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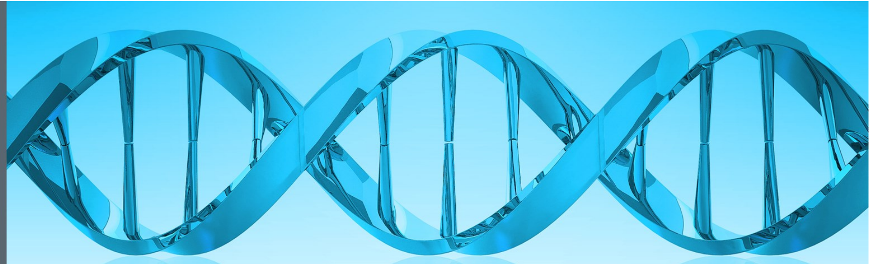

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Coming Soon to a Hospital near You: Mandatory Bundled Payments for Common Surgeries

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Recent action by the Centers for Medicare and Medicaid Services (CMS) announces significant change in reimbursement methodology for high volume orthopedic surgical procedures in many markets nationwide. Affected stakeholders now await CMS' final rule following submission of numerous comments to the pending Comprehensive Care for Joint Replacement initiative (CCJR). The proposed CCJR rule will become effective for a five-year period beginning January 1, 2016, unless CMS relents to requests for delay from the American Hospital Association and others.

While the proposal is nuanced and subject to change, several key CCJR issues are summarized below, and underscore the need for affected hospitals and health systems to address CCJR development and related issues on an expedited basis in the changing regulatory environment.

What is CCJR?

CCJR is a mandatory bundled payment program for all hospitals participating in Medicare which perform Lower Extremity Joint Replacement (LEJR) inpatient procedures assigned to MS-DRG 469 or 470 in 75 selected Metropolitan Statistical Areas (MSAs); a list of affected MSAs is attached as Table 1.

As framed, CCJR treats hospitals as "episode initiators" which are financially responsible for most costs of knee and hip replacements (some of Medicare's most common procedures resulting in billions of dollars in annual spending) from the date of hospital admission and for 90 days following discharge. Within the covered episodes of care, the combined cost of inpatient and post-acute care—including Medicare Part A, Part B, DME and covered drug expenses, as well as skilled nursing facilities (SNFs), home health agencies (HHAs) and other providers—all of whom will still be reimbursed on a conventional fee for service (FFS) basis—will be measured against a total target price derived from blended hospital-specific and regional composite data over the five year program duration.

How Does CCJR Work?

If CMS' performance year reconciliation process calculates hospital savings below the target price, the hospital will receive its positive net payment reconciliation amount (NPRA) as a bonus. However, if the NPRA is negative (i.e., the cost of care exceeds the overall episode target price), the hospital must repay those amounts following the first performance year (i.e., after 2016 as presently written). Significantly, no positive NPRA will be paid to a hospital unless threshold quality measures are met, and there are data sharing and other variables which may also affect the amount of payment.

To provide some transitional cushion, downside risk sharing for negative NPRA will not occur until performance year two. In calculating the amount of positive or negative NPRA, CMS first applies a 2% reduction from the historical reimbursement level to generate automatic program savings for Medicare before hospitals are themselves evaluated and a bonus or repayment is determined.

While the programs' rationale does overlap and both promote similar policy objectives, CCJR is distinct from CMS' voluntary Bundled Payments for Care Improvement Initiative (BPCI) in material respects. Importantly, CCJR is a mandatory program for all covered hospitals within a selected MSA. Although orthopedic bundles are also included, BPCI additionally encompasses many non orthopedic episodes of care, while CCJR is initially limited to LEJR procedures. Going-forward, it can fairly be anticipated that CMS may ultimately expand CCJR to impose a bundled payment (i.e., episode of care) reimbursement methodology across a broad array of other procedures and treatments, for the stated purpose of "changing our health care system to pay for quality over quantity" and improve care for patients.

In assessing CCJR's likely impact, it should be noted that CMS has imposed a 20% "stop gain" ceiling and a 10% (second year) and 20% (years 3-5) "stop loss" floor for participating hospitals not qualifying for other rural or small facility exceptions.

Scope of Permitted Financial Arrangements Under CCJR

Gainsharing payments, including both positive NPRA and hospital-generated internal cost savings, may be made from hospitals to CCJR collaborators (including SNFs, HHAs, physicians and medical groups) if defined contractual requirements are followed. In addition, alignment payments imposing collective responsibility for downside risk are also permitted between hospitals and CCJR collaborators under a legally-compliant sharing arrangement allocating overall economic loss, if desired.

Significantly, neither CMS nor DHHS' Office of Inspector General (OIG) has yet issued Stark Law exceptions or Anti-Kickback Statute safe harbors exempting such financial arrangements from the overall fraud and abuse laws. In contrast, CMS and OIG have earlier issued important waivers under the Medicare Shared Savings Program as well as the Model 2 BPCI Initiative. For CCJR, however, the enforcement agencies have only indicated to date that all financial arrangements "must comply with all relevant laws and regulations, including the fraud and abuse laws" (proposed 42 CFR §510.500(a)(i)), although the proposed rule does also describe certain criteria which may guide CCJR participants (proposed 42 CFR §510.500(c)) and thereby assist in crafting lawful CCJR participation agreements.

Next Legal and Operational Steps

As suggested, the CCJR is likely a precursor to other future changes as reimbursement increasingly moves away from FFS. Even if the January 1, 2016 proposed effective date were postponed, hospitals and health systems will likely confront a variety of near-term tasks, including:

- Creation of steering committees or similar hospital-physician bodies to define structural and operational pathways forward
- Determination of whether gainsharing (upside) or alignment (downside) arrangements to allocate savings and risk will be implemented among CCJR participants
- Development of effective, patient-centric educational and

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communication tools consistent with Medicare beneficiaries' protected freedom of choice and patient rights under HIPAA and otherwise

- If gainsharing and alignment arrangements are pursued, negotiation and preparation of appropriate collaborative arrangements between the hospital and CCJR collaborators which conform to legal requirements
- Assessment of other compliance issues across a spectrum of regulatory areas including antitrust, insurance, professional liability and related variables, in addition to the above-noted fraud and abuse considerations

Conclusion

While the scope and breadth of CCJR may seem surprising, the proposal does reflect previously articulated CMS policy goals. The probability that commercial payors will also encourage similar "best practices" for various clinical episodes underscores the need for affected hospitals and health systems to address CCJR development and related issues on an expedited basis in the changing regulatory environment.

TABLE 1

MSAs Where CCJR Program Will Be Mandated

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
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

MSA	MSA Name
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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For More Information

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[1] *U.S. News & World Report, November 2014*
[2] *Modern Healthcare, June 2015*
[3] *Chambers USA: America's Leading Lawyers for Business, May 2015*

About Polsinelli

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