
Health Law Daily Wrap Up

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The first episode-of-care payment model that makes the participation of hospitals in certain metropolitan statistical areas (MSA) mandatory, not optional, will take effect April 1, 2016. The Comprehensive Care for Joint Replacement (CJR) model will hold hospitals accountable for quality in episodes of care revolving around hip and knee replacements (lower extremity joint replacements, or LEJRs) and other major leg procedures, and will run through December 31, 2020. CMS believes that the participation of hospitals with varying utilization patterns, markets, and populations, that might not otherwise participate in in a bundled payment initiative, “could inform future Medicaid payment policy” (Final rule, 80 FR 73274, November 24, 2015).

Background. Hip and knee replacements are common surgeries, with more than 400,000 performed in 2014, but costs and quality vary significantly among hospitals, with average total Medicare expenditures for surgery, hospitalization, and recovery ranging from $16,500 to $33,000 across geographic areas. The CJR model, overseen by Center for Medicare and Medicaid Innovation created by sections 3021 and 10306 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), is intended to encourage hospitals to coordinate care with physicians, home health agencies, skilled nursing facilities, and other providers to allow for the best possible outcomes for patients and the best financial outcomes for the Medicare programs. Acute care hospitals serving as surgical sites that participate in the model can earn performance-based payments by "appropriately reducing expenditures" and meeting quality metrics. Conversely, hospitals that incur high costs and fail to meet quality measures may be required to repay fee-for-service payments.

Changes to Proposed rule. CMS received more than 400 comments in response to the Proposed rule it published on July 14, 2015 (see How's that working for you? CMS to test new payment method for joint replacement, July 14, 2015). As a result, the agency made a number of changes to the Proposed rule.

• Start date. CMS was persuaded by comments indicating that participants would be unable to implement necessary changes prior to a January 1, 2016 implementation date, in part because participating hospitals’ baseline data would be unavailable prior to that date and they would be unable to assess the need for changes. As a result, CMS moved the start date to April 1, 2016 and pledged to make “baseline data available upon request in advance of the April 1, 2016 start date.”

• Site selection. The Final rule decreases the number of participating MSAs from 75 to 67. CMS updated the list of Bundled Payments for Care Initiative (BCPI) and removed from consideration the count of BCPI episodes of care involving patients who would have been attributed to a BPCI Model 2 initiating physician group practice in Phase 2 for an LEJR episode as of October 1, 2015, resulting in the decreased number.

• Quality measures in pay-for-performance model. In lieu of proposed threshold methodology, CMS is finalizing the use of a composite quality score based on quality performance and improvement on the total hip arthroplasty (THA) and total knee arthroplasty (TKA) Complications measure (National Quality Forum [NQF] #1550) and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0116), along with submission of THA/TKA voluntary patient-reported outcome (PRO) and limited risk variable data, and places participant hospitals in one of four quality categories for each performance year, “Below Acceptable,” “Acceptable,” “Good,” and “Excellent.”
• **Payment.** In the Final rule, CMS has created a gradual timeline for repayment responsibility and decreased stop-loss limits, with a parallel approach for stop-gains limits.
  - **Performance Year 1:** No repayment responsibility
  - **Performance Year 2:** Stop-loss limit of 5 percent
  - **Performance Year 3:** Stop-loss limit of 10 percent
  - **Performance Years 4 and 5:** Stop-loss limit of 20 percent, except for rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals

• **Fraud and abuse waivers.** Rather than including information about fraud and abuse waivers in the Final rule, CMS and the HHS Office of Inspector General (OIG) are publishing a notice reflecting waivers applicable to the CJR model on their websites (see Some fraud waivers available during joint replacement payment model testing, November 17, 2015).