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CMS Issues Final Rule Implementing Mandatory Bundled Payment Program for Lower Extremity Joint Procedures

The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule (Final Rule) that implements the Comprehensive Care for Joint Replacement model (CJR Model), a new bundled payment program covering certain orthopedic procedures reimbursed by Medicare. The Final Rule is effective on January 15, 2016, and the first model performance period begins on April 1, 2016. Under the CJR Model, acute care hospitals in certain geographic areas (Participant Hospitals) will receive bundled payments for episodes of care associated with a lower extremity joint replacement or a reattachment of a lower extremity (collectively, a CJR Procedure). The CJR Model aims to improve the efficiency and quality of care for Medicare beneficiaries, from initial hospitalization through recovery, by incentivizing improvement of coordination and transition of care, as well as encouraging provider investment in infrastructure and redesigned care processes across the inpatient and post-acute care spectrum. CMS anticipates that the CJR Model will save Medicare $343 million over its five performance years while furthering CMS's goal of improving the efficiency and quality of care for common medical procedures such as the CJR Procedures.

CJR Procedures are among the most common surgeries for Medicare beneficiaries, and the quality and cost of these procedures can vary greatly by provider and by region. The Final Rule aims to align providers' financial incentives by establishing a bundled payment system for CJR Procedures conducted in acute care hospitals located in 67 metropolitan statistical areas (MSAs) across the country. Among the MSAs chosen to participate are New Haven-Milford, Connecticut; Norwich-New London, Connecticut; and New York-Newark-Jersey City, New York-New Jersey-Pennsylvania.

PARTICIPATING HOSPITALS

In general, all hospitals currently paid under Medicare's Inpatient Prospective Payment System (IPPS) and located within one of the selected MSAs are required to participate in the CJR Model. Hospitals participating in CMS's Bundled Payments for Care Improvement Initiative (BPCI) will be excluded from participating in the CJR Model during the time that their qualifying episodes are included in a BPCI model. Beneficiaries eligible for inclusion in the CJR Model are those enrolled in Medicare Parts A and B for the duration of an episode of care, for whom Medicare is their primary payer and who are not enrolled in a managed care plan; those covered by Medicare due to end stage renal disease; or those covered by a policy for retired mine workers. Eligible Medicare beneficiaries who receive care at a Participant Hospital will not be able to opt out of the CJR Model. Participant Hospitals will be required to supply beneficiaries with written information regarding the design of the CJR Model and remind beneficiaries of their right to receive care from a provider of their choice, and CMS has stated that it will also provide beneficiaries with information about the CJR Model.

EPISODES OF CARE

The CJR Model holds Participant Hospitals financially accountable for the quality and cost of a beneficiary's entire episode of care arising from a CJR Procedure. An "episode" under the CJR Model begins with admission of an eligible beneficiary to a Participant Hospital for a procedure that upon discharge is reimbursed under the IPPS through 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). An episode ends 90 days after the date of discharge from the Participant Hospital following the CJR Procedure and includes the CJR Procedure, inpatient stay, and related care provided during that 90-day period covered under Medicare Parts A and B, including hospital care, post-acute care, and physician services, with certain exclusions for chronic and acute clinical conditions not affected by, or arising from, the CJR Procedure. CMS intentionally defines "episode of care" broadly under the CJR Model to incentivize comprehensive care for beneficiaries following a CJR Procedure. CMS will publish a list of items or services excluded from the CJR Model on its website annually or more frequently as determined by CMS.

TEST PERIOD

The CJR Model will be tested during five performance years. The first performance year will begin on April 1, 2016, and end on December 31, 2016, and subsequent performance years will take place during calendar years 2017, 2018, 2019, and 2020 respectively. During each performance year, Participant Hospitals will be given separate episode target prices for MS-DRGs 469 and 470, which will represent regional target prices applicable to all Participant Hospitals within an MSA. Each target price will be calculated using historical CJR episode payments and will be risk stratified for each MS-DRG–anchored episode, based on a beneficiary's hip fracture status. CMS will update episode target prices at least twice per year to reflect Medicare payment updates.

TWO-SIDED RISK MODEL

The Final Rule phases in a two-sided risk model to help Participant Hospitals prepare to assume the financial risk associated with the CJR Model. Participant Hospitals will initially be paid for episode services according to Medicare's Fee-For-ervice payment system. At the end of a performance year, the Medicare payments for services related to all of a Participant Hospital's episodes of care will be combined to calculate the total amount of actual episode payments. CMS will then reconcile a Participant Hospital's total amount of episode payments against the hospital's total episode target amounts for the performance year and apply certain adjustments to derive a net payment reconciliation amount (NPRA). If a Participant Hospital has a positive NPRA, it will receive a reconciliation payment from Medicare (as long as the hospital also receives a qualifying composite quality score from CMS for the applicable performance year). Starting in performance year two, if a Participant Hospital has a negative NPRA, the hospital will be required to make a repayment. CMS will apply escalating stop-loss and stop-gain limits during successive performance years to the NPRA calculation process to facilitate Participant Hospitals' mandatory transition into the CJR Model.

SHARING ARRANGEMENTS

The Final Rule contemplates alignment of financial incentives between Participant Hospitals and other providers involved in a joint replacement episode of care by allowing Participant Hospitals to enter into sharing arrangements with key providers and suppliers that incentivize engagement of the parties providing care to beneficiaries during an episode. Sharing arrangements must be entered into before care is furnished to CJR beneficiaries under the arrangement and include quality criteria as well as meet other regulatory requirements described in the Final Rule.

FRAUD AND ABUSE WAIVERS

Concurrent with the release of the Final Rule, CMS and the Office of Inspector General jointly issued a notice (Notice) of three fraud and abuse waivers for purposes of testing the CJR Model. Under the first waiver, the physician self-referral law (Stark law) and the federal Anti-Kickback Statute (AKS) are waived for the distribution of gainsharing payments and alignment payments under sharing

arrangements between a Participant Hospital and a CJR collaborator. Under the second waiver, the Stark law and the AKS are waived with respect to the distribution of payments from a physician group practice that is a CJR collaborator to a practice collaboration agent. Under the third waiver, the AKS and the beneficiary inducements prohibition contained within the Civil Monetary Penalties Law are waived for patient engagement incentives provided by a Participant Hospital to Medicare beneficiaries during an episode of care. The waivers are limited to certain financial arrangements expressly permitted under the CJR Model. To qualify for protection under one of the CJR Model waivers, an arrangement must meet the conditions described in the Notice applicable to the particular waiver.

Robinson+Cole's Health Law Group has extensive experience counseling clients on operations and compliance with CMS payment programs, including the Shared Savings Program and the Bundled Payments for Care Improvement Initiative.

If you have any questions, please contact a member of Robinson+Cole's Health Law Group:

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