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COMMENTARY

New CMS Proposed Rule: Comprehensive Care for Joint Replacement

On July 9, 2015, the Centers for Medicare & Medicaid Services ("CMS") announced a proposed rule to test a new payment model, the Comprehensive Care for Joint Replacement ("CCJR"), for hip and knee replacements (also called lower extremity joint replacements or "LEJRs") (the "CCJR Proposed Rule"). The average Medicare expenditures for LEJRs, including surgery, hospitalization, and recovery, can range from $16,500 to $33,000. The CCJR Proposed Rule is designed to test bundled payment models and hold certain hospitals that do not otherwise participate in the Bundled Payment for Care Improvement ("BPCI") initiative financially accountable for the quality and cost of care provided to Medicare beneficiaries. BPCI is a demonstration project being conducted by the Centers for Medicare and Medicaid Innovation ("CMMI") to test the effects of episode-based payment.

Previously, on January 26, 2015, Health and Human Services ("HHS") Secretary Burwell announced an aggressive timeline to transition 30 percent of traditional Medicare fee-for-service payments to an alternative payment models by 2016. This CCJR Proposed Rule evidences the federal government's continued efforts toward its goal of meeting its ambitious timeline for risk-based payment model and to increase coordination among doctors, hospitals, health care professionals, and suppliers, while improving quality of care for and accountability to patients.

As discussed in more detail below, many elements of the CCJR model incorporate guidelines and requirements from the ongoing BPCI initiative.

Mandatory Participation and Proposed Timeframes

Unlike the voluntary, application-based BPCI initiative, the proposed CCJR model *requires* hospitals that are located in 75 specified geographic areas in 33 states to participate in this bundled payment reimbursement model. Each of the specified geographic areas, defined by Metropolitan Statistical Areas ("MSAs"), has a core urban population of 50,000 or more and had at least 400 eligible lower extremity joint replacement cases for Medicare beneficiaries between July 2013 and June 2014. All hospitals located in the selected MSAs that do not currently participate in Model 1 of the BPCI or in phase II of Model 2 or Model 4 of the BPCI for the MS-DRGs 469 and 470 (the lower extremity joint replacement clinical episodes) are mandatorily required to participate in the CCJR model. A list of proposed geographic regions

is available on the CMS website. No application is required for participation within the identified geographic areas.

The CCJR model, a five-year payment model, is proposed to be implemented on January 1, 2016.

CCJR Model Design and Pricing

Like Model 2 of the BPCI initiative, CCJR is a "retrospective bundled payment model" designed to promote accountability for the cost and quality of patient care by reconciling the actual health care spend for an episode of care ("Episode of Care") against a predetermined target price. For CCJR, an Episode of Care is initiated by an inpatient admission billed under MS DRG 469 or 470 of an eligible Medicare fee-for-service beneficiary to the hospital and continues for 90 days following discharge. The Episode of Care would include all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, including physicians' services, inpatient hospital service, readmissions (subject to limited exceptions), skilled nursing facility services, durable medical equipment, and Part B drugs.

Prior to the start of each performance year, CMS will set a target price for each hospital for each of the two Episodes of Care. The target price generally will include a 2 percent discount over expected episode spending, and it incorporates a blend of hospital-specific and regional spending for knee and joint replacement episodes. Over time, regional Medicare costs will weigh more heavily in the target price mix.

During an Episode of Care, all providers and suppliers providing Medicare Part A and Part B services will continue to be paid under the current Medicare fee-for-service payment system. Following the completion of a CCJR performance year, hospitals that achieve actual spending below the target price per Episode of Care *and* meet certain quality performance thresholds will receive a reconciliation payment from CMS for the difference between the target price and actual episode spending, subject to a cap. Starting from the second CCJR performance year, participant hospitals that exceed their target price for the Episode of Care will be responsible for paying the difference to CMS. As noted above, to qualify for a reconciliation payment from CMS, hospitals must also meet the quality performance standards, which are based on the following measures: complications, readmissions, and patient experience surveys. For each CCJR performance year, the quality requirements will be adjusted to encourage and improve hospitals' performance.

Payment Waivers

Similar to the BPCI initiative, the proposed CCJR model includes waivers of certain existing payment system requirements to promote timely, cost-effective, and accessible care. These waivers include the requirement for a three-day inpatient hospital stay prior to admission for a covered skilled nursing facility admission (the three-day stay rule), allowing payment for physician-directed home visits for non-homebound beneficiaries without meeting certain direct supervision requirements and allowing payment for certain physician visits to a beneficiary in his or her home via telehealth.

Financial Arrangements

As part of the CCJR model, although hospitals are not required to do so, CMS anticipates that many hospitals may want to enter into certain financial arrangements with other providers and suppliers (generally referred in the CCJR Proposed Rule as "Collaborators") who are engaged in care redesign and provide services as part of the continuum of care. The CCJR Proposed Rule permits participating hospitals and Collaborators to enter into sharing arrangements for the following: a hospital's internal cost savings, net reconciliation payment amounts (shared savings) from CMS, and a hospital's responsibility to repay CMS. As proposed, these sharing arrangements permit Collaborators to receive "gainsharing" or "alignment" payments provided certain requirements are met. A "gainsharing" payment refers to an amount distributed from a hospital to a Collaborator. An "alignment" payment refers to an amount distributed from a Collaborator to a hospital (e.g., to help repay shared losses owed to CMS).

A gainsharing payment to a Collaborator must be distributed on an annual basis pursuant to an agreement that satisfies the required elements for a sharing arrangement. For instance, the calculation, distribution, and frequency of distribution of gainsharing payments must be identified in the agreement and administered in accordance with generally accepted accounting principles. Any internal cost savings

distributed as a gainsharing payment must be based upon the measurable, actual, and verifiable hospital internal cost savings achieved through care redesign activities and "may not reflect 'paper' savings from accounting conventions or past investment in fixed costs." CCJR Proposed Rule at 41264. The aggregate amount of gainsharing payments distributed by hospitals to Collaborators cannot exceed the reconciliation amount received from CMS. As with the BPCI initiative, the total amount of an annual gainsharing payment paid to an individual physician or non-physician practitioner who is a Collaborator must not exceed 50 percent of the total Medicare-approved amounts under the Physician Fee Schedule for services furnished during an Episode of Care.

The CCJR Proposed Rule also sets forth limits on an alignment payment from Collaborators to a participant hospital for repayments to CMS. For instance, an alignment payment to be received from Collaborators during a performance year may not exceed 50 percent of a repayment amount due to CMS, while participant hospitals must remain responsible for at least 50 percent of such repayment amount.

Alternative Payment Program Overlap

The CCJR payment model is intended to build upon existing alternative payment programs (e.g., Medicare Shared Savings Program accountable care organizations and BPCI). To avoid overlap with ongoing CMS initiatives, hospitals participating in BPCI Model 1 or those participating in the risk-bearing phase of BPCI Models 2 and 4 for CCJR-related Episodes of Care will be excluded from participation in CCJR. In instances where overlap of Medicare beneficiaries does occur, CMS proposes that BPCI will take precedence over CCJR.

CMS will be accepting comments regarding the CCJR Proposed Rule until September 8, 2015. As such, stakeholders are best served by engaging in a careful and meaningful review of the CCJR Proposed Rule and pursuing opportunities to submit comments to CMS that might affect the ultimate course of the final rule.

Lawyer Contacts

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com/contactus/.

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