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in the news

Health Care

February 2016

Not Fooling This Time: CJR Bundled Payments Begin April 1 for Covered Hospitals Nationwide

In this Issue:

The promotion of "value not volume" in the health care delivery system is an important theme of the Affordable Care Act and many related efforts to reform the American health care system. In this context, Health and Human Services (HHS) Secretary Burwell has stressed the agency's intent to move significant amounts of Medicare reimbursement away from a conventional fee for service (FFS) system to alternative payment methodologies, which concurrently improve the quality of patient care.[1]

Now, HHS' Nov. 24, 2015, promulgation of a final rule involving the "Comprehensive Care for Joint Replacement Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" (80 CFR 226, commonly known as the "CJR" program) has accelerated Medicare's promotion of systemic delivery and payment reform away from FFS by mandating bundled payments for common surgeries in many communities.

Starting April 1, 2016, the hospital-specific processes and activities required under CJR include:

- Updating a hospital's existing compliance program to assure review and monitoring of gainsharing and alignment arrangements under CJR
- Requiring Governing Body (i.e., Board of Directors or Trustees) oversight concerning CJR participation

[1] See http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html (Jan. 26, 2015).

- Adopting hospital policies for the appropriate selection of CJR collaborators, including selection criteria related to quality performance
- Requiring that physician group practice collaborators do tangibly contribute to a hospital's CJR care redesign activities
- Delineating in the collaboration agreement an acceptable methodology to determine and verify the hospital's internal cost savings related to care redesign undertaken with collaborators, as permitted
- Specifying quality criteria for use in determining available gainsharing payments
- Assuring adherence to other related compliance obligations.

The broad contours of the CJR program — which mandates participation by all Medicare-enrolled hospitals performing knee and hip replacements in the 67 selected Metropolitan Statistical Areas (MSAs) listed in Table 1 — are outlined below.

The Overall CJR Framework: How the Program Works

When the program commences on April 1, 2016, CJR will be similar to — but distinct from — Model 2 of the Bundled Payments for Care Improvement (BPCI) Initiative previously implemented by HHS' Center for Medicare and Medicaid Innovation (CMMI). Both programs pursue common cost, quality and care coordination policy goals. BPCI and CJR both involve bundled payments for defined episodes of care covering a given patient admission and specified period of post-acute care; CJR specifically includes 90 days following hospital discharge. One contrasting element is that BPCI encompasses as many as 48 clinical episodes (including orthopedic care), while CPR is presently limited to Lower Extremity Joint Replacement (LEJR) procedures (MS-DRG 469 and 470). CJR also expressly seeks to minimize unwanted variations in care, especially in the post-acute care setting.

One significant difference between BPCI and CJR is that participation in the BPCI Initiative is voluntary. In contrast, with limited exceptions, all hospitals in the selected MSAs that perform LEJR surgeries will be required to participate in CJR beginning April 1, 2016, for a five-year program duration; only critical access hospitals and certain current BPCI participants are exempted from mandatory CJR participation.

CJR's Reimbursement Model

Under CJR, all Medicare providers and suppliers continue to be paid on a conventional FFS basis during the inpatient phase of treatment and for 90 days following discharge. CMS later calculates the total costs incurred for all items and services during the applicable episode of care and reconciles the actual amount spent against a covered hospital's target price. The target price begins as a blend of facility-specific historic charges and regional charges, and moves incrementally over the CJR program duration toward a target price based entirely on regional data.

Subject to meeting a quality threshold and after applying a discount percentage to generate savings to the Medicare program, if the net payment reconciliation amount (NPRA) is positive, i.e., the amount of actual expenditures is less than the target price, the hospital initiating the episode receives a bonus payment reflecting savings achieved. However, for CJR performance years starting Jan. 1, 2017, if the NPRA is negative the hospital as episode initiator is at risk and must repay CMS the deficit amount. Stop loss and stop gain corridors, which cap potential hospital exposure and benefit, will increase to as

much as 20 percent for most hospitals over the CJR program's life until 2021.

Financial Arrangements Under CJR

The Centers for Medicare and Medicaid Services and the HHS Office of Inspector General have jointly issued narrow but important waivers of the fraud and abuse laws (Anti-Kickback Statute, Stark Law, Civil Monetary Penalty Law) for participants in the CJR program.

Expanding on parallel fraud and abuse waivers under the BPCI Initiative, the CJR final rule permits gainsharing between a participating hospital and a variety of potential collaborators, including not only physicians and physician group practices but also other network participants such as skilled nursing facilities, home health agencies and outpatient therapists, among others. Strict protocols protecting program integrity must be followed in calculating and distributing through the gainsharing process both internal cost savings (ICS) generated from care redesign as well as positive NPRA amounts.

In addition, CJR expressly permits a hospital to contractually require a collaborator to pay defined alignment payments, which allocate downside risk resulting from the facility's potential repayment obligation to CMS if the actual price for an episode of care exceeds the target amount. Other specific compliance and operational requirements must also be addressed in documenting both upside and downside sharing arrangements and related issues between a covered hospital and collaborators.

Hospital Implementation and Oversight Obligations

If a covered hospital does implement sharing arrangements that involve gainsharing and/or alignment payments with collaborators, the final CJR rule imposes additional oversight and related obligations upon participating facilities.

All of the noted legal and operational requirements must, in turn, be addressed in a collaborator agreement consistent with the CJR final rule and through other appropriate documentation, as applicable.

Especially given HHS' stated goals for payment reform, the agency's current expedition into bundled payments for knee and hip replacements seems likely to expand into other episodes of care as informed by experience gained through BPCI and CJR. Depending on the outcome of such Medicare initiatives, it is also probable that similar programs will expand in the private sector marketplace in many communities. A variety of business and regulatory issues will require attention to achieve success in a legally compliant manner.

At this time, although CJR does not impose downside financial risk on affected hospitals until Jan. 1, 2017, there may well be a need for covered facilities to assess relevant processes and consider development of necessary arrangements to address CJR's impending reimbursement changes as they unfold in the near future.

Mandatory MSAs

MSA	MSA Title
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
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
12420	Austin-Round Rock, TX
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR

MSA	MSA Title
26900	Indianapolis-Carmel-Anderson, IN
28140	Kansas City, MO-KS
28660	Killeen-Temple, TX
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
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

MSA	MSA Title
39340	Provo-Orem, UT
39740	Reading, PA
40980	Saginaw, MI
41860	San Francisco-Oakland-Hayward, CA
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
48620	Wichita, KS

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For More Information

For more information regarding this alert, please contact the author, a member of the Polsinelli's Health Care practice, or your Polsinelli attorney.

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