McGUIREWOODS

Questions and Answers on the CMS Comprehensive Care for Joint Replacement Model

MEGGAN BUSHEE, ESQ.
704.343.2360 | mbushee@mcguirewoods.com
201 North Tryon Street, Suite 3000
Charlotte, North Carolina 28202-2146

GRETCHEN TOWNSHEND, ESQ.
312.849.8237 | gtownshend@mcguirewoods.com
77 West Wacker Drive, Suite 4100
Chicago, Illinois 60601-1818

JUDY TSUI, ESQ.
312.849.8150 | jtsui@mcguirewoods.com
77 West Wacker Drive, Suite 4100
Chicago, Illinois 60601-1818

February 2016
www.mcguirewoods.com

On November 12, 2015, the Centers for Medicare & Medicaid Services (CMS) finalized regulations that will govern the Comprehensive Care for Joint Replacement model (the "CJR Model"). The CJR Model will begin on April 1, 2016, for certain selected acute care hospitals, which will receive bundled payments for lower extremity joint replacement (LEJR) procedures and related care provided within a 90-day episode of care.

The CJR Model will be tested over five performance years, beginning April 1, 2016, and ending December 31, 2020. The objectives of the model are to increase the quality and efficiency of care for patients undergoing LEJR procedures and to encourage alternative protocols in order to reduce overall costs with respect to these procedures, as these procedures have been found to require lengthy and costly recovery and rehabilitation periods and have a high rate of complications. CMS has indicated that hip and knee replacement surgeries are the most common inpatient surgery for Medicare beneficiaries, and thus, a key area where alternative treatment plans can have a considerable impact.

The following Q&A outlines the key requirements of the CJR Model:

1. Which hospitals are required to participate in the CJR Model?

The CJR Model will be implemented in 67 Metropolitan Statistical Areas (MSAs). Inpatient Prospective Payment System (IPPS) acute care hospitals located within the selected 67 MSAs will be required to participate in the CJR Model, excluding those hospitals already participating in Model 1 or Phase II of Models 2 or 4 of the CMS Bundled Payments for Care Improvement (BPCI) initiative. Critical access hospitals are also excluded from participation in the CJR Model.

Unlike earlier bundled payment models like the BPCI, the CJR Model is mandatory rather than voluntary. Accordingly, all acute care hospitals within the selected MSAs are required to participate unless subject to an applicable exclusion. There are approximately 800 hospitals that will be required to participate in the CJR Model (each, a "Participant Hospital").

2. How are LEJR episodes of care defined?

A LEJR episode of care is triggered by an admission of a Medicare beneficiary as an inpatient to a Participant Hospital where such stay would be paid under 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 major complications or comorbidities) under the IPPS. The episode of care runs from the date of admission as an inpatient until 90 days post-discharge and includes all items and services paid under Medicare Part A and Part B, with the exception of specific excluded items and services that are clinically unrelated to the episode (collectively, the "Episode of Care").

See Table 1 below for excluded and included services during an LEJR Episode of Care.

Table 1: Excluded versus Included Services

Excluded	Included Services
• Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of LEJR surgery • Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care	• Physicians' services • Inpatient hospital services (including readmissions but excluding certain types of inpatient hospitalization, including admission for oncology and trauma medical MS-DRGS) • Inpatient Psychiatric Facility (IPF) services • Long-term care hospital (LTCH) services • Inpatient rehabilitation facility (IRF) services • Skilled nursing facility (NSF) services • Home health agency (HHA) services • Hospital outpatient services • Outpatient therapy services

Table 1: Excluded versus Included Services	
Excluded	**Included Services**
	• Clinical laboratory services • Durable medical equipment (DME) • Part B drugs • Hospice

3. Which Medicare beneficiaries are included under the CJR Model?

A beneficiary is included under the CJR Model if Medicare is the primary payer for such beneficiary and:

- The beneficiary is enrolled in Medicare Part A and Part B for the entire duration of the Episode of Care;
- The beneficiary's eligibility for Medicare is not on the basis of End Stage Renal Disease;
- The beneficiary is not enrolled in any managed care plan (e.g., Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations, etc.); *and*
- The beneficiary is not covered under a United Mine Workers of America health plan.

4. Who bears the financial risk under the CCJR Model?

Participant Hospitals bear the financial responsibility under the CJR Model, and will be responsible for certain payments owed to CMS if the aggregate amount paid by CMS for an LEJR Episode of Care exceeds the target price established under the CJR model. These penalty payments are known as "alignment payments" (see below for further discussion).

5. How are Participant Hospitals compensated under the CJR Model?

CJR payment methodology will be applied retrospectively.

During each performance year, Participant Hospitals and other providers will continue to submit claims to CMS and be compensated according to the established Medicare FFS payment systems in the same manner as they would before commencement of the CJR Model. After the completion of a performance year, all payments made to the Participant Hospital and other providers for an LEJR Episode of Care will be aggregated and compared to CJR target prices for that performance year. The CJR target prices will be determined by CMS using a hospital's specific and regional blended historical payments, less 2%. There will be a separate set of target prices for each of MS-DR6469 and MS-DR6470 that will change on an annual basis. With a particular performance year's set of target prices, there will be target prices that will apply to LEJR Episodes of Care occurring during January through September, and target prices that will apply to LEJR Episodes of Care occurring during October through December, to account for Medicare payment system updates that occur in January and October of each year. Participant Hospitals will be given their specific target prices prior to the start of each performance year and then again closer to October to reflect any Medicare payment system updates.

If the sum of actual payments made by CMS for the Episode of Care is less than the applicable CJR Model target price *and* the Participant Hospital has met certain CMS quality requirements, CMS will pay the difference to the Participant Hospital in the form of a "reconciliation payment" (subject to a cap). However, if the sum of actual payments made by CMS for the Episode of Care exceeds the applicable CJR Model target price, the Participant Hospital will be required to pay the difference back to CMS in the form of an alignment payment (also subject to a cap).

A Participant Hospital's responsibility to repay CMS would be phased in, with no responsibility to repay CMS in the first performance year. See Table 2 below.

Table 2: Hospital Responsibility to Make Alignment Payments to CMS	
Year 1	No required payments to CMS
Year 2	Repayment to Medicare capped at 5% of target price

Year 3	Repayment to Medicare capped at 10% of target price
Years 4 and 5	Repayment to Medicare capped at 20% of target price

Reconciliation payments by CMS to Participant Hospitals would also be phased in. See Table 3 below.

Table 3: Reconciliation Payments to Hospital by CMS	
Years 1 and 2	Reconciliation payments by CMS capped at 5% of target price
Year 3	Reconciliation payments by CMS capped at 10% of target price
Years 4 and 5	Reconciliation payments by CMS capped at 20% of target price

A CJR Model performance year runs from January 1st to December 31st, with the exception of the first performance year which will run from April 1, 2016 to December 31, 2016. See Table 4 below.

Table 4: CJR Model Performance Years		
Performance year	**Calendar year**	**Episodes included in performance year**
1	2016	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
2	2017	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
3	2018	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
4	2019	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
5	2020	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

6. What are the quality metrics used to establish whether Participant Hospitals are eligible for reconciliation payments?

The following two quality metrics will govern whether a Participant Hospital may receive reconciliation payments from CMS when payments made by CMS for the Episode of Care are less than the applicable CJR Model target price:

- Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166)

The minimum thresholds on these two quality measures would increase with time under the model.

7. May Participant Hospitals enter into risk-sharing arrangements with other providers?

Yes, Participant Hospitals may enter into risk-sharing arrangements with various collaborating providers including:

- Physician and nonphysician practitioners
- Home health agencies
- Skilled nursing facilities
- Long term care hospitals
- Physician Group Practices
- Inpatient rehabilitation facilities
- Inpatient and outpatient physical and occupational therapists

These arrangements must be set forth in a written Collaborator Agreement between the Participant Hospital and the collaborating provider. The content of the Collaborator Agreement is strictly governed by the CMS regulations implementing the CJR Model. CMS has not yet released an example of a form Collaborator Agreement.

Under these Collaborator Agreements, a Participant Hospital may, in the aggregate, assign up to 100% of the Medicare reconciliation payment it receives from CMS to collaborating providers, subject to a cap on the amount that can be assigned to each individual collaborating provider.[1] Additionally, a Participant Hospital can share its obligation to make repayments to CMS, but cannot share more than 50% of its repayment responsibility with collaborating providers, in the aggregate, or more than 25% of its repayment responsibility with any one collaborating provider. The Participant Hospital has the option of having collaborating providers share in both reconciliation payments and alignment payment obligations, or just one.

When Participant Hospitals enter into Collaborator Agreements with providers, CMS will continue to deal only with the Participant Hospital in making reconciliation payments or requesting alignment payments. Thus, Participant Hospitals are responsible for forwarding appropriate shares of reconciliation payments to, or collecting portions of alignment payments from these collaborating providers, according to the applicable Collaborator Agreement.

A Participant Hospital can enter into a Collaborator Agreement at any point during a CJR Model performance year, provided that, a Collaborator Agreement cannot be given any retroactive effect, and a collaborator can only participate in gain sharing payments or be responsible for alignment payment obligations for future Episodes of Care during which the collaborator provided services.

8. How does a Participant Hospital select which providers it permits to enter into a Collaborator Agreement?

CMS does not specifically dictate how providers are selected by a Participant Hospital to enter into Collaborator Agreements. Collaborating providers can include both physician and non-physician providers, as discussed in more detail above under number 7. However, a Participant Hospital must have a written policy that details the criteria it uses to select collaborating providers. Such selection criteria must be related to quality of care delivered by CJR collaborators during a CJR Episode of Care. Additionally, the selection criteria cannot be based directly or indirectly on the volume or value of referrals or other business generated by, between, or among the collaborating provider and the Participant Hospital.

9. What incentives can Participant Hospitals offer to potential collaborators?

Participant Hospitals may incentivize collaborators to share the hospital's risk under the CJR Model by offering to share reconciliation payments, internal cost savings, or a combination of both. However, all payments made by a Participant Hospital to collaborators are subject to an aggregate cap that is equal to the amount of the Medicare reconciliation payment received by the Participant Hospital (regardless of whether the hospital calculates incentive payments to collaborators based upon reconciliation payments or internal cost savings). For example, if a Participant Hospital does not receive a reconciliation payment from CMS for an Episode of Care, it is not permitted to make payments to collaborators related to such Episode of Care, even if there was internal cost savings.

Further, in order for collaborating providers to be eligible for incentive payments from a Participant Hospital, collaborators must have furnished services during the applicable LEJR Episode of Care.

[1] Aggregate payments made to a single collaborating provider in a calendar year cannot exceed 50% of the total Medicare approved amounts under the Physician Fee Schedule for services furnished to the hospital's CJR patients during an LEJR Episode of Care by such provider. If the collaborating provider is a physician group practice ("PGP"), the total amount of payments for a calendar year paid to the PGP by the hospital must not exceed 50% of the total Medicare approved amounts under the Physician Fee Schedule for services that are billed by the PGP and furnished during a calendar year by members of the PGP to the Participant Hospital's CJR beneficiaries during CJR episodes.

If a Participant Hospital decides to calculate incentive payments to collaborators based upon internal cost savings (as opposed to a pre-determined percentage of the amount of a reconciliation payment from CMS), such savings must be calculated in accordance with generally accepted accounting principles and Government Auditing Standards and reflect actual savings resulting from implementation of care redesign elements. The Participant Hospital must have a written policy that clearly outlines how internal cost savings is calculated. CMS has not provided any further guidance on how to track internal cost savings related to the CJR Model.

10. What if Collaborator Agreements between Participant Hospitals and Collaborators implicate fraud and abuse laws?

Arrangements between Participant Hospitals and collaborating providers may implicate the civil monetary penalty (CMP) law (sections 1128A(a)(5), (b)(1) and (b)(2) of the Act), the Federal Anti-Kickback Statute (section 1128B(b)(1) and (2) of the Act), or the physician self-referral prohibition (section 1877 of the Act) ("Stark").

In many cases, hospitals can avoid violating these laws by using existing safe harbors or exceptions. However Section 1115A(d)(1) of the Act also allows the Secretary of the U.S. Department of Health and Human Services to waive certain fraud and abuse laws to the extent that this is necessary for testing the CJR Model.

11. What waivers of existing Medicare payment system requirements exist for Participant Hospitals under the CJR Model?

CMS has issued waivers of certain Medicare payment system requirements for Participant Hospitals so that they can more easily provide efficient care for Medicare beneficiaries. These waivers include the following:

(a) Skilled Nursing Facility (SNF) Admission Waiver:

For all CJR Episodes of Care during performance years 2 through 5, CMS will waive the requirement of a three-day inpatient hospital stay prior to a Medicare beneficiary's being admitted to a SNF. However, this waiver will only apply if Medicare beneficiaries are transferred to SNFs rated 3 stars or higher on CMS' Nursing Home Compare Website, available at ***www.medicare.gov/NursingHomeCompare/***.

(b) Post Discharge Home Visits Waiver

CMS will waive the requirement that services and supplies furnished incident to a physician's professional services must be furnished under the direct supervision of the physician (or other practitioner) to permit home visits. Instead, the licensed clinical staff of a physician may conduct a home visit in the beneficiary's home if the beneficiary does not qualify for Medicare coverage of home health services. This waiver allows a maximum of 9 visits during the LEJR Episode of Care, and must be billed under the Physician Fee Schedule using an HCPCS code created under the CJR Model.

(c) Billing and Payment for Telehealth Services Waiver

CMS will waive the geographic site requirement and the originating site requirements (allowing telehealth visits to originate in the beneficiary's home or place of residence for all LEJR Episodes of Care) for services that: (1) may be furnished via telehealth under existing requirements; and (2) are included in the Episode of Care.

Under the waiver, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and telehealth visits cannot be a substitute for in-person home health services paid under the home health prospective payment system. The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary's home.

12. What happens if a Participant Hospital does not comply with CJR Model requirements?

CMS may respond to a Participant Hospital's noncompliance by taking one or more of the following courses of action:

- Issuing a warning letter;
- Requiring the offending hospital to develop a corrective action plan;
- Reducing or removing a hospital's reconciliation payment;
- Expelling the hospital from the CJR Model or suspending payments (limited to extremely serious circumstances).

We anticipate CMS will continue to release additional guidance on the CJR Model as we approach the April 1, 2016, commencement date. Should you have any questions regarding this article, please contact the authors.

13. Can a Participant Hospital participate in both the CJR Model and the CMS Bundled Payments for Care Improvement (BPCI) Initiative?

Concurrent participation in the CJR Model and BPCI Model 1 or Phase II of BPCI Models 2 or 4 is not permitted. CMS has stated that hospitals that are in the BPCI Model 1 or Phase II of BPCI Models 2 or 4 are not required to participate in the CJR Model. However, if a hospital is not already participating in the BPCI Initiative, the hospital is not permitted to enroll in the BPCI Initiative in lieu of participation in the CJR Model.

70819125.4