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Bundled Payments

The authors examine a CMS proposed rule outlining a new payment model for joint replacement surgeries at hospitals in 75 metropolitan areas. They expect the experience with this new model will affect future bundled payment initiatives.

CMS Proposes to Broadly Test Bundled Payments For Certain Elective Surgical Procedures in the Hospital

By Lynn Shapiro Snyder and Lesley R. Yeung

On July 9, 2015, the Centers for Medicare & Medicaid Services' Innovation Center (''CMS Innovation Center'') released a proposed rule outlining a new bundled payment model for Medicare beneficiaries undergoing lower extremity joint replacements (''LEJR,'' commonly referred to as ''hip and knee replacements'').[1] The new bundled payment model, called the Comprehensive Care for Joint Replacement (''CCJR'') Model, would **require** hospitals in 75 randomly selected Metropolitan Statistical Areas (''MSAs'') (referred to as ''participant hospitals'') to be accountable for all costs for Medicare Part A and Part B services related to LEJR surgeries for a 90-day period, starting with the inpatient hospital admission through 90 days after the beneficiary's discharge from the hospital. Depending on the participant hospital's quality and cost performance relative to a target price for the 90-day episode, the participant hospital would either earn a financial reward or be required to repay Medicare for a portion of the costs incurred for the care episode. This calculation is based upon a comparison of the participant hospital's target price for a performance year and a retrospective review of the original Medicare Part A and Part B fee for ser-

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[1] The proposed rule is published in the Federal Register at 80 Fed. Reg. 41,198 (Jul. 14, 2015).

vice (''FFS'') payments made for each care episode. This bundled payment model is expected to give participant hospitals an incentive to work with other providers and suppliers involved in the care episode, including physicians, home health agencies, nursing facilities, as well as drug and device manufacturers and suppliers, to improve the quality and coordination of care with the goal of reducing avoidable hospitalizations and complications. This is the first CMS pilot that is requiring certain hospitals to accept a bundled payment for an episode of care, and this effort is likely to inform future Medicare bundled payment initiatives, so stakeholders with interests in applications that are broader than LEJR procedures alone should review and consider commenting on this proposed rule.

CMS encourages all interested stakeholders to submit comments on the proposed CCJR Model. Comments to the proposed rule are **due by 5:00 p.m. EDT on September 8, 2015**.

CCJR Model Details: The Basics

Who: The CCJR Model would be mandatory for all hospitals located in the 75 MSAs randomly selected by CMS. The only hospitals excluded from participation in the CCJR Model would be those hospitals that are not paid under the inpatient prospective payment system (''IPPS'') (e.g., critical access hospitals,[2] acute care hospitals in Maryland), hospitals not physically located in one of the 75 MSAs, and hospitals participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payments for Care Improvement (''BPCI'') initiative for LEJR episodes.[3]

What: The CCJR Model would apply to elective surgical procedures that result in discharges 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). Medicare episode target prices would be set for each participant hospital. The target price includes payment for all related services received by eligible Medicare FFS beneficiaries who have LEJR procedures at a participant hospital.[4] All providers and suppliers would be paid under the original Medicare Part A and Part B FFS payment system rules and procedures for episode services throughout the year. Following the end of a CCJR Model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) would be compared to the Medicare episode target price for the responsible participant hospital. If the participant hospital performs well with respect to the identified quality measures,[5] and if episode spending is less than the target price, the hospital may receive an additional payment from Medicare (called a ''reconciliation payment''). Alternatively, if episode spending is above the target price, the participant hospital may be required to repay Medicare for a portion of the episode spending that exceeds the target price.

When: The CCJR Model would apply to **discharges occurring on or after January 1, 2016, and continue for five years (ending on December 31, 2020)**. A few elements of the CCJR Model are phased in over the 5-year period. First, participant hospitals would not be subject to downside risk (i.e., be required to repay Medicare for episode spending that exceeds the target price), until the second year of the CCJR Model, and the repayment amount limits would increase in the third year of the CCJR Model.[6] Second, quality performance requirements would increase over the lifetime of the CCJR Model in order to incentivize continuous improvement on the three selected measures.[7] Third, tar-

[2] Other categories of hospitals that have special payment protections or additional payment benefits under the Medicare program, such as rural hospitals, sole community hospitals (''SCHs''), Medicare-dependent hospitals (''MDHs''), and rural referral centers (''RRCs'') are not excluded from participation in the CCJR Model. However, CMS proposes several safeguards to ensure that these participant hospitals have limited repayment responsibility due to their lower risk tolerance and less infrastructure and support to achieve efficiencies for high payment care episodes.

[3] The BPCI initiative is a demonstration project implemented by the CMS Innovation Center to test four models using retrospective or prospective bundled payment arrangements for 48 possible episodes of care. Model 1 is testing retrospective bundled payments for episodes of care related to inpatient acute care hospital stays only. Model 2 is testing retrospective bundled payments for episodes of care related to the inpatient acute care hospital stay plus post-acute care. Model 4 is testing prospective bundled payments for all services furnished during an inpatient acute care hospital stay. Phase II of Models 2 and 4 is referred to as the ''risk-bearing'' period for these Models, in which participants have moved from the ''preparation'' period into implementation and assumption of financial risk for the applicable episodes of care. More information about the BPCI initiative is available at http://innovation.cms.gov/initiatives/bundled-payments/.

[4] Categories of eligible services included in the care episode are: physicians' services, inpatient hospital services (including readmissions), inpatient psychiatric facility services, long-term care hospital services, inpatient rehabilitation facility services, skilled nursing facility services, home health agency services, hospital outpatient services, independent outpatient therapy services, clinical laboratory services, durable medical equipment, Part B drugs and biologicals, and hospice services. Unrelated services that are excluded from the care episode are: chronic conditions that are generally not affected by the LEJR procedure or post-surgical care, and acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery.

[5] Eligibility for additional payments under the CCJR Model is based on a participant hospital's performance on three quality measures, including: hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty; hospital-level 30-day, all-cause risk-standardized readmission rate following elective primary total hip arthroplasty and/or total knee arthroplasty; and the Hospital Consumer Assessment of Healthcare Providers and Systems (''HCAHPS'') Survey. Participant hospitals also may voluntarily submit patient-reported outcomes data to CMS. For participant hospitals that successfully submit patient-reported outcomes data, the discount percentage used to set their target price will be reduced from 2.0 percent to 1.7 percent.

[6] In year 2, participant hospitals would be obligated to repay up to 10 percent of the net payment reconciliation amount (''NPRA''). In years 3 through 5, participant hospitals would be obligated to repay up to 20 percent of the NPRA. For SCHs, MDHs, and RRCs, financial losses are limited to 3 percent of the NPRA in year 2 and 5 percent of the NPRA in years 3 through 5.

[7] In years 1, 2, and 3, a participant hospital's measure results for all three quality measures must be at or above the 30th percentile of the national hospital measure results calculated for all hospitals participating in the Hospital Inpatient Quality Reporting Program. In years 4 and 5, a participant's

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get prices initially would be based on a blend of the participant hospital's historical spending and regional historical spending for an episode, and then transition to being entirely based on regional historical spending in years 4 and 5 of the CCJR Model.

Where: The 75 selected MSAs are identified on the CCJR Model website (*see* http://innovation.cms.gov/initiatives/ccjr/index.html). The selected MSAs include a broad range of areas, including some of the largest cities (New York City, Los Angeles, and Miami), mid-size markets (Boulder, CO, Evansville, IN-KY, Lincoln, NE), and even the smallest MSAs (Carson City, NV, Hot Springs, AR, and Cape Girardeau, MO-IL). An MSA is defined as a county with a core urban area that has a population of at least 50,000.

Why: The Obama Administration is committed to transforming the health care system to deliver better quality care and spend health care dollars in a smarter way (i.e., to achieve enhanced efficiency and quality of care). By proposing to apply a 2 percent discount from the expected cost in setting the target price for the 90-day episode, and subjecting participant hospitals to downside risk if episode spending exceeds the target price, CMS anticipates achieving $153 million in savings over 5 years.

Unprecedented Expansion of Bundled Payments

Hip and knee replacements are among the most common and most costly inpatient surgeries for Medicare beneficiaries, and therefore it makes sense why CMS would want to focus on reducing the wide variability in cost for these procedures.[8] Further, on January 26, 2015, Secretary of Health and Human Services Sylvia M. Burwell announced explicit goals for Medicare to pay providers based on ''quality, rather than the quantity of care they give patients.''[9] To assist in meeting these two goals, CMS proposes to make the CCJR Model mandatory in the 75 selected MSAs, thereby making this the first time that CMS has mandated participation in a bundled payment initiative.

The CCJR Model is being proposed under the authority of the CMS Innovation Center included in Section 1115A of the Social Security Act (''SSA''). Specifically, Section 1115A allows the CMS Innovation Center to ''test innovative payment and service delivery models to reduce program expenditures under the applicable titles[10] while preserving or enhancing the quality of care furnished to individuals under such titles.''[11] CMS makes it clear that, although the CCJR Model is based on CMS' experience with the BPCI initiative, the CCJR Model is not an expansion of the BPCI initiative under the CMS Innovation Center's expansion authority.[12] Rather, CMS relies on the authority at Section 1115A(a)(5) to justify testing the CCJR Model on a regional basis, in a limited number of MSAs.[13] However, unlike other demonstrations that the CMS Innovation Center has implemented, all hospitals paid under the IPPS in those 75 selected MSAs would be required to participate in the CCJR Model and to be financially responsible for the cost of the care episode. CMS justifies the required participation of all hospitals in the selected areas because ''realizing the full potential of new payment models will require the engagement of an even broader set of providers than have participated to date, providers who may only be reached when new payment models are applied to an entire class of providers of a service.''[14] Further, CMS states that it is ''interested in testing and evaluating the impact of a bundled payment approach for LEJR procedures in a variety of circumstances, especially among those hospitals that may not otherwise participate in such a test.''[15]

The statute is silent as to whether CMS can require hospitals to participate in a demonstration implemented by the CMS Innovation Center. However, CMS does state in the proposed rule that certain aspects of the establishment of a demonstration project under the 1115A authority are not subject to administrative or judicial re-

hospital measure results for all three quality measures must be at or above the 40th percentile.

[8] Average Medicare expenditures for surgery, hospitalization, and recovery from hip and knee replacements range from $16,500 to $33,000 across regions. *See* CMS, Comprehensive Care for Joint Replacement Model, *available at* http://innovation.cms.gov/initiatives/ccjr/.

[9] HHS has set a goal of tying 30 percent of Medicare FFS payments to quality or value through alternative payment models, such as accountable care organizations (''ACOs'') or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all Medicare FFS payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. *See* HHS Press Release, Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value (Jan. 26, 2015), *available at* http://www.hhs.gov/news/press/2015pres/01/20150126a.html.

[10] ''Applicable title'' means Title XVIII of the Social Security Act (''SSA'') (related to Medicare), Title XIX (related to Medicaid), or both.

[11] SSA § 1115A(a)(1).

[12] CMS has the authority, through rulemaking, to ''expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under [the CMS Innovation Center's authority] or a demonstration project under Section 1866C, to the extent determined appropriate by the Secretary'', if—(1) the Secretary determines that such expansion is expected to reduce spending without reducing the quality of care, or improve the quality of patient care without increasing spending; (2) the Chief Actuary of CMS certifies that such expansion would reduce (or would not result in any increase in) net program spending; and (3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals. *See* SSA § 1115A(c). The Secretary has made such a determination only once since the enactment of this section of the SSA, for the Pioneer ACO Model. The determination that expansion of the Pioneer ACO Model would ''improve the quality of patient care and reduce spending'' was made in May 2015. *See* HHS Press Release, Affordable Care Act payment model saves more than $384 million in two years, meets criteria for first-ever expansion (May 4, 2015), *available at* http://www.hhs.gov/news/press/2015pres/05/20150504a.html.

[13] ''For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.'' SSA § 1115A(a)(5).

[14] 80 Fed. Reg. at 41,201.

[15] 80 Fed. Reg. at 41,201. *See also* 80 Fed. Reg. at 41,204 (''[P]articipation of hospitals in selected geographic areas will allow CMS to test bundled payments without introducing selection bias such as the selection bias inherent in the BPCI model due to self-selected participation.'').

view, including: the selection of models for testing or expansion; the selection of organizations, sites or participants to test those models selected; and the elements, parameters, scope, and duration of such models for testing or dissemination.[16]

While certain providers may question the proposal to require participation in the CCJR Model for hospitals in the 75 selected MSAs, one benefit of implementing this program under the CMS Innovation Center's authority is the ability of CMS to waive statutory Medicare program requirements as necessary to carry out the CCJR Model.[17] Indeed, for the CCJR Model, CMS has proposed to waive the 3-day inpatient hospital stay requirement for skilled nursing facility (''SNF'') admissions in years 2 through 5 if the SNF has a quality rating of 3 stars or better under the Five-Star Quality Rating System,[18] to allow payments for certain physician visits to occur in a patient's home via telehealth, to allow payment for certain physician-directed home visits for patients who do not qualify for home health services (i.e., are not homebound),[19] and to allow participant hospitals to enter into gainsharing arrangements with collaborating providers who are engaged in care redesign and furnish services to patients during the care episode. Accordingly, stakeholders should review the waivers that CMS has proposed, and comment on any additional waivers that might be necessary for those hospitals that are being required to test the CCJR Model.

More Collaboration and Better Coordination is Key

CMS sees only upside potential for patients, who would ''benefit from their hospitals and other health care providers (e.g., physicians, home health agencies, and nursing facilities) working together more closely to coordinate their care,'' which in turn leads to ''better outcomes, a better experience, and fewer complications such as preventable readmissions, infections, or prolonged rehabilitation and recovery.''[20] In order to achieve these results, CMS includes a number of proposals to encourage more collaboration and better coordination, both among health care providers and with the beneficiaries themselves.

First, participant hospitals may choose to provide in-kind patient engagement incentives to beneficiaries for free or below fair market value, in order to engage the beneficiary in better managing his or her own health. The incentive must be provided to the beneficiary during the CCJR episode, and the item or service must be reasonably connected to the beneficiary's medical condition. The item or service must also be a preventive care item or service, or an item or service that advances a clinical goal specified by CMS including: beneficiary adherence to drug regimens; beneficiary adherence to a follow-up care plan or care; reduction of readmissions and complications resulting from LEJR procedures; and management of chronic diseases and conditions that may be affected by the LEJR procedure. The participant hospital must maintain a list of all items and services given as beneficiary incentives that exceed $10. Items and services involving technology provided to a beneficiary may not exceed $1,000 in value. Further, items of technology exceeding $50 must remain the property of the participant hospital and must be retrieved from the beneficiary at the end of the CCJR episode.

Second, CMS proposes to give participant hospitals additional tools to improve the effectiveness of their care coordination efforts. For example, CMS proposes to make available to participant hospitals spending and utilization data that may be useful for those hospitals to determine appropriate ways to increase the coordination of care, improve quality, and enhance efficiencies in the delivery of care. CMS also proposes to facilitate the sharing of best practices among participant hospitals through a ''learning and diffusion program.''[21]

Third, CMS proposes to allow participant hospitals to enter into gainsharing or other financial arrangements with CCJR collaborators, which are defined to include physicians and non-physician practitioners, home health agencies, SNFs, long-term care hospitals, physician group practices, inpatient rehab facilities and inpatient and outpatient physical and occupational therapists. CCJR collaborators would be required to engage with the participant hospital in its care redesign strategies, and directly furnish services under the care episode to a beneficiary, in order to be eligible for shared payments with the participant hospital. Participant hospitals may also share up to 50 percent of the downside

[16] SSA § 1115A(d)(2). *See* discussion at 80 Fed. Reg. at 41,260.

[17] ''The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).'' SSA § 1115A(d)(1).

[18] CMS noted in an open door forum on July 15, 2015 that direct admission to a SNF is not allowed, as the episode must originate from a hospital admission. Further, beneficiaries retain the right to choose their providers, and should a beneficiary choose to receive care at a SNF that does not have at least a 3-star rating, the beneficiary's choice should be honored and the participant hospital would not be able to rely on the waiver of the SNF 3-day rule.

[19] CMS proposes to waive both the direct supervision requirements and billing requirements under the 90-day post-operative global surgical period to allow for separate billing of certain post-discharge home visits.

[20] CMS, Comprehensive Care for Joint Replacement Consumer Fact Sheet (Jul. 9, 2015), *available at* http://innovation.cms.gov/Files/fact-sheet/Comprehensive-Care-for-Join-Replacement-Consumer-Fact-Sheet.pdf.

[21] CMS, Comprehensive Care for Joint Replacement Model Provider and Technical Fact Sheet (Jul. 9, 2015), *available at* http://innovation.cms.gov/Files/fact-sheet/Comprehensive-Care-for-Join-Replacement-Technical-Fact-Sheet.pdf.

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risk with CCJR collaborators, however no more than 25 percent of the downside risk may be assigned to any single entity or individual who is a CCJR collaborator.

Medical device manufacturers should be working in collaboration with participant hospitals, physicians, and others to demonstrate how the use of the right device, on the right patient, can achieve cost savings for the care episode.

Device manufacturers are generally skeptical of gainsharing arrangements because these arrangements can lead to restricted access to devices for patients in order to achieve cost savings under the target price of the episode. However, device manufacturers should be working in collaboration with participant hospitals, physicians, and other CCJR collaborators to demonstrate how the use of the right device, on the right patient, can achieve cost savings for the care episode if the device avoids complications and readmissions or improves patient satisfaction and function. Similarly, high cost post-acute care providers will need to demonstrate their value proposition under the bundled payment, as the tendency will be to shift services to less expensive home settings and using telemedicine to deliver services.

The Future of Medicare Payments

CMS' experience with the CCJR Model will likely inform future bundled payment initiatives and further movement away from traditional FFS Medicare payments. The CCJR Model proposed rule is complex and lengthy, but it is worth investing the time to understand the proposed parameters of the program in order to be at the forefront of where CMS is heading (i.e., away from paying for volume and towards paying for performance) for all Medicare provider types.