Administrative Manual
Policy #: 1283

COMPREHENSIVE CARE FOR JOINT REPLACEMENT PROGRAM GOVERNING BODY OVERSIGHT

Objective: To establish Governing Body oversight of Covenant HealthCare's Comprehensive Care for Joint Replacement (CJR) program.

Scope: All Covenant facilities and wholly owned entities.

Definitions: The following terms when used in this Policy and all Comprehensive Care for Joint Replacement Policies, shall have the meanings set forth below:

(a) "Actual Episode Payment" means the sum of Medicare claims payments for items and services that included an episode of care excluding certain items and services described in Sec. 510.200(d) of the CJR Regulations.

(b) "Alignment Payment" means a payment from a CJR Collaborator to a participant hospital under a sharing agreement for only the purpose of sharing the participant hospital's responsibility for repayments to Medicare.

(c) "Anchor Hospitalization" means the initial hospital stay upon admission for a lower extremity joint replacement.

(d) "CNN" means the CMS certification number.

(e) "CJR Collaborator" means one of the following Medicare-enrolled persons or entities that enters into a sharing agreement with a participant hospital:

(1) A skilled nursing facility ("SNF");
(2) A home health agency ("HHA")
(3) A long-term care hospital ("LTAC")
(4) An inpatient rehabilitation facility ("IRF")
(5) A physician
(6) A non-physician practitioner
(7) A provider or supplier of outpatient therapy services or
(8) A physician group practice ("PGP")

(f) "CJR Eligible Beneficiary" means Medicare beneficiaries who have Medicare as their primary payer, are enrolled in Medicare Parts A and Part B, are not eligible for Medicare based on the diagnosis of End Stage Renal Disease, are not enrolled in any managed care plan and are not covered under a United Mine Workers of America health care plan.

(g) "CJR Reconciliation Report" means the report prepared by CMS after each reconciliation period notifying the participating hospital of the outcome of the reconciliation.

(h) "Collaborator Agreement" or "Agreement" means an agreement between the Hospital and CJR Collaborator participating in a Sharing Agreement.

(i) "Composite Quality Score" means the score computed for Hospital to summarize the Hospital's level of quality performance and improvement on the specific quality measures applicable to the CJR Program as set forth in 42 CFR 510.315.

(j) "Comprehensive Care for Joint Replacement" (CJR) means the CMS program codified at 42, C.F.R. Part 510, that holds Covenant financially and clinically responsible for all Medicare Lower Extremity Joint Replacement (LEJR) patient episodes.

(k) "DME" means durable medical equipment.

(l) "EFT" means electronic funds transfer.

(m) "Episode of Care" or "Episode" means all Medicare Part A and B items and services described in Section 510.200(b) of the CJR Regulations, excluding those items and services described in Section 510.200(d) of the CJR Regulations, during the time period that begins with the beneficiary's admission to an Anchor Hospitalization and which ends on the 90th day after the date of discharge for the Anchor Hospitalization, with the day of discharge itself being counted as the first day of the 90 day post-discharge period.

(n) "Episode Target Price" means the amount determined in accordance with Section 510.300 and applied to an Episode in determining a net payment reconciliation amount.

(o) "ESRD" means end stage renal disease.

(p) "Gainsharing Payment" means a payment for a participant hospital to a CJR Collaborator, under a sharing agreement, composed of only reconciliation payments or internal cost savings or both.

(q) "HCAHPCS" means Hospital Consumer Assessment of Healthcare Providers and Systems.

(r) "HCPCS" means the CMS Common Procedure Coding System.

(s) "ICD-CM" means the International Classification of Diseases, Clinical Modification.

(t) "Inpatient Prospective Payment System" or "IPPS" means the payment systems for subsection (d) hospitals as defined in Section 1886(d)(1)(B) of the Social Security Act

(u) "Internal Cost Savings" means the measurable, actual, and verifiable cost savings realized by the Hospital resulting from care redesign undertaken by Hospital in connection with providing items and services to beneficiaries within specific CJR Episodes of Care. Internal Cost Savings does not include savings realized by any individual or entity that is not the Hospital.

(v) "IPF" means an inpatient psychiatric facility.

(w) "Lower Extremity Joint Replacement" or "LEJR" means any procedure that is within MS-DRG 669 or 470, including lower extremity joint replacement procedures or reattachment of a lower extremity.

(x) "Medicare Severity Diagnosis Related Group" or "MS-DRG" means, for the purposes of the CJR Program, the classification of inpatient hospital discharges updated in accordance with 42 CFR 412.10.

(y) "Member of the PGP" or "PGP Member" means a physician, non-physician practitioner, or therapist who is an owner or employee of the PGP and who has reassigned to the PGP his or her right to receive Medicare payment.

(z) "Net Payment Reconciliation Amount" or "NPRA" means the amount determined in accordance with Section 510.305(e) of the CJR Regulations.

(aa) "OIG" means the Department of Health and Human Services Office of the Inspector General.

(bb) "PAC" means post-acute care.

(cc) "Participant Hospital" means Covenant Medical Center, Inc.

(dd) "Performance Year" means one of the years in which the CJR model is being tested. Performance Years for the CJR Program correlate to calendar years.

(ee) "PGP" means physician group practice.

(ff) "Physician" has the meaning set forth in Section 1861(r) of the Social Security Act.

(gg) "Post-episode Spending Amount" means the sum of Medicare Parts A and B payments for items and services that are furnished to a Medicare Beneficiary within 30 days after the end of the beneficiary's episode.

(hh) "Quality Improvement Points" mean points that CMS adds to the Hospital's Composite Quality Score for a measure if the Hospital's performance percentile on an individual quality measure increases from the previous performance year by at least 3 deciles on the performance percentile scale

(ii) "Qualifying Episode" shall mean an Episode of Care in which the Collaborating Physician (i) met the required performance metrics for such Episode, as required in policy 12.83.3, Exhibit A, and (ii) the NPRA for the Episode is a positive number.

(jj) "Quality Performance Points" are points that CMS adds to the Hospital's composite quality score for a measure based on the performance percentile scale and for successful data submissions of patient reported outcomes.

(kk) "Reconciliation Payment" means a payment made by CMS to the Hospital as determined in accordance with Section 510.305(f) of the CJR Regulations.

(ll) "Repayment Amount" means the amount owed by the Hospital to CMS as reflected on a reconciliation report.

(mm) "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 Program.

(nn) "Target Price" shall mean the Medicare established goal cost for an Episode of Care as calculated by CMS under the provisions of Section 510.300 of the Regulations for each Performance Year.

(oo) "TKA/THA" means total knee arthroplasty/total hip arthroplasty.

(pp) "TIN" means taxpayer identification number

Policy: Covenant HealthCare, as a CMS-identified Metropolitan Statistical Area (MSA) for the Comprehensive Care for Joint Replacement Payment Model, shall be accountable for the quality and total Medicare cost of care provided to Medicare fee-for-service beneficiaries for LEJR procedures and recovery. Covenant HealthCare's Board of Directors has the legal obligation to oversee participation in the CJR model, including arrangements with Collaborators, payment of Gainsharing Payments, receipt of Alignment Payments, and the use of beneficiary incentives in the CJR model, in compliance with 42 C.F.R. §510.500, Subpart F.

Procedure:

1. Covenant HealthCare Board of Directors shall review and approve annually all CJR Program policies and procedures to ensure compliance with relevant Federal laws and regulations.

2. The Board of Directors shall annually review and approve all proposed Gainsharing Payments to Collaborators and alignment payments received from Collaborators.

3. The Board of Directors shall receive and approve an annual report relating to the implementation, operation and compliance with all relevant regulations.

4. The Board of Directors, or its Committee on Business Ethics and Compliance, shall approve all Sharing Arrangements with Collaborators. Such approval must be received before a Collaborator may begin financial participation in the Sharing Arrangement.

5. The Board of Directors shall review and approve any beneficiary incentive programs prior to implementation, and annually thereafter, as allowed under 42 C.F.R. §510.500, Subpart F.

Related Policies, Procedures, Guidelines:

- Policy 12.83.1, Comprehensive Care for Joint Replacement Program Sharing Arrangement Requirements
- Policy 12.83.2, Comprehensive Care for Joint Replacement Collaborator Payment Methodology
- Policy 12.83.3, Comprehensive Care for Joint Replacement Annual Quality Criteria
- Policy 12.83.4, Comprehensive Care for Joint Replacement Program Beneficiary Protections
- Policy 12.83.5, Comprehensive Care for Joint Replacement Program Beneficiary Incentives

Effective Date: February 2017

Review Date: February 2019

Revised: January 2018

Reviewed: January 2018

Reviewed by: Executive Team- December 2016
Committee on Business Ethics and Compliance- January 2017
Board of Directors- January 2018

Approved By:

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Lawrence H. Sims, Chairman of the Board Date

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Daniel M. George, Executive Vice President of Operations Date