Comprehensive Care Joint Replacement Model: Physical Therapy Perspective

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Learning Objectives

• Explain the new CJR model and the potential impact on PT practice.
• Describe key factors that may influence the decision to become a collaborator in the CJR model.
• Determine the changes to practice operations you need to make in preparation for the CJR model in 2016.
• Identify APTA resources dedicated to the CJR model.
Poll 1: What is your primary role (select one):
   - Clinician
   - Administrator
   - Educator
   - Other

Poll 2: What is your practice setting:
   - Acute care hospital
   - Inpatient rehabilitation facility
   - Skilled nursing facility
   - Home health
   - Outpatient facility (hospital, ORF)
   - Private practice
Poll 3: How would you rate your understanding of the CJR model:

- Excellent
- Good
- Fair
- Poor

Value-based Payment

HHS Transition Timelines

- Alternative Payment Models
  - 30% of payments tied to alternative payment models by 2016; 50% by the end of 2018
- Linking Payment to Outcomes
  - 85% of fee for service payments tied to outcome measures by end of 2016; 90% by end of 2018

The Health Care Transformation Task Force

- 75% of payments into value-based models by January 2020
Alternative Payment Models

- Not fee-for-service
- Accountable care organizations
- Bundled payment models
- Comprehensive Care Joint Replacement Model
Poll 4: Hospitals in selected metropolitan areas must participate in the CJR model:

- True
- False
Poll 5: Providers who participate in the CJR model will be paid under their respective payment systems:
   – True
   – False

CJR: Need to Know

1. Are you in a selected metropolitan area?
2. Do you see elective primary hip and knee replacement patients in your practice?
3. What are your costs per episode for this patient population?
4. What are your outcomes for this patient population?
5. Would your practice benefit from engaging as a collaborator in this model?
Comprehensive Care for Joint Replacement (CJR) Model

• CJR Model is focused on elective primary hip and knee replacement patients. It will begin on April 1, 2016 and run for 5 years
• Unlike other innovative models, CJR requires that all IPPS hospitals in the selected MSAs must participate
• Model includes inpatient stay and post discharge care 90 days after discharge

CJR Model Savings

• The average Medicare payment for hip and knee procedures ranges from $16,500 to $33,000, according to the CMS
• Medicare estimates a cost savings of $153 million over the 5 years of the model
CJR Payment: How it Works

- Hospitals are given a target cost per episode annually
- Providers are still paid under their respective payment systems
- Cases are reconciled post episode to determine if they have met the target cost
- Hospitals may have financial relationships with collaborators allowing them to share risk and savings in the episode to support their efforts to improve quality and reduce costs
CJR Collaborators

- All Collaborators are required to engage with the hospital in its care redesign strategies and to furnish services during a CJR episode
- Collaborators may include:
  - Skilled nursing facilities
  - Home health agencies
  - Long term care hospitals
  - Inpatient rehabilitation facilities
  - Physician Group Practices
  - Physicians, non physician practitioners, and providers and suppliers of outpatient therapy.

CJR Episode Risk Adjustment

- CMS will have pricing for each MS-DRG
  - MS-DRG 469: Major joint replacement or reattachment of lower extremity with major complications or comorbidities
  - MS-DRG 470: Major joint replacement or reattachment of lower extremity without major complications or comorbidities
- Risk stratification will be used to adjust pricing for patients with a hip fracture
CJR Episode Cost Calculation

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Excluded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ services</td>
<td>Acute clinical conditions not arising from existing episode-related chronic</td>
</tr>
<tr>
<td></td>
<td>clinical conditions or complications of the LEJR surgery</td>
</tr>
<tr>
<td>Inpatient hospitalization (including</td>
<td>Chronic conditions that are generally not affected by the LEJR procedure or</td>
</tr>
<tr>
<td>readmissions)</td>
<td>postsurgical care</td>
</tr>
<tr>
<td>Inpatient psychiatric facility</td>
<td>The list of excluded MS-DRGs and ICD-CM diagnosis codes, including both ICD-9-CM</td>
</tr>
<tr>
<td></td>
<td>and ICD-10-CM, is posted on the CMS Web site</td>
</tr>
<tr>
<td>Long-term care hospital (LTCH)</td>
<td></td>
</tr>
<tr>
<td>Inpatient rehabilitation facility (IRF)</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td></td>
</tr>
<tr>
<td>Home health agency (HHA)</td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td></td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td></td>
</tr>
<tr>
<td>Clinical laboratory</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
</tr>
<tr>
<td>Part B drugs</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
</tbody>
</table>

CJR Risks and Rewards

<table>
<thead>
<tr>
<th>CJR Year</th>
<th>Dates</th>
<th>Stop-loss* limit of target price</th>
<th>Hospital (minimum)</th>
<th>CJR Collaborator (maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4/1-12/31/2016</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>1/1-12/31/2017</td>
<td>5%</td>
<td>2.5%</td>
<td>1.25%</td>
</tr>
<tr>
<td>3</td>
<td>1/1-12/31/2018</td>
<td>10%</td>
<td>5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>4</td>
<td>1/1-12/31/2019</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>5</td>
<td>1/1-12/31/2020</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Stop-loss= Stop-gain; except year 1 where stop-gain=5%
<table>
<thead>
<tr>
<th>Akron, OH</th>
<th>Gainesville, GA</th>
<th>Ogden-Clearfield, UT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque, NM</td>
<td>Greenville, NC</td>
<td>Oklahoma City, OK</td>
</tr>
<tr>
<td>Asheville, NC</td>
<td>Harrisburg-Carlisle, PA</td>
<td>Orlando-Kissimmee-Sanford, FL</td>
</tr>
<tr>
<td>Athens-Clarke County, GA</td>
<td>Hot Springs, AR</td>
<td>Pensacola-Ferry Pass-Brent, FL</td>
</tr>
<tr>
<td>Austin-Round Rock, TX</td>
<td>Indianapolis-Carmel-Anderson, IN</td>
<td>Pittsburgh, PA</td>
</tr>
<tr>
<td>Beaumont-Port Arthur, TX</td>
<td>Kansas City, MO-KS</td>
<td>Port St. Lucie, FL</td>
</tr>
<tr>
<td>Bismarck, ND</td>
<td>Killeen-Temple, TX</td>
<td>Portland-Vancouver-Hillsboro, OR-WA</td>
</tr>
<tr>
<td>Boise, ID</td>
<td>Las Vegas-Henderson-Paradise, NV</td>
<td>Provo-Orem, UT</td>
</tr>
<tr>
<td>Buffalo-Cheektowaga-Niagara Falls, NY</td>
<td>Lincoln, NE</td>
<td>Reading, PA</td>
</tr>
<tr>
<td>Cape Girardeau, MO IL</td>
<td>Los Angeles-Long Beach-Anaheim, CA</td>
<td>Richmond, VA</td>
</tr>
<tr>
<td>Carlsbad, NM</td>
<td>Madison, WI</td>
<td>Saginaw, MI</td>
</tr>
<tr>
<td>Charlotte-Concord-Gastonia, NC-SC</td>
<td>Medina, OH</td>
<td>San Francisco-Oakland-Hayward, CA</td>
</tr>
<tr>
<td>Cincinnati, OH-KY-IN</td>
<td>Memphis, TN-MS-AR</td>
<td>Seattle-Tacoma-Bellevue, WA</td>
</tr>
<tr>
<td>Colorado Springs, CO</td>
<td>Miami-Fort Lauderdale-West Palm Beach, FL</td>
<td>Sebastian-Vero Beach, FL</td>
</tr>
<tr>
<td>Corpus Christi, TX</td>
<td>Milwaukee-Waukesha-West Allis, WI</td>
<td>South Bend-Mishawaka, IN-IL</td>
</tr>
<tr>
<td>Decatur, IL</td>
<td>Modesto, CA</td>
<td>St. Louis, MO-IL</td>
</tr>
<tr>
<td>Denver-Aurora-Lakewood, CO</td>
<td>Monroe, LA</td>
<td>Staunton-Waynesboro, VA</td>
</tr>
<tr>
<td>Dothan, AL</td>
<td>Montgomery, AL</td>
<td>Tampa-St. Petersburg-Clearwater, FL</td>
</tr>
<tr>
<td>Durham-Chapel Hill, NC</td>
<td>Naples-Immokalee-Marco Island, FL</td>
<td>Toledo, OH</td>
</tr>
<tr>
<td>Evansville, IN</td>
<td>Nashville-Davidson--Murfreesboro--Franklin, TN</td>
<td>Topeka, KS</td>
</tr>
<tr>
<td>Flint, MI</td>
<td>New Haven-Milford, CT</td>
<td>Tuscaloosa, AL</td>
</tr>
<tr>
<td>Florence, SC</td>
<td>New Orleans-Metairie, LA</td>
<td>Tyler, TX</td>
</tr>
<tr>
<td>Fort Collins, CO</td>
<td>New York-Newark-Jersey City, NY-NJ-PA</td>
<td>Virginia Beach-Norfolk-Newport News, VA-NC</td>
</tr>
<tr>
<td>Gainesville, FL</td>
<td>Norwich-New London, CT</td>
<td>Wichita, KS</td>
</tr>
</tbody>
</table>
Poll 6: Providers participating in the CJR model must collect quality data:

- True
- False
CJR Quality Measures

• Required:
  – Hospital-level Risk-Standardized Complication Rate following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
  – HCAHPS Survey measure
• Hospital’s performance on these measures is available at hospital compare:
  https://www.medicare.gov/hospitalcompare/search.html

CJR Quality Measures

• Voluntary reporting:
  – Pre-op (90 to 0 days prior) & Post-op (270-365 after)
  – Year 1 submit data on 50%of patients or 50 patients
  – Patient reported outcome measures
    • PROMIS Global or VR (Veterans RAND) 12 AND
    • HOOS Jr or HOOS Pain AND Function, Daily Living Subscales OR
    • KOOS Jr or Stiffness, Pain AND Function, Daily Living Subscales
  – Risk variable data
    • 4 unique patient identifier(s) to enable matching of the PRO data with administrative claims data + 11 risk variable data elements
CJR Quality Measures and Payment

- Hospitals will be placed in one of four quality categories for each performance year: Below Acceptable, Acceptable, Good, and Excellent
- Categories will be determined by quality composite score (scoring methodology on CMS website)

<table>
<thead>
<tr>
<th>Quality Category</th>
<th>Eligible for Reconciliation Payment</th>
<th>Eligible for Quality Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Acceptable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Acceptable</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Good</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Excellent</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

CJR Data and PTs

- PTs will need to data to demonstrate value in the model
  - Cost
    - Will need to be able to accurately identify and track this patient population (coding)
  - Outcomes
    - Recommend use of the PROs identified by CMS
      - PROMIS or Veterans RAND
      - HOOS or KOOS
Evidence-based Practice

- PTs should be familiar and promote with most recent evidence-based practice
- CJR is an opportunity to be involved with care redesign including post-operative protocols
  - Protocols will be an important tool in standardizing care
- APTA has a variety of resources related to clinical practice on our CJR website
Coding and Billing

• Capturing accurate coding information is critical to tracking these patients
  – Aftercare visit codes (Z codes) cover situations in which the disease has been removed and the patient requires continued care during the healing or recovery phase or for the long-term consequences of the disease.
• Example:
  – Patient is seen by the PT after a total knee replacement to remove osteoarthritis in the right knee. Codes include:
    • Z47.1 Aftercare following joint replacement surgery
    • Z96.651 Presence of right artificial knee joint
    • Additionally, document the primary symptom(s) that physical therapist care will address

Ensuring Success: Performance Improvement

- Identify best EBP (post-op protocols, etc.), and educate staff
- Implement EBP, and begin data collection
- Make changes to address variations and improve outcomes as needed
- Audit your performance. What are your outcomes? Is there variation?
WAIVERS

Medicare Program Rule Waivers

• Can waive the SNF 3 day rule if SNF is rated 3 stars or higher on Nursing Home Compare
• Can waive “incident to” rule for physician services to allow clinical staff of a physician to furnish home visits. *(only for non HHA covered patients)*
• Telehealth- waives originating site requirements so service may be originated in patient’s home *(dependent upon PT recognition under Medicare)*
Fraud and Abuse Law Waivers

- Portions of Stark and Anti-kickback are waived to allow distribution of incentive payments between hospital and CJR collaborator
- A written agreement must be in place to share payments
- High bar to meet fraud and abuse waivers (all requirements of the rule must be met including quality of care)
- Only providers in good standing with Medicare
- Hospital cannot impose any additional restrictions on sharing of incentive payments outside of the CJR regulations

Other Fraud and Abuse Waiver Considerations

- Does the arrangement meet existing anti-kickback safe harbors or Stark exceptions?
- Case-by-case assessments
- Compliance with IRS tax exemptions for hospitals
- OIG and CMS reserve the right to suspend or modify the fraud and abuse waivers at any time
- Exclusive to CJR and are not applicable to other hospital arrangements
CJR REGULATORY AND LEGAL CONSIDERATIONS

Overlap with Existing Innovation Programs

• Potential overlaps
  – Pioneer ACO model
  – Medicare Shared Savings Program (ACO)
  – Next Generation ACO Model
  – Bundled Payments for Care Improvement (BPCI)
Potential Issues with Overlapping Programs

- Hospitals participating in BPCI in the applicable MSA’s will not be required to participate in CJR
- CJR reconciliation payments and repayments attributed to a specific episode may not be counted for in other models when determining cost of care
- Hospitals participating in the Medicare Shared Savings Program (MSSP) can also participate in CJR
- The CJR episode savings may not be achieved because the savings is paid back under the Shared Savings Program if the beneficiary is assigned to both models

Beneficiary Rights

- Freedom of choice to select any provider whether they are participating in or outside of the bundle
- Entitled to care for all Medicare covered services
- Does not change cost sharing responsibilities (copays and coinsurance)
- Hospitals may offer certain items and services to beneficiaries during episode (may not be inducements)
Beneficiary Incentives

• CMS allows for “in-kind patient engagement incentives” to CJR beneficiaries
  – May be offered for free or below market value
  – Can only be provided during the CJR episode
  – Must be reasonably connected to medical care
  – Must be preventative or tied to specific health goals
  – Must not be tied to care from a specific provider
  – Must be provided directly from the hospital or approved agent
  – Cost cannot be shifted to another federal health care program

Contractual Obligations

Sharing Agreement
• Financial arrangements set forth in writing
• Voluntary participation
• Between participating hospital and CJR collaborator
• Lays out reconciliation payments, hospital’s internal cost savings and responsibility to repayment to CMS

Collaboration Agreement
• Written and signed agreement
• Entered into before care is furnished to the beneficiary
• Between a participating hospital and CJR collaborator
• Must meet the terms set forth for financial (sharing) arrangements
Payments and Recoupment

- Determined under the CJR Reconciliation Report for a participating hospital each performance year
- Recoupment efforts will triggered immediately after the determination
- CMS will be “vigorous” in seeking repayment (i.e. demand letters, Treasury dept. or other legal means)

<table>
<thead>
<tr>
<th>Model Performance Year</th>
<th>Model Performance Period</th>
<th>Reconciliation Claims Submitted</th>
<th>Reconciliation Payment or Repayment</th>
<th>2nd Calculation to Address Overlaps and Claims Run-Out</th>
<th>2nd Calculation Adjustment to Reconciliation Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 (no liability)</td>
<td>Episodes ending June 30, 2016 to December 31, 2016</td>
<td>March 1, 2017</td>
<td>Q2 2017</td>
<td>March 1, 2018</td>
<td>Q2 2018</td>
</tr>
<tr>
<td>Year 2</td>
<td>Episodes ending January 1, 2017 to December 31, 2017</td>
<td>March 1, 2018</td>
<td>Q2 2018</td>
<td>March 1, 2019</td>
<td>Q2 2019</td>
</tr>
<tr>
<td>Year 3</td>
<td>Episodes ending January 1, 2018 to December 31, 2018</td>
<td>March 1, 2019</td>
<td>Q2 2019</td>
<td>March 1, 2020</td>
<td>Q2 2020</td>
</tr>
<tr>
<td>Year 4</td>
<td>Episodes ending January 1, 2019 to December 31, 2019</td>
<td>March 1, 2020</td>
<td>Q2 2020</td>
<td>March 1, 2021</td>
<td>Q2 2021</td>
</tr>
<tr>
<td>Year 5</td>
<td>Episodes ending January 1, 2020 to December 31, 2020</td>
<td>March 1, 2021</td>
<td>Q2 2021</td>
<td>March 1, 2022</td>
<td>Q2 2022</td>
</tr>
</tbody>
</table>
Dispute Resolution
(How to Appeal)

Calculation of error form

- Initiated by the participating hospital
- First step is to review Reconciliation report
- Written notice to CMS with CE form
- 45 day deadline to submit error calculations
- Failure to timely submit will result in loss of appeal rights

Reconsideration review

- Initiated after dissatisfactory response to CE form
- Conducted by CMS
- Detailed explanation of the dispute and supporting documentation
- Must send within 10 calendar days of initial decision
- Scheduling notice issued sent within 15 days of receipt and determination within 30 days
- Determination is final and binding

Documentation and Record Maintenance

- Participating hospitals and CJR collaborators must maintain books and records for a 10-year period
- Begins on the last day of participation in the CJR model
- Extended an additional 6 years in the case of a dispute or allegation of fraud
CJR Compliance Checklist

- Who is the point person in your organization for review, questions or concerns?
- Do you have a written agreement with the hospital?
- What are the terms of the agreement and how long is the contractual obligation?
- Are you an affiliated provider or a CJR collaborator?
- Is all payment tied to patient care, quality and outcomes?
- Are you performing duties outside of the normal Medicare rules? If so, is there an exception?
- Has the patient been informed of their right to choose?
- If you are a hospital, are payment distributions meeting the gainsharing exceptions? Are there any practices that compromise tax law/charitable status?
- Make sure to reconcile claims internally and compare to CMS reports for errors in order to appeal if necessary.

APTA RESOURCES
CJR Resources

- APTA: [www.apta.org/cjr](http://www.apta.org/cjr)
- CMS: [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)

Poll 7: How would you rate your understanding of the CJR model now:
- Excellent
- Good
- Fair
- Poor
QUESTIONS

If you have additional questions on CJR please feel free to contact us at 800 999 2782 ext 8511 OR advocacy@apta.org