COMPREHENSIVE CARE FOR
JOINT REPLACEMENT

A Guide to Collaboration Agreements for Post-Acute Care Providers Participating in the CJR Demonstration

December 2016
LEGAL DISCLAIMER

This document is not intended as legal advice and should not be used as or relied upon as legal advice. It is provided for general information purposes only and may not be substituted for legal advice. Specific legal advice is crucial when preparing for or negotiating an important contract that would have significant financial and legal consequences:

 ALWAYS SEEK THE ADVICE OF KNOWLEDGEABLE COUNSEL TO PROVIDE ADVICE THAT IS TAILORED TO THE ACTUAL FACTS AND CIRCUMSTANCES AND TAKES INTO ACCOUNT ALL RELEVANT LAW.
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1. **Introduction**

This Contracting Guide is intended to be a resource for post-acute providers who want to partner with hospitals participating in Medicare’s Comprehensive Care for Joint Replacement Payment Model (the “CJR Program”) and/or Medicare’s Surgical Hip Fracture and Femur Fracture Treatment Model (the “SHFFT Program”). The Guide contains an overview of the key elements of the CJR and SHFFT Programs, a breakdown of the process involved in contracting with participating hospitals and practical advice for approaching the contract negotiation. At the end of the Guide we have included a glossary of key terms for your reference along with list of resources that will provide additional background information on the programs.

In many ways, the CJR and SHFFT Programs are an outgrowth of the current trends in Medicare reimbursement. Bundled payment models centering on specific episodes of care are increasingly common and more are on the horizon. These programs are complex and require that hospitals and post-acute providers work closely to establish systems that effectively coordinate treatment for patients that require post-acute care. Those post-acute providers that can demonstrate success with the CJR and SHFFT Programs will also be well positioned to benefit from episode payment models in the future. We hope that this Guide can serve as a resource to help post-acute providers position themselves as they move forward with partnerships with hospitals who participate in the CJR and SHFFT Programs as well as the next wave of bundled payment models.

2. **Overview of the Comprehensive Care for Joint Replacement Model**

On April 1, 2016, approximately 800 hospitals across the country were enrolled in the CJR Program. The CJR Program is a retrospective two-sided bundled payment model where participating hospitals bear the entire financial risk of the cost of all Medicare services provided to applicable patients during a covered joint replacement episode. Under the program, episodes of care include all hospital inpatient and post-acute services provided to Medicare joint replacement patients during the inpatient stay and the first 90 days of post-discharge care. Depending on how well they manage costs, participating hospitals may be eligible for shared savings payments from CMS in the event that the actual cost of care for eligible Medicare beneficiaries during applicable episodes is below the CMS quality adjusted target price. Hospitals will also be required to repay CMS a percentage of cost overruns in the event that costs exceed the quality adjusted target price.

The CJR Program only applies to specific Medicare joint replacement episodes of care that include an anchor inpatient hospitalization billed under MS-DRG 469 and 470. Because the CJR Model also includes all services provided to eligible Medicare beneficiaries during the first
90 days of post-acute care, the program will impact a wide range of Medicare providers who treat lower extremity replacement patients including physicians, skilled nursing facilities, intermediate rehabilitation facilities, long-term care hospitals and home health agencies. In a draft regulation released in late July 2016, CMS proposed expanding the list of participating providers to include ACOs as well as partnerships between acute care and critical access hospitals.

Although Medicare’s use bundled payments is not new, the CJR Program represents a significant step forward evolution of CMS’ bundled payment initiatives and has the potential to have a large impact on the operations of both hospitals and post-acute providers nationwide. Hip and knee replacements are the most common hospital inpatient surgery procedure for Medicare beneficiaries and accounted for almost $7 billion in Medicare expenditures in 2014. Unlike prior bundled payment initiatives, such as the CMS Bundled Payments for Care Improvement (“BPCI”), the new CJR Program is mandatory for those hospitals selected to participate. The CJR Program is mandatory for almost all urban and suburban hospitals that perform 400 or more lower extremity joint replacement surgeries per year in 67 metropolitan areas designated by CMS.

CMS has made it clear that the CJR Program is intended to improve quality and reduce expenditures for the most common Medicare inpatient surgery procedure. In order to achieve these objectives, CMS has empowered participating hospitals to assume a larger role in managing the entire episode of care for participating Medicare beneficiaries, which is a different approach than CMS has taken previously with models like the BPCI. To incentivize cooperation between hospitals and those post-acute providers who provide care during covered episodes, not only will hospital be eligible for shared savings, but they are also permitted to enter into written “collaborator agreements” or “sharing arrangements” with post-acute providers pursuant to which hospitals can share savings and distribute risk associated with managing the cost of care. The CJR regulations include a long list of requirements for the written sharing arrangements, which are outlined in Section 5 of this Guide.

The first performance year for the CJR Program is defined as April 1, 2016 – December 31, 2016. During the first year, participating hospitals have the opportunity to receive up to 5% in shared savings if Medicare costs for joint replacement beneficiaries come in under the CMS target price. Post-acute providers are also eligible to receive portion of the shared savings through gainssharing payments from hospitals so long as the payments are made pursuant to written sharing arrangements. Importantly, during this first year hospitals will not be required to make repayments to CMS even if episode costs exceed the CMS target price. The first performance year is structured as a grace period that provides an opportunity for hospitals and post-acute providers to gain experience as they transition to the program.
Beginning January 1, 2017, hospitals will be subject to both upside and downside risk. For the 2017 measurement period, the potential upside and downside risk for hospitals will capped at 5% of the target price. The potential gains and losses increase to 20% of target price by year four of the CJR Program.

3. Model Expansion—Hip Fractures and the SHFFT Program

On July 25, 2016, CMS announced a new episode payment model (“EPM”) called the SHFFT Program, which is structured as an expansion of the existing CJR Program. The SHFFT Program, which is being tested with the exact same hospitals currently participating in the CJR Program, will include all surgical treatment options for Medicare beneficiaries with hip fractures (hip arthroplasty and fixation). As with the original CJR Program, CMS has indicated that the decision to create an episode payment model for hip fractures was driven largely by cost considerations. Citing data from 2010, CMS indicated in the proposed rule that the lifetime cost for all hip fractures for people 65 and older was an estimated $20 billion.

The proposed structure of the SHFFT Program is almost identical to the CJR Program with the exception of the specific procedure being studied and some elements of the applicable Medicare program waivers. Notably, unlike the CJR Program, the SHFFT Program does not include a waiver of the SNF three-day qualifying stay requirement. Given that the hospitals participating in the SHFFT Program will be the same as those currently participating in the CJR Program, existing or future CJR sharing arrangements will likely need to incorporate hip fracture episodes. The first performance year under the SHFFT program is currently scheduled to begin July 1, 2017.

The draft regulations published by CMS on July 25, 2016 are just a proposed rule, so there may be changes to the regulations when the final rules are published in November 2016. That being said, the structure of the SHFFT Program will likely not change dramatically and post-acute care collaborators should make every effort to incorporate hip fracture episodes in agreements with participating hospitals to be best positioned to be successful when the program goes into effect in 2017.

4. Overview of the Risk Sharing Structure and Reconciliation Process

As described above, the risk-sharing model for both the CJR and SHFFT Programs involves payments of shared savings and recoupment of cost overruns depending on how participating hospitals and post-acute providers manage costs associated with providing care for eligible joint replacement and hip-fracture patients. In order to implement the program, CMS established a target budget for each hospital, representing the total amount CMS expects to spend for each of the CJR Program cases, under both Medicare Part A and B, from the time the patient is admitted to the hospital for the procedure, until 90 days after discharge. The target price is based on three years of historical data and includes a built in 3% discount to serve as Medicare’s savings. Because of the quality component built into the target price, CMS uses the term
“quality adjusted target price” in the updated CJR regulations. Initially CMS will calculate the price using a blend of hospital-specific and regional episode data, although by year four of the program CMS will rely entirely on regional pricing.

a. Annual Reconciliation – Shared Savings and Repayments

Under the CJR and SHFFT Programs, all participating providers will continue to be paid by Medicare on a fee-for-service basis for their services when the costs are incurred, however, hospitals will assume the responsibility for ensuring the cost of the entire episode of care is at or below the CMS quality adjusted target price. CMS defines an episode payment as “the sum of related Medicare claims payments for items and services furnished to a beneficiary during a[n]… episode.” Target price is based on the type of operation or procedure, “with consideration of additional payment adjustments based on quality performance, post-episode spending, and policies to limit hospital financial responsibility.”

At the end of each annual performance period, CMS will compare its actual expenditures for CJR and SHFFT Program patients who were seen at each hospital to the budget for that hospital. Hospitals will either receive a share of any savings compared to the target budgets, subject to achieving reporting and quality requirements, or will owe a share of any cost overruns. The actual shared savings and repayment obligation will be capped at fixed percentage of the total amount each hospital is over or under the target budget. Over the initial five-year term of the CJR Program, the percentage of savings hospitals will be eligible to receive escalates year over year according to the schedule described in the following table:

<table>
<thead>
<tr>
<th>Shared Savings Limits (Stop-Gain)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years 1 and 2</strong>&lt;br&gt;April 1, 2016 – December 31, 2017</td>
<td>Capped at 5%</td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;January 1, 2018 – December 31, 2018</td>
<td>Capped at 10%</td>
</tr>
<tr>
<td><strong>Years 4 and 5</strong>&lt;br&gt;January 1, 2019 – December 31, 2020</td>
<td>Capped at 20%</td>
</tr>
</tbody>
</table>
Similarly, the share of losses participating hospitals will be required to repay under the CJR Program is scheduled to escalate annually over the life of the program according to the schedule described in the following table:

<table>
<thead>
<tr>
<th>Repayment Limits (Stop-Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1</strong>&lt;br&gt;April 1, 2016 – December 31, 2016</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;January 1, 2017 – December 31, 2017</td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;January 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td><strong>Years 4 and 5</strong>&lt;br&gt;January 1, 2019 – December 31, 2020</td>
</tr>
</tbody>
</table>

Under the SHFFT Program, the annual step-up in shared savings and repayment limit percentages follows the same basic formula as the CJR Program – ranging from 0% to 20% over the life of the program. However, as the start date for the SHFFT Program is not until July 2017, the schedule is a year behind the CJR Program. Currently, the performance periods under the SHFFT Program are set-up as follows:

<table>
<thead>
<tr>
<th>Proposed SHFFT Program Performance Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1</strong>&lt;br&gt;No Downside Risk</td>
</tr>
<tr>
<td><strong>Year 2 (NDR)</strong>&lt;br&gt;No Downside Risk</td>
</tr>
<tr>
<td><strong>Year 2 (DR)</strong>&lt;br&gt;Downside Risk Starts</td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
</tr>
</tbody>
</table>

Under the current schedule, there will be no downside risk under the SHFFT Program until April 1, 2018. The exact start date for the SHFFT program is subject to confirmation the CMS final rule to be published in November 2016.
b. Distribution of Risk and Savings – Gainsharing vs. Alignment Payments

In order to facilitate the efficient management of CJR and SHFFT episodes, the applicable regulations permit participating hospitals to share the potential savings they receive from CMS with post-acute providers who treat CJR or SHFFT patients during the 90 days following an applicable inpatient procedure. Shared savings can only be distributed to those post-acute providers – CMS uses the terms “collaborator” or “EPM collaborator” – who have entered into written sharing agreements with participating hospitals. The requirements for sharing agreements are described Section 5 of this Guide.

The applicable regulations limit the amount of downside risk participant hospitals are permitted to share with its collaborators. In any individual performance year, participant hospitals must retain at least 50% of the downside risk associated with the episodes included in the CJR and SHFFT programs and cannot share more than 25% of the downside risk with any one collaborator.

When a participating hospital distributes shared savings to collaborators, the payments are referred to as “gainsharing payments.” Alternatively, when hospitals require collaborators to reimburse hospitals for losses incurred under the CJR and SHFFT Programs, those payments are referred to as “alignment payments.” Under the regulations, gainsharing payments can consist of only shared savings and internal cost savings. Internal cost savings are the measurable, actual, and verifiable cost savings realized by the hospital resulting from care redesign undertaken by such participant in connection with providing items and services to beneficiaries within specific CJR and or SHFFT episodes. Internal cost savings does not include savings realized by any individual or entity that is not the participating hospital.

5. Components of a CJR Sharing Agreement

In order to be eligible to participate in the CJR and SHFFT Programs and receive gainsharing payments from hospitals, collaborators must satisfy the threshold eligibility requirements set out in the regulations and enter into written sharing agreements. The regulations contain numerous restrictions for both gainsharing payments and the written collaborator agreements. The next few Sections of this Guide contain an overview of the applicable regulatory requirements under the CJR and SHFFT Programs.

a. Threshold Eligibility Requirements

To be eligible to participate in sharing arrangements and receive gainsharing payments or make alignment payments, persons or entities must satisfy the following threshold requirements:

- Providers must meet the applicable quality criteria for the calendar year for which the gainsharing or alignment payment is determined by the participant hospital;


- Providers must directly furnish a billable service to a CJR and/or SHFFT beneficiary (as applicable) during a CJR or SHFFT episode (as applicable) that occurred in the
  same calendar year in which the savings or loss was created; and

- Providers must enter into a sharing arrangement before care is furnished to CJR or
  SHFFT beneficiaries (as applicable) under the terms of the sharing arrangement.

b. Elements of Written Sharing Arrangements

In addition to the threshold eligibility requirements for collaborators, CMS established a complex set of requirements and restrictions for sharing arrangements between hospitals and collaborators. The specific requirements and restrictions for written sharing arrangements are described in the following table, below:

<table>
<thead>
<tr>
<th>Requirements and Restrictions for Written Sharing Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Must be in writing and signed by the parties, and entered into before care is furnished to beneficiaries under the sharing arrangement.</td>
</tr>
<tr>
<td>3. Must contain a requirement that the collaborator and its employees, contractors (including collaboration agents), and subcontractors comply with the following:</td>
</tr>
<tr>
<td>(i) The CJR/SHFFT Program requirements (including requirements regarding beneficiary notifications, access to records, record retention, and participation in any evaluation, monitoring, compliance, and enforcement activities performed by CMS or its designees);</td>
</tr>
<tr>
<td>(ii) All applicable Medicare provider enrollment requirements (including having a valid and active TIN or NPI); and</td>
</tr>
<tr>
<td>(iii) All other applicable laws and regulations.</td>
</tr>
<tr>
<td>4. Must contain a requirement that the collaborator have a compliance program that includes oversight of the sharing arrangement and compliance with the requirements of the CJR/SHFFT Program(s).</td>
</tr>
<tr>
<td>5. Must not pose a risk to beneficiary access, beneficiary freedom of choice, or quality of care.</td>
</tr>
<tr>
<td>7. Must specify the following:</td>
</tr>
<tr>
<td>(i) The purpose and scope of the sharing arrangement;</td>
</tr>
<tr>
<td>(ii) The obligations of the parties, including specified CJR/SHFFT activities and other services to be performed by the parties under the sharing arrangement;</td>
</tr>
</tbody>
</table>
(iii) The date of the sharing arrangement;

(iv) Management and staffing information, including type of personnel or contractors that will be primarily responsible for carrying out CJR/SHFFT activities; and

(v) The financial or economic terms for payment, including: (A) the eligibility criteria for a gainsharing payment; (B) the eligibility criteria for an alignment payment; (C) the frequency of gainsharing or alignment payment; (D) the methodology and accounting formula for determining the amount of a gainsharing payment or alignment payment.

8. The sharing arrangement must not—

   (i) Incentivize the participant hospital, collaborator, or any employees, contractors, or subcontractors of the participant hospital or collaborator to reduce or limit medically necessary services to any Medicare beneficiary; or

   (ii) Restrict the ability of a collaborator to make decisions in the best interests of its patients, including the selection of devices, supplies, and treatments.

c. Requirements for Gainsharing and Alignment Payments

The regulations for the CJR and SHFFT Programs contain a series of requirements that must be satisfied in order for collaborators to be eligible to receive gainsharing payments or make alignment payments under applicable sharing arrangements:

<table>
<thead>
<tr>
<th>Requirements for Gainsharing and Alignment Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gainsharing payments must:</td>
</tr>
<tr>
<td>(i) Be derived solely from reconciliation payments, or internal cost savings, or both</td>
</tr>
<tr>
<td>(ii) Be distributed on an annual basis (not more than once per calendar year);</td>
</tr>
<tr>
<td>(iii) Not be a loan, advance payment, or payment for referrals or other business;</td>
</tr>
<tr>
<td>(iv) Be clearly identified as a gainsharing payment at the time it is paid; and</td>
</tr>
</tbody>
</table>

## Requirements for Gainsharing and Alignment Payments

1. **Be made by via a traceable cash transaction.**

2. **The methodology calculating internal cost savings must:**
   - **(i)** Be transparent, measurable, and verifiable in accordance with GAAP;
   - **(ii)** Reflect the actual, internal cost savings achieved by the participant hospital through the documented implementation of CJR/SHFFT activities identified by the participant hospital and must exclude: (A) Any savings realized by any individual or entity that is not the participant hospital; and (B) “Paper” savings from accounting conventions or past investment in fixed costs; and
   - **(iii)** Not directly account for the volume or value business otherwise generated between the participant hospital and any collaborator.

3. The amount of any gainsharing payments must be determined in accordance with a methodology that is substantially based on quality of care and the provision of CJR/SHFFT activities. The methodology **may take into account** the amount of such CJR/SHFFT activities provided by a collaborator relative to other CJR collaborators.

4. The aggregate amount of all gainsharing payments that are derived from a reconciliation payment must not exceed the amount of the reconciliation payment the participant hospital receives from CMS.

5. The sharing arrangement must require the participant hospital to recoup any gainsharing payment that contained funds derived from a CMS overpayment on a reconciliation report or was based on the submission of false or fraudulent data.

6. Alignment payments from a collaborator to a participant hospital may be made at any interval that is agreed upon by both parties, and must not be—
   - **(i)** Issued, distributed, or paid prior to the calculation by CMS of a repayment amount reflected in a reconciliation report;
   - **(ii)** Loans, advance payments, or payments for referrals or other business; or
   - **(iii)** Assessed by a participant hospital if it does not owe a repayment amount.

7. The participant hospital must not receive any amounts under a sharing arrangement from a collaborator that are not alignment payments.
<table>
<thead>
<tr>
<th>Requirements for Gainsharing and Alignment Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. For a performance year, the aggregate amount of all alignment payments received by the participant hospital <strong>must not exceed 50 percent of the participant hospital's repayment amount.</strong></td>
</tr>
<tr>
<td>10. The aggregate amount of all alignment payments from a collaborator to the participant hospital <strong>may not be greater than 25 percent of the participant hospital's repayment amount.</strong></td>
</tr>
</tbody>
</table>

**d. Example Provisions**

Although the preceding Sections of this Guide demonstrate the relative complexity of the requirements for sharing agreements and gainsharing/alignment payments under the CJR and SHFFT Programs, the requirements can be divided into a few key topic areas for ease of reference:

1. compliance requirements
2. quality-related requirements;
3. care re-design descriptions and processes; and
4. financial terms.

Below are some examples of provisions that can be included in sharing arrangements to address each of these central topic areas:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Sample Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with Laws, Regulations, Rules, and Standards</td>
<td>During the Term, Facility, and Hospital as applicable, shall:</td>
</tr>
<tr>
<td></td>
<td>1. Comply with the applicable requirements of the Regulations and Waiver, including, without limitation, requirements with respect to access to records, record retention, and documentation of any Gainsharing Payments from Hospital to Facility and/or Alignment Payments from Facility to Hospital. Without limiting the foregoing, Facility shall:</td>
</tr>
<tr>
<td></td>
<td>(a) Provide written notice to a [CJR and or SHFFT Beneficiary], no later than the time at which the [CJR and or SHFFT Beneficiary] first receives services</td>
</tr>
</tbody>
</table>

1 The limit is 50% for ACOs.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Sample Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>from Facility, of the structure of the [CJR and/or SHFFT Model] and the existence of the Facility’s sharing arrangement with Hospital;</td>
</tr>
<tr>
<td></td>
<td>(b) Develop and implement a compliance program as of the Effective Date that includes oversight of compliance with this Agreement, the Regulations, and the Waiver;</td>
</tr>
<tr>
<td>2.</td>
<td>Cooperate to provide each other and CMS access to records, information, and data for purposes of monitoring and reporting as may be required under the [CJR and/or SHFFT Model] and any other lawful purpose;</td>
</tr>
<tr>
<td>3.</td>
<td>Comply with all applicable laws, rules, and regulations of the United States, the State of [_________] and any other applicable governmental agency in the performance of and the billing for Covered Services;</td>
</tr>
<tr>
<td>4.</td>
<td>Ensure that each person that contracts with, or is employed by, Facility to provide professional services, including without limitation, physicians, registered nurses, licensed vocational nurses, and certified nursing assistants shall be a participating provider in the Medicare and Medicaid programs, and be in compliance with all Medicare enrollment requirements set forth at 42 C.F.R. § 424.500, including maintaining an active and valid TIN or NPI.</td>
</tr>
<tr>
<td>Quality Protocols</td>
<td>Facility and Hospital shall collaborate with respect to the [CJR and/or SHFFT Model] in accordance with all protocols, policies, procedures, rules, regulations, and any other guidance adopted by the Hospital. As a condition of participation in the [CJR and/or SHFFT Model], Facility shall adhere to the quality and efficiency standards adopted by the Hospital in connection with the [CJR and/or SHFFT Model], as set forth in [Exhibit __ (“Quality Criteria”)], as may be updated from time to time. The Quality Criteria shall be used in determining the [Gainsharing and/or Alignment Payment] to which Facility is eligible, if any.</td>
</tr>
<tr>
<td>Topic</td>
<td>Sample Provision</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Care Redesign and Internal Cost Savings</td>
<td>Plans regarding care redesign with respect to [CJR and/or SHFFT Episodes], in addition to applicable changes in care coordination or delivery and a description of how success under the [CJR and/or SHFFT Model] will be measured are set forth in [Exhibit __], along with management and staffing information, including the type of personnel or contractors that will be primarily responsible for carrying out changes to care under the [CJR and/or SHFFT Model]. The specific methodology for accruing, calculating, and verifying the internal cost savings generated by Hospital based on the care redesign elements associated with Facility is set forth in [Exhibit __].</td>
</tr>
</tbody>
</table>
| Gainsharing and/or Alignment Payments      | **Gainsharing Payments.** Hospital may provide Facility with a portion of reconciliation payments made by CMS to Hospital as determined in accordance with 42 C.F.R. § 510.305 (“Reconciliation Payments”) that occur during the term of this Agreement as further described in [Exhibit __] (“Gainsharing Payments”). Gainsharing Payments shall be made not more than once per calendar year, and shall be derived solely from Hospital’s Reconciliation Payments or internal cost savings.  

**Alignment Payments.** Facility shall pay to Hospital a portion of any Reconciliation Payments made by Hospital to CMS as determined in accordance with 42 C.F.R. § 510.305 that occur during the term of this Agreement as further described in [Exhibit __ ] (“Alignment Payments”). Alignment Payments shall be made not more than once per calendar year, and shall be derived solely from Hospital’s Reconciliation Payments to CMS. |
6. Medicare Fraud and Abuse and Program Waivers

To facilitate sharing arrangements between hospitals and their collaborators, the CJR and SHFFT Program regulations include waivers of certain Medicare program rules and applicable healthcare fraud and abuse laws (including the Stark law and the Federal Anti-Kickback Statute).

a. Waiver of SNF Three-Day Stay Requirement For CJR Program

Beginning January 1, 2017, the CJR Program will include a waiver of the SNF three-day rule for coverage of a SNF stay for a CJR beneficiary following an anchor hospitalization for discharges to certain qualifying SNFs. According to CMS, the Medicare Part A SNF benefit is intended for Medicare beneficiaries who require a short-term intensive stay in a SNF that requires skilled nursing, or skilled rehabilitation care, or both. Normally, in order to qualify for the Medicare SNF benefit, patients must have a prior inpatient stay of at least three consecutive days. With the waiver, this condition will no longer be required for qualifying CJR beneficiaries discharged to qualifying SNFs.

In connection with the waiver, CMS will prepare a list of qualifying SNFs each calendar quarter based on a review of the most recent 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. In order to qualify in any particular quarter, a SNF must maintain a rating of three stars or better for at least seven of the preceding 12 months. The waiver is similar to waivers that have been part of prior CMS initiatives including BPCI Model 2 and the Pioneer ACO Model. In practice, given the challenges associated with the Nursing Home Compare system, providers and participating hospitals should carefully consider how the waiver is used in connection with sharing agreements for the CJR Program.

In the regulations, CMS notes that all other Medicare coverage rules for coverage and payment of Part A covered SNF services will continue to apply. This means, for example, that the waiver would apply to a beneficiary who is discharged to his or her home less than 3 days from the anchor hospitalization, who requires SNF services within 30 days of the discharge.

CMS has expressed some concern regarding the need for beneficiary protections surrounding the application of the three-day stay waiver. Unlike the application of the waiver in other initiatives, in the CJR Program, participating hospitals (rather than SNFs) are responsible for the cost of care provided under the bundle and CMS believes it is appropriate that hospitals are also financially responsible for costs associated with the misuse of the three-day waiver requirements. Participant hospitals are required to consult the published CMS list of qualifying SNFs prior to utilizing the three-day stay waiver for any participating beneficiary and to include
a disclaimer regarding the use of the waiver in the discharge planning notice provided to participating beneficiaries.

Importantly, the proposed regulations for the SHFFT Program do not contain a waiver of the SNF three-day rule for coverage of a SNF stay for a SHFFT beneficiary following an anchor hospitalization. In its proposed rule, CMS stated that there was insufficient data to support the waiver for the episodes included in the SHFFT Program. In the event that hospitals and collaborators enter into sharing arrangements involving both the CJR and SHFFT Programs, the parties should take care to document the differences in the discharge process for beneficiaries from the two different programs.

b. Application of Fraud and Abuse Waivers

As with other CMS demonstration projects (including ACOs and the BPCI), in connection with the CJR Program, the Secretary of Health and Human Services (“HHS”) issued a notice of certain waivers of the Stark law and the Federal Anti-Kickback Statute. The waivers will immunize certain sharing agreements (and corresponding gainsharing and alignment payments) from scrutiny under these fraud and abuse laws, as long as the arrangements meet the detailed requirements contained in the CJR Program regulations and the HHS waiver. The waiver includes the following requirements:

<table>
<thead>
<tr>
<th>Requirements for Fraud &amp; Abuse Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any sharing arrangement (and corresponding gainsharing and alignment payments) must satisfy all requirements outlined in the CJR Program regulations.</td>
</tr>
<tr>
<td>2. The sharing arrangement must satisfy the beneficiary choice and beneficiary notification requirements contained in the CJR Program regulations.</td>
</tr>
<tr>
<td>3. The sharing arrangement must not add conditions, limitations, or restrictions to any sharing arrangement other than those required or permitted under the CJR regulations.</td>
</tr>
<tr>
<td>4. The criteria for selecting CJR collaborators must include criteria related to, and inclusive of, the quality of care to be delivered by the collaborators and the sharing arrangement must require that collaborators meet applicable quality criteria for selection.</td>
</tr>
<tr>
<td>5. CJR collaborators must meet quality criteria for the calendar year for which the applicable gainsharing payment is determined, which must be set forth in the applicable sharing agreement.</td>
</tr>
</tbody>
</table>
HHS has not yet issued any waiver of applicable fraud and abuse laws for the SHFFT program, however, in its proposed rule, CMS does contemplate that a waiver similar to the CJR Program may be necessary. If a waiver is issued, it would likely be distributed in connection with the final rule for the SHFFT program around November 2016.

7. Key Negotiation Areas, Approaches and Questions

Although under the CJR and SHFFT Programs participating hospitals are financially responsible for managing the cost of care for eligible Medicare beneficiaries, hospitals cannot achieve successful outcomes without the cooperation of numerous post-acute providers. A successful partnership begins with the implementation of a workable sharing agreement that clearly defines the relationship and anticipates the specific steps required to effectively manage care for eligible beneficiaries. Below are descriptions of strategies, key terms, and topic areas that post-acute providers should discuss with hospitals when negotiating successful sharing arrangements.

a. Showing up with a Plan – Key Background Materials for the Negotiation

The CJR and SHFFT Programs are complex and figuring out what it takes to be successful will require a lot of financial information, clinical protocols and quality data. The CJR and SHFFT Programs represent a real opportunity for post-acute providers to establish or expand upon successful partnerships with local hospitals that can generate shared savings for both parties and improve patient outcomes at the same time.

When considering how to approach participating hospitals it is critical for post-acute providers to come to the table with the information that both parties need to make an informed decision about the best way to structure a potential partnership. In the context of the CJR and SHFFT Programs, the following information is probably the most important:

<table>
<thead>
<tr>
<th>Requirements for Fraud &amp; Abuse Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. The methodology for determining gainsharing payments must be based, at least in part, on criteria related to, and inclusive of, the quality of care to be delivered to CJR beneficiaries.</td>
</tr>
</tbody>
</table>

- **Average Length of Stay Data for Relevant Conditions**: The CJR and SHFFT Programs are about managing cost. Successfully demonstrating that post-acute providers treat patients in an efficient, but high-quality manner will help specific providers stand out.
<table>
<thead>
<tr>
<th><strong>Readmission Rates for Relevant Conditions</strong></th>
<th>As with average length of stay data, providers who can demonstrate high-quality care through low readmission rates will be particularly attractive to participating providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Statistics</strong></td>
<td>Providers should be prepared to share the quality statistics associated with the Medicare’s Nursing Home Compare and the Five-Star Quality Rating System.</td>
</tr>
<tr>
<td><strong>Positive Patient Experiences</strong></td>
<td>Providers should be prepared with data to support why they believe they can provide high-quality care. Using patient survey data and other patient satisfaction materials will be particularly helpful.</td>
</tr>
<tr>
<td><strong>Experience in Other Bundled Payment Programs/ACOs</strong></td>
<td>Given the overlap with other bundled payment and alternative payment models (including the BPCI and the Pioneer ACO Model), if applicable, providers should highlight past experiences for participating hospitals.</td>
</tr>
<tr>
<td><strong>Ways to Effectively Partner Post-Discharge and Meaningfully Coordinate Care</strong></td>
<td>A big part of whether partnerships between hospitals and post-acute providers are ultimately successful will depend on how providers handle transitions from one facility to another and from one facility to the patient’s home. Providers should outline a specific process for handling the care coordination that includes identification of staff from each facility who can coordinate to ensure that each facility handles the transitions efficiently and effectively.</td>
</tr>
</tbody>
</table>

b. **Why Me? – Skilled Nursing vs. Home Health vs. Other Providers**

One element of structuring an effective partnership may include an evaluation of the specific types of patients that will be most successful in particular kinds of post-acute facilities. For example, SNFs may be able to demonstrate to participating hospitals that particular kinds of patients would be more successful if they were discharged to a SNF more quickly rather than spending more time as an inpatient before being discharged to a different kind of post-acute provider. Alternatively, it may be the case that other kinds of patients would be better served by spending additional time as an inpatient before being discharged into a home health setting so long as the providers use additional staff to work on the transitions and the care coordination elements of the treatment.
The CJR and SHFFT Programs are about delivering high quality care efficiently – figuring out how to do that will require getting very specific in how the parties look at particular patients. Post-acute providers who come to the negotiation table with this kind of data will not only stand out, but they will likely end up creating a more successful partnership and better outcomes for more patients.

c. Structure of Risk Distribution – Accept Downside Risk?

One of the key areas of discussion must center around the allocation of shared savings and potential downside risk. The regulations governing the CJR and SHFFT Programs do not require that collaborators accept downside risk as a prerequisite to receiving gainsharing payments. However, all collaborators are required to engage with participating hospitals in the care redesign strategies implemented as part of the CJR and SHFFT Programs, and hospitals often expect post-acute providers to accept some measure of accountability as part of the redesign and quality improvement process implemented by the parties. Providers should consider whether or not to accept downside risk in the context of the overall negotiation and development of a successful relationship with participating hospitals. Ultimately, the most successful relationships will involve a true partnership where parties are share the some financial responsibility for the success or failure of the enterprise. Providers should also keep in mind that participating hospitals must retain at least 50% of the total downside risk under the CJR and SHFFT Programs (calculated separately) and can distribute no more than 25% of the downside risk to any one collaborator.

d. Gainsharing and/or Alignment Payments

As with other elements of the sharing arrangement, the parties should make every effort to be as clear and precise as possible when describing the process for calculating and distributing gainsharing and alignment payments. The CJR and SHFFT Programs contain detailed requirements for how payments can be calculated and distributed, but there is still ample room to tailor the methodology to the specific facility and relationship in question. By providing as much detail as possible at the outset of a sharing agreement the parties can limit the possibility of disputes in the future.

A few key areas the parties will need to resolve include:

- Will the sharing agreement include gainsharing payments and alignment payments or just gainsharing payments?
- How will gainsharing and/or alignment payments be calculated?
- Will payments limited to reconciliation payments (performance-based) or also
include internal cost savings?

- If gainsharing payments involve the distribution of internal cost savings realized in connection with the implementation of CJR/SHFFT Program activities, how much transparency will be involved?

The calculation of gainsharing and alignment payments can be a complex process. The regulations for the CJR and SHFFT Programs permit gainsharing payments to be composed of either reconciliation payments (the amounts participating hospitals receive from CMS if total costs come in under the CMS target price), internal cost savings or both. CMS defines “internal cost savings” as are the “measurable, actual, and verifiable cost savings” realized by the participating hospitals that result from care redesign undertaken in connection with providing items and services to beneficiaries within specific CJR or SHFFT episodes.

When considering the structure for gainsharing arrangements it should be thought of as a two-step process. The preliminary, and most straightforward step, is to figure out how to share the potential savings participating hospitals receive from CMS in the form of reconciliation payments. For many providers this may be the end of the calculation. The second step should be to consider whether or not to include internal cost savings in the methodology. This step is much more complicated because it will require hospitals to share detailed cost information with providers. The process of allocating costs to specific CJR and SHFFT activities is likely labor intensive and hospitals may not be interested in inviting post-acute providers to share in their internal cost calculations.

Under the current CJR regulations the methodology for calculating internal cost savings generated by the participant hospital must identify the particular savings generated based on the care redesign elements associated with the particular collaborator. Under the revised CJR regulations and the proposed rule for the SHFFT program the methodology is a little more flexible, but the calculation of any gainsharing payments may take into account the amount of CJR activities provided by a CJR collaborator relative to other CJR collaborators. The methodology must still be substantially based on the quality of care and provision of CJR activities by each particular collaborator.
e. Establishing Quality and Care Redesign Criteria

The central component of both the CJR and SHFFT Programs is the implementation of care redesign and quality criteria intended to improve quality and reduce costs associated with treating Medicare beneficiaries. Actually establishing the specific criteria that will be implemented should be a central focus of the negotiation of the sharing agreement between CJR collaborators and participating hospitals.

**A few key areas the parties will need to resolve include:**

- What quality elements will be used by the hospital to evaluate performance?
- What role will collaborators play in quality developing criteria?
- What role will collaborators play in developing care redesign criteria?
- How will care specific actions be tied to payments under sharing agreements?

Post-acute providers will be best served by approaching participating hospitals with a plan that includes specific quality and care redesign elements that could be implemented. Assisting participating hospitals to tailor the care redesign process to the specific facility and specific providers will place all participants in the best position to succeed. Constructing a plan that is realistic, achievable and tailored the specific strengths of the collaborators will allow both parties to achieve quality thresholds and shared savings objectives.

f. Focus on Transitions Between Hospital, Post-Acute Facility and Patient Home

In preparing care redesign and quality criteria to be used to implement CJR and SHFFT activities there is tremendous value in spending time on the front-end to carefully consider how patient transitions will function. In order to provide high-quality care efficiently for the duration of the applicable CJR or SHFFT episode, providers will need to carefully assess the appropriate times to move patients from one setting to another. Moving a patient too soon might increase the chance of readmission, but keeping a patient too long in one setting may unnecessarily increase the cost of the entire episode. Providers should also consider the best way to use staff to assist with transitions between one facility and another and between a facility and the patient’s home.

g. Implementing Program Waivers and SNF Three-Day Stay Requirement

A key element of the CJR Program for SNF providers is the waiver of the SNF three-day stay requirement available for eligible CJR beneficiaries starting January 1, 2017. The CJR regulations include specific requirements that must be followed in order to use the waiver, and the proposed regulations published in July 2016 added additional restrictions.
When negotiating a sharing agreement with a participant hospital it is important to include a provision that addresses the procedure the parties will follow when using the three-day stay waiver. The provision should include a provision that requires: (1) the hospital to provide all CJR beneficiaries with the discharge planning notice required under § 501.405(b)(4); (2) the parties to confirm that the SNF appears on the then current CMS list of qualifying SNFs (those with a 3-star or higher rating for 7 of the prior 12 months) and; (3) that the parties comply with all other applicable Medicare payment and coverage policies.

The proposed CJR regulations published in July 2016 clarify that participating hospitals will bear the financial responsibility for discharges to SNFs that do not meet the terms of the three-day stay waiver, however, CMS is currently seeking comments as to whether it is more appropriate for SNFs to bear some financial responsibility. Under the circumstances, it is particularly important for all parties that sharing arrangement includes assurances that the requirements of the waiver are satisfied for every CJR discharge.

In negotiating the sharing agreement it is also important to keep in mind that the SNF three-day stay waiver is only available under the CJR Program and not under proposed regulations for the SHFFT Program. Other proposed EPMs do include the waiver, so collaborators should look closely at the episodes included in any sharing agreement and tailor the provision governing the waiver accordingly.

h. Fraud and Abuse Regulatory Compliance – Application of Waivers

In connection with the implementation of the CJR Program, the Secretary of Health and Human Services issued waivers of the Stark law and the Federal Anti-Kickback Statute for gainsharing and alignment payments made between participating hospitals and CJR collaborators. The waivers contain specific pre-requisites that must be satisfied in order for the waivers to apply. In negotiating a sharing agreement it is important for the parties to explicitly reference the fraud and abuse waivers and the corresponding requirements. As of the date of this Guide, the Secretary of Health and Human Services has not yet issued any waiver of the Stark law and the Federal Anti-Kickback Statute in connection with the SHFFT Program. In the proposed rule for the SHFFT Program, CMS stated that a waiver may be forthcoming, but providers should confirm whether any applicable waiver has been issued before the start date for the SHFFT Program in July 2017.

In considering compliance with applicable fraud and abuse laws, it is important to recognize that the CJR and SHFFT Programs are focused on quality of care and the implementation of care redesign elements. All gainsharing and alignment payments made
pursuant to sharing agreements should be explicitly tied to quality components and should not make reference to the value or volume of business generated between the parties.

When negotiating a sharing arrangement it is also important to keep in mind that the fraud and abuse waivers for the CJR Program only apply to gainsharing and alignment payments made in connection with services rendered to Medicare beneficiaries. Efforts should be made to ensure that non-Medicare beneficiaries are excluded.

i. **Overlap with Other Bundled Payment Arrangements (Including Commercial Payors)**

When starting a negotiation with a participating hospital for a sharing agreement under the CJR Program it is worth considering whether there are other bundled payment programs that might be available. Now that CMS has proposed the new SHFFT Program, those episodes should probably be rolled into any CJR Program sharing agreement given that the participating hospitals are the same under both the CJR and SHFFT Programs. In addition, it is worth considering whether any other bundled payment programs should be rolled into the agreement.

In addition to bundled payment models on the Medicare side, increasingly commercial payors are implementing contracts with hospitals that mirror models such as the CJR and SHFFT Programs. These commercial contracts create opportunities for post-acute providers and there is efficiency in addressing multiple programs with one comprehensive sharing agreement.

8. **Glossary of Key Terms**

**Alignment payment** means a payment from a CJR collaborator to a participant hospital under a sharing arrangement, for only the purpose of sharing the participant hospital's responsibility for repayments to Medicare.

**CJR collaborator** means one of the following Medicare-enrolled persons or entities that enters into a sharing arrangement: (1) Skilled nursing facility (SNF); (2) Home health agency (HHA); (3) Long-term care hospital (LTCH); (4) Inpatient rehabilitation facility (IRF); (5) Physician; (6) Nonphysician practitioner; (7) Provider or supplier of outpatient therapy services; or (8) Physician group practice (PGP). In the proposed rule published July 25, 2016, CMS has proposed adding Accountable Care Organizations, acute care hospitals and critical access hospitals to the list of possible CJR collaborators.

**CJR reconciliation report** means the report prepared after each reconciliation that CMS provides to each participant hospital notifying the participant hospital of the outcome of the reconciliation.

**Collaborator agreement** means a written, signed agreement between a CJR collaborator and a participant hospital that meets the requirements of §510.500(c).
**Distribution arrangement** means a financial arrangement between a PGP that is a CJR collaborator and a practice collaboration agent in which the PGP distributes some or all of a gainsharing payment that it received from a participant hospital.

**Distribution payment** means a payment made by a PGP that is a CJR collaborator to a practice collaboration agent under a distribution arrangement.

**Episode of care (or Episode)** means all Medicare Part A and B items and services described in §510.200(b) (and excluding the items and services described in §510.200(d)) that are furnished to a beneficiary described in §510.205 during the time period that begins with the beneficiary's admission to an anchor hospitalization and ends on the 90th day after the date of discharge from the anchor hospitalization, with the day of discharge itself being counted as the first day of the 90-day post-discharge period.

**Episode target price or quality adjusted target price** means the amount determined in accordance with §510.300 and applied to an episode in determining a net payment reconciliation amount.

**Gainsharing payment** means a payment from a participant hospital to a CJR collaborator, under a sharing arrangement, composed of only reconciliation payments or internal cost savings or both.

**Internal cost savings** are the measurable, actual, and verifiable cost savings realized by the participating hospital resulting from care redesign undertaken by such participant in connection with providing items and services to beneficiaries within specific CJR and or SHFFT episodes. Internal cost savings does not include savings realized by any individual or entity that is not the participating hospital.

**Lower-extremity joint replacement (LEJR)** means any procedure that is within MS-DRG 469 or 470, including lower-extremity joint replacement procedures or reattachment of a lower extremity.

**Sharing arrangement** means a financial arrangement between a participant hospital and a CJR collaborator for the sole purpose of making gainsharing payments or alignment payments under the CJR model.
9. **Additional Resources**

CMS created a website that it uses to post information on the CJR Program. The site includes helpful information such as lists of participating hospitals, program fact sheets, frequently asked questions and pricing and quality data. The CMS site can be accessed at: https://innovation.cms.gov/initiatives/CJR


CMS has posted a copy of the full text of the final rule governing the CJR Program. The full text can be accessed through the CMS website at: https://innovation.cms.gov/initiatives/CJR or directly at: https://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf

CMS has posted a copy of the full text of the proposed rule governing the SHFFT Program and proposed changes to the CJR Program. The full text can be accessed through the CMS website at: https://innovation.cms.gov/initiatives/CJR or directly at: https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf