CMS Proposed Rule: Comprehensive Care for Joint Replacement Bundled Payment Program

American Hospital Association

Comprehensive Care for Joint Replacement

Proposed Rule: Hip & Knee Bundled Payment

Rule issued	July 9
Comments due	September 8
Final rule anticipated	November 1
Proposed effective date	January 1

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Special Bulletin

Friday, July 10, 2015

CMS PROPOSES MANDATORY HIP AND KNEE BUNDLED PAYMENT PROGRAM FOR MANY HOSPITALS

This bulletin is five pages.

Late July 9, the Centers for Medicare & Medicaid Services proposed a new payment model that would bundle payment to acute care hospitals for hip and knee replacement surgery – the Comprehensive Care for Joint Replacement (CCJR) model. Under this model, the hospital in which the joint replacement takes place would be held financially accountable for quality and costs for the entire episode of care, from the date of surgery through 90 days post-discharge. According to CMS, the model would be implemented in 75 geographic areas across the country and mandatory for most hospitals in those areas (see "Participation in the CCJR Model" below).

Details of the proposed rule follow.

Participation in the CCJR Model: CMS proposes that participant hospitals would be the episode initiators and bear financial risk. Specifically, the agency proposes to require inpatient prospective payment system (PPS) hospitals in 75 metropolitan statistical areas (MSAs) to participate in the model (see Appendix A for a listing of the 75 MSAs). There are about 800 inpatient PPS hospitals in these MSAs. Certain hospitals participating in the Bundled Payment for Care Improvement program would be excluded.

Episode of Care: CMS proposes to test the CCJR model for five years, beginning Jan. 1, 2016 and ending Dec. 31, 2020. An episode would begin with a beneficiary's admission to an inpatient PPS hospital for a procedure assigned to either Medicare-severity diagnosis-related group (MS-DRG) 469 or 470.[1] The episode would end 90 days after the date of discharge from the hospital. It would include the surgical procedure and inpatient stay, as well as all related care covered under Medicare Parts

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- STACHs are episode initiators
- Required of most hospitals in 75 markets
  - CAHs excluded
  - BPCI Model 1 excluded
  - BPCI Models 2&4 LEJRs excluded
- Jan. 1, 2016 – Dec. 31, 2020

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Proposed Rule: Hip & Knee Bundled Payment

- 90-day episode
  - Triggered by MS-DRG 469 + 470
    - All diagnoses falling into both MS-DRGs
      1) Elective Hip/Knee Replacement
      2) Emergent Hip Fractures
      3) Pathologic Hip Fractures
      4) Non-union hip/knee replacement
    - No risk adjustment

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Proposed Rule: Hip & Knee Bundled Payment

- **90-day episode**
  - **Triggered by MS-DRG 469 + 470**
    - All diagnoses falling into both MS-DRGs
    - No risk adjustment
  - **Includes all related Part A & B care**
    - No unrelated hospital readmissions
    - No unrelated Part B services
    - All post-acute care

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Proposed Rule: Hip & Knee Bundled Payment

- **Retrospective payment methodology**
  - ✓**FFS payments continue**

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Proposed Rule: Hip & Knee Bundled Payment

- **Retrospective payment methodology**
  - ✓FFS payments continue
  - ✓**Settle up to 2-percent discount**

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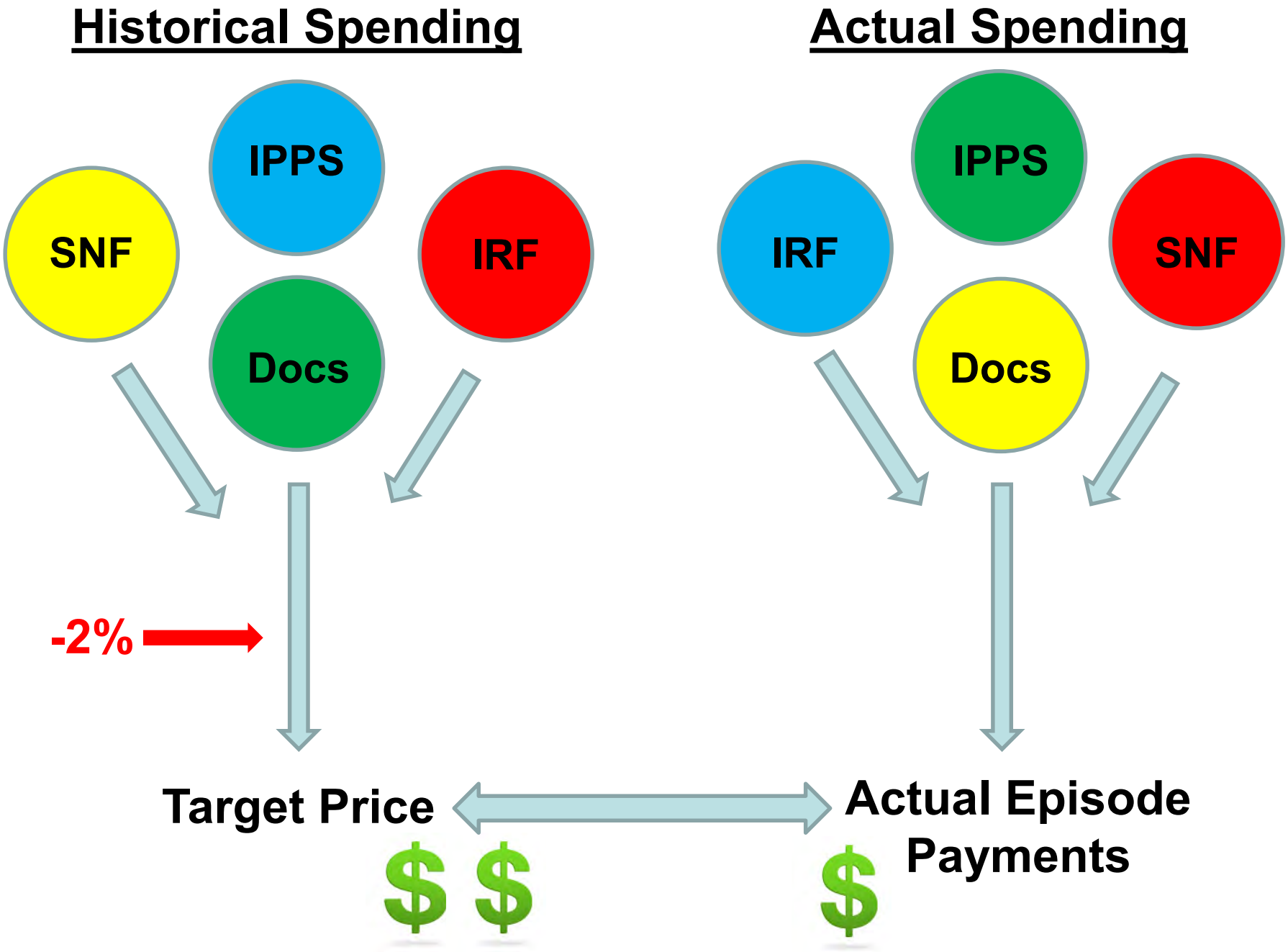
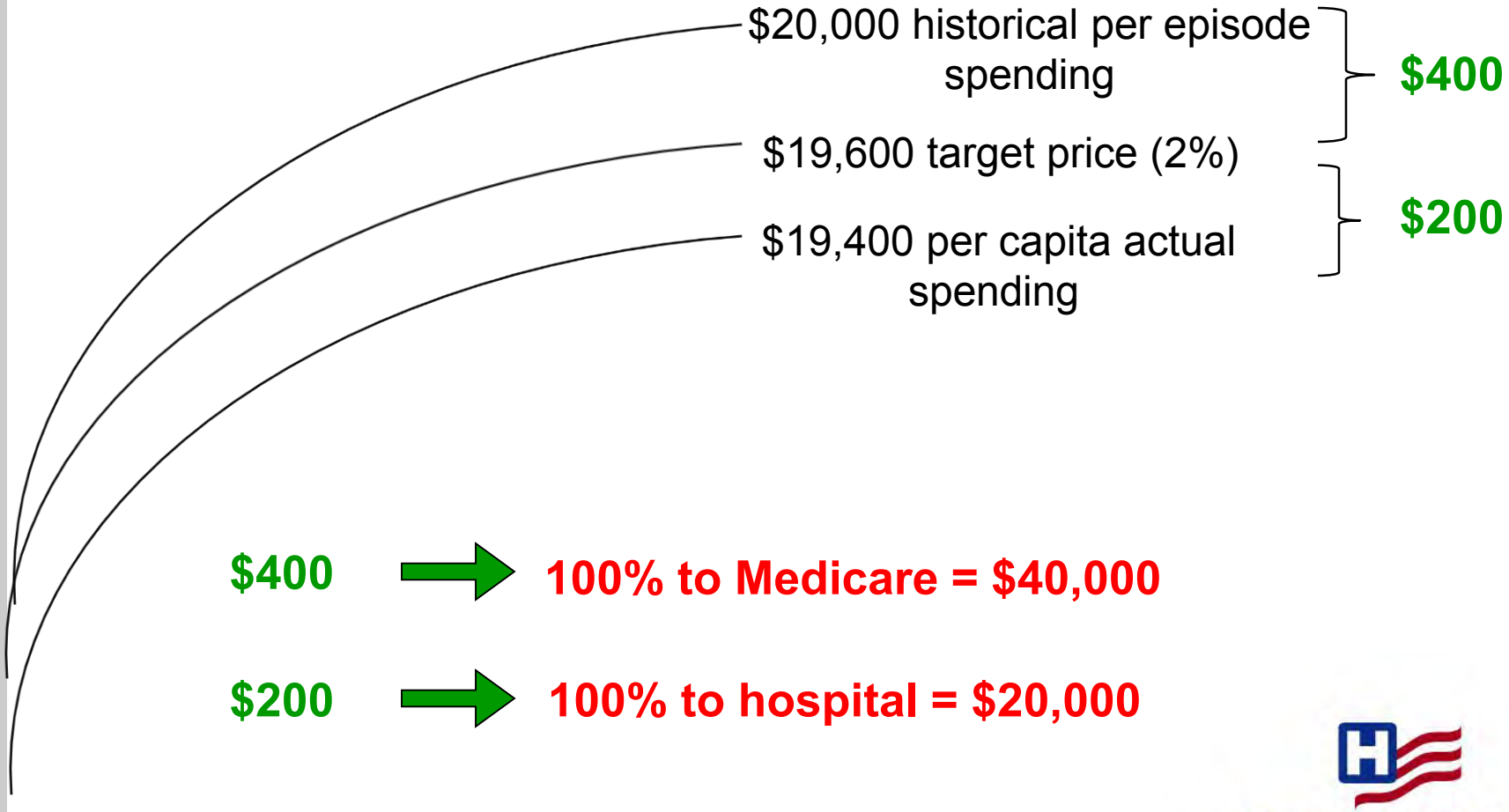

Historical Spending
Actual Spending
IPPS
SNF
IRF
Docs
IPPS
IRF
SNF
Docs
-2%
Target Price
Actual Episode Payments

Reconciliation Payment Example

USA Hospital: 100 LEJR Episodes



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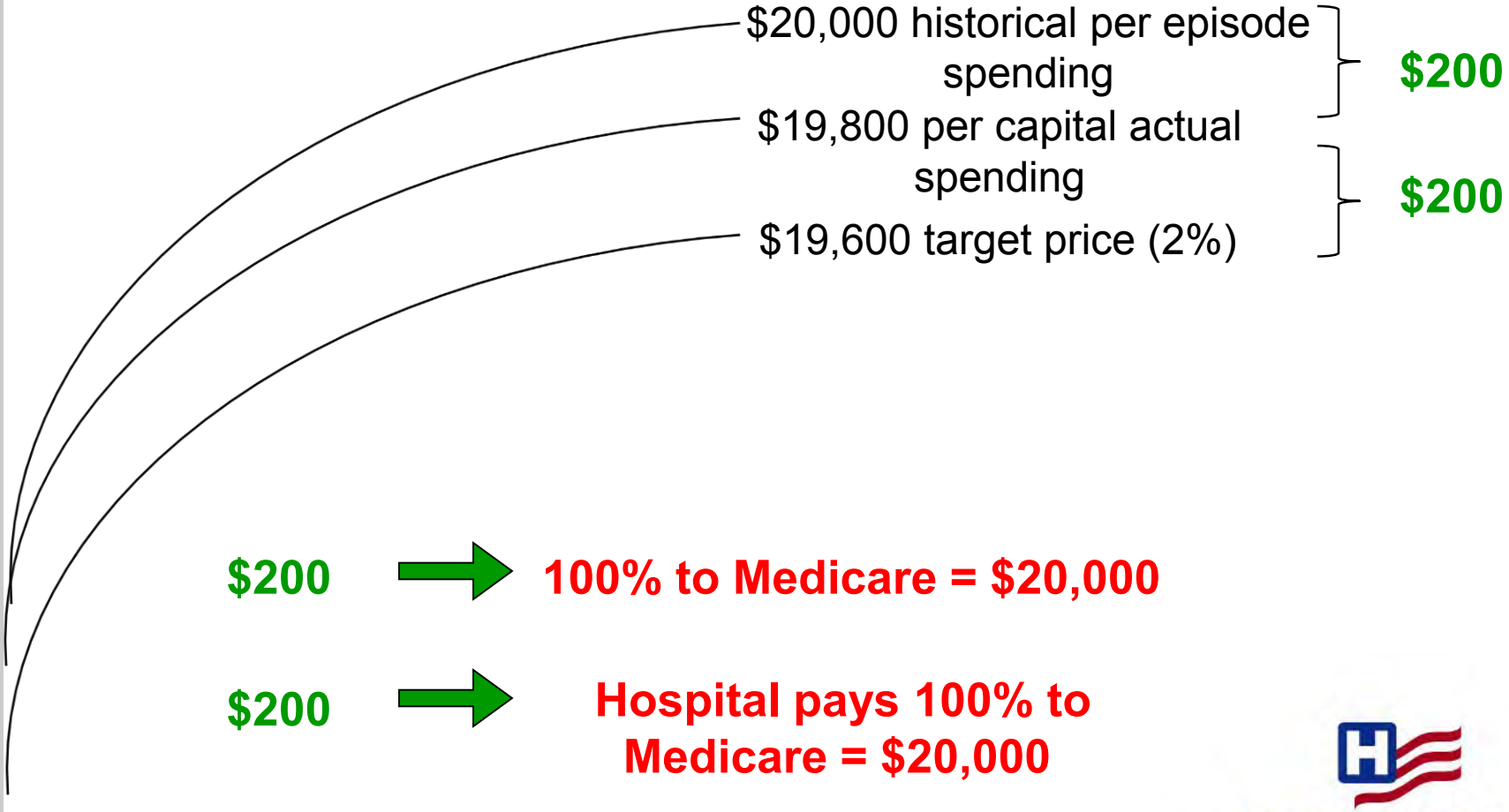
Repayment Example

USA Hospital: 100 LEJR Episodes



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Proposed Rule: Hip & Knee Bundled Payment

- **Retrospective payment methodology**
  - ✓FFS payments continue
  - ✓Settle up to 2-percent discount
  - ✓**No downside risk in Year 1**

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Discount Factor by Performance Year

Performance Year	Discount for Purposes of Reconciliation Payments	Discount for Purposes of Repayments to Medicare
1	2%	No repayments required
2	2%	1%
3	2%	2%
4	2%	2%
5	2%	2%

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- **Retrospective payment methodology**
  - ✓FFS payments continue
  - ✓Settle up to 2-percent discount
  - ✓No downside risk in Year 1
  - ✓**Quality measure requirements**

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- **Three Quality Measures:**
  - **Hip/knee hospital readmissions within 30 days**
  - **Hip/knee complications within 90 days**
  - **HCAHPS (all patients, not just hip/knee)**
- **Performance Threshold (national data):**
  - **Years 1 through 3: 30th percentile**
  - **Years 4 and 5: 40th percentile**

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PRO Measure Bonus

- Gather patient perspective on recovered function, reduced symptom burden, etc.
  - Collects extensive pre/post-procedure data
- Successful Report = Smaller Discount
  - Successful Report = 80 percent of applicable hip/knee patients
  - 1.7% discount instead of 2.0%

Proposed Rule: Hip & Knee Bundled Payment

- **Retrospective payment methodology**
  - ✓FFS payments continue
  - ✓Settle up to 2-percent discount
  - ✓No downside risk in Year 1
  - ✓Quality measure requirements
  - ✓**Stop-loss and stop-gain**

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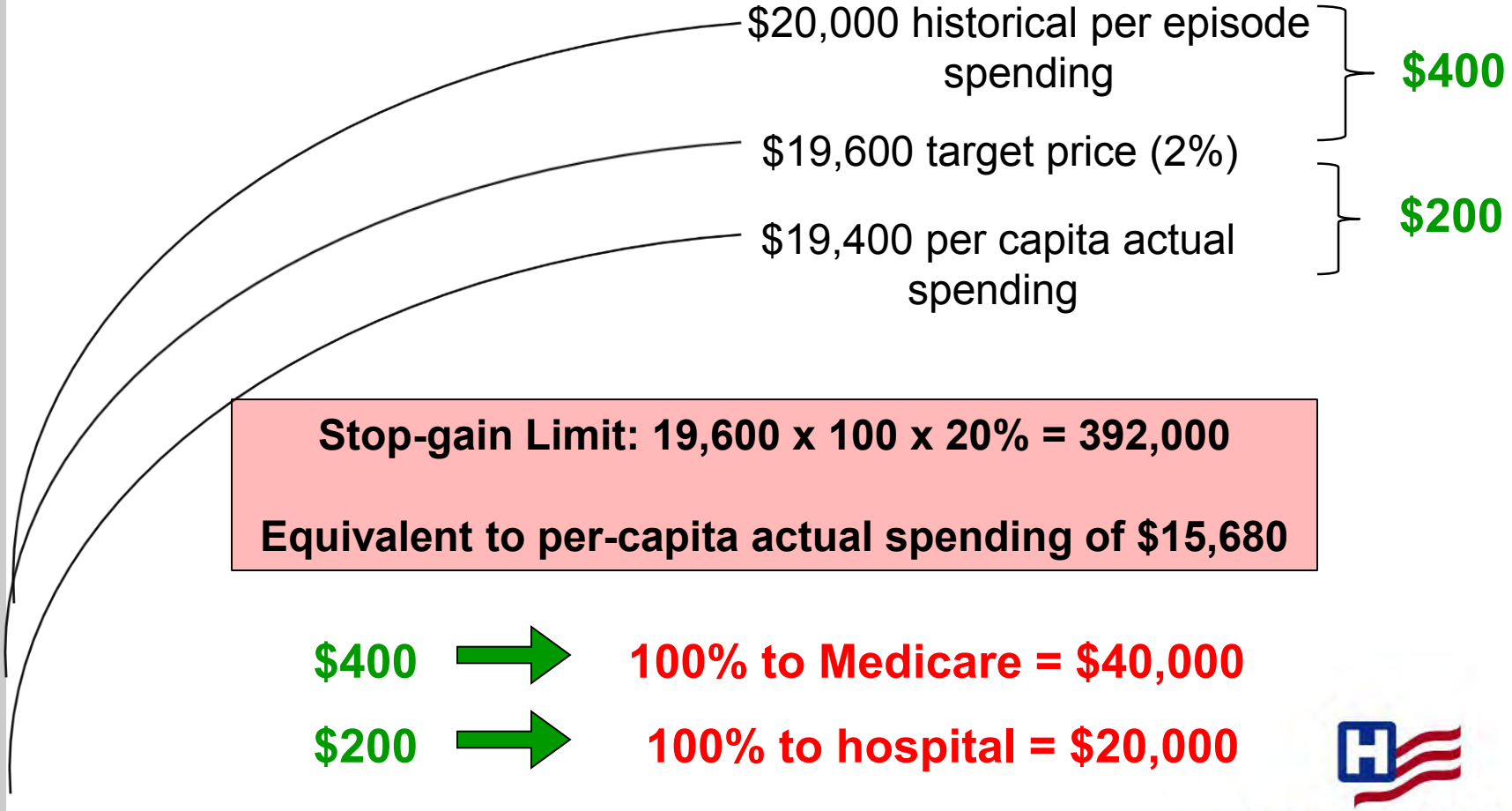
Stop-gain Example

USA Hospital: 100 LEJR Episodes



Stop-gain Limit: 19,600 x 100 x 20% = 392,000

Equivalent to per-capita actual spending of $15,680

$400 → **100% to Medicare = $40,000**

$200 → **100% to hospital = $20,000**

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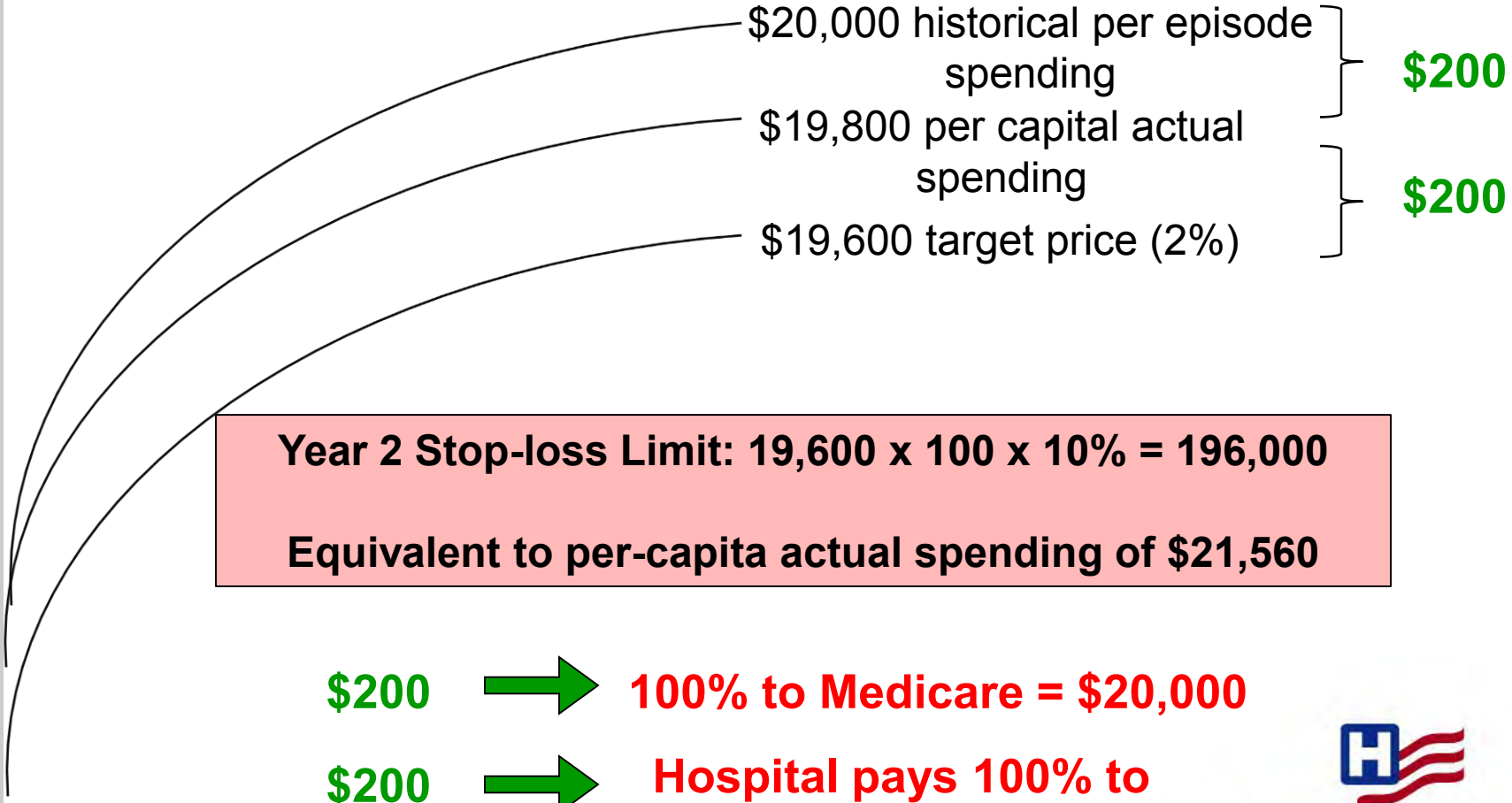
Stop-loss Example

USA Hospital: 100 LEJR Episodes



Year 2 Stop-loss Limit: 19,600 x 100 x 10% = 196,000

Equivalent to per-capita actual spending of $21,560

$200 → **100% to Medicare = $20,000**

$200 → **Hospital pays 100% to Medicare = $20,000**

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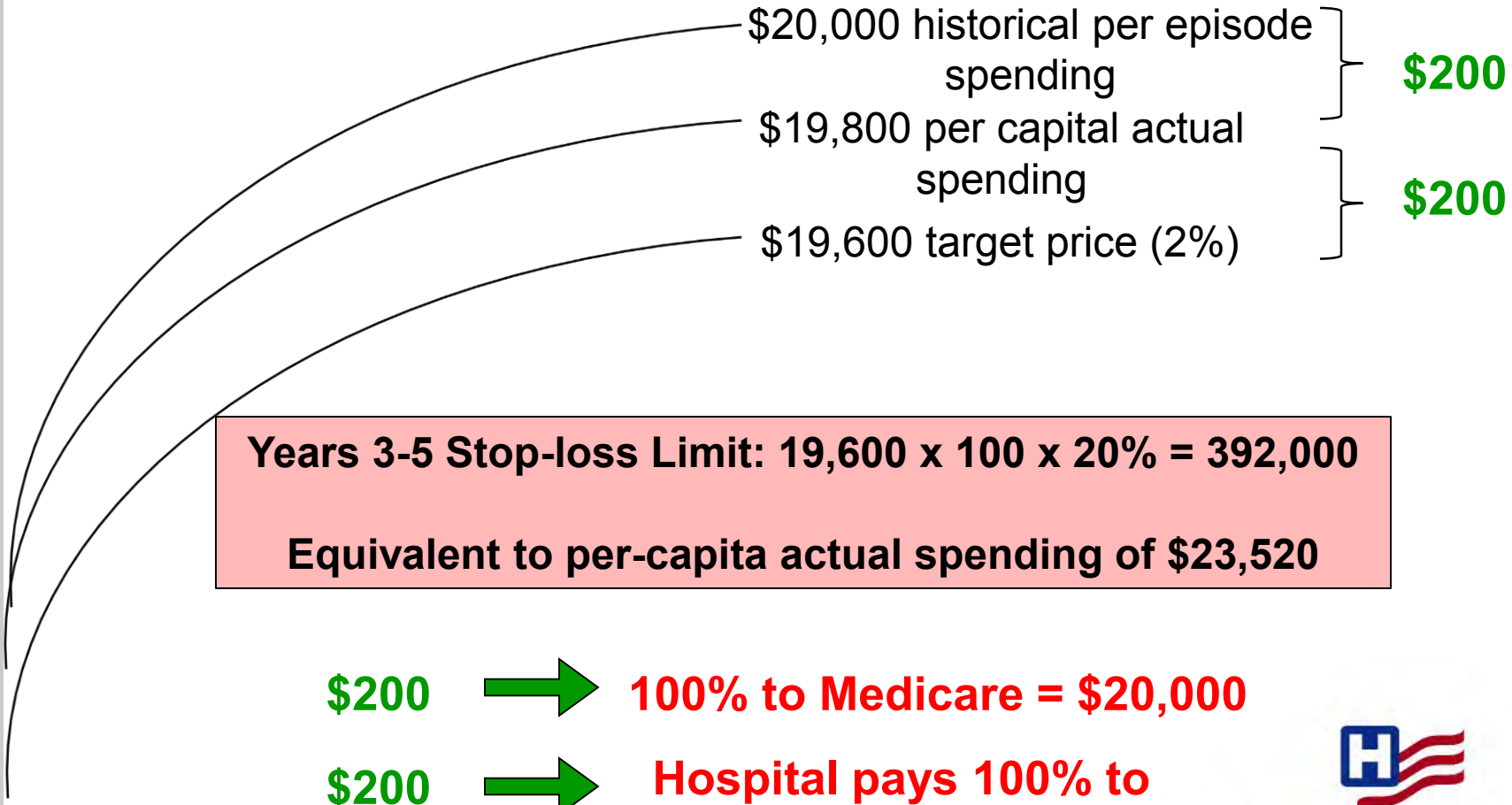
Stop-loss Example

USA Hospital: 100 LEJR Episodes



Years 3-5 Stop-loss Limit: 19,600 x 100 x 20% = 392,000

Equivalent to per-capita actual spending of $23,520

$200 → **100% to Medicare = $20,000**

$200 → **Hospital pays 100% to Medicare = $20,000**

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Proposed Rule: Hip & Knee Bundled Payment

Waived 	Not Waived 
	Stark
	Anti-kickback
	CMP

Proposed Rule: Hip & Knee Bundled Payment

Waived 	Not Waived 
Physician "incident to" rule	Stark
SNF 3-day rule **	Anti-kickback
Telehealth	CMP
	60% Rule/3-hour Rule
	HH homebound rule
	Patient steering