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Eli's Rehab Report

Payment Reform: Put It on Your Radar: New Joint Replacement Payment Demonstration for Hospitals

Post-acute care providers could use this to their advantage.

Starting in January, more than 800 acute care hospitals in select areas of the U.S. are slated to undergo a new payment initiative for hip and knee replacements. While post-acute rehab payments aren't directly affected, playing your care plan cards carefully could make a big difference in your patient load and business relationships with participating hospitals.

The initiative, known as the Comprehensive Care for Joint Replacement Payment Model, (CCRJ) is a bundled care model the **Centers for Medicare & Medicaid Services** (CMS) proposed last July that would involve a test period between Jan. 1, 2016, through Dec. 31, 2020.

The catch: Unlike a typical CMS demonstration project, participation is mandatory for the selected facilities.

Hospitals Brace for At-Risk Payments

The model would hold participating hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries receiving hip and knee replacements for the entire episode of care. That is, hospitals would be responsible for outcomes from admission to 90 days post-discharge, including all related care, both Medicare Part A and Part B.

All providers would continue to receive payments under existing Medicare payment systems; however, depending on the hospital's quality and cost performance during the episode, the hospital may receive an additional payment or be required to repay Medicare for a portion of the episode costs. To determine this, each year, CMS would set Medicare episode prices for each participant hospital. At the end of each model performance year, CMS would compare actual spending for the episode (including Medicare Parts A and B) to the Medicare estimate.

The reasoning: "The quality and cost of care for these hip and knee replacement surgeries still vary greatly among care providers," CMS said in a press release, citing that the rate of complications after surgery can be more than three times higher at some facilities than others and can cost anywhere between $16,500 to $33,000.

Also, hospitals would have an incentive to work with physicians, home health agencies, nursing facilities, and other post-acute care providers to make sure beneficiaries get the coordinated care they need, with the goal of reducing avoidable hospitalizations and complications, CMS said.

Determine Your Stakes in the Playing Field

While the CCRJ payment model would not change how rehab providers are paid, therapists may still feel an impact.

"The proposed CCJR model closely resembles the BPCI (Bundled Payments for Care Initiatives) program that was greeted with mixed reviews from hospital and post-acute providers who explored the option previously," says **Dan Avants, JD,** vice president with **Murer Consultants, Inc.,** in Mokena, IL.

"There are opportunities and challenges that therapists will face in this new model," says **Heather L. Smith,** director of quality for the **American Physical Therapy Association** (APTA). "Some opportunities include: less fragmented care for patients, the ability to design care to meet best practices, expansion and growth of practice, and increased interdisciplinary teamwork."

"Challenges include a short timeline for implementation, contracting complexities, managing the volume of patients in a given area, and communication with the care team," Smith says.

In its comments to CMS, APTA supported the agency's initiatives to improve quality and access to patient care. However, APTA suggested delaying implementation for at least a year, making participation voluntary, ensuring patient choice and access to care, and allowing waivers for telehealth, outpatient therapy limits, and other care variations "that reflect a patient-centered, rather than regulation-based, approach to care."

"The unique aspect of the CCJR is that for the first time, outpatient therapy will be bundled with the acute and post-acute care," points out **Christina Metzler,** chief public affairs officer for the **American Occupational Therapy Association** (AOTA). "This will be a new level of consideration for the coordinating provider.

Key: The discharge planner needs to have enough knowledge to assure that a qualified and appropriate outpatient rehab practitioner (one familiar with joint replacement rehab), is available, Metzler notes. But "that may be beyond what many discharge planners are knowledgeable about. It may mean that a new type of discharge planner with more emphasis on care coordination would be required."

CCJR may move the system in that direction, Metzler suggests. "Improving and expanding discharge planning to comprehensive care coordination over time would be a positive goal to achieve under this model," she says. But "the infrastructure of care decision making and coordination are key to achieving optimum outcomes."

Expect Business Opportunities if Your Performance is High

Post-acute rehab providers who are stellar at delivering efficient, low-cost and high-quality care could see a real growth opportunity. However, this "could negatively impact post-acute providers who are currently struggling to provide low-cost care," Avants says.

Some post-acute care providers may even choose to enter into contracts with hospitals as collaborators, Smith says. "Collaborators, based on the terms of their contract with the hospital, may share in gains and/or be subject to some portion of the risk."

Some pluses: "Episodes of care are proposed at 90 days, which would further call upon post-acute care and appropriate discharge spending," Avants says. "There are potential opportunities for telehealth and home health inclusion, which would benefit post-acute providers with a strong care coordination infrastructure, all selling points for a current or future hospital partner."

Plan ahead: "PTs who become collaborators in this model with hospitals may have to adjust their practice to accommodate the new volume of patients," Smith says. "Additionally, PT collaborators will work with an interdisciplinary team, across care settings, to redesign care for this patient population."

Rehab practitioners "will have to hone their practice skills and clinical judgment to a fine point to be able to achieve appropriate outcomes within the timeframe of the pilot," Metzler says. "But this is just a matter of occupational therapy practitioners infusing contemporary principles of OT promoting good outcomes and facilitating interdisciplinary collaboration to achieve the goals of the IMPACT Act, of PQRS, and of other quality and reform measures being developed across settings, across facilities and across patient groups." The same applies for PTs and SLPS, too.

"There are certainly challenges for post-acute rehab providers with this proposed CCJR model, but those providers who have been working toward improved quality at reduced costs will have a chance to succeed, while others will be forced to adapt quickly," Avants says.

Note: For more information, visit:
http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-09.html and
http://innovation.cms.gov/initiatives/ccjr/ .

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