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Contract terms to use when participating in the joint replacement model

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When partnering with a hospital as part of the comprehensive care for joint replacement model, clarify how care transitions will work among all participants and how information will be shared.

It's vital for agencies to carefully review any collaborator agreement and consider several risk areas, including how care transitions will work.

If you don't pay close attention to what's in the contract, you could end up with a bad deal you can't live up to and/or fare poorly financially.

Requirements for the agency and the hospital should be spelled out, understood and agreed upon, says attorney Laura Bond with Spencer Fane in Overland Park, Kan. A contract also protects the agency's relationship with the hospital.

The joint replacement model being rolled out in 67 metropolitan areas provides hospitals a bundled payment for hip and knee replacement episodes of care.

Since the episode includes the 90 days after discharge, hospitals are required to coordinate care with post-acute providers. If costs are less than a target cost for the episode of care, the hospital will be paid the difference. If costs exceed the target, the hospital must repay the difference to Medicare.

The model started April 1, and hospitals won't be penalized for exceeding the target until 2017.

While agencies not in the areas where the model is being launched don't have to deal with this now, CMS may expand the program further if it demonstrates savings for the Medicare program. In addition, private payers will likely follow CMS' lead and impose or encourage similar programs.

At this point hospitals are still beginning to put together networks with post-acute care providers and to create collaborator contracts, Bond says. So the time remains ripe for agencies to contact hospitals about getting on board.

However, while most of the savings in the joint replacement model is in post-acute care, many hospitals are new to bundled payments for joint replacement and don't have a clear understanding of either the model itself or of home health, she says. They also will have different financial, operational and quality requirements for agencies.

Complicating matters is that CMS has not provided a sample joint replacement collaborator agreement, so hospitals don't have a model from which to work, Bond says.

Address these provisions in contracts

To protect themselves, agencies should carefully review any joint replacement model collaborator agreement presented and consider these risk areas:

- **Ensure bonus and repayment amounts are appropriate if your agency is accepting risk.** Providers in the joint replacement program will continue to be paid the way they have been in the past, and agencies don't have to share risk with the hospital, Bond says. However, agencies may want to share in bonuses the hospital receives — this is called gainsharing. If so, don't be surprised if the hospital wants the agency to share in the downside risk and repayment (called alignment) if the hospital's costs exceed the target, says Kenneth Miller, chair of the practice committee of the home health section of the American Physical Therapy Association. Make sure the quality and financial goals set, the gainsharing bonus amount and the alignment repayment amount your agency is on the hook for are reasonable.

- **Make sure the number of visits provided is based not just on containing costs but also factor in patient need.** This may take some education. Some hospitals may want to skimp on post-acute care to keep down costs. However, they may not be aware that home health agencies are paid on a prospective episodic payment — and an increase of the number of visits may not mean an increase in costs, Miller notes. Assurance Healthcare, a home health agency in Tucson, Ariz., is participating in a voluntary Bundled Payment for Care Initiative. The mandatory joint replacement model is based on the voluntary bundled initiative. Susan Weber, the agency's chief nursing officer, created a spreadsheet to present to the physicians in the initiative who wanted to reduce the number of home health visits. The spreadsheet explained HHRGs. After, they jointly agreed to an average number of home health visits for each type of joint replacement with specific patient protocols. Some patients receive that number of visits; others receive more or less.

- **Determine what care management is expected of your agency.** Hospitals are required to have a care redesign plan, and post-acute providers must participate in it. The model makes hospitals responsible for an episode of care from surgery to 90 days after discharge. Hospitals must have a plan in place to move from what is currently more fragmented care to coordinated care with the providers involved. However, different hospitals will have different plans, Bond says. Make sure your agency's obligations are clear.

- **Make sure you can meet the quality criteria.** Regulations require hospitals to have policies and procedures regarding selection of collaborators, which includes quality criteria, Bond says. Make sure you know what those criteria are for both participating and for receiving a gainsharing bonus. Don't agree to something you can't deliver, she notes. For instance, the hospital may ask for overly burdensome staffing requirements.

- **Clarify how care transitions will work among participants.** This is one of the most effective ways for partners to coordinate care and work collaboratively. Weber's agency met weekly with all of the players in its bundled initiative, including the hospital, doctors, case managers and skilled nursing facilities. Doing so allowed them to set up their program, report, adjust and monitor it. They meet monthly now that it's up and running. They also share clinical and financial reports and other data throughout the episode of care.

- **Address logistics and parameters of rehospitalization determinations.** In part because of the added cost involved, hospitals won't want to unnecessarily readmit a patient during an episode. The contract should outline your agency's role in rehospitalization determinations — giving you a place at the table. For instance, one patient in Weber's agency's bundled payment initiative who was discharged home wanted to be readmitted after seeing what he believed was extensive blood when he removed bandages. He finally agreed to let an on-call nurse come to his home. The nurse discovered the blood was actually Betadine, thus avoiding a return to the hospital.

- **Make sure the contract complies with the program.** If a hospital needs to repay CMS for exceeding the target, it can't ask for more than 25% of the total repayment from one collaborator and can't ask for more than 50% from all collaborators, Bond says. The contract should state how this breaks down and how it would be policed.

- **Review termination provisions.** The joint replacement model runs until 2020, but you may not want to remain in it if it turns out it's not working for you. A contract should allow a termination for cause with a shorter timeframe and termination without cause with a longer one. Agencies should make sure they have this option. For instance, the hospital may prove difficult to work with or the model may be more work than an agency can handle.

***Related link**: View a list of the areas included within the model at http://bit.ly/1UhQsNe.*