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Structuring Comprehensive Care for Joint Replacements Collaborator Agreements

Selecting Partners, Implementing CJR Arrangements, Ensuring Compliance

WEDNESDAY, OCTOBER 5, 2016

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Today's faculty features:

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At The Intersection of New Bundled Payment Programs and New Discharge Rules: Private Equity Opportunities

POSTED BY CHRISTOPHER J. DONOVAN, C. FREDERICK GEILFUSS II AND ALEXIS FINKELBERG BORTNIKER ON 24 MARCH 2016
POSTED IN COMPLIANCE; REGULATORY DEVELOPMENTS; REIMBURSEMENTS

Recently, CMS has promulgated new bundled payment rules for Comprehensive Joint Replacement (CJR) that require the mandatory participation of approximately 800 hospitals across the US. This bundle includes not only the inpatient DRG care, but also 90 days of post-discharge care. Contemporaneously, CMS has initiated rulemaking which totally revamps the discharge planning process for hospitals by requiring a) a multi-disciplinary discharge plan within 24 hours of admission; b) both patient and physician input as to preferences and quality indicators of post-acute care options; and c) community support resource availability. The goal of the new discharge rules is to revolutionize a now disjointed discharge process that leaves both patients and clinicians uninformed and uncoordinated at a very sensitive point in care transition that dramatically impacts the likelihood of possible readmission or costly complications. The new discharge rules seek to create more quality transparency that will result in lower costs and better outcomes through a process of joint patient/clinician engagement.

The intersection of the new discharge rules with the CJR is vital to hospitals since they will bear the risk of the repayments to CMS even though they are not directly providing the post-discharge care—hence their need to focus on proper and effective discharge protocols as mandated by the new discharge rules. These twin forces of

bundled payments and rigorous discharge processing will present challenges for hospitals in the following ways:

1. Already strained hospital budgets will be further stretched by the need to hire additional personnel to develop, train and implement the new discharge rules;
2. The ability to identify and screen post-acute players that qualify for the various program waivers (the CJR model waives the required 3-day hospital before a SNF admission if the CJR patient is admitted to a SNF that has a 3 Star Compare rating) even in cases where uniform quality indicators may be lacking (e.g., IRFs) without violating patient choice and that now incentivize the least expensive quality and effective location for post-acute care;
3. The need to track cost data over an episode of post-discharge care as compared to a moving benchmark target will require unique data analytics capabilities in both gainsharing creation and care redesign cost savings that many hospitals may find lacking or inadequate; and
4. The need to proactively plan for discharge earlier in the inpatient episode and coordinate the discharge via EMR and other interoperable platforms will stretch the IT and infrastructure budgets of many hospitals.

However, where challenges exist, opportunities may also arise. Firms that can provide solutions on an outsourced and cost effective basis to the above needs will be well positioned to transform care episodes that reflect possibilities for poor outcomes and costly complications to ones that will allow for cost reduction over time. For example, aggregating existing cost data from unbundled sources to a rolled up bundle amount requires focused data efforts. Those efforts allow providers to logically allocate upside and downside but also will allow providers to identify the most likely sources of cost savings. Working with providers that provide quality care (as measured objectively) will be a sine qua non of successful bundled partnerships among providers. How to collect, maintain and calibrate that data to ensure development of a quality network of post-acute providers with aligned incentives will drive the future generation of bundled payment programs. Hospitals which can master that data will be well positioned to success in the alternative payment model world that CMS has warned is coming.

Private equity companies historically have been able to develop "tool" model business outsourcing portfolio firms in health care in many areas without being a direct provider or supplier themselves (e.g. RCM, EHR, practice management, patient engagement software etc.). The new bundled payment programs (which will only increase over time) coupled with the new focus on care transition management

as embodied in the proposed discharge rules offer a similar area of opportunity for PE firms to reduce costs in a process that has historic inefficiencies based on siloed payment paradigms.

The new payment models will drive more collaboration amongst previously disparate players in the health continuum as well as create more openings for investors seeking to facilitate and accelerate better outcomes at lower cost.

TAGS: BUNDLED PAYMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES, CJR, COMPREHENSIVE JOINT REPLACEMENT, HOSPITALS, POST ACUTE CARE, PRIVATE EQUITY, PROVIDERS

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CMS Expands Mandatory Bundled Payments to Cardiac Care

POSTED BY CHRISTOPHER J. DONOVAN, C. FREDERICK GEILFUSS II AND ALEXIS FINKELBERG BORTNIKER ON 1 AUGUST 2016
POSTED IN COMPLIANCE; REGULATORY DEVELOPMENTS

On Monday July 25, 2016, CMS proposed new models that expand mandatory participation in bundled payments and continue CMS's initiative to shift Medicare payments from fee for service to alternative payment models. Coming just as the Comprehensive Care for Joint Replacement (CJR) initiative gets underway, the new models are, according to CMS, intended to reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery. The proposed rule (available here, the "Proposed Rule") contains three new policies:

1. New bundled payment models for cardiac care and an extension of the existing bundled payment model for hip replacements to other hip surgeries
2. A new model to increase cardiac rehabilitation utilization
3. A proposed pathway for physicians with significant participation in bundled payment models to qualify for payment incentives under the proposed Quality Payment Program

The new bundled payment model for cardiac care (the "Cardiac Care Model") will require mandatory participation by all hospitals within 98 randomly selected service areas beginning July 1, 2018. The episodes to be included in the Cardiac Care Model would be acute myocardial infraction (MS-DRGs 280-282 or 246-251) and coronary artery bypass graft surgery (MS-DRGs 231-236). Unlike, the CJR, in which applicable

service areas were selected based on population and certain other criteria, for the Cardiac Care Model, selection will be randomized. CMS identified 294 areas that meet its selection criteria, and has proposed to randomly select 98 of those 294 for participation. Much like the CJR, the first year will provide for upside potential only, with downside risk being introduced incrementally over the last four years of the program. Similarly, like the CJR, the hospital in which a patient is admitted for care for a heart attack or bypass surgery would be accountable for the cost and quality of care provided to Medicare fee-for-service beneficiaries during the inpatient stay and for 90 days after discharge. Participating hospitals will receive a separate target price for each MS-DRG under the model. All providers and suppliers would be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. At the end of a model performance year, actual spending for the episode would be compared to the Medicare quality-adjusted target episode price that reflects episode quality for the responsible hospital. Hospitals that work with physicians and other providers to deliver the needed care for less than the quality-adjusted target price would be paid the savings achieved. Hospitals with costs exceeding the quality-adjusted target price would be required to repay Medicare.

CMS noted in the Proposed Rule that these episodes of cardiac care have been selected because, like the CJR episodes, these episodes represent high-expenditure, high-volume episodes of care for Medicare beneficiaries. However, the episodes typically result in very different patterns of care than those in the CJR. Most episodes are emergent, and not elective, and beneficiaries in these episodes commonly have chronic conditions that contribute to the initiation of the episodes and need both planned and unplanned care throughout the episode.

The Proposed Rule also expands the scope of the CJR to include MS-DRGs 480-482 for surgical hip/femur fracture treatment. CMS has not increased the services areas subject to the CJR, but will test the new episode payments for those 67 areas already participating.

CMS has noted that it intends to build the Cardiac Care Model on lessons learned and comments received in the establishment of the CJR. One notable distinction is that ACO's are allowed to be collaborators under the new Cardiac Care Model, where they could not be under the CJR. CMS notes that this is due to the interest of ACOs in gainsharing during the CJR model rule making.

The Cardiac Care Model confirms what many have suspected, that bundled payment and alternative payment model participation will quickly become mandatory across the industry, requiring all providers to begin to engage with the concepts of care redesign and the prospect of bearing risk.

The Proposed Rule also describes a new cardiac rehabilitation incentive payment model that would test the impact of providing an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery, which would be based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge. CMS believes increasing the use of cardiac rehabilitation services has the potential to improve patient outcomes and help keep patients healthy and out of the hospital. Under this model, CMS will pay the participating hospital a per- cardiac rehabilitation incentive payment. These payments would be available to hospital participants in 45 geographic areas that were not selected for the cardiac care bundled payment models, as well as 45 geographic areas that were selected for the cardiac care bundled payment models.

Additional information on the Cardiac Care Model and the other components of the Proposed Rule can be found here. Stay tuned for additional information from Foley & Lardner LLP to follow.

TAGS: BUNDLED PAYMENT, CARDIAC CARE, CMS, PAYMENT MODELS, PAYMENTS

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Comprehensive Joint Replacement Bundled Payment Program Begins April 1st

POSTED BY ALEXIS FINKELBERG BORTNIKER, CHRISTOPHER J. DONOVAN AND C. FREDERICK GEILFUSS II ON 7 MARCH 2016

POSTED IN COMPLIANCE; REGULATORY DEVELOPMENTS; REIMBURSEMENTS

Approximately 800 hospitals in 67 Metropolitan Statistical Areas will begin mandatory participation in the Comprehensive Care for Joint Replacement (CJR) Model on April 1, 2016. The CJR bundled payment program applies to MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) and MS-DRG 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities) and covers all Medicare Part A and Part B services in episodes starting with the hospitalization through 90 days post-discharge, with few exceptions.

The CJR Model is part of CMS' effort to introduce alternative purchasing models and have 90% of Medicare fee-for-service be in value-based purchasing categories by 2018. The CJR Model is the first program requiring certain hospitals to participate in a value-based program model that includes taking downside risk with respect to the care provided.

Under the CJR Model, a participant hospital serves as the hub and must participate over a five-year term. An episode target price is established for each joint replacement, based on Medicare Part A and Part B covered services, including the hospitalization, physician services, post-acute care through 90 days post discharge with LTACHs, SNFs, home health agencies, hospices, and inpatient rehabilitation

facilities, DME, Part B drugs, clinical lab, outpatient therapy and more. Each provider bills Medicare on a fee-for-service basis, with the aggregate Part A and Part B payments compared to the episode target price. As a general matter, averaged over all patients receiving a covered joint replacement at the participant hospital in a year, if all payments come in below the target, after factoring in the government's discount, the hospital and its contracted "Collaborators" share the upside (gainsharing payments). After the initial year in which there is no downside payment, if all aggregate fee-for-service payments exceed the target, the hospital and its contracted Collaborators are required to repay the excess (alignment payments). There are caps to the gainsharing payment and alignment payment that vary over time, and quality performance affects the payment of savings and repayment obligations.

Key Takeaways for Hospitals

While hospitals are the ones with responsibility, they may share up to 50% of the upside and downside by entering into Collaboration Agreements with other providers (called Collaborators) involved in a covered episode of care. There are specific requirements that must be included in each Collaboration Agreement, including engagement in care redesign strategies and a commitment to quality.

The CJR Model also allows for Medicare programmatic waivers. The CJR Model includes waivers of:

1. the SNF three-day requirement for a SNF stay in a three-star rated SNF following a hospitalization,
2. the "incident to" direct supervision requirement for post-charge home visits, and
3. the geographic site requirement for any service on the Medicare-approved telehealth list.

CMS and OIG have also agreed that certain fraud and abuse laws will be waived under certain specified conditions, allowing:

1. sharing of gainsharing and alignment payments with Collaborators pursuant to Collaboration Agreements,
2. Physician Group Practitioners sharing gainsharing payments with its physician collaboration agents, and
3. the provision of certain in-kind beneficiary engagement incentives provided to beneficiaries, which incentives meet specified requirements.

Hospitals and potential Collaborators will need to understand the CJR Model's design, the detailed requirements for Collaboration Agreements, and the new compliance issues that the model creates. They also will want to develop strategies for successful participation.

For More Information

Foley is holding a complimentary webinar, on Friday, March 11, at noon central, to provide a further description of the CJR Model and some practical advice related to it. Register here.

TAGS: CENTERS FOR MEDICARE & MEDICAID SERVICES, CJR, HOSPICE, HOSPITALS, JOINT REPLACEMENT, OUTPATIENT SERVICES, REHABILITATION, SKILLED NURSING FACILITY, SNFS, TELEHEALTH, WAIVERS

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