CMS FINAL RULE ESTABLISHES SIGNIFICANT CHANGES TO COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

On December 20, 2016, the Centers for Medicare & Medicaid Services ("CMS") published a Final Rule that included several changes to the recently implemented Comprehensive Care for Joint Replacement ("CJR") program. The CJR Model is a retrospective bundled payment program limited to lower extremity joint replacement ("LEJR") procedures and is designed to encourage hospitals to collaborate with other providers in care redesign measures to improve quality and control costs in LEJR care episodes. This article will provide a summary of the Final Rule's revisions to the CJR regulations. (Click here to view the November 2015 CJR Final Rule and here to view Hall Render's summary of the existing CJR regulations). A high level summary of the entire Final Rule is provided in our related Health Law News article, which can be found here.

Revisions Applicable to CJR Reconciliation Process. The Final Rule outlines several modifications to the CJR reconciliation and payment process. These modifications include changing the term "episode target price" as used in the 2015 CJR Final Rule to "quality-adjusted target price" ("QATP") in order to align with the episode payment models ("EPMs") also outlined in the Final Rule. The QATP represents the price used to determine whether the CJR participant hospital is eligible for a reconciliation payment from Medicare or required to make a repayment to Medicare. Other revisions to the CJR reconciliation process include technical updates to calculation methodologies to account for post-episode spending amounts, inclusion of Medicare Shared Savings Program ("MSSP") accountable care organizations ("ACOs") as collaborators in CJR episodes and inclusion of ACO payments, reconciliation payments and repayments in calculating and updating the QATP for CJR Model performance years 3 through 5.

Overlap with ACOs. For CJR episodes beginning on or after July 1, 2017, the Final Rule excludes beneficiaries who are prospectively aligned with a Next Generation ACO, an End Stage Renal Disease ("ESRD") Seamless Care Organization or a MSSP ACO in Track 3.

Financial Arrangements Between Hospitals and Other Providers. The Final Rule involves a number of revisions to regulations governing permitted financial arrangements under the CJR Model.

- CJR Collaborators. CMS has expanded the categories of collaborators with which CJR participating hospitals may enter into financial sharing arrangements. Permitted CJR collaborators now include:
  - Accountable Care Organizations;
  - Skilled Nursing Facilities ("SNFs");
  - Home Health Agencies ("HHAs");
  - Long-Term Care Hospitals ("LTCHs");
  - Inpatient Rehabilitation Facilities ("IRFs");
  - Physicians;
  - Nonphysician Practitioners;
  - Therapists in Private Practice;
  - Comprehensive Outpatient Rehabilitation Facilities;
  - Providers of Outpatient Therapy Services;
  - Physician Group Practices ("PGPs");
  - Hospitals;

- Critical Access Hospitals;
- Nonphysician Practitioner Group Practices ("NPPGPs"); and
- Therapy Group Practices ("TGPs").

Previously, eligible CJR collaborators were limited to SNFs, HHAs, LTCHs, IRFs, physicians or PGPs, nonphysician practitioners and outpatient therapy providers/suppliers.

- Sharing Arrangements and Collaborator Agreements. Pursuant to the Final Rule, the term "collaborator agreement" is deleted from the CJR regulations effective July 1, 2017, and all requirements for financial arrangements between a CJR participant hospital and a collaborator are encompassed under the term "sharing arrangements" (a term that was essentially used interchangeably with the term "collaborator agreement" under the 2015 CJR Final Rule). CMS is also adding the term "CJR activities" in order to capture the activities of direct care and care redesign for CJR episodes. The Final Rule also revises and reorganizes requirements for written sharing arrangements and sets forth requirements for sharing arrangements for the newly added categories of collaborators. These requirements largely track requirements for sharing arrangements with existing categories of collaborators.
- Distribution Arrangements. The Final Rule expands on existing regulations related to distribution arrangements. Under the 2015 CJR Final Rule, a PGP that receives a CJR gainsharing payment from a hospital is permitted to distribute such payments only to those individual PGP members who furnished a billable service to a CJR beneficiary during the relevant performance year. Further, such distribution payments may not exceed 50 percent of the total professional fees received by the PGP member for care of CJR beneficiaries during the performance year.

One of the most significant CJR revisions contained in the Final Rule allows PGPs to distribute gainsharing payments to PGP members in accordance with the Stark Law's PGP exception. Very briefly, in order to comply with the Stark PGP exception, a PGP must meet requirements related to the structure, size and business decision-making of the practice; the scope and percentage of services each physician provides through the group practice; and the methodology for calculating compensation to individual physicians (including, for example, a requirement that overall profits of the group are not distributed in a manner directly related to the volume or value of designated health services referrals made by the physician).

Under the Final Rule, so long as the PGP distributes any gainsharing payment in compliance with the Stark PGP exception, the PGP may distribute part of a gainsharing payment to a physician who made no contribution to CJR activities and who provided no care to beneficiaries in CJR episodes. Moreover, so long as the distribution is made in compliance with the Stark PGP exception, distributions to individual physicians are not subject to the cap of 50 percent of the physician's aggregate professional fees for care of patients in CJR episodes.

The Final Rule also outlines requirements permitting ACOs, NPPGPs and TGPs to enter into distribution arrangements with their respective members, though each has slightly different requirements from a PGP distribution arrangement.

- Clarification of "Actually and Proportionally Related." The Final Rule clarifies the existing CJR requirement that any gainsharing payments to collaborators and distribution payments to collaborator practice agents (a term that includes individual PGP members, ACO participants or ACO providers/suppliers) must be "actually and proportionally related to care of beneficiaries in a CJR episode." The Final Rule instead requires that such payments must be substantially based on quality of care and the provision of CJR activities and that the methodology for calculating such payments may take into account the amount of CJR activities provided by a CJR collaborator relative to other CJR collaborators.
- Downstream Distribution Arrangements. CMS has finalized revisions to the 2015 CJR Final Rule designed to accommodate ACOs as collaborators, including provisions to address distributions to individuals termed "downstream collaboration agents." These provisions largely mirror those related to distributions to PGP members under the existing CJR regulations. In the Final Rule, CMS has also added policies for NPPGPs and TGPs that enter into downstream distribution arrangements with members.

Beneficiary Incentives. Beneficiary incentives under the CJR model allow hospitals to provide Medicare beneficiaries with certain items or services that promote the engagement of a beneficiary in the management of his or her own care. The Final Rule makes only a few changes to these requirements, including a requirement that participant hospitals retain and provide CMS with access to beneficiary incentive

documentation.

SNF 3-Day Waiver Beneficiary Protections. Under the 2015 CJR Final Rule, CMS waived the so-called "SNF 3-day rule" for all CJR episodes in performance years 2 through 5 if the admitting SNF had a rating of three stars or better on the Five-Star Quality Rating System. In the Final Rule, CMS has included additional beneficiary financial protections under the SNF 3-day waiver due to concerns that a beneficiary may be subject to financial liability for non-covered SNF services related to misuse of the waiver. CMS will hold participant hospitals financially responsible for SNF stays where the waiver requirements are not met. Specifically, when a participant hospital has discharged a beneficiary to a non-qualifying SNF without providing the required notice of financial responsibility to the beneficiary, the financial responsibility for the non-covered SNF stay will rest with the participant hospital, rather than with Medicare or the beneficiary.

Mandatory Participation in Surgical Hip/Femur Fracture Treatment ("SHFFT") Model. The Final Rule finalizes CMS's proposal that the SHFFT EPM be implemented in those metropolitan statistical areas where the CJR Model is currently implemented. All current CJR participant hospitals are required to participate in the SHFFT EPM under the Final Rule. Click here for more details regarding the SHFFT EPM.

Advanced Alternative Payment Models. Under the Final Rule, CMS also seeks to align the CJR Model with other pay-for-performance models, including the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). Very briefly, the MACRA physician Quality Payment Program links quality to payment through, among other things, allowing clinicians to participate in Advanced Alternative Payment Models ("APMs"). Eligible clinicians who meet the requirements to participate as Qualified Providers ("QPs") in Advanced APMs can receive APM incentive payments and favorable payment updates under the Medicare Physician Fee Schedule. CMS outlines how the EPMs and the updated CJR Model meet the requirements to be considered Advanced APMs, thus permitting physicians collaborating with hospitals in these programs to meet the requirements to be considered eligible QPs under the Advanced APMs.

CMS is implementing two different CJR tracks: Track 1, an Advanced APM track; and Track 2, a non-Advanced APM track. CJR participant hospitals interested in participating in Track 1, and thus qualifying their CJR Model programs as Advanced APMs, must attest to their use of certified electronic health information technology functions to document and communicate clinical care with patients and other health care professionals. In order to allow CMS to determine whether CJR collaborating clinicians are QPs for purposes of MACRA, CJR participant hospitals must also provide CMS a list of clinician financial arrangements that discloses each clinician's name, tax identification number and national provider identifier, as well as the start and end dates for the financial sharing agreement under which the clinician participates. As a practical matter, CMS points out that participation in Track 1 does not otherwise change any CJR participating hospital's obligations (including obligations to make any required repayments) under the CJR Model, nor does participation in Track 1 alter the hospital's opportunity to earn reconciliation payments under the CJR Model. However, by providing an opportunity for physicians and other clinicians to meet QP requirements under MACRA, participation in Track 1 may provide an additional incentive for such clinicians to take an active role in collaborating with hospitals under the CJR Model.

PRACTICAL TAKEAWAYS

It is unclear whether the new Trump administration will continue programs under the Center for Medicare & Medicaid Innovation ("CMMI"), including the CJR model. The new administration and Congressional Republicans have been vocal regarding their intent to repeal and replace the Affordable Care Act. House Speaker Paul Ryan's health plan, "A Better Way," explicitly calls for dismantling CMMI. There is therefore still uncertainty about which ACA and CMMI programs will be retained and which may be repealed.

However, hospitals currently participating in the CJR model should be fully prepared to comply with the provisions of the Final Rule. This may include preparing to enter into sharing arrangements with ACOs and other hospitals, evaluating current payment methodologies and preparing for new calculation methods under the QATP. CJR participant hospitals should also assess their preparedness to participate in the SHFFT EPM, which CMS is making mandatory for CJR participant hospitals under the Final Rule.

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