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Medicare Announces First Mandatory Bundled Payment Model: Comprehensive Care for Joint Replacement

+Insights

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Hospitals in the 75 metropolitan areas selected for mandatory participation in the new payment model should begin preparations to establish partnerships with appropriate providers and develop internal infrastructure to manage their participation in the program. Comments on the proposed rule are due September 8, 2015.

On July 9, 2015, the Centers for Medicare & Medicaid Services (CMS) proposed to implement a bundled payment model for hip and knee replacements that would require the mandatory participation of most hospitals in 75 metropolitan areas around the United States. The model, which is scheduled to begin on January 1, 2016, represents a dramatic leap toward the agency's goal of increasing the number of payments made pursuant to outcomes-based alternative payment models.

The Comprehensive Care for Joint Replacement (CCJR) model is being proposed under the authority of the Center for Medicare & Medicaid Innovation (CMMI), the health system transformation laboratory established by Congress under the Affordable Care Act to identify, test and spread new payment and delivery models. With the establishment of CMMI, Congress gave CMS unique authority to scale up or expand demonstration projects without the administrative hurdles that generally are required.

Payment Model Overview

Under the CCJR, hospitals in 75 randomly selected geographic areas would be held financially accountable for the quality and cost of care for the entire episode of care from

For the **first time**, hospitals would be **required** to participate. All previous bundled payment initiatives have been voluntary.

the time of surgery thorough 90 days following discharge. While a variety of providers, such as physicians, hospitals and post-acute care providers, would contribute to the spending during the episode of care, CMS proposes to hold only the hospital where the inpatient stay occurred financially accountable. CMS intends to run the CCJR for five years, and estimates that it will result in savings of $153 million to Medicare over that period.

Under the proposed model, providers would continue to be paid for their services under existing fee-for-service (FFS) payment methodologies, such as the Inpatient and Outpatient Prospective Payment Systems (IPPS and OPPS) and the Medicare Physician Fee Schedule. At the end of the year, all spending for the episode of care would be compared to a target price. The target price generally would expect 2 percent savings over expected episode spending after accounting for a blend of historical hospital-specific and regional spending for lower extremity joint replacement (LEJR) episodes, with the regional component of the blend increasing over time.

Participant hospitals that achieved actual episode spending below the target price and met quality performance thresholds would be eligible to earn a bonus payment from Medicare based on the difference between the target and actual episode spending, up to a specified cap. Hospitals with episode spending in excess of the target price would be financially responsible for repaying the difference to Medicare up to a specified repayment limit. Hospitals would not be required to pay Medicare back if actual spending was greater than the target spending in performance year one (CY 2016), but would be subject to the repayment responsibility in subsequent years with their repayment exposure increasing between years two and three.

CCJR Is the First Medicare Mandatory Bundling Program

While CMS has tested a variety of alternative payment models through its Innovation Center, this model is unique and significant because it would be the first time hospitals would be ***required*** to participate. All previous bundled payment initiatives have been voluntary. On January 26, 2015, Health and Human Services Secretary Sylvia Burwell announced a goal of tying 30 percent of traditional FFS Medicare payments to quality or value through alternative payment models or other arrangements by 2016, and tying 50 percent by the end of 2018. At the time, many viewed the Secretary's goal as ambitious, but this CCJR proposal reflects the seriousness of the Secretary's goal and is a harbinger of similar proposals to come in the near future.

In designing this payment model, CMS was informed by two previous initiatives: the Medicare Acute Care Episode (ACE) demonstration and the Bundled Payment for Care Initiative (BPCI). The three-year ACE demonstration, which was initiated in 2009 and has since ended, tested the use of a global payment for an episode of care as an alternative approach to payment for FFS delivery. The MS-DRGs tested under the ACE model included 469 and 470, the same as those proposed for inclusion in the CCJR model.

Hospitals would be held **accountable** and made to **repay** payments in excess of the target.

BPCI was initiated in 2013 and is ongoing. Under this demonstration, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. There are four models being tested: Model 1 (Retrospective Acute Care Hospital Stay Only), Model 2 (Retrospective Acute Care Hospital Stay plus Post-Acute Care), Model 3 (Retrospective Post-Acute Care Only), and Model 4 (Acute Care Hospital Stay Only).

Hospital Selection Process and Protections for Certain Hospitals

Participating hospitals would be the episode initiators and bear the financial risk under the proposed CCJR model. CMS has identified 75 MSAs selected for participation by stratified random assignment. Subject to a few exceptions, such as participation in a qualifying voluntary demonstration, hospitals in those 75 geographic areas would be required to participate. Table 3 in the proposed rule identifies the proposed MSAs by MSA number and location. Proposed selected locations include major population centers such as New York City, Miami and San Francisco, as well as less densely populated areas such as Bismarck, North Dakota and Lincoln, Nebraska. All hospitals paid under the IPPS and physically located in the selected geographic locations would be required to participate with limited exceptions. These exceptions include those participating in Model 1 or Phase II of Models 2 or 4 of the BPCI initiative for LEJR episodes. Otherwise, hospitals paid under the IPPS and physically located in the selected MSAs would be required to participate. Hospitals outside these geographic areas would not be able to participate. There is no application process for this model.

Sole Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs) and Rural Referral Centers (RRCs) are eligible for enhanced payments under the IPPS and in some cases under the OPPS, and many facilities may receive additional payments related to their participation in various quality initiatives. The majority of IPPS hospitals also receive additional payments for Medicare Disproportionate Share Hospital and Uncompensated Care, and IPPS teaching hospitals can receive additional payments for Indirect Medical Education. CMS proposes to exclude these payments when calculating actual episode payments, setting episode target prices, comparing actual episode payments with target prices, and determining whether a reconciliation payment should be made to the hospital or funds should be repaid by the hospital. CMS also indicated that it would take into account the effects of sequestration when analyzing episode payments.

CMS also has modified the proposed repayment limits, referred to as stop-loss

limits, for rural hospitals, SCHs, RRCs and MDHs. The agency believes these modifications are necessary since these facilities may have a lower risk tolerance and less infrastructure and support to achieve efficiencies for high-payment episodes. These modifications are summarized in the chart below.

PROPOSED STOP-LOSS LIMITS FOR THE CCJR PAYMENT MODEL

Performance Year	Standard Stop-Loss Limit	Stop-Loss Limit* for Rural Hospitals, SCHs, RRCs, and MDHs
1	N/A	N/A
2	10%	3%
3-5	20%	5%

*Refers to the percent of the hospital's target price for the anchor MS-DRG multiplied by the number of the hospital's CCJR episodes with that anchor MS-DRG in the performance year that would be owed by the hospital to Medicare.

Post-Acute Care Services Could Be the Key Variable for Success

Hip and knee replacements are among the most common surgeries for Medicare beneficiaries. In 2013, there were more than 400,000 inpatient primary LEJR procedures, costing Medicare more than $7 billion for hospitalization alone. CMS believes that the quality and cost of care for these hip and knee replacement surgeries still vary greatly among providers. Because of this volume and variability, the agency selected LEJR for this first national mandatory demonstration.

This model also would provide an opportunity to address an issue identified by CMS and the Medicare Payment Advisory Commission (MedPAC): variation in use of post-acute care. In a recent analysis of Medicare claims data by episode of care, MedPAC found that post-acute care accounts for a minority of spending, but the majority of variation in spending. MedPAC concluded that one way to improve episode spending efficiency is for hospitals to guide patients to high-value post-acute care services. CMS indicated in the proposed rule that research specific to LEJR also has found substantial regional variation in post-acute care referral patterns and in the intensity of post-acute care services provided for LEJR patients, resulting in significant variation in post-acute expenditures across LEJR episodes initiated at different hospitals. CMS believes that the CCJR model would incentivize hospitals to consider and manage the post-acute care decisions.

With the start date of the CCJR payment model less than six months away, hospitals in the 75 randomly selected MSAs should begin planning immediately. Preparations should include establishing partnerships with the appropriate providers (physician and post-acute care providers) and building the internal infrastructure to properly manage participation in the program.

Comments on the proposed rule are due by September 8, 2015. CMS will hold a webinar to discuss the contents of this proposed rule on July 15, 2015, from 1–2 pm EST, and on July 16, 2015, from 2–3 pm EST. Additional information and a link to the proposed rule is available on the CMMI website.

CCJR Overview	
Performance Years	Five year payment model, CY 2016 to CY 2020.
Provider Selection Methodology	All IPPS hospitals, with limited exceptions, in the 75 randomly selected MSAs will be required to participate.
Services Included	DRG 469, Major joint replacement or reattachment of lower extremity with MCC.
	DRG 470, Major joint replacement or reattachment of lower extremity without MCC.
Bundle Definition	LEJR procedure, inpatient stay, all related care covered under Medicare Parts A and B within 90 days after the discharge, including hospital care, post-acute care and physician services.
Quality Measures	Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551), an administrative claims-based measure.
	Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure.
	HCAHPS Survey measure.
Retrospective Payment Methodology	All providers would be paid according to usual Medicare FFS payment systems.
	At the end of the year, sum of all payments for bundled service would be reconciled against target price with consideration of additional payment adjustments based on quality performance and post-episode spending.
	If positive, payment would be made to the **participant hospital**; if negative CMS would require repayment from the **participant hospital**.
	In Performance Year 1 (CY 2016) hospitals would not be required to pay Medicare back if actual spending is greater than the target price.

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