Issue Brief

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KEY POINTS

- The proposed rule encourages hospitals, physicians and post-acute care providers to work together to improve quality and coordination of care throughout the entire episode of care by holding hospitals accountable for the quality and cost.
- CMS proposes to implement the model in 75 geographic areas as defined by metropolitan statistical areas.

CMS Releases Proposed Joint Replacement Payment Model for Acute Care Hospitals

The Centers for Medicare & Medicaid Services has issued a proposed rule calling for the creation and testing of a new payment model called the Comprehensive Care for Joint Replacement Model under the authority of the Center for Medicare and Medicaid Innovation (Innovation Center or CMMI). CCJR is to test whether bundled payments to acute care hospitals for lower-extremity joint replacement episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

The proposal would implement a new Medicare Part A and B payment model under section 1115A of the Social Security Act in which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity. All related care within 90 days of hospital discharge from the joint replacement procedures would be included in the episode of care.

A copy of the 439-page rule is on the *Federal Register* website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-17190.pdf. Publication is scheduled for July 14. A 60-day comment period ending Sept. 8 is provided.

COMMENT

This proposal would not be voluntary. It would mandate the participation of hospitals in multiple geographic areas that might not otherwise participate in the testing of bundled payments for episodes of care. The proposal is intended to last five years and would commence Jan. 1, 2016, and end Dec. 31, 2020.

SUMMARY OF THE MAJOR PROVISIONS

1. Model Overview: LEJR Episodes of Care

LEJR procedures are currently paid under the Inpatient Prospective Payment System through one of two Medicare Severity-Diagnosis Related Groups: MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC). Under the proposed model, episodes would begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS and would end 90 days after the date of discharge from the acute care hospital.

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4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MISSOURI HOSPITAL ASSOCIATION

2. Model Scope

CMS proposes that participant hospitals would be the episode initiators and bear financial risk. CMS proposes to require all hospitals paid under the IPPS and physically located in selected geographic areas to participate in the CCJR model, with limited exceptions.

3. Payment

CMS proposes to test the CCJR model for 5 performance years. During these performance years CMS would continue paying hospitals and other providers according to the usual Medicare FFS payment systems. However, after the completion of a performance year, the Medicare claims payments for services furnished to the beneficiary during the episode, based on claims data, would be combined to calculate an actual episode payment. The actual episode payment is defined as the sum of related Medicare claims payments for items and services furnished to a beneficiary during a CCJR episode. The actual episode payment would then be reconciled against an established CCJR target price, with consideration of additional payment adjustments based on quality performance and post-episode spending.

CMS proposes to make reconciliation payments to participant hospitals that achieve quality outcomes and cost efficiencies relative to the established CCJR target prices in all performance years of the model. CMS also proposes to phase in the requirement that participant hospitals whose actual episode payments exceed the applicable CCJR target price pay the difference back to Medicare beginning in performance year two. Under this proposal, Medicare would not require repayment from hospitals for performance year one for actual episode payments that exceed their target price in performance year one.

4. Quality Measures and Reporting Requirements

CMS is proposing to adopt three hospital-level quality of care measures for the CCJR model. Those measures include a complication measure, readmission measure, and a patient experience survey measure.

5. Economic Effects

CMS expects the proposed model to result in savings to Medicare of $153 million over the five years of the model.

PROVISIONS OF THE PROPOSED RULE

COMMENT

The material that follows is based on certain aspects of the rulemaking. Not all items are reflected below. This section of the proposal is some 330 pages. CMS has a very short timeframe to make this proposal operational by Jan. 1, 2016. However, the fact that providers will be paid under current provisions with a retrospective reconciliation occurring after the first year — that is Jan. 1, 2017 — may provide CMS with the time it needs to work out final details. There is much discussion regarding payment reconciliation and shared savings, thresholds and losses; too much information to possibly include in the material below. Perhaps the most important aspect at this juncture is to know who may be impacted.

A. Proposed Definition of the Episode Initiator and Selected Geographic Areas

Episodes would begin with admission to an acute care hospital for an LEJR procedure that is paid under the IPPS through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of

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lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

The statutory definition of hospital includes only acute care hospitals paid under the IPPS.

CMS is proposing that for the CCJR model, it would hold only the participant hospitals financially responsible for the episode of care.

CMS proposes to use a stratified random sampling method to select geographic areas and require all hospitals paid under the IPPS in those areas to participate in the CCJR model and be financially responsible for the cost of the episode, with certain exceptions.

CMS is proposing the following 75 MSAs to be included in the CCJR model.

MSA	MSA Name
10420	Akron, OH
10740	Albuquerque, NM
11700	Asheville, NC
12020	Athens-Clarke County, GA
12420	Austin-Round Rock, TX
13140	Beaumont-Port Arthur, TX
13900	Bismarck, ND
14500	Boulder, CO
15380	Buffalo-Cheektowaga-Niagara Falls, NY
16020	Cape Girardeau, MO-IL
16180	Carson City, NV
16740	Charlotte-Concord-Gastonia, NC-SC
17140	Cincinnati, OH-KY-IN
17820	Colorado Springs, CO
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
21780	Evansville, IN-KY
22420	Flint, MI
22500	Florence, SC
22660	Fort Collins, CO
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR
26900	Indianapolis-Carmel-Anderson, IN

MSA	MSA Name
28140	Kansas City, MO-KS
28660	Killeen-Temple, TX
29820	Las Vegas-Henderson-Paradise, NV
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
32780	Medford, OR
32820	Memphis, TN-MS-AR
33100	Miami-Fort Lauderdale-West Palm Beach, FL
33340	Milwaukee-Waukesha-West Allis, WI
33700	Modesto, CA
33740	Monroe, LA
33860	Montgomery, AL
34940	Naples-Immokalee-Marco Island, FL
34980	Nashville-Davidson--Murfreesboro--Franklin, TN
35300	New Haven-Milford, CT
35380	New Orleans-Metairie, LA
35620	New York-Newark-Jersey City, NY-NJ-PA
35980	Norwich-New London, CT
36260	Ogden-Clearfield, UT
36420	Oklahoma City, OK
36740	Orlando-Kissimmee-Sanford, FL
37860	Pensacola-Ferry Pass-Brent, FL
38300	Pittsburgh, PA
38940	Port St. Lucie, FL
38900	Portland-Vancouver-Hillsboro, OR-WA
39340	Provo-Orem, UT
39740	Reading, PA
40060	Richmond, VA
40420	Rockford, IL
40980	Saginaw, MI
41860	San Francisco-Oakland-Hayward, CA
42660	Seattle-Tacoma-Bellevue, WA
42680	Sebastian-Vero Beach, FL
43780	South Bend-Mishawaka, IN-MI
41180	St. Louis, MO-IL
44420	Staunton-Waynesboro, VA
45300	Tampa-St. Petersburg-Clearwater, FL
45780	Toledo, OH
45820	Topeka, KS
46220	Tuscaloosa, AL
46340	Tyler, TX
47260	Virginia Beach-Norfolk-Newport News, VA-NC
48620	Wichita, KS

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B. Episode Definition for the Comprehensive Care for Joint Replacement Model

CMS proposes that an episode of care in the CCJR model is triggered by an admission to an acute care hospital stay (hereinafter "the anchor hospitalization") paid under MS-DRG 469 or 470 under the IPPS during the model performance period.

Related items and services included in CCJR episodes would be the following items and services paid under Medicare Part A or Part B, after limited exclusions are applied:

- Physicians' services
- Inpatient hospital services (including readmissions), with certain exceptions
- Inpatient psychiatric facility services
- LTCH services
- IRF services
- SNF services
- HHA services
- Hospital outpatient services
- Independent outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs
- Hospice

CMS proposes to exclude from CCJR drugs that are paid outside of the MS-DRG, specifically hemophilia clotting factors (§ 412.115), identified through HCPCS code, diagnosis code, and revenue center on IPPS claims.

CMS proposes to exclude IPPS new technology add-on payments for drugs, technologies, and services from CCJR episodes, excluding them from both the actual historical episode expenditure data used to set target prices and from the hospital's actual episode spending that is reconciled to the target price.

CMS proposes that admissions for oncology and trauma medical MS-DRGs be excluded from CCJR episodes.

CMS proposes to exclude hospital admissions for chronic disease surgical MS-DRGs, such as prostatectomy (removal of the prostate gland), as they are not unrelated to the clinical condition that led to the LEJR nor would they have been precipitated by the LEJR. Finally, CMS is proposing that hospital admissions for acute disease surgical MS-DRGs, such as appendectomy, be excluded because they are highly unlikely to be related to, or precipitated by, LEJR procedures and would not be affected by LEJR episode care redesign.

C. Proposed Methodology for Setting Episode Prices and Paying Model Participants under the CCJR Model

CMS proposes that hospitals will be eligible to receive reconciliation payments from Medicare based on their quality and actual episode spending performance under the CCJR model in each of CCJR performance years one through five. Additionally, CMS proposes to phase in the responsibility for hospital repayment of episode actual spending if episode actual spending exceeds their target price starting in performance year two and continuing through performance year five. Under this proposal in performance year one, participant hospitals would not be required to pay Medicare back if episode actual spending is greater than the target price.

CMS proposes that, to the extent that a Medicare payment for included episode services spans a period of care that

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extends beyond the episode, these payments would be prorated so that only the portion attributable to care during the episode is attributed to the episode payment when calculating actual Medicare payment for the episode.

CMS proposes to prospectively update historical CCJR episode payments to account for ongoing Medicare payment system (for example, IPPS, OPPS, IRF PPS, SNF, PFS, etc.) updates to the historical episode data and ensure CMS incentivizes hospitals based on historical utilization and practice patterns, not Medicare payment system rate changes that are beyond hospitals' control.

CMS proposes three measures to determine hospital quality of care and to determine eligibility for a reconciliation payment under the CCJR model. The measures are as follows:

- Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551), an administrative claims-based measure
- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
- HCAHPS Survey measure

CMS proposes that certain financial arrangements between a participant hospital and a CCJR collaborator be termed a "CCJR Sharing Arrangement," and that the terms of each CCJR Sharing Arrangement be set forth in a written agreement between the participant hospital and the CCJR collaborator. CMS proposes to use the term "Participation Agreement" to refer to such agreements. CMS proposes that a "CCJR Sharing Arrangement" would be a financial arrangement contained in a Participation Agreement to share only the following: (1) CCJR reconciliation payments; (2) the participant hospital's internal cost savings and (3) the participant hospital's responsibility for repayment to Medicare.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting