Comprehensive Care for Joint Replacement (CJR) Final Rule Summary

On November 16, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Comprehensive Care for Joint Replacement (CJR, formerly known as CCJR) payment model. Under CJR, participation will be mandatory for 791 hospitals in 67 geographic areas. These hospitals will be held accountable for the quality and total Medicare cost of care provided to Medicare fee-for-service beneficiaries for lower extremity joint replacement (LEJR) procedures and recovery, including all hip and knee replacement surgeries — some of the most common inpatient surgeries for Medicare beneficiaries. The hospitals will be held accountable for CMS defined episode target prices for all Medicare FFS Part A and B costs of care during the hospital stay as well as Medicare costs for 90 days post hospital discharge including all SNF care (e.g., the episode of care). The CJR payment model will be codified at 42 CFR Part 510.

This document serves as a high-level summary of the CJR final rule. Over the coming months, AHCA will be developing a range of resources and tools to help members understand the new rule and learn how to succeed under the CJR program. Components of this summary will be expanded into more comprehensive analyses, and these products will be packaged into a member toolkit that will be housed on the AHCA/NCAL website. AHCA members should feel free to contact James Michel with any questions.

I. Model Overview

Clinical Conditions

LEJR procedures are currently paid under the inpatient prospective payment system (IPPS) through one of two Medicare Severity-Diagnosis Related Groups (MS-DRGs): MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC).

Episode Parameters

Under the CJR model, episodes will begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the hospital inpatient prospective payment system (IPPS) and will end 90 days after the date of discharge from the acute care hospital. The episode will include the LEJR procedure and related hospital costs, the inpatient stay, as well as all related care covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care (PAC) (including the skilled nursing facility (SNF) stay), outpatient care including physical and occupational therapy visits billed under Part B during a person’s stay in a nursing center, related readmissions, and physician services.
Thus, while hospitals will establish desired parameters for post-discharge Medicare costs, CMS only will set episode target prices for the two included MS-DGRs inclusive of all hospital costs as well as Medicare costs 90 days post discharge. CMS does not define parameters for Medicare costs for an portion of the total episode price (i.e., inpatient services, PAC, etc.).

**Episode Exclusions**

CMS does identify a number of excluded services that, if delivered to a CJR patient during the 90 day window following hospital discharge, which will *not* be incorporated into the episode target price or be counted toward the episode spending. The full exclusions list can be accessed by clicking here.

**Timing**

The CJR final rule officially goes into effect on January 15, 2016, but the program will begin for providers on April 1, 2016. This start date reflects a four-month delay from the originally proposed start date of January 1, allowing providers additional time to prepare. The program will run for five performance years (PY), ending on December 31, 2020. Only PY 1 is truncated (April 1 to December 31, 2016). PYs 2-5 will follow the calendar year.

II. **Model Scope**

**Participation**

CMS has identified 67 Metropolitan Statistical Areas (MSAs) in which they will test this model. Unlike other payment reform demonstrations CJR is mandatory. CMS will require all hospitals paid under the IPPS in the selected geographic areas to participate in the CJR model, with limited exceptions. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

Originally CMS proposed to test the model in 75 MSAs, but eliminated eight MSAs from the list in the final rule. A final list of impacted MSAs can be found [here](#). The eight eliminated MSAs were:

- 17820 - Colorado Springs, CO
- 21780 - Evansville, IN-KY
- 22660 - Fort Collins, CO
- 29820 - Las Vegas-Henderson-Paradise, NV
- 32780 - Medford, OR
- 40060 - Richmond, VA
- 40420 - Rockford, IL
- 47260 - Virginia Beach-Norfolk-Newport News, VA-NC

Participating hospitals in the 67 MSAs will change throughout the demonstration due to an array of market factors including participation in CMS’s Bundled Payments for Care Improvement (BPCI) program, hospital acquisitions and opening, and closure of hospitals. For a complete list of hospitals by MSA, as well as for updates to the list, please click [here](#). MSA are listed at the bottom of the page and updated lists of participating hospitals are available within the interactive MSA list.
III. Payment

Target Pricing

Every year during the approximate five performance years of this model, CJR hospitals will receive separate episode target prices for MS-DRGs 469 and 470, reflecting the differences in spending for the 90 day episodes initiated by each MS-DRG. CMS will also use a simple risk stratification methodology to set different target costs of care for patients with hip fractures within each MS-DRG.

Episode target costs of care will be established based initially on a mix of both hospital-specific and regional historic spending eventually transitioning to only regional. In early PYs 90 day target costs of care will be established based primarily on hospital-specific historic spending during the 90 day episode, but in later PYs90 day target costs of care will be established based solely on regional historic spending. Regions are defined using the nine US Census Division region definitions. CMS will use the most recent three years of available claims data for establishing the baseline period for each performance year to calculate the historical benchmark against which actual spending will be compared. Historical benchmarks will be rebased every two years. Table 1 summarizes target cost of care setting and historical benchmarking methodologies.

Table 1: Summary of Historical Benchmarking Methodology

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital-specific</th>
<th>Regional</th>
<th>Baseline Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY 1 (Apr-Dec 2016)</td>
<td>2/3</td>
<td>1/3</td>
<td>2012-2014</td>
</tr>
<tr>
<td>PY 2 (CY 2017)</td>
<td>2/3</td>
<td>1/3</td>
<td>2012-2014</td>
</tr>
<tr>
<td>PY 3 (CY 2018)</td>
<td>1/3</td>
<td>2/3</td>
<td>2014-2016</td>
</tr>
<tr>
<td>PY 4 (CY 2019)</td>
<td>0/3</td>
<td>3/3</td>
<td>2014-2016</td>
</tr>
<tr>
<td>PY 5 (CY 2020)</td>
<td>0/3</td>
<td>3/3</td>
<td>2016-2018</td>
</tr>
</tbody>
</table>

Discount Rate

Under CJR, CMS will apply an automatic discount to the episode target cost of care. The discount percentage will vary from anywhere in between 1.5 and 3 percent, based upon the CJR hospital’s quality composite score (see Section V below).

Payments to Providers

All providers (including SNFs) and suppliers will continue to be paid under the usual fee-for-service payment system rates, rules and procedures of the Medicare program for episode services throughout the year. However, after the completion of a performance year, the Medicare claims payments for services furnished to the beneficiary during the episode, based on claims data, will be combined to calculate an actual episode payment.
Reconciliation Payments

The actual episode payment is defined as the sum of related Medicare claims payments for items and services furnished to a beneficiary during a CJR episode. The actual episode payment will then be reconciled against an established CJR target price that is stratified based on the beneficiary’s fracture status, with consideration of additional payment adjustments based on quality performance, post-episode spending, and policies to limit hospital financial responsibility. The amount of this calculation, if positive, will be paid to the participant hospital (“reconciliation payment”). If negative, CMS will require the hospital to pay back some or all of the difference.

Transition to Downside Risk

CMS will make reconciliation payments to participant hospitals that achieve quality outcomes and cost efficiencies relative to the established CJR target prices in all performance years of the model. CMS will also phase in the requirement that participant hospitals whose actual episode payments exceed the applicable CJR target price pay the difference back to Medicare, beginning in PY 2. Under this final rule, Medicare will not require repayment from hospitals for PY 1 for actual episode payments that exceed their target price in PY 1.

Stop-Loss and Stop-Gain Policies

CMS will limit how much a hospital can gain (in reconciliation payments from Medicare) or lose (in repayments back to Medicare) based on its actual episode payments relative to the target prices. These are termed stop-gain and stop-loss limits, respectively. Both stop-gain and stop-loss limits gradually increase over the course of the CJR program. Table 2 illustrates the gradual increase in limit percentages, and included below are two examples to illustrate how the stop-gain and stop-loss policies will function in CJR.

Table 2: Stop-Loss/Stop-Gain Policies

<table>
<thead>
<tr>
<th>Year</th>
<th>Stop-Gain Limit</th>
<th>Stop-Loss Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY 1 (Apr-Dec 2016)</td>
<td>5%</td>
<td>N/A</td>
</tr>
<tr>
<td>PY 2 (CY 2017)</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>PY 3 (CY 2018)</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>PY 4 (CY 2019)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>PY 5 (CY 2020)</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Example 1: A hospital treats 10 LEJR episodes in PY 1 with a target price of $10,000 each, for a total of $100,000. Actual spending across all 10 episodes was only $85,000, leaving a difference of $15,000. The stop-gain limit in PY 1 is 5%, so the hospital would receive a $5,000 reconciliation payment.

Example 2: A hospital treats 10 LEJR episodes in PY 3 with a target price of $10,000 each, for a total of $100,000. Actual spending across all 10 episodes was $120,000, leaving an overage of $20,000. The stop-loss limit in PY 3 is 10%, so the hospital would be required to pay back Medicare a total of $10,000.
IV. Interaction with Other Programs

**BPCI Precedence Rules**

CMS will exclude some hospitals in the 67 MSAs from participation in CJR for hospitals participating in the risk-bearing phase of the Bundled Payments for Care Improvement (BPCI) demonstration Models 2 and 4 for LEJR episodes, as well as acute care hospitals participating in BPCI Model 1. CMS will also exclude certain patients from CJR if they trigger a BPCI episode under any model currently being tested under that demonstration. If a skilled nursing facility is currently participating in BPCI Model 3, and has elected to test the LEJR episode(s), their BPCI episodes would take precedence and be excluded from CJR. CMS is not excluding beneficiaries in CJR model episodes from being included in other Innovation Center models or CMS programs, such as the Medicare Shared Savings Program (MSSP).

**Other Overlap**

In regard to Accountable Care Organizations (ACOs) and other alternative payment models or delivery systems, CMS intends to account for CJR overlap, that is, where CJR beneficiaries are also included in other models and programs, to ensure the financial policies of CJR are maintained and results and spending reductions are attributed to the correct model or program.

V. Quality Measures and Reporting Requirements

**Quality Program Overview**

CMS is adopting three hospital-level quality of care measures for the CJR model: a complications measure, a patient satisfaction survey measure, and self-reported patient-reported outcome (PRO) measure that focuses on pain management. CMS will then create a composite score for each hospital based on (1) performance in both the complications measure and the patient satisfaction measure, as well as (2) the submission of PRO data to CMS. A hospital’s composite score will determine whether or not they are eligible to receive reconciliation payments from CMS.

**Measure Definitions**

1. THA/TKA Complication Rate (NQF #1550): Hospital level risk-standardized complication rate (RSCR) following elective primary THA and/or TKA.
2. HCAHPS Survey (NQF #0166): Hospital Consumer Assessment of Healthcare Provider and Systems Survey.
3. THA/TKA Patient-Reported Outcomes (PRO) with focus on pain management and Limited set of information about the patient termed Risk Variable Data: Submitting the PRO and list of pre- and post-operative data elements for 50% or 50 total eligible patients; data will be used to develop PRO measures.
CMS originally proposed including a 30-day all-cause readmission measure in the CJR quality program, but ultimately dropped the measure in the final rule. CMS plans to post CJR hospitals’ quality performance scores on their Hospital Compare website.

**Composite Score Methodology**

CMS will assign each CJR acute care hospital a quality composite score based on the three quality measures and how the hospital ranks on the program’s quality measures relative to other CJR hospitals in the program. The quality composite score will be on a scale from 0-20, with each measure having a different weight contribution to the overall score. The measures are weighted into the composite score as follows:

- THA/TKA Complications (NQF #1550): 50%
- HCAHPS Survey (NQF #0166): 40%
- PRO Data (Reporting Only): 10%

The composite quality score is based out of 20 total points. Each hospital earns points determined by CJR hospitals’ relative performance within the quality measures. Where a hospital ranks relative to other CJR hospitals (e.g., percentile) will determine how many points are achieved by each hospital for each quality measure. Table 3 below outlines the points for each quality measure based on a hospital’s ranking.

<table>
<thead>
<tr>
<th>Percentile Rank</th>
<th>Points for THA/TKA Complications</th>
<th>Points for HCAHPS Survey</th>
<th>Points for submitting PRO Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;90th</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>&gt;80th and &lt;90th</td>
<td>9.25</td>
<td>7.4</td>
<td>“</td>
</tr>
<tr>
<td>&gt;70th and &lt;80th</td>
<td>8.5</td>
<td>6.8</td>
<td>“</td>
</tr>
<tr>
<td>&gt;60th and &lt;70th</td>
<td>7.75</td>
<td>6.2</td>
<td>“</td>
</tr>
<tr>
<td>&gt;50th and &lt;60th</td>
<td>7</td>
<td>5.6</td>
<td>“</td>
</tr>
<tr>
<td>&gt;40th and &lt;50th</td>
<td>6.25</td>
<td>5</td>
<td>“</td>
</tr>
<tr>
<td>&gt;30th and &lt;40th</td>
<td>5.5</td>
<td>4.4</td>
<td>“</td>
</tr>
<tr>
<td>&lt;30th</td>
<td>0</td>
<td>0</td>
<td>“</td>
</tr>
</tbody>
</table>

**Additional Points for Improvement**

Hospitals may receive an additional 1 point for improvement on the THA/TKA Complications measure and an additional 0.8 points for improvement on the HCAHPS Survey measure even if their ranking is low.

**Converting Composite Score to Payment and Repayment**

A CJR hospital’s quality composite score will impact their payment in two ways. First, if the overall composite score is “below acceptable,” the hospital will be ineligible to receive reconciliation payments regardless of their performance on the cost measures. Second, the
composite score will determine the “effective discount percent” for both reconciliation payments (in PYs 1-5) and repayments (PYs 2-5 only). If a hospital performs very well on the quality composite score, their effective discount percent to the episode target price will be reduced to 1.5%. Conversely, if a hospital does poorly on the quality composite score, the effective discount percent will be increased to 3%. This interaction creates an added financial incentive for hospitals to focus on quality performance and improvement. Table 4 below summarizes the interactions between the quality composite score and payment.

Table 4: Interaction between Quality Composite Score and Payment

<table>
<thead>
<tr>
<th>Quality Composite Score Range out of 20</th>
<th>Quality Category</th>
<th>Eligible for Reconciliation Payment</th>
<th>Effective Discount % for Reconciliation Payment</th>
<th>Effective Discount % for Repayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;13.2</td>
<td>Excellent</td>
<td>Yes</td>
<td>1.5%</td>
<td>PY1: N/A*  PY2-3: 0.5%  PY4-5: 1.5%</td>
</tr>
<tr>
<td>&gt;6 and &lt;13.2</td>
<td>Good</td>
<td>Yes</td>
<td>2%</td>
<td>PY1: N/A  PY2-3: 1%  PY4-5: 2%</td>
</tr>
<tr>
<td>&gt;4 and &lt;6</td>
<td>Acceptable</td>
<td>Yes</td>
<td>3%</td>
<td>PY1: N/A  PY2-3: 2%  PY4-5: 3%</td>
</tr>
<tr>
<td>&lt;4</td>
<td>Below Acceptable</td>
<td>No</td>
<td>3%</td>
<td>PY1: N/A  PY2-3: 2%  PY4-5: 3%</td>
</tr>
</tbody>
</table>

*Providers bear no downside risk in PY 1.*

VI. Hospital Discharge Planning & Beneficiary Freedom of Choice

Eligible beneficiaries who receive services from a participant hospital for the two included procedures will not have the option to opt out of inclusion in the model. However, under the CJR model, beneficiaries retain the right to obtain health services from any individual or organization qualified to participate in the Medicare program CMS requires participant hospitals to supply beneficiaries with written information regarding the design and implications of this model as well as their rights under Medicare, including their right to use their provider of choice.

CMS will require hospitals to present certain information to beneficiaries upon discharge related to PAC provider quality, to help inform the patient and engage them in the decision-making process. While little detail is provided in this final rule regarding specific activities and behaviors, CMS indicated that they will promulgate subregulatory guidance in the coming months detailing more specific information.
VII. Financial Arrangements

As stated above, CMS will hold only acute care hospitals financially responsible for CJR LEJR episodes as participants in the model. While only hospitals are directly subject to the requirements of this final rule for the CJR model, they may elect to share risk with other entities, including skilled nursing facilities, up to a limit.

Collaborators

CMS will allow CJR hospitals to execute risk-sharing agreements with other direct care providers and suppliers. Providers who partner with hospitals in risk-sharing arrangements under CJR will be termed “Collaborators.” CJR Collaborators may be:

- Physicians or non-physician practitioners
- Physician group practices
- Inpatient rehab facilities
- Long-term care hospitals
- Skilled nursing facilities
- Home health agencies
- Provider/supplier of outpatient therapy services

CMS has placed a number of restrictions and requirements that hospitals must follow in order to execute risk-sharing agreements with Collaborators. Hospitals must establish Participation Agreements with each Collaborator with whom it wishes to gainshare. CMS also requires CJR hospitals to establish quality criteria that potential Collaborators must meet in order to qualify for gainsharing payments from the hospital.

CMS explicitly does not allow a CJR hospital to partner with a non-provider, third-party entity (such as a care management organization or a convener) where the financial relationship between the hospital and the entity is dependent on financial performance within the CJR program. Hospitals may continue to partner with these entities so long as the financial arrangement is not directly tied to their performance under CJR.

Sharing Limits

CMS places a limit on how much financial risk a CJR hospital is allowed to share with Collaborators. A CJR hospital must retain at least 50 percent of its total risk, meaning that if the hospital owes CMS a repayment, it cannot share more than 50 percent of that repayment responsibility with Collaborators. Additionally, it cannot share more than 25 percent of its responsibility with any single CJR Collaborator.
VIII. Program Policy Waivers

CMS finalized a number of Medicare policy waivers in the CJR program.

- **Telehealth Waiver**
  CMS will waive the geographic site requirement and the originating site requirement for telehealth services for patients who fall under CJR. CMS will allow telehealth services to be provided in a CJR beneficiary’s home or residence, and providers will be able to bill for in-home visits under one of 9 new G-codes.

- **Post-Discharge Home Visit Waiver**
  CMS will waive the supervision requirement so that clinical staff may provide home visits under general supervision to CJR patients. Providers will be able to bill for these visits under one of 9 new G-codes.

- **SNF 3-Day Qualifying Stay Waiver**
  CMS waives the SNF 3-day rule for a CJR beneficiary following the anchor hospitalization only if the SNF meets certain qualification criteria at the time of the beneficiary’s SNF admission. CMS defines a qualified SNF as one that has an **overall rating of three stars or better** in the Five-Star Quality Rating System for SNFs on the Nursing Home Compare Web site for at least 7 of the 12 preceding months, as determined by CMS based on the most recent rolling 12 months of SNF star rating data available for the calendar quarter that includes the date of the beneficiary’s admission to the SNF. CMS will post the list of qualified SNFs quarterly to the CMS website. If a SNF is on this list, the other requirements for the waiver as listed previously are met, and other existing Medicare coverage requirements are met, the SNF stay for the CJR beneficiary will be covered under Part A under the CJR model SNF 3-day rule waiver.

IX. Additional Resources

- CJR Final Rule in the Federal Register:  

- CMS’ Comprehensive Care for Joint Replacement Resource Page:  
  [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)

- CMS’ Technical Fact Sheet on CJR:  

- CMS’ FAQ on CJR:  
  [https://innovation.cms.gov/Files/x/cjr-faq.pdf](https://innovation.cms.gov/Files/x/cjr-faq.pdf)

- AHCA/NCAL Webinar Presentation on CJR:  