What Hospitals, Physicians, Therapists and SNFs Need to Know about Medicare's Comprehensive Joint Replacement Program and Gainsharing Too

By: David Glaser

March 2, 2016

Fredrikson & BYRON, P.A.


DELTA
CONNECTION

Comprehensive Care for Joint Replacement (CJR)

- Makes hospital responsible for cost of a bundle from admission to 90 days post discharge for nearly all Part A/B payments for Total Hip/Knee replacements (DRGs 469/470).
- Hospital will get bonus/penalty based on meeting a target price, patient satisfaction and outcomes measures.
- Applies in 67 MSAs unless hospital is episode initiator in Model 2 or 4 of BCPI, or in Model 1.

MSAs Included in the CJR Model

10740	Albuquerque, NM
11700	Asheville, NC
12020	Athens-Clarke County, GA
12420	Austin-Round Rock, TX
13140	Beaumont-Port Arthur, TX
13900	Bismarck, ND
14500	Boulder, CO
15380	Buffalo-Cheektowaga-Niagara Falls, NY
16020	Cape Girardeau, MO-IL
16180	Carson City, NV
16740	Charlotte-Concord-Gastonia, NC-SC
17140	Cincinnati, OH-KY-IN
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR
26900	Indianapolis-Carmel-Anderson, IN
28140	Kansas City, MO-KS
28660	Killeen-Temple, TX
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
32820	Memphis, TN-MS-AR
33100	Miami-Fort Lauderdale-West Palm Beach, FL
33340	Milwaukee-Waukesha-West Allis, WI
33700	Modesto, CA
33740	Monroe, LA
33860	Montgomery, AL
34940	Naples-Immokalee-Marco Island, FL
34980	Nashville-Davidson—Murfreesboro-Franklin, TN
35300	New Haven-Milford, CT
35380	New Orleans-Metairie, LA
35620	New York-Newark-Jersey City, NY-NJ-PA
35980	Norwich-New London, CT
36260	Ogden-Clearfield, UT
36420	Oklahoma City, OK
36740	Orlando-Kissimmee-Sanford, FL
37860	Pensacola-Ferry Pass-Brent, FL
38300	Pittsburgh, PA
38940	Port St. Lucie, FL
38900	Portland-Vancouver-Hillsboro, OR-WA
39340	Provo-Orem, UT
39740	Reading, PA
40980	Saginaw, MI
41860	San Francisco-Oakland-Hayward, CA
42660	Seattle-Tacoma-Bellevue, WA
42680	Sebastian-Vero Beach, FL
43780	South Bend-Mishawaka, IN-MI
41180	St. Louis, MO-IL
44420	Staunton-Waynesboro, VA
45300	Tampa-St. Petersburg-Clearwater, FL
45780	Toledo, OH
45820	Topeka, KS
46220	Tuscaloosa, AL
46340	Tyler, TX
48620	Wichita, KS

Target Price

- Blend of hospital specific and regional expenditures.
- Uses moving 3 years of data.
- Begins 2/3 hospital, 1/3 regional years 1-2, then flips year 3, regional only thereafter.
- Some quirks for low volume, merged split hospitals.

Caps

- Some caps on repayment.
  - 0 year one
  - 5% year 2
  - 10% year 3
  - 20% year 4-5
- Same caps on bonus but can be 5% in year one.

CCJR Details

- Hospitals may, but are not required to incent other care providers/suppliers ("collaborators").
- Other care providers are not at direct risk, so the hospital will feel real pressure.
- Participation Agreements (similar to gainsharing) are a legitimate alignment tool for hospitals and surgeons.
- The legal impact is small. The practical impact is likely huge.

Key Lingo

- Participation Agreement
  - Sharing Agreement.
- Collaborator: SNF, HHA, LTCH, IRF, Dr./PGP, NPP, Outpatient PT/OT/SLP.
- Alignment payment: from collaborator to hospital.
- Reconciliation payment: from CMS to hospital.
- Gainsharing: from hospital to collab, includes reconciliation or internal cost savings
- Repayment: From hospital to CMS.

Key Lingo

- Internal Cost Savings: measurable, actual verifiable HOSPITAL savings.
- Distribution Agreement - Within a physician group practice (PGP).
- Practice Collaboration Agent: Dr./NPP/Therapist with a distribution agreement with PGP rather than the hospital.
- NPRA: Net Payment Reconciliation Amount.

“Episode of Care”

- Hospital is responsible for all costs in the episode.
- Costs that may seem unrelated to joint replacement are included (MH/CD, hospice)
- Target prices are based on historical data.
- Is this really rationing?? What are other explanations?

"Episode of Care"

1) Physicians' services
2) Inpatient hospital services (including hospital readmissions)
3) Inpatient psychiatric Facility services
4) Long Term Care Hospital services
5) Inpatient Rehabilitation Facility services
6) SNF services
7) Home Health Agency services
8) Hospital outpatient services
9) Outpatient therapy services
10) Clinical laboratory services
11) DME
12) Part B drugs and biologicals
13) Hospice services
14) Per Beneficiary Per Month payments under models tested under section 1115A of the Act

Services Excluded From Episode

- Hemophilia clotting factors
- New Technology Add-on payments
- Transitional pass-through payments for medical devices.
- Certain Part B Payments for acute trauma, some chronic diseases, some PBPM payments,

Admissions Excluded from Episode of Care

- Oncology.
- Trauma medical.
- Certain chronic disease like prostatectomy.
- Acute surgical diseases such as appendectomy.

FAQ

- Can hospitals require patients to use certain physicians therapists or SNFs?
- Can you fire patients using expensive vendors? Can you fire non-compliant patients?
- Can the hospital require collaborators to agree to a contract?
- Can collaborators share gain without sharing downside risk?

Hospital Beneficiary Notice

- Later of admission/decision to perform LEJR.
- Detail on the program and how it may affect care.
- Freedom of choice.
- How patients can access care records and claims data and how to share Blue Button EHI.
- All protections apply and how to report quality concerns.
- List of collaborators.

Other Beneficiary Notices

- Collaborator Physicians, upon LEJR decision, must provide notice of structure and any sharing agreement.
- All other collaborators reveal collaborator agreement.
- Discharge planning notice must address non-covered care.

Limits on Risksharing

- Must set terms before care is furnished to any patients.
- Must agree upon quality criteria that the collaborator must satisfy in order to receive the payment.
- The total distribution payments paid to a physician practice in a year may not exceed 50% of the total Medicare physician fee schedule payments for services to CJR beneficiaries.
- Only physicians who actually perform services to CJR beneficiaries during at least one episode of care may receive any portion of the gainsharing payment.
- Must use EFT.

Limits on Risksharing

- Hospital may not recoup money from a collaborator unless the hospital owes CMS.
- Hospital may not recoup from collaborators more than 50% of what it owes CMS.
- Hospital may not collect more than 25% of what it owes CMS from any single collaborator.
- No payment if collaborator “subject to any action for noncompliance with this part or fraud and abuse laws.”

Limits on Cost Savings Payments

- GAAP and Government Auditing Standards (Yellow Book.)
- Must be actual HOSPITAL savings accomplished through care redesign and documented by the hospital. Savings by anyone other than the hospital are irrelevant.

Flexibility In Sharing

- Sharing may based on the amount the hospital is paid for beating the target price, internal hospital savings or both. (The cap applies, however.)
- Any payments on internal savings must satisfy Stark, Antikicback Statute and tax exemption rules.

Hospitals Must

- Update compliance plan to include oversight.
- Have Board oversight of CJR model.
- Have written policies for selecting collaborators, including quality. Can't be directly or indirectly referral related.

Requirements for Collaborator Agreements

- Date, parties, description, scope, terms, frequency of payment methodology of calculation.
- Ensure alignment payments only repay Medicare.
- Plans for care redesign.
- Changes in care coordination.
- Success metrics.

Requirements for Collaborator Agreements

- Management and staffing info, including who will carry out changes to care.
- Requirement to comply with all of the rules. (must they be detailed??)
- Requirement be in compliance with Medicare enrollment provisions of 424.500.
- Require collaborator to have a compliance program that includes oversight of CJR.

Requirements for Collaborator Agreements

- Specific detail for internal cost savings
  - Care redesign elements done by hospital or collaborator.
  - Must have quality criteria, can't be directly related to volume.
  - Must be transparent measurable, verifiable.
  - Require recoupment if data is false or fraudulent data.

Documentation Requirements

- Current and historical list of all collaborators' addresses, updated quarterly and publicly listed on Web. (Oddly, must post historical!)
- Documentation all payments, including reason, amount, date.
- Records showing you verified Medicare eligibility of collaborators.
- Proving ability to measure and track cost savings. (Really??)

Documentation Requirements

- The plan to track cost savings.
- Info on accounting systems for tracking savings.
- Description of current HIT, including systems to track cost savings.
- Plan for tracking gainsharing and alignment payments.
- Any recoupment due to overpayment, false or fraudulent data.

Issues for Participation Agreements

- Physicians must realize there is more of a cap on their gain than loss.
- Do you have control over the factors determining payment?
- What is the worst that can happen?
- Can you have a multi-party agreement?

How Can Clinics Distribute Payments?

- Only physicians involved in an episode of care may receive any payment.
- Payment needn't be equal. (In most cases it CAN'T be.)
- CMS seems to want payment based on involvement. Does this support larger payment to more "active" physicians?

Can You Have Long Term Payments?

- Yes!
- The conventional wisdom limits gainsharing payments to one year. It's wrong.
- See Advisory Opinion 12-22. "The management agreement is written with a three-year term, and thus is limited in duration."
- Some people claim it only addresses co-management. They're wrong.
- The payment must be reasonable.

What are the quality metrics?

- THA/TKA Complication measure:
  - acute myocardial infarction;
  - pneumonia, or sepsis/septicemia within 7 days of admission;
  - surgical site bleeding, pulmonary embolism or death within 30 days of admission; or
  - mechanical complications, periprosthetic joint infection, or wound infection within 90 days of admission. (50%)
- Hospital Consumer Assessment of Health Providers and Systems Survey Measure (HCAHPS) survey. (Patient satisfaction tool covering bathrooms cleanliness to pain management. (40%))
- Voluntary submission of outcomes & risk variable data. (10%)

Quality Metrics Notes

- Collaborators have limited impact on many measures.
- Metrics are converted to points.
- Generally speaking, must avoid being in the bottom 30% of either measure to receive any reconciliation payment.
- Quality Improvement Points awarded for a 3 decile improvement.

Can Penalize hospitals if they or Collaborator:

- Avoid high cost patients.
- Target low cost patients.
- Over/under provide care.
- Fail to provide info.
- Restrict choice.
- Fail to enforce collaborator agreements.
- Are subject to intervention in FCA or demand letter under civil sanction authority.

Beneficiary Incentives

- In kind, by hospital or its agent to the beneficiary during the episode.
- Reasonably connected to the episode.
- Must be preventive care item/service or advances a “clinical goal” (see next slide) for managing health.
- Can’t be tied to receipt of services outside of episode.
- Can’t be tied to specific provider/supplier.
- Can’t be advertised/promoted except notification at time beneficiary could benefit.
- Can’t shift cost to another health care program.

Clinical Goals

- Adherence to drug regime.
- Adherence to care plan.
- Reduction of readmission and complication.
- Measurement of chronic diseases/conditions.

Technology

- Cap of $1,000 in “retail value” per episode. (Ipad??)
- Minimum necessary to advance clinical goal.
- If item is $300 or more, hospital must retain title and attempt to retrieve it, documenting all retrieval attempts.

Documentation of Incentives

- Document all over $25.
- Contemporaneous with date and identity.
- Kept 10 years after end of participation or completion of audit.

CCJR as a Tipping Point: Practical Impacts

- Hospitals have responsibility/control over total joint episodes. (They are the general contractor. But the sub can do an end run!)
- Hospitals will need to drive cost reductions in episode of care.
- Most key costs are outside of the hospital's direct control. Implants are a notable exception. ("We have the best price.")
- Hospitals outside of 67 MSAs will be watching.
- Other service lines?

GAINSHARING

Gainsharing/Shared Savings/Co-Management/Alignment Your Label Here!

- What is it?
- Labels don't really matter. What is "Shared Savings"??

Shared Savings

- Goal is reducing waste.
- Savings may be from conservation.
  - Avoiding drug wastage.
  - Avoid using costly service.
- Savings may come from standardization.
- Payment for efficiency is kosher, and popular.
- Savings from lower costs implants.


bp
regular 384.9
silver 394.9
ultimate 404.9
diesel 409.9
BP gasoline
invigorate

CMS Worries About

- Limiting use of quality-improving but more costly devices, tests or treatments: “stinting.”
- Treating only healthier patients: “cherry picking.”
- Avoiding sicker patients: “steering.”
- Discharging patients earlier: “quicker-sicker.”

CMS Seeks to Encourage

- Transparency.
- Quality controls.
- Safeguards against payments for referrals.

Gainsharing/Shared Savings/Co-Management/Your Label Here!

- Labels do not matter, but…..
- Law DOES matter.
- Federal law prohibits payments intended to reduce services to Medicare beneficiaries.
- The government used to say gainsharing was illegal. That is totally last century.
- It is 100% clear that gainsharing/shared savings can be done legally.

Gainsharing/Shared Savings/Co-Management/Your Label Here!

- At least 16 favorable OIG Advisory Opinions, starting in 2001.
- "Pending further notice from the OIG, gainsharing arrangements are not an enforcement priority for OIG unless the arrangement lacks sufficient patient in-program safeguards." 79 F.R. 59715, 59729 (Oct. 3, 2014).
- The advisory opinions offer guideposts:
  - Payment caps.
  - Utilization targets.
  - Disclosure.
  - Hourly payments are low risk.

How Do You Split the Savings?

- The Advisory Opinions are 50-50.
- Advisory Opinions are not law, but they are useful guidance.
- CMS worries when payments exceed the Medicare fee schedule payments.
- Know the 4 big laws.

The 4 Big Laws

- Stark – civil but you MUST meet an exception.
- Antikickback – Criminal, but you don't need to meet a safe harbor. Intent controls.
- Tax Exemption.
- Antitrust.

Can You Have Long Term Payments?

- The conventional wisdom limits payments to one year.
- But see Advisory Opinion 12-22. “The management agreement is written with a three-year term, and thus is limited in duration.”
- Some people claim it only addresses co-management. They’re wrong.
- The payment must be reasonable.

Co-Management Details

- Do you need a new entity?
- Make sure the terms are clear.
- Can physicians really control the key payment factors.
  - Press-Gainey scores?
  - Turn-around times?
  - Scheduling?
  - Staff turnover?
  - Implant use?

The Hidden Trap

Gainsharing: Good Idea Goes Bad

- According to her lawsuit, Kathleen Davis suffered a significant complication after having a Medtronic pacemaker implanted at Methodist in 2004. She said that her cardiologist made a startling confession when she asked what happened to cause a twitching in her abdomen. He told her that she probably would have fared better with another brand of pacemaker,

A Good Idea Goes Bad

- but that Methodist administrators had leaned on him to install the Medtronic model to help the hospital collect on what he called a kickback deal, the lawsuit said.

Des Moines Register, Feb. 9, 2006.

Think before you type

- "Frank [the physician] has made no attempt to comply with the contract. . . . I am prepared to reschedule his devices to be in compliance with the contract," wrote Tim Nelson, a hospital manager who has since left the company, in one e-mail obtained from the court file.
    - Des Moines Register, Feb. 9, 2006.

Think before you type

- In another e-mail in the court records, Butz [another administrator] wrote: "Frank did say . . . that he would abide by a contract that paid him money for compliance." In the e-mail, which Butz wrote to Methodist's chief operating officer, David Stark, he said, "Isn't there a joke along these lines — now that we have established what he is, we are simply negotiating over price."

    - Des Moines Register, Feb. 9, 2006.

The Bottom Line

- Think about the Bottom Line!
- How you say things really matters.
- Bundled payments are likely here to stay. Cost pressure isn't likely to abate.
- Be wary of direct involvement by device companies. Discounted devices seem quite defensible.

The Bottom Line

- Savings are good. Offering or receiving financial incentives for savings is legal, and wise. Just be smart.
- Shared savings is no risker than many other practices.

Contact Info

Presented by:

David Glaser
612.492.7143
dglaser@fredlaw.com