

Comprehensive Care for Joint Replacement (CJR) Model

Provider and Technical Fact Sheet

On November 16, 2015, the Centers for Medicare & Medicaid Services (CMS) finalized regulations regarding the Comprehensive Care for Joint Replacement (CJR) Model (formerly using the acronym CCJR).

This final rule implements a new Medicare Part A and B payment model under section 1115A of the Social Security Act, called the Comprehensive Care for Joint Replacement (CJR) Model, in which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity (collectively referred to as LEJR). All related care within 90 days of hospital discharge from the LEJR procedure will be included in the episode of care. We believe this model will further our goals of improving the efficiency and quality of care for Medicare beneficiaries for these common medical procedures and will encourage hospitals, physicians, and post-acute care providers to work together to improve the coordination of care from the initial hospitalization through recovery.

The first performance period will begin on April 1, 2016.

Overall Model Design

The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. A CJR episode is defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that eventually results in a discharge paid under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities).

The episode of care continues for 90 days following discharge. Part A and Part B services related to the CJR episode are included in the episode. For each performance year of this model, CMS will set Medicare episode prices for each participant hospital that include payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital. All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. Following the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) will be compared to the Medicare episode price for the participant hospital where the beneficiary had the initial LEJR surgery. Depending on the participant hospital's quality and episode spending performance, the

hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

Major Policy changes from the Proposed Rule to the Final Rule

There are several major policy changes from the proposed rule to the final rule. The major rule changes are bulleted below.

- ***Start Date:*** In order to allow participant hospitals more time to prepare, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016, performance period start date.
- ***Site Selection:*** The CJR Model will be implemented in 67 metropolitan statistical areas (MSAs), instead of the proposed 75 MSAs, to respond to comments asking for us to incorporate the increased participation in the Bundled Payments for Care Improvement (BPCI) initiative since publication of the proposed rule and to incorporate BPCI physician group practice participation levels into our MSA selection methodology.
- ***Pricing:*** CJR hospitals will receive separate episode target prices for MS-DRGs 469 and 470, reflecting the differences in spending for episodes initiated by each MS-DRG. In response to comments, we will implement a specific pricing methodology for hip fracture patients due to the significantly higher spending associated with these more complex cases. We will use a simple risk stratification methodology to set different target prices for patients with hip fractures within each MS-DRG.
- ***Linking Quality to Payment:*** We did not finalize our proposal for performance percentile thresholds for reconciliation payment eligibility. Instead we adopted a composite quality score methodology. The composite quality score is a hospital-level summary quality score reflecting performance and improvement on the two quality measures finalized for this model (THA/TKA Complications measure (NQF #1550) and the HCAHPS patient experience Survey measure (NQF #0166)), and successful reporting of THA/TKA patient-reported outcomes and limited risk variable data. We adopted a composite quality score methodology to determine: 1) the hospital eligibility for reconciliation payments if savings are achieved beyond the target price; and 2) the amount of quality incentive payment that may be made to the hospital.
- ***Payment:*** In the proposed rule, we had proposed to apply stop-loss limits of 10 percent in performance year 2 and 20 percent in performance years 3 through 5 for participating hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals. Several commenters requested a more gradual transition to downside risk and a lower stop-loss limit to allow for hospitals to have more time to gain experience under the model. In response, we are finalizing our policy for no repayment responsibility in performance year 1, as well as a reduced discount percentage for repayment responsibility in performance years 2 and 3. We have finalized a stop-loss limit of 5 percent in performance year 2, a stop-loss limit of 10 percent in performance

year 3 and a stop-loss limit of 20 percent in performance years 4 and 5 for participating hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals. (We are finalizing the stop-loss limit for these hospitals at 3 percent in performance year 2 and 5 percent in performance years 3 through 5.) We have finalized a parallel approach for the stop-gain limits to provide proportionately similar protections to CMS and hospital participants, as well as to protect the health of beneficiaries. All hospital participants will be eligible to earn up to 5 percent of their target price in performance years 1 and 2, 10 percent in performance year 3, and 20 percent in performance years 4 and 5. We believe it is appropriate that as participant hospitals increase their downside risk, they can similarly increase their opportunity for additional payments under this model. We also believe that these changes will both facilitate participants' abilities to be successful and allow for a more gradual transition to financial responsibility under the model.

General Model Overview

Participants

The CJR model will be implemented in 67 geographic areas, defined by MSAs. MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection. Eligible MSAs must have had a at least 400 eligible (not included in the BPCI initiative) cases between July 2013 and June 2014, and no more than 50 percent of otherwise qualifying LEJR procedures occurring in a Maryland hospital, hospital participating in BPCI, or receiving post-acute care services at a skilled nursing facility (SNF) or home health agency (HHA) participating in BPCI. The originally proposed 75 participant MSAs were selected using a two-step stratified, randomization process. First, MSAs were placed into eight groups based on average wage-adjusted historic LEJR episode payment quartiles and the MSA population size divided at the median. Second, MSAs were randomly selected within each group using a selection percentage within each payment quartile (30 percent for lowest payment quartile to 45 percent for highest payment quartile). After reviewing the comments, we assessed MSA eligibility criteria using more recent information about participation in BPCI since the publication of the proposed rule and subsequently removed 8 MSAs from selection. The 67 MSAs selected can be found on our website. <https://innovation.cms.gov/initiatives/cjr>

Participant Hospitals in these selected geographic areas are all acute care hospitals paid under the inpatient prospective payment system (IPPS) that are not concurrently participating in Model 1 or Models 2 or 4 of the BPCI initiative for LEJR episodes.

As of November 12, 2015, approximately 800 hospitals are required to participate in the CJR Model. This list can be found on our website at <https://innovation.cms.gov/initiatives/cjr>.

Episode definition

The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 or 470 and ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries. The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions. The following categories of items and services are included in the episodes: physicians' services; inpatient hospital services (including hospital readmissions); inpatient psychiatric facility (IPF) services; long-term care hospital (LTCH) services; inpatient rehabilitation facility (IRF) services; skilled nursing facility (SNF) services; home health agency (HHA) services; hospital outpatient services; outpatient therapy services; clinical laboratory services; durable medical equipment (DME); Part B drugs; hospice; and some per beneficiary per month (PBPM) care management payments under models tested under section 1115A of the Social Security Act. Unrelated services are excluded from the episode. Unrelated services are for acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of LEJR surgery; and chronic conditions that are generally not affected by the LEJR procedure or post-surgical care. The complete list of exclusions can be found on our website at <https://innovation.cms.gov/initiatives/cjr>, accompanied by the list of excluded MS-DRGs and ICD-10-CM diagnosis codes.

Pricing and payment

The CJR model is a retrospective bundled payment model. CMS will provide participant hospitals with Medicare episode prices, called the target prices, prior to the start of each performance year. Target prices for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and for episodes with hip fractures vs. without hip fractures will be provided to participant hospitals. The target price generally will include a discount over expected episode spending and incorporate a blend of historical hospital-specific spending and regional spending for LEJR episodes, with the regional component of the blend increasing over time. All providers and suppliers furnishing LEJR episodes of care to beneficiaries throughout the year will be paid under existing Medicare payment systems.

Following completion of a CJR model performance year, participant hospitals that achieve LEJR actual episode spending below the target price and achieve a minimum composite quality score will be eligible to earn a reconciliation payment from Medicare for the difference between the target price and actual episode spending, up to a specified cap. We are finalizing the proposed policy for no repayment responsibility in performance year 1 of the model, as well as a reduced discount percentage for repayment responsibility in performance years 2 and 3, in order to phase in financial responsibility for spending during CJR episodes throughout the model performance years. We are also finalizing parallel stop-loss and stop-gain limits that provide additional financial protections for hospitals.

All hospital participants that achieve LEJR actual spending below the target price and achieve a minimum composite quality score will be eligible to earn up to 5 percent of their target price in performance years 1 and 2, 10 percent in performance year 3, and 20 percent in performance years 4 and 5. Hospitals with LEJR episode spending that exceeds the target price will be financially responsible for the difference to Medicare up to a specified repayment limit. We have finalized a stop-loss limit of 5 percent in performance year 2, a stop-loss limit of 10 percent in performance year 3 and a stop-loss limit of 20 percent in performance years 4 and 5 for participant hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals. (We are finalizing the stop-loss limit for these hospitals at 3 percent in performance year 2 and 5 percent in performance years 3 through 5.) We have finalized a parallel approach for the stop-gain limits to provide proportionately similar protections to CMS and hospital participants, as well as to protect the health of beneficiaries. We believe it is appropriate that as participant hospitals increase their financial responsibility, they can similarly increase their opportunity for additional payments under this model. We also believe that these changes will both facilitate participants' ability to be successful under this model and allow for a more gradual transition to financial responsibility under the model.

Additional flexibilities for participant hospitals and collaborating providers and suppliers

The model waives certain existing payment system requirements to assist participant hospitals in caring for beneficiaries in the most efficient, convenient setting, to encourage timely, accessible care, and to facilitate improved communication and treatment adherence. These include: a waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered SNF stay under certain conditions; allowing payment for certain physician visits to a beneficiary in his or her home via telehealth; and allowing payment for certain types of physician-directed home visits for non-homebound beneficiaries. In addition, a participant hospital may wish to enter into certain financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain incentives to advance the clinical goals of their care, under certain conditions.

No waivers of any fraud and abuse authorities are being issued in the final rule. However, CMS and HHS Office of the Inspector General (OIG) will jointly issue waivers of certain fraud and abuse laws for purposes of testing this model. The notice will be published on the CMS and OIG websites.

Quality and the Pay-for-Performance Methodology

The CJR model has the potential to improve quality in four ways. First, the model adopts a quality first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price. Second, higher episode quality, considering both performance and improvement, may lead a hospital to receive quality incentive payments based on the hospital's composite quality score, a summary score reflecting hospital performance and improvement on the following two measures:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF#1550); and
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF#0166).

The composite quality score also takes into consideration a hospital's submission of THA/TKA patient-reported outcomes and limited risk variable voluntary data.

Third, in addition to quality performance requirements, the model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments.

Fourth, CMS provides additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals with relevant spending and utilization data; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of care; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

More information on quality in the pay-for-performance methodology can be found on our website at <https://innovation.cms.gov/initiatives/cjr> .

Beneficiary benefits and protections

Beneficiaries retain their freedom of choice to choose services and providers. Physicians and hospitals are expected to continue to meet current standards required by the Medicare program. All existing safeguards to protect beneficiaries and patients remain in place. If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800- MEDICARE or contact their state's Quality Improvement Organization by going to <http://www.qioprogram.org/contact-zones>. The rule also describes additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services.

Participants in the CJR model

Except for those participating in Model 1 or Models 2 or 4 of the BPCI initiative for LEJR episodes during the time of their involvement, hospitals paid under the IPPS and located in MSAs selected for participation are required to participate in the CJR model. Hospitals outside these geographic areas are not able to participate. There is no application process for this model.

Interaction with other models and programs

Hospitals participating in other CMS models or programs such as the Shared Savings Program and other ACO initiatives are included in the CJR model if they are located in a selected MSA. Beneficiaries included in an LEJR episode under the CJR model may also be assigned or aligned to an ACO. We are finalizing policies to account for overlap and attribution of savings in such scenarios.

Innovation Center

The CJR model has been designed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models to reduce CMS program expenditures and improve quality for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.

The CJR model final rule can be viewed at <https://www.federalregister.gov> starting November 12, 2015.

For **more information** about the CJR model, go to <https://innovation.cms.gov/initiatives/cjr>

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