

Comprehensive Care for Joint Replacement Model

Purpose

To set forth the general requirements to be followed by all Adventist Health System (AHS) hospitals required to participate in the Comprehensive Care for Joint Replacement (CJR) model pursuant to Section 1115A of the Social Security Act, as amended.

Policy

The CJR model aims to support better and more efficient care for Medicare beneficiaries undergoing hip and knee replacements. This model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.

An episode of care commences when a participant hospital admits a Medicare beneficiary who meets at the time of his/her anchor admission the inclusion criteria set forth below and who, upon discharge, is assigned a MS-DRG of 469 (with or without hip fracture) or MS-DRG 407 (with or without hip fracture):

- The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.
- The beneficiary's eligibility for Medicare is not on the basis of End Stage Renal Disease.
- The beneficiary must not be enrolled in any managed care plan.
- The beneficiary must not be covered under a United Mine Workers of America health plan.
- Medicare must be the primary payer.

A Medicare beneficiary's episode of care is canceled (and not included in the participant hospital's net payment reconciliation amount (as hereinafter defined) if the Medicare beneficiary no longer meets the above inclusion criteria or if the Medicare beneficiary is readmitted to any participant hospital for another anchor hospitalization, initiates a lower-extremity joint replacement episode ("LEJR") under Bundled Payment for Care Improvement (another initiative of the Centers for Medicare and Medicaid Services) or dies.

A Medicare beneficiary's episode of care ends 90 days after his/her discharge from the anchor hospitalization and the day of discharge itself counts as the first day of the post-discharge

period.

Each performance year of the CJR model, a participant hospital is to receive from the Centers for Medicare and Medicaid Services (“CMS”) separate episode target prices for MS-DRGs 469 and 470, reflecting the differences in spending for episodes initiated by each MS-DRG. The participant hospital will receive payment under the usual payment system rules and procedures of the Medicare program for episode of care services rendered throughout the year. At the end of each performance year, actual spending for the episode of care (i.e., total expenditures for related services under Medicare Parts A and B) will be compared to the Medicare target episode price for the participant hospital. Depending on the participant hospital’s quality and episode spending performance, the participant hospital may receive an additional payment from Medicare (i.e., Net Payment Reconciliation Amount [“NPRA”]) or be required to repay Medicare (i.e., Alignment Payment) for a portion of the episode of care spending.

In order to maximize a participant hospital’s NPRA (or reduce exposure to remit an Alignment Payment), a participant hospital may elect to enter into financial sharing arrangements with one or more of the following Medicare enrolled persons or entities (“CJR Collaborator”): (i) skilled nursing facilities; (ii) home health agencies; (iii) long-term care hospitals; (iv) inpatient rehabilitation facilities; (v) physicians; (vi) non-physician practitioners (limited to physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, clinical social workers and registered dietitians/nutritional professionals); (vii) providers or suppliers of outpatient therapy services; and (viii) physician group practices. Any financial sharing arrangement (i.e., gainsharing payments or alignment payments) must be set forth in a written collaborator agreement signed by the participant hospital and CJR Collaborator. Each collaborator agreement must be submitted through the AHS Contract Review process prior to execution.

The governing board of the participant hospital retains responsibility for oversight of the participant hospital’s participation in the CJR model, including the responsibility for the participant hospital’s:

- arrangements with CJR collaborators,
- payment of gainsharing payments and receipt of alignment payments, and
- use of Medicare beneficiary incentives employed in association with the CJR model.

Criteria for Selecting Providers and Suppliers as CJR Collaborators

Participant hospitals may engage in financial arrangements to share with a CJR Collaborator a portion of the NPRA received from CMS or hospital internal cost savings resulting from care redesign of services rendered to Medicare beneficiaries covered by the CJR model (“Gainsharing Payment”) or both, as well as responsibility for repaying Medicare. In order to participate in a financial arrangement, a CJR Collaborator must make contributions to the hospital’s episode of care performance on spending and quality, including:

1. CJR Collaborator must directly furnish related items or services to a CJR beneficiary during the episode of care and/or specifically participate in CJR model LEJR episode care redesign activities, such as:
 - a. attending CJR meetings and learning activities;
 - b. drafting LEJR episode care pathways;
 - c. reviewing CJR beneficiaries’ clinical courses;
 - d. developing episode analytics;
 - e. preparing reports of episode performance under the direction of the participant hospital or a CJR Collaborator that directly furnishes related items and services to CJR beneficiaries.
2. In addition to playing a role in the participant hospital’s episode of care spending or quality performance, a CJR Collaborator (other than physician group practices) must directly furnish a billable service to the Medicare beneficiary for the episode of care that occurred during the performance year for which the savings or loss was created in order to receive a Gainsharing Payment as a result of their financial arrangement with the participant hospital. A physician group practice must have billed for an item or service that was rendered by one or more

members of the physician group practice to a Medicare beneficiary during the episode of care that occurred during the performance year in which the participant hospital's internal cost savings was generated, or to which the NPRA applied.

3. The criteria used for selecting CJR Collaborators may not be based directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the participant hospital, the CJR Collaborator, and any individual or entity affiliated with the participant hospital or CJR Collaborator.
4. All collaborator agreements must require the CJR Collaborator to have met, or agree to meet, the quality criteria used by the participant hospital in selecting its CJR Collaborators.

Documentation Requirements

A participant hospital must maintain accurate current and historical lists of all of its CJR Collaborators, including names and addresses of each CJR Collaborator. The participant hospital must update the lists on at least a quarterly basis and publicly report the current and historical lists of CJR Collaborators on a public-facing Web page on the participant hospital's Web site.

The participant hospital and each CJR Collaborator must maintain documentation of the payment or receipt of any Gainsharing Payment or Alignment Payment. The documentation must identify at least the following:

1. The nature of the payment (Gainsharing Payment or Alignment Payment);
2. The identity of the parties making and receiving the payment;
3. The date of the payment;
4. The amount of the payment; and
5. The date and amount of any recoupment of all or a portion of a CJR Collaborator's Gainsharing Payment.

The participant hospital must keep records of the following:

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1. Its process for determining and verifying the eligibility of CJR Collaborators to participate in Medicare.
2. Information confirming the organizational readiness of the participant hospital to measure and track internal cost savings.
3. The participant hospital's plan to track internal cost savings.
4. Information on the accounting systems used to track internal cost savings.
5. A description of current health information technology, including systems to track reconciliation payments and internal cost savings.
6. The participant hospital's plan to track gainsharing payments and alignment payments.
7. Whether the participant hospital recouped any Gainsharing Payment received by a CJR Collaborator that contains funds derived from a MCS overpayment on a reconciliation report, or were based on the submission of false or fraudulent data.

Access to Records and Record Retention

All participant hospitals and CJR Collaborators who enter into sharing arrangements must provide to CMS, the Office of Inspector General (OIG), and the Comptroller General or their designees scheduled and unscheduled access to all books, contracts, records, documents, and other evidence sufficient for an audit, evaluation, inspection, or investigation.

All such books, contracts, records, documents, and other evidence must be maintained for a period of 10 years from the last day of the participant hospital's participation in the CJR model or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless CMS determines that there is a special need to retain the records for a longer period.

Beneficiary Choice

As part of discharge planning and referral, participant hospitals must inform beneficiaries of all Medicare participating post-acute care providers in an area and must identify those post-acute care providers with whom they have sharing arrangements (i.e., a Collaborator Agreement). Participant hospitals may recommend

preferred providers and suppliers consistent with applicable statutes and regulations. Participant hospitals may not limit beneficiary choice to any list of providers or suppliers in any manner other than what is permitted by regulations and they must respect patient and family preferences when they are expressed.

Beneficiary Notification

Each participant hospital must provide written notice to any Medicare beneficiary that meets the inclusive criteria (see page 1 of the Policy of his or her inclusion in the CJR model.

The notice must be provided at the time the Medicare beneficiary is admitted to the participant hospital or immediately following his/her decision to schedule an LEJR surgery, whichever occurs later. The beneficiary notification must contain all of the following:

1. A detailed explanation of the CJR model and how it might be expected to affect the beneficiary's care.
2. Notification that the beneficiary retains freedom of choice to choose providers and services.
3. Explanation of how patients can access care records and claims data through an available patient portal, and how they can share access to their Blue Button® electronic health information with caregivers.
4. A statement that all existing Medicare beneficiary protections continue to be available to the beneficiary. These include the ability to report concerns of substandard care to Quality Improvement Organizations and 1-800-MEDICARE.
5. A list of the providers and suppliers with whom the participant hospital has a Collaborator Agreement.

A participant hospital must require any physician that is a CJR Collaborator to provide written notice of the structure of the CJR model and the existence of the physician's sharing arrangement with the participant hospital to any Medicare beneficiary that meets the inclusion criteria (see Page 1 of the Policy). The notice must be provided at the time the decision to undergo LEJR surgery is made.

A participant hospital must require any provider or supplier, other than the treating physician with whom it has executed a

Collaborator Agreement to provide written notice of the existence of its sharing arrangement with the participant hospital to any Medicare beneficiary that meets the inclusion criteria (see Page 1 of the Policy). The notice must be provided no later than the time at which the Medicare beneficiary first receives services from the provider or supplier during the episode of care.

A participant hospital must provide the Medicare beneficiary with a written notice of any potential financial liability, associated with non-covered services recommended or presented as an option as part of discharge planning, no later than the time that the beneficiary discusses a particular post-acute option or at the time the beneficiary is discharged, whichever occurs earlier.

Beneficiary Incentives

Participant hospitals may choose to provide in-kind patient engagement incentives to Medicare beneficiaries in an episode of care, subject to the following conditions:

1. The incentive must be provided directly by the participant hospital or by an agent of the hospital under the hospital's direction and control to the beneficiary during an episode of care.
2. The item or service provided must be reasonably connected to medical care provided to a beneficiary during an episode of care.
3. The item or service must be a preventive care item or service or an item or service that advances a clinical goal by engaging the beneficiary in better managing his or her own health.
4. The item or service must not be tied to the receipt of items or services outside the episode of care.
5. The item or service must not be tied to the receipt of items or services from a particular provider or supplier.
6. The availability of the items or services must not be advertised or promoted except that a beneficiary may be made aware of the availability of the items or services at the time the beneficiary could reasonably benefit from them.
7. The cost of the items or services must not be shifted to another federal health care program.

The following are the particular clinical goals of the CJR model, which may be advanced through beneficiary incentives:

1. Beneficiary adherence to drug regimens.
2. Beneficiary adherence to a care plan.
3. Reduction of readmissions and complications resulting from LEJR procedures.
4. Management of chronic diseases and conditions that may be affected by the LEJR procedure.

Items or services involving technology provided to a Medicare beneficiary in an episode of care may not exceed \$1,000 in retail value for any one beneficiary in any one episode of care and must be the minimum necessary to advance a clinical goal (identified above).

Documentation and Retention of Beneficiary Incentives

Participant hospitals must maintain documentation of items and services furnished as beneficiary incentives that exceed \$25 in retail value. The documentation must be contemporaneous with the provision of the items and services and must include at least the following:

1. The date the incentive is provided.
2. The identity of the beneficiary to whom the item or service was provided.

Items of technology exceeding \$100 in retail value must remain the property of the participant hospital and be retrieved from the beneficiary at the end of the episode of care. All retrieval attempts must be documented, including the ultimate date of retrieval. Documented, diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.

All participant hospitals that provide in-kind patient engagement incentives to beneficiaries in CJR episodes must:

1. Provide to CMS, the OIG, and the Comptroller General or their designees scheduled and unscheduled access to all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation,

References

inspection, or investigation of the participant hospital's compliance with CJR requirements for beneficiary incentives.

2. Maintain all such books, contracts, records, documents, and other evidence for a period of 10 years from the last day of the participant hospital's participation in the CJR model or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:
 - a. CMS determines that there is a special need to retain the records for a longer period; or
 - b. There has been a dispute or allegation of fraud against the participant hospital, in which case the records must be maintained for an additional 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

Sources:

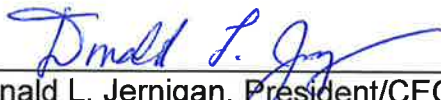
- 42 CFR Part 510 published November 24, 2015
- OIG Publication: Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Comprehensive Care for Joint Replacement Model – November 16, 2015

Adventist Health System

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Approved By


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