment models in general, and bundled payment systems in particular.
- No matter what happens with the ACA and the upcoming elections, value-based payment systems have broad bipartisan support and are unlikely to disappear with changing political winds.
- With bundled payments, CMS envisions redesigning essential aspects of care provision. According to CMS, this payment model "can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work closely together across all specialties and settings."

Concluding Thoughts

- Achieving this lofty goal, however, requires that institutional providers, physician groups, individual physicians, and all varieties of post-acute practitioners – who historically have not worked in concert, often don't understand each other's roles and contributions, and who have widely disparate bargaining power – work together to design continuums of care that achieve the best outcomes at the lowest cost, and fairly and adequately reimburse each of the practitioners for the services provided.
- This will require open lines of communication, thoughtful negotiations, thorough understanding of the statutes and regulations, development of sophisticated financial arrangements, enormously detailed compliance efforts, and careful and complete documents of myriad types.

Contact Information

Patricia ("Pia") Dean

Holland & Hart LLP

555 17th Street, Suite 3200

Denver, Colorado 80202

Telephone: 303-295-8464

Facsimile: 303-975-5370

E-mail: pdean@hollandhart.com