Metro Area SNFs to Experience Mandatory Bundled Medicare Payments

By Joseph M. Greenman, Lane Powell PC

On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) finalized the Comprehensive Care for Joint Replacement (CJR) model, its first mandatory bundled payment initiative. The rule implements retrospective bundled payments for episodes of care for hip or knee replacements in 67 metropolitan statistical areas (MSAs) across the country, including the Portland MSA which includes Clackamas, Columbia, Multnomah, Washington, Yamhill, Clark, and Skamania counties. The program began April 1, 2016.

Through retrospective research, CMS identified the lower extremity joint replacement (LEJR) episode of care as one of the most expensive and highly utilized procedures for Medicare beneficiaries, in large part due to the drastic variation between post-acute care (PAC) referral patterns. In 2014, there were more than 400,000 LEJR procedures in the U.S. (1,938 in the Portland MSA), totaling a cost of more than $7 billion for the hospitalizations alone. The new CJR model will test whether bundled payments to acute care hospitals for the LEJR episode will ultimately reduce Medicare expenditures, while also preserving quality of care.

In cases of LEJR, an episode of care begins with an admission to a participant hospital of a patient who is ultimately discharged under MS-DRG 469 or 470. The participant hospital has sole accountability for the cost and quality of care during the entire LEJR episode, which includes the inpatient surgery as well as 90 days post-discharge. The episode includes all related items and services paid under Medicare Part A and Part B, including PAC services. Using the new CJR model, the bundled payment will be retrospective, based on the FFS Medicare claims submitted throughout the episode and compared to a pre-episode negotiated target price.

Throughout the performance year, CMS will continue to pay hospitals and other CJR providers by the standard Medicare FFS payment system. The difference will be that at the end of each performance year, the submitted Medicare claims payments will be aggregated to form the actual episode payment, the total cost of claims payments for items and services throughout the episode. This number will be compared to the pre-episode established CJR target price.

In performance year one of the CJR model, hospitals will not be at-risk of reduced pricing for LEJR episodes and will be eligible for reconciliation payments. The phased-in repayment responsibility will start in performance year two, when hospitals begin accountability for any excess spending within the episode. CMS believes downside risk, or the financial risk, will incentivize better coordination of care among entities producing higher quality of care but will allow a full performance year to help providers prepare for the risk-based phase of the model. Hospitals will then be able to gain or lose financially based upon their actual episode payments relative to pre-determined target prices. All hospitals will be able to earn up to five percent of their target price in performance years one and two (though will not have downside risk in year one), ten percent in performance year three, and 20 percent in performance years four and five.

CJR hospitals will create agreements and form partnerships with physicians, home health, skilled nursing facilities (SNFs), and other PAC providers. The rule addresses alignment payments, collaborator agreements, distribution arrangements, distribution payments, gainsharing payments, and sharing agreements as methods for aligning incentives between providers. On November 16, 2016, CMS and OIG released a joint notice regarding the waiver of certain fraud and abuse laws (including the Federal anti-kickback statute) for the purpose of testing these types of agreements.

The new CJR model has the potential to drastically change the PAC landscape, in how PACs treat patients, as well as enhance their relationships with hospitals. CJR could have an effect of creating winners and losers among PAC providers, if PACs do not proactively strategize and adjust course in how they manage care for this program. PACs will likely seek opportunity to work more closely with CJR hospitals to develop appropriate networks, care pathways, and delivery patterns and will be expected to draw distinction between those patients who belong to the CJR program and those who receive care under FFS, managing their care jointly on the former. ○

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