The Centers for Medicare and Medicaid (CMS) recently took a significant step forward in its campaign to shift Medicare fee-for-service payments to alternative payment models by proposing the first mandatory bundled payment —the Comprehensive Care for Joint Replacement (CCJR) model.
Mandatory Bundled Payments:
Top 12 Things To Know About the Comprehensive Care for Joint Replacement (CCJR) Model

1 CCJR Bundle for Joint Replacement .................................................................3
2 CCJR is Mandatory in Selected Geographies ....................................................3
3 Why Medicare Choose LEJR ...........................................................................4
4 CCJR Only Applies to Medicare FFS Beneficiaries ..........................................4
5 CCJR Phases In Downside Risk .......................................................................5
6 Definition of the Bundle ..................................................................................5
7 Hospitals Can Share Risk ................................................................................5
8 Bundles are Retrospective ..............................................................................6
9 CCJR Quality Measures ..................................................................................6
10 Common Misunderstanding about Typical Episodes ......................................7
11 Hospital Financial Gain and Penalties ............................................................7
12 Significant Impact on Post-acute Care Providers ............................................7
TOP 12 THINGS TO KNOW ABOUT CCJR

1

Bundle is for Lower Extremity Joint Replacement

CCJR is a bundled payment for lower extremity joint replacement (LEJR) procedures; commonly knee replacement and full/partial hip replacement. Six (6) other infrequent procedures are also included.

Procedure Frequency in MS-DRGs*

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Knee Replacement</th>
<th>Total Hip Replacement</th>
<th>Partial Hip Replacement</th>
<th>Six (6) Other Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY11</td>
<td>70%</td>
<td>46%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>FY12</td>
<td>60%</td>
<td>30%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>FY13</td>
<td>50%</td>
<td>20%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>FY14</td>
<td>40%</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Part 412

2

CCJR is mandatory in selected geographies, with exceptions

Medicare used a two-part randomization process to select 75 Metropolitan Statistical Areas (MSA) for participation. Inpatient Prospective Payment System (IPPS) hospitals in the selected MSAs are required to participate in CCJR. The 75 MSAs selected are represented in 33 states.

The 75 MSAs are each defined based on counties (or county equivalents). The 334 counties included in CCJR represent only 11% of the total U.S. counties, but the populations of the 75 MSAs represent nearly 32% of the U.S. population. Medicare’s MSA selection methodology explains some of this focus on geographies with higher population density; it eliminated nearly half of the MSAs nationwide based on low LEJR procedure volume in 2013-2014.

The only exceptions to the mandatory CCJR program are for Bundled Payments for Care Improvement (BPCI) Phase 2 LEJR hospitals, Non-IPPS hospitals (i.e. Critical Access Hospitals) and Maryland hospitals due to the Maryland All-Payor Model.

Selected MSAs Include Counties in These States

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Florida
- Georgia
- Illinois
- Indiana
- Kansas
- Kentucky
- Louisiana
- Michigan
- Mississippi
- Missouri
- Nebraska
- Nevada
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- Wisconsin

*Medicare-Severity Diagnostic-Related Groups
Why did Medicare Choose LEJR?

Under fee-for-service, Medicare pays appropriate claims by providers based on the applicable fee schedule without regard to individual patients’ outcomes and coordination throughout the episode of care. As such, the average payments which Medicare makes for an episode of care (defined as inpatient stay through 90-days post-discharge) varies widely by provider within geographies and varies even more widely when comparing different geographies to one another.

In the selected CCJR MSAs, for example, the average episode payment in Medford, Oregon, is $21,573 compared to Miami-Fort-Lauderdale-West Palm Beach, Florida, which has an average episode payment of $33,072. The intent is to reduce the variation among and within MSAs while lowering costs and improving outcomes. For hospitals, it will be critical to understand the potential impact that CCJR could have on finances and market share.

CCJR Only Applies to Medicare Fee-for-Service Beneficiaries

From the proposed rule, eligible beneficiaries must be enrolled in Medicare Part A and Part B throughout the duration of the episode and Medicare must be the primary payer.

Patient attribution in BPCI Model 2 follows very similar rules to those proposed for CCJR. BPCI Model 2 hospitals have struggled to accurately identify patients for which the provider will bear risk; that is largely due to Parts A & B coverage gaps by beneficiaries, and precedence issues related to other bundled payments participants providing services to the beneficiary such as post-acute care providers or operating physicians.

As proposed, CCJR would simplify beneficiary attribution because hospitals are the only providers that are eligible to bear risk in the model. Other attribution nuances which disqualify a beneficiary from initiating a CCJR episode are:

- End Stage Renal Disease
- Enrollment in a Medicare Advantage plan and the beneficiary must not be covered
- Coverage under a United Mine Workers of America health plan
- If the beneficiary is provided services by a BPCI Model 2 or 3 entity that was in risk-bearing Phase 2 on or before July 1, 2015.

The chart below shows historical average Medicare payments for CCJR episodes by Census Region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Regional historical average CCJR payments for MS-DRG 469 anchored CCJR episodes</th>
<th>Regional historical average CCJR payments for MS-DRG 470 anchored CCJR episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>$47,928</td>
<td>$24,858</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>$52,028</td>
<td>$27,406</td>
</tr>
<tr>
<td>East North Central</td>
<td>$50,954</td>
<td>$25,480</td>
</tr>
<tr>
<td>West North Central</td>
<td>$46,189</td>
<td>$23,800</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$51,239</td>
<td>$25,989</td>
</tr>
<tr>
<td>East South Central</td>
<td>$50,328</td>
<td>$26,345</td>
</tr>
<tr>
<td>West South Central</td>
<td>$55,448</td>
<td>$27,464</td>
</tr>
<tr>
<td>Mountain</td>
<td>$47,925</td>
<td>$23,734</td>
</tr>
<tr>
<td>Pacific</td>
<td>$48,874</td>
<td>$23,245</td>
</tr>
</tbody>
</table>

Source: http://innovation.cms.gov/initiatives/ccjr/
CMS proposes to implement CCJR as a retrospective bundle, meaning that CMS will continue to pay each claim individually based on the appropriate fee schedule. Annually, Medicare will reconcile payments made on CCJR episodes to determine whether or not the hospital, in aggregate, achieved its target price.

CMS will only pay positive gain share amounts to hospitals in the first year of the program; to qualify for this gainsharing, a hospital must achieve a price point below its target price and achieve quality goals in three (3) domains. Hospitals will not be eligible for downside risk in the first performance year. This policy decision in the Proposed Rule offers providers a full year to develop their programs before facing negative financial consequences.

Staggered Time Frames

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Upside only; no downside</td>
</tr>
<tr>
<td>2017</td>
<td>Downside risk starts; 10% stop loss cap</td>
</tr>
</tbody>
</table>
| 2018-2020 | Downside risk fully implemented; 20% stop loss cap |}

The maximum repayment amount in the second year of the CCJR program would be limited to 10% of the aggregate target amount and 20% of the target in subsequent years.

The bundle is defined as starting with the inpatient stay and ending 90 days after discharge from the acute care hospital. The program covers discharges for MS-DRG 469 and MS-DRG 470, which are described as major joint replacement or reattachment of the lower extremity, each with different levels of complications and comorbidities. Among the reasons selected, these two MS-DRGs represent high volume services for Medicare beneficiaries and pose opportunities to reduce spending for post-acute services while reducing acute care readmissions.

Medicare places all related services in the bundle, including management of chronic conditions and preventive care. In practice, many providers would prefer more narrow definitions of included services in bundles, but as proposed, the definitions of what is included in CCJR bundles is considered by practitioners as quite broad.

Hospitals Can Share Risk

The proposed Rule specifies that hospitals may enter financial arrangements with CCJR collaborators to support the hospitals’ efforts to improve quality and reduce costs. Medicare believes “CCJR collaborators should have a role in the hospital’s episode spending or quality performance.” Collaborators can take upside and/or downside risk with the hospital in CCJR.

<table>
<thead>
<tr>
<th>Eligible CCRJ Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Physician Group Practices</td>
</tr>
<tr>
<td>Home Health Agencies</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
</tr>
<tr>
<td>Long-term Care Hospitals</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facilities</td>
</tr>
<tr>
<td>Non-Physician Practitioners</td>
</tr>
<tr>
<td>Outpatient Therapy Providers</td>
</tr>
</tbody>
</table>
TOP 12 THINGS TO KNOW ABOUT CCJR

Bundles Are Retrospective

CCJR is not a lump sum of money to be divvied up among providers; such an approach would make the bundle a “prospective” bundled payment. All providers throughout an episode of care will continue to submit claims to and be paid by Medicare as they normally would in a pure fee-for-service environment. Total Medicare expenditures are calculated retrospectively and compared against the pre-assigned target price.

Episode target prices for the two major joint MS-DRGs will be set using Medicare claims data from a baseline period. Target price will be set at 98% of historical price; 2 percent is retained by Medicare. CMS’ portion is reduced from 2% to 1.7% if a hospital submits voluntary quality and patient functional outcomes data.

For the first two performance years, the targets will be calculated by blending an individual hospital’s historical performance with regional pricing in the hospital’s census region. The table below shows the relative weighting of hospital and regional performance in calculating a target price.

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Performance</th>
<th>Regional Performance By Census Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Two-Thirds Weight (2/3)</td>
<td>One-Third Weight (1/3)</td>
</tr>
<tr>
<td>2017</td>
<td>One-Third Weight (1/3)</td>
<td>Two-Thirds Weight (2/3)</td>
</tr>
<tr>
<td>2018</td>
<td>Not Included In Target Price Calculation</td>
<td>Exclusive Factor In Calculating Target Price</td>
</tr>
</tbody>
</table>

By transitioning to exclusively regional pricing, market competition will be unique and likely powerful. This process also rectifies a common complaint about Bundled Payments for Care Improvement which bases its pricing exclusively on a hospital’s historic performance; the BPCI approach serves as a pseudo penalty for providers that had been efficient in the baseline period.

There are exceptions to this process for low volume hospitals and new providers.

CCJR Quality Measures

Eligibility for positive reconciliation payments from CMS are predicated on the participating hospital meeting certain thresholds on three (3) quality performance requirements.

1. Risk-standardized complication rate following elective hip or knee replacement surgery
2. Risk-standardized readmission rate 30 days following elective hip or knee replacement surgery
3. Patient health care assessment of health providers and system (HCAHPS)

These quality measures are already collected, and would simply be applied to CCJR. Hospitals must meet the 30th or 40th percentile (depending on performance year) on all three measures to qualify for gain distribution from Medicare. Voluntary reporting on patient outcomes – separate from these three (3) measures – reduces the Medicare discount from 2.0% to 1.7% to offset the expected cost to hospitals of administering the outcomes collection protocol.
Common Misunderstanding about Typical Episodes

There are two common misperceptions about episodic payments: (1) that episodic spending is normally distributed around the mean and (2) that every case needs to save 2% or more for the initiative to succeed. Neither of these assumptions are true. The graph (to the right/left/above/below) plots every MS-DRG 470 episode spending; the long right tail on this graph represents the small minority (25-35%) of very expensive episodic cases. Rather than focus on reducing expenditures on every episode, successful organizations focus on eliminating high-end outlier cases.

Hospitals’ Financial Gain/Penalties

The bundle will be upside only for the first year of the program, offering providers a full year to develop their programs before facing financial risk. Target prices for the two major joint episodes will be set using Medicare claims data from a baseline period. Target price set will be at 98% of historical price. Two percent is retained by Medicare. CMS’ portion is reduced from 2% to 1.7% if hospital submits voluntary quality and patient functional outcomes data. Loss repayment (downside risk) starts calendar year 2017. Starting in 2017, CMS will phase in a 1% episode discount, introducing downside risk to the model.

Significant Impact on Post-acute Care Providers

Based on experiences with BPCI Model 2 and the similarities between the two models, providers can expect that CCJRs will have similar effect on post-acute care as BPCI Model 2 has. The most notably effect has been a material increase in discharges to home health care and a correlated decrease in discharges to skilled nursing facilities and other high-acuity post-acute care settings. The rationale for this is fairly straight-forward: providers believe home health and other low-acuity post-discharge services can meet a patient’s clinical needs at a more affordable price point.

As a result of CCJR, hospitals may build formal or informal post-acute care networks in an effort to control costs and demonstrate quality in a value-based reimbursement model. Medicare has been very clear that beneficiary choice must be maintained in CCJR, so a post-acute care network may have limited effectiveness.
Next Steps for Providers?

If a hospital’s geography has been selected for CCJR, the first step is to define the opportunity through robust data and analytics. Empirical analysis of this nature is unique and helps hospitals understand utilization data in the hospital’s market and identify current care delivery patterns and areas for improvement.

DHG Healthcare has developed among other solutions, CCJR Fast Start - a limited-scope data and advisory engagement to support CCJR hospitals.

industry insights

about dhg healthcare

DHG Healthcare is the national healthcare industry practice of Dixon Hughes Goodman LLP. The practice provides a full range of assurance and tax services, and also includes a boutique healthcare consulting business built on four distinctive market-facing service platforms (Strategy, Reimbursement, CFO Advisory and Analytic Solutions). DHG Healthcare is sharply focused on the critical business issues facing healthcare organizations in today’s transformative industry environment.

dhg healthcare contacts

Craig Tolbert  
Principal, DHG Healthcare  
D. 205.212.5355  
craig.tolbert@dhgllp.com

Melinda Hancock  
Partner, DHG Healthcare  
D. 804.474.1249  
melinda.hancock@dhgllp.com

Edward Stall  
Principal, DHG Healthcare  
D. 864.312.5515  
edward.stall@dhgllp.com

Michael Wolford  
Manager, DHG Healthcare  
D. 330.655.3323  
michael.wolford@dhgllp.com

For additional information, visit www.dhgllp.com/healthcare

Copyright © 2015 DHG LLP. All products or organization names mentioned may be trademarks or service marks of the respective organization.