Comprehensive Care for Joint Replacement (CJR) Model

The Advancing Care Coordination through Episode Payment Models final rule makes several modest adjustments to the Comprehensive Care for Joint Replacement (CJR) model to clarify, simplify, and streamline existing requirements. These include refinements for use of the Skilled Nursing Facility (SNF) waiver, exclusion of beneficiaries assigned to selected Accountable Care Organizations (ACOs), and revisions to the target pricing calculations to include reconciliation and repayment amounts for performance years 3, 4, and 5. The Centers for Medicare & Medicaid Services (CMS) is finalizing the proposed revisions to the quality adjustment methodology to incorporate improvement as well as absolute performance in model payment calculations. CMS is also finalizing giving clinicians additional opportunities to qualify for a 5 percent incentive payment through the Advanced Alternative Payment Model (APM) path under the new Quality Payment Program (QPP). Clinicians may have these additional opportunities beginning in the 2017 performance year if they collaborate with participant hospitals that choose the Advanced APM track of CJR. Lastly, CMS is finalizing changes to align CJR with the new Episode Payment Models around financial arrangements and beneficiary engagement incentives, compliance enforcement, appeals processes, and beneficiary notifications. Some changes will become effective on July 1, 2017 to give participant hospitals ample time to come into compliance with these changes and also to align with the start of the EPMs.

Overall Model Design

The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care. This final rule expands the financial arrangement provisions of the CJR model to include hospitals, critical access hospitals, non-physician practitioner group practices and Accountable Care Organizations among the physicians and providers and suppliers of care that can have financial arrangements with participant hospitals to incentivize increased coordination of care across the episodes. 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. Most Part A and Part B services related to the CJR episode are included in the episode. For each performance year of this model, CMS has established 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.

General Model Overview

**Participants**

The CJR model is operating in 67 geographic areas, defined by metropolitan statistical areas (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 at least 400 eligible (not included in the Bunded Payments for Care Improvement (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 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 Models 1, 2, or 4 of the BPCI initiative for LEJR episodes.

Approximately 800 hospitals 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 largely includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with 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 episode payment model. CMS provides participant hospitals with Medicare episode prices, called the quality-adjusted target prices, prior to the start of each
performance year. Quality-adjusted target prices for episodes anchored by MS-DRG 469 or MS-DRG 470 and for episodes with hip fractures vs. without hip fractures will be provided to participant hospitals. The quality-adjusted target price generally includes a discount over expected episode spending and incorporates 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 are paid under existing Medicare payment systems.

Following completion of a CJR model performance year, participant hospitals that achieve LEJR actual episode spending below the aggregated quality-adjusted target price and achieve a minimum composite quality score are eligible to earn a reconciliation payment from Medicare for the difference between the aggregated quality-adjusted target price and actual episode spending, up to a specified cap. There is 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. Parallel stop-loss and stop-gain limits exist to provide additional financial protections for hospitals.

All hospital participants that achieve LEJR actual spending below the aggregated quality-adjusted target price and achieve a minimum composite quality score are eligible to earn up to 5 percent of their aggregated quality-adjusted 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 aggregated quality-adjusted target price are financially responsible for the difference to Medicare up to a specified repayment limit. There is 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. (For these hospitals, stop-loss limits are set at 3 percent in performance year 2 and 5 percent in performance years 3 through 5.) Stop-gain limits that parallel the stop-loss limits are also set in order 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.

Waivers of Medicare Payment Policy, Financial Arrangements, and Beneficiary Incentives

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 Medicare-enrolled individual or entities 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. Starting July 1, 2017, participant hospitals may also enter into certain financial arrangements with Hospitals, Critical Access Hospitals, Non-Physician Provider Group Practices, and ACOs, as these terms are defined in the rule.

Also, 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 were issued in the current CJR model regulations. CMS and HHS Office of the Inspector General (OIG) jointly issued waivers of certain fraud and abuse laws for purposes of testing this model. The notice is published on the CMS and OIG websites. CMS and OIG also plan to jointly issue waivers for purposes of testing this model as revised.

**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 either receive a higher reconciliation payment or have less repayment responsibility at reconciliation 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

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](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 his or her state’s Quality Improvement Organization by going to [http://www.qioprogram.org/contact-zones](http://www.qioprogram.org/contact-zones). Additional monitoring of claims data from participant hospitals exists to ensure that hospitals continue to provide all necessary services.

**Participants in the CJR model**

Except for those participating in Models 1, 2, or 4 of the BPCI initiative for LEJR episodes during the time of their involvement, most 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. For episodes beginning prior to July 1, 2017, beneficiaries included in an LEJR episode under the CJR model may also be assigned or aligned to an ACO. Policies exist to account for overlap and attribution of savings in such scenarios. For episodes beginning on or after July 1, 2017, however, a CJR episode will not be initiated for beneficiaries who are prospectively aligned with 1) a Next Generation ACO, 2) an ESRD Seamless Care Organization (ESCO), or 3) a Medicare Shared Savings Program ACO participating in Track 3.

**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 program expenditures and preserve or enhance the quality of care for Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries. The Innovation Center’s mission is to take locally-driven approaches – approaches from doctors and other health care partners providing care to patients every day – and give them platform to scale through a collaborative and highly transparent process.

For more information on the adjustments to the CJR model in the Advancing Care Coordination through Episode Payment Models final rule, please go to: [https://www.federalregister.gov/public-inspection/current](https://www.federalregister.gov/public-inspection/current)

For more information about the CJR model, go to [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)

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