Eli's Rehab Report

CJR: To Partner or Not to Partner? Prepare for Hospitals to Knock at Your Door

Physician Fee Schedule Final Rule bumps CJR start date to April 1.

If you're involved in rehab for major lower extremity replacements, keep your eye on the new Comprehensive Care for Joint Replacement (CJR) model because affected hospitals may be seeking your collaboration.

The **Centers for Medicare & Medicaid Services** (CMS) proposed CJR, a new bundled care payment initiative, last July for total hip replacements (THRs) and total knee replacements (TKRs), and the 2016 Physician Fee Schedule Final Rule made it a reality. The actual MS-DRGs involved will be 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) and 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities).

Who's affected: Per the Final Rule, 67 geographical areas have been singled out for the demo. (Go to https://innovation.cms.gov/initiatives/cjr to see if your city is on the list.) Unlike the usual payment demonstrations, however, participation is mandatory. The only exception is if the hospital is already participating in CMS' Bundled Payments for Care Improvement (BCPI) models 1, 2, or 4.

The timing: Originally set to begin Jan. 1, CMS has moved the start date to April 1. The demo will last 5 years, ending Dec. 31, 2020.

Hospitals Cash In or Pay Up

Participating hospitals performing the THRs and the TKRs are the responsible parties, so rehab folks aren't directly affected. However, those hospitals may soon be knocking on your door to discuss continuum of care partnership options. The question is: Will you want to hold part of that financial responsibility?

Here's the skinny: Each year, CMS would set a target amount that hospitals should spend for a THR/TKR episode of care, from admission to 90 days post-discharge. Participating hospitals would be financially responsible for the entire episode of care (Medicare Part A and Part B), including the procedure, inpatient care, and post-acute care. Hospitals and post-acute providers would still be paid via the existing payment systems, but the hospitals would stand to gain or lose based on where their outcomes and spending fall compared to the CMS target amount.

If the hospital's total spending is less than CMS' target, the hospital may receive additional reimbursement if it has met certain quality requirements. On the flip side,

if the hospital spends more than the CMS target amount, it may have to pay the agency portion of the difference, known as a "stop loss" limit. Hospitals wouldn't be required to make repayments until the second year of the payment

demonstration. Repayment requirements would be set at 5 percent that second year, 10 percent for the third year, and 20 percent for the fourth and fifth years of the CJR demo.

Partnering: Pros Appear to Outweigh the Cons

So, do you want a hand in the risk if hospitals ask you to partner, or is it better just to stay out of these arrangements? In foresight, rehab industry experts are leaning toward partnering.

"I think every post-acute provider who has an opportunity to participate should first, from a defensive posture (if you don't do it, your competitor will); secondly and more important, we know Medicare is moving toward a value-based pay-for-performance reimbursement model, and the sooner you can shape your intervention processes around this concept, the better prepared you will be," says **Garry Woessner, MA-CCC, MBA,** regional director of rehabilitation for **Benedictine Health System** in Minneapolis.

In addition, "surgeries for joint replacement are generally low-risk and highly predictable with few complications during the acute phase it's the post-acute phase that needs to deal with the complications..." Woessner says. "We own the piece of pie with the greatest variability and risk, yet don't get to eat any of the pie that's left over! Why does Medicare think the docs and hospitals should keep all of the payment incentives when the burden of cost-management lies at the feet of the post-acute providers?"

More pros: "Inpatient rehabilitation hospitals and units have an opportunity to build closer relationships with short-term acute care hospitals by forging cooperative care planning processes to identify which patients still need to go to IRH/Us or skilled nursing facilities, versus care at home or in the outpatient setting," says **Bruce M. Gans, MD,** chairman of the **American Medical Rehabilitation Providers Association** (AMRPA).

"If the required quality measures and additional ones under CJR are used to monitor in real time the care and outcomes of patients, then improvements in both quality and costs should result," Gans says, who is also executive VP and chief medical officer of the **Kessler Institute for Rehabilitation** and the national medical director for rehabilitation at **Select Medical Corporation.**

Cons to consider: "If inpatient rehabilitation providers were caring for these types of patients, they will see losses of volume and need to balance advocating for what is right for patients with what they need to do to maintain their occupancy," Gans says. "Patients are at risk for being hard-steered into less expensive but also less appropriate settings for post-acute care, so those entities (i.e., CJR participant hospitals) that are less diligent may be putting patient experience and outcomes at risk due to how they have responded to the economic incentives."

Make Your Move Carefully

If you choose to partner with a hospital, be sure to do so with all the facts. **Donna Thiel, JD,** shareholder with **Baker Donelson** in Washington, D.C., offers the following tips:

Know your costs. If the cost of rehab services exceeds the hospital's payment, the rehab provider won't be compensated for the difference. Are there savings that can be realized by working "under arrangement" with the

hospital, or will standard documentation and other requirements apply?

Know what services you are agreeing to. This can be a challenge because the CJR program is new, and hospitals may not yet be certain which services they want to provide under contract. Be specific not only about clinical services but also about documentation and items and services downstream from the rehab.

Know how and when you'll get paid. Since hospitals own the episode payment, not the post-acute care providers, nail down when you can expect to receive payment from the hospital. Clarify: Who bears the risk for non-payment by Medicare? Is there any potential for an upside? Know how much you will get paid, but also how much the hospital is to be paid for its services.

Finally, make sure you won't run into any legal issues from your arrangement, such as limitations on gainsharing or kickback laws, Thiel cautions. "CMS and OIG have issued a joint statement that waives the federal anti-kickback statute and the physician self-referral law with respect to certain financial arrangements. These waivers will protect payments made under gainsharing and share risk agreements that comply with the CJR program requirements; nonetheless, all arrangements should be vetted," Thiel says.