CJR Model: Three-Year Extension and Changes to Episode Definition and Pricing Webinar[i]

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Carrie Kolleck: Good afternoon and welcome to the Comprehensive Care for Joint Replacement Model, Three Year Extension and Changes to Episode Definition and Pricing. For today's agenda we'll go over some quick meeting logistics, will have a presentation on the recently published Final Rule, followed by time for questions and answers. Finally, we'll wrap up with some announcements and reminders. Throughout the presentation, you may want to enlarge the slides to full screen, and to do that, just click on the rectangle in the upper right-hand corner just above the slides. When you're ready to return to the original view, just click on that rectangle again and you'll be back in that original view.

We do have some resources available for you to download in the event resources pod. If you want to download just a single file, select that file and click on the downward facing arrow and that will open up a pop-up window and that will allow you to save the document to your computer. You can also download all of the files by clicking on the three dots and selecting “Download All”.

Now let's transition into a recorded presentation on the Three Year Extension and Changes to Episode Definition and Pricing. Before we play the recording, we wanted to share that this presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference. This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulation. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their content. With that, let's go ahead and play the recording.

Laura Maynard: Thank you. The Final Rule was published on May 3rd, 2021, and the link to the Federal Register where the rule may be found is on this slide, slide seven. This rule finalized several changes to the CJR model. Most notably, it finalized the extension of the CJR model for an additional three performance years, performance year six in 2021, through performance year eight in 2024.

The rule also finalizes changes to the definition of a CJR episode to include outpatient knee and hip replacements. CMS is finalizing this episode definition change in order to address changes to the inpatient only list that now allow for total knee and total hip replacements to be treated in the outpatient setting. Additionally, the rule finalizes changes to the CJR target price calculation. Specifically, CMS has finalized changing the basis for the target price from three years of claims data to the most recent one year of claims data, to remove the national update factor and twice yearly update to the target prices that accounts for prospective payment system and fee schedule updates, to remove anchor factors and weight, to incorporate additional risk assessment to the target pricing, and to change the high episode spending cap calculation methodology.

Additionally, CMS has finalized several changes to the CJR reconciliation process. Specifically, the Final Rule has finalized moving from two reconciliation periods conducted two and 14 months after the close of each performance year to one reconciliation period that would be conducted six months after the close of each performance year. Also, the rule finalizes adding an additional episode level risk adjustment beyond fracture status, such that target prices will be further adjusted at the episode level based on the individual beneficiary’s, age and hierarchical condition category count.

CMS is also finalizing a change to the high episode spending cap calculation methodology used at reconciliation to add a retrospective trend adjustment factor that will better capture changes in Medicare program payment updates and care delivery patterns, and to change the quality discount factors applicable at reconciliation to participants with excellent and good quality scores to better recognize high quality care. The Final Rule finalized changes to beneficiary notification, gainsharing caps, appeals process and waiver sections to align with the finalized model extension as well as the finalized modifications to episode definition.

The CJR model is a CMS Center for Medicare and Medicaid Innovation Model that aims to reduce Medicare expenditures while preserving or enhancing quality of care for Medicare beneficiaries. The model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. Under the CJR model, these participant hospitals receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity, and these are collectively referred to as LEJR.

Originally, a CJR episode began with an inpatient admission for 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 includes, with limited exceptions, all care for 90 days following discharge.

Originally established to run for five performance years, the CJR model was designed to further CMS goals of improving the efficiency and quality of care for Medicare beneficiaries, and to encourage hospitals, physicians and post-acute care providers to work together to improve coordination of care from the initial hospitalization through recovery.

Additional information and background materials regarding the CJR model are available at the web link https\innovation.cms.gov\initiatives\cjr. This link is available in the web links pod on your screen.

In the November 2015 Final Rule, participant hospitals were located in 67 selected Metropolitan Statistical Areas or MSAs with limited exceptions. The MSAs were randomly selected from 294 eligible MSAs and presented in the Final Rule. In the December 2017 Final Rule, rural and low income hospitals selected for participation in the CJR model, as well as those hospitals in 33 of the 67 MSAs were given a one-time option to choose whether to continue their participation in the model through December 31st, 2020. The remaining 34 MSAs were required to continue participating in the model. This Final Rule will apply only to those participant hospitals with a CMS certification number, CCN, and primary address in the 34 mandatory MSAs.

The model changes and extension will exclude participant hospitals in those mandatory MSAs that are low volume hospitals, or that have received a notification from CMS, dated prior to July 4th, 2021 that they have been designated as rural hospitals, each as defined in 42 CFR510.2, and that voluntarily elected to participate in the CJR model for performance years three through five.

A list of CJR participant hospitals that will no longer be participating in the model for performance years six through eight has been posted on the CJR web page, which also is listed in the web links pod on your screen.

Currently, CJR model episodes are initiated by an inpatient MS-DRG 469 or 470 discharge of an eligible Medicare beneficiary from a CJR participant hospital. The May 2021 Final Rule finalizes changing this episode definition in order to address the removal of Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty (THA) from the inpatient only list, which allows these procedures to be reimbursed by Medicare when performed in the outpatient setting.

CMS is finalizing that TKA and THA procedures performed in the outpatient setting will trigger a CJR episode. Outpatient TKA episodes will be reconciled against the MS-DRG 470 target price while outpatient THA episodes will be reconciled against either the MS-DRG 470 target price or, if there is a primary hip fracture, the MS-DRG 522 target price. Now we'll be covering payment and pricing and financial arrangements.

Alicia Goroski: Thank you. While there are a number of changes to the CJR payment and pricing methodology in the May 2021 Final Rule, the general concept remains the same. Participant hospitals are provided with prospective episode target prices based on historical episode spending. Those hospitals have the opportunity to achieve a reconciliation payment if their performance year spending is below the applicable target price, or they may owe a repayment if their spending is above the applicable target price.

New payment methodology provisions in the Final Rule related to target pricing are listed here on slide 13. Specifically, instead of using three years of historical data to calculate target prices, we will use the most recently available one year of historical data. Therefore, we will base performance year six target prices on episode baseline data from 2019, performance year seven target prices on episode baseline data from 2021 and performance year eight target prices on episode baseline data from 2022.

We believe that using only the most recently available one year of baseline data will provide the best available picture of spending patterns we would expect to see during the performance period, which will allow us to calculate more accurate target prices. Since we will continue using 100% regional pricing data to calculate target prices and not use hospital specific data, we removed the use of anchor factors and weights in the target price calculation.

In the May 2021 Final Rule, we finalized a number of changes to the reconciliation process as well. First, in an effort to recognize the greater needs of certain beneficiaries that are beyond a participant hospitals' control, we will incorporate episode-specific risk adjustment factors for performance years six through eight. Specifically, we will adjust target prices at reconciliation using three patient level risk factors: the age of a beneficiary, the CJR HCC count (or the number of CMS hierarchical condition categories of a beneficiary) and the dual eligibility status of a beneficiary. We will incorporate these risk adjustment factors in combination with the existing factors related to the presence or absence of a hip fracture.

Next, we will replace the current CJR methodology of twice yearly updates for fee schedule changes with a retrospective market trend factor adjustment during reconciliation. We anticipate the market trend factor will ensure that target prices better capture spending trends and changes. Lastly, we will no longer conduct a second CJR reconciliation 14 months after the end of each performance year. Instead, we will conduct one CJR reconciliation six months after the end of a performance year. This change is intended to reduce the administrative burden of an additional reconciliation for Medicare and CJR participant hospital.

The composite quality score determines whether a participant is eligible for a reconciliation payment (if savings are achieved beyond the quality adjusted target price), and what effective discount percentage is applied to the CJR episode benchmark price for reconciliation payment. A participant hospital's quality performance determines their rating for each performance year of unacceptable, acceptable, good or excellent.

Currently, participants with unacceptable quality are not eligible for reconciliation payments and have an effective discount percentage of 3%. The Final Rule does not change this. Currently, those hospitals with acceptable, good or excellent quality are eligible for reconciliation payments and have an effective discount percentage of 3%, 2%, or 1.5% respectively. The May 2021 Final Rule moves to a 0% quality withhold for participants with excellent quality scores, and a 1.5% withhold for good quality scores. CJR participant hospitals with a higher level of quality performance will generally experience a lower effective discount percentage at reconciliation, resulting in greater financial opportunity for the CJR participants.

The last change to the payment methodology relates to our strategy to limit the impact of extremely high cost episodes. The high episode spending cap policy is designed to prevent participant hospitals from being held responsible for catastrophic episode spending amounts that they could not reasonably have been expected to prevent by capping the cost for those episodes.

We currently apply a cap at two standard deviations above the regional mean, also known as the "High Episode Payment Ceiling" when calculating initial CJR target prices and when comparing actual CJR episode payments to CJR episode benchmark and quality adjusted target prices at reconciliation. The Final Rule sets the cap at the 99th percentile of arrayed actual costs for each episode type for each region. We anticipate this approach to capping high cost episodes will more accurately apply to true outlier episode costs than the previous method.

As a result of COVID-19, and the shift in start and end dates to performance years six through eight, we made changes in the Final Rule to the data used for target price and risk adjustment calculations. We removed calendar year 2020 claims data, since it will likely not be as reflective of true market conditions as if the COVID-19 public health emergency had not occurred. Therefore, we will use calendar year 2019 claims data to calculate target prices for performance year six, calendar year 2021 claims data to calculate target prices for performance year seven, and calendar year 2022 claims data to calculate target prices for performance year eight.

While we will similarly avoid using 2020 claims data for risk adjustment coefficient calculations, given the time to receive and process annual CMS HCC condition count data, performance year six risk adjustment coefficient will be held constant for performance year seven. Updated risk adjustment coefficients will be calculated for performance year eight using calendar year 2021 claims data.

Consistent with applicable law and regulation, CJR participant hospitals may currently engage in financial arrangements under the model. Specifically, CJR participant hospitals may share reconciliation payments and internal cost savings with collaborators such as accountable care organizations, hospitals, critical access hospitals, non-physician provider group practices and therapy group practices. Collaborators may then share gainsharing payments as distribution payments to collaboration agents such as physician group practice members, non-physician group practice members, ACO participants or ACO providers or suppliers. Collaboration agents that are PGPs or non-physician PGPsapart of a collaborator ACO may share distribution payments as downstream

distribution payments to downstream collaboration agents who are physician group practice members or non-physician group practice members.

In regard to physicians or non-physician practitioners, the CJR model has always included a cap on gainsharing payments, distribution payments, and downstream distribution payments. However, we are eliminating the 50% cap on gainsharing payments, distribution payments and downstream distribution payments. It was determined that the existing cap is arbitrary and limiting, its burdens outweigh its benefits, and the elimination of the cap is consistent with the BPCI advanced policy.

Additionally, we believe that participant hospitals, CJR collaborators, collaboration agents and downstream collaboration agents are now accustomed to the episode based CJR payment methodology and that administrative burden should be reduced and further flexibility should be offered to allow hospitals to share internal savings or earned reconciliation payments by removing the gainsharing cap. Next, we will discuss waivers.

Laura Maynard: Thank you. Currently, the CJR model waives the Skilled Nursing Facilities (SNF) three-day rule for coverage of a SNF stay for a CJR beneficiary if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of the CJR beneficiaries' admission to that SNF. As discussed previously, in this Final Rule we changed the episode of care to include outpatient procedures for total knee arthroplasty and total hip arthroplasty. Therefore, for performance years six through eight, CMS has extended the waiver to include beneficiaries who initiate CJR episodes in the outpatient setting.

We do not anticipate that a beneficiary who receives an LEJR procedure in the outpatient setting will need a SNF stay. However, in the event that a participant hospital performs an LEJR procedure in the outpatient setting and due to unforeseen circumstances the beneficiary needs a SNF stay and has not had a qualifying three-day inpatient stay, we do not want the beneficiary to be held financially liable for these costs. Beneficiaries would still need to be discharged pursuant to the waiver and must be admitted to SNFs rated three stars or higher on the CMS nursing home compare website.

CMS also updated the direct supervision requirement in the Final Rule. Section 510.600 of the CJR model regulations waives the direct supervision requirements to allow clinical staff to furnish certain post-discharge home visits under the general supervision rather than direct supervision of the physician or non-physician practitioner. This program rule waiver will now apply for LEJR procedures performed in the outpatient setting as well.

As previously discussed, the definition of anchor procedure means a TKA or THA procedure that is permitted and reimbursable by Medicare when performed in the outpatient setting and billed through the OPPS. We believe that the beneficiary should be notified of his or her inclusion in the CJR model whether the procedure takes place in an inpatient or an outpatient setting and therefore have included this requirement in the Final Rule. Also, CMS finalized a change to the timing requirement for the beneficiary notification.

Now, prior to discharge from the anchor hospitalization, or prior to discharge from the anchor procedure, as applicable, the participant hospital must provide the CJR beneficiary with a participant hospital beneficiary notification. The CJR model team will provide updated beneficiary notifications prior to the start of performance year six.

The evaluation of the CJR model assesses the impact of the model on the aims of improved care quality and efficiency as well as reduced healthcare costs. Focus areas for this evaluation include

payment and utilization impact, quality of care and outcomes, unintended consequences, referral patterns and market impact, and potential for extrapolation of results. This concludes the presentation.

Carrie Kolleck: Wonderful now let's go ahead and take some questions from some of our attendees. Just a reminder, if you do have a question you can submit your question by typing into the Q&A pod on the screen and you can either select the upward facing arrow to send that over or just hit send on your keyboard. Let's go to the questions.

Lauren Nir: Thank you. Our first question is, if we are voluntary we will not be allowed to participate, is that correct?

Laura Maynard: Yes, that is correct. Only those hospitals who have a CCN primary address in the 34 mandatory MSAs will be participating in the three-year extension period. Participant hospitals in those mandatory MSAs that are low volume hospitals, or that got a notification from CMS dated prior to July 4th, 2021, that they've been designated as rural hospitals, will not be participating in the extension. A list of the hospitals that will no longer be participating in performance year six through eight has been posted to the CJR website.

Lauren Nir: Our next question is, are outpatient patients included in CJR in 2021 if they are a DRG 469 and 470?

Laura Maynard: MS-DRG 469 and 470 represent inpatient hospitalizations. However, TKA and THA procedures performed in the hospital outpatient setting based on an outpatient claim for CPT 27447 or 27130 will trigger CJR episodes beginning on July 4, 2021. Now, the exception is that if the TKA or THA procedure is followed within three days by an inpatient hospitalization for a CJR MS-DRG, then the inpatient hospitalization will trigger the episode. Outpatient TKA episodes will be reconciled against the MS-DRG 470 target price, while outpatient THA episodes will be reconciled against either the MS-DRG 470 or 522 target price as applicable.

Lauren Nir: So I'm seeing our next question come in, how is the final different from the proposed rule from Spring 2020?

Laura Maynard: The May 2021 Final Rule finalized most of the proposed policies from the February 2020 rule, with the exception of certain policies related to the timing and payment methodology for performance years six to eight. The primary difference is the dates of the extension. Performance year six will begin on October 1st, 2021, and will be 15 months in duration concluding on December 31st, 2022.

Performance year seven will run for 12 months from January 1st, 2023 through December 31st, 2023. Performance year eight will run for 12 months from January 1st of 2024 through December 31st of 2024. There are also differences to the payment methodology that was proposed in the February 2020 rule. The May 2021 Final Rule adds dual eligibility status as a risk adjustment variable and updates the baseline data used to calculate target prices and risk adjustment coefficients to accommodate the shift in performance year dates.

Lauren Nir: Okay, our next question is how would new hospitals be treated in this program? Will they be excluded?

Laura Maynard: The extension only applies to participant hospitals who are not designated as rural or low volume hospitals that are located in the 34 mandatory metropolitan statistical areas for

whom participation has been mandatory since the beginning of the model in 2016. New hospitals in the 34 mandatory MSAs will not be included in the CJR model for performance years six through eight.

Lauren Nir: Great. Our next question is what are the anchor stay dates for performance year five extension?

Laura Maynard: Yes, so for PY5.2, anchor hospitalizations with a discharge date from October 4th, 2020 to July 3rd, 2021.

Lauren Nir: Great, I'm seeing another question in here about baseline claims data. Do you know when those will be available?

Laura Maynard: We expect to deliver baseline claims data for performance year six target prices to the CJR data portal by the beginning of July 2021.

Lauren Nir: All right, our next question is from someone who is new to CJR and feels that they didn't really have a great orientation. They're asking if there is some sort of cheat sheet with templates for documents that must be uploaded to CMS and any timeframes for those uploads. Is there something like that?

Laura Maynard: No, there's not a cheat sheet. But all announcements of deadlines and key model activities, including templates and important model documents are available on CJR Connect. If you don't yet have a CJR Connect account, you can request one by going to https://app.innovation.cms.gov/cmmiconnect/idmlogin. Go there and click new user registration and you'll be able to log in for a CJR Connect account where you'll be able to find those announcements of deadlines and announcements of activities as well as templates and important model documents.

Lauren Nir: All right, shifting to a different topic here. Will the new timeline for PRO submission be presented today?

Laura Maynard: No, we will not cover the new timeline for PRO submission. This is going to be covered in a later webinar. But you can refer back to the rule itself for any clarification in the interim before that webinar.

Lauren Nir: All right, and shifting topics again, are ASCs owned by the hospital counted or only hospital based ASUs?

Laura Maynard: CJR episodes will only be initiated in the inpatient setting or in the hospital outpatient department. Procedures performed in ambulatory surgical centers will not be included in CJR.

Lauren Nir: All right back to PRO reporting for a second. Will PRO reporting apply to outpatients or only to inpatients?

Laura Maynard: The patient reported outcomes reporting will apply to all CJR beneficiaries 65 and over during the extension period. However, this will include beneficiaries only in the inpatient setting. The PRO eligibility definition hasn't changed, so it's beneficiaries that are inpatient only. We're continuing to study the feasibility of including procedures in the outpatient setting.

Lauren Nir: All right, so our next question is will CJR hospitals be provided with regularly updated target prices throughout the year based on projected market trends?

Laura Maynard: No, the retrospective market trends factor adjustment will occur just once annually during reconciliation for each performance year.

Lauren Nir: Okay, and will beneficiary level risk adjustment data be provided for both baseline and performance periods?

Laura Maynard: Yes, the beneficiary level risk adjustment data will be provided for both baseline and for performance period data.

Lauren Nir: Okay. Our final question that we have time for, will the HCC count be based on a full calendar year of claims data or some discrete timeline?

Laura Maynard: When applying the risk adjustment factors at reconciliation, CJR HCC count applicable to a beneficiary will be determined based on a full calendar year of claims data. We will calculate performance year six and seven CJR HCC count coefficients from episode baseline data from 2019, and performance year eight CJR HCC count coefficients from episode baseline data from 2021.

Lauren Nir All right, thank you so much. We will go back now to do some final announcements and reminders. Thank you all. So we do still see some questions coming in. I do want to let you know that we are gathering all of these questions. If we did not have time to answer your question today, we have passed these questions along to our presenters. We will do our best to get to all of these in the near future.

I want to wrap up today with just a few announcements and reminders. You may have seen these as you were entering into the event today, the performance year three evaluation report is available. If you have not checked that out, please go ahead and look on the CMS Innovation Center CJR web page and you can access that report there. There is also a video with the findings from that report available there too. We do have some new resources available in that event resources pod for you. You can download the toolkit as well as some additional spotlights that we have developed in the recent couple of months. We do also have some on-demand events that are available if you've missed them. And finally, please send any questions or CJR model points of contact updates to CJRSupport@cms.hhs.gov. If you do not have a CJR Connect account, you can go to the website here on the screen or in the web links pod and you can just click on New User Registration to request an account. Then the last announcement today, we will be sending you a post event survey to fill out following today's event so that you all can provide some feedback on how this event went. We do use that feedback to develop future events for you, and the link to that survey has just popped up so if you can take a couple of minutes, we are ending early today so that you can fill this out and let us know how we did. We hope that you all have a great rest of your afternoon.

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[i] *Please note that this transcript is designed to help organizations implement the CJR model. The Center for Medicare & Medicaid Services (CMS), its employees, agents, and staff assume no responsibility for any errors or omissions in the content of this transcript. CMS makes no guarantees of completeness, accuracy, or reliability for any data contained or not contained herein. CMS shall not be held liable for any use of the information described and/or contained herein and assumes no responsibility for anyone's use of the information. This transcript does not serve as advice provided by CMS. CMS and the Department of Health and Human Services Office of the Inspector General have not verified this transcript as compliant with Title 42 CFR Part 510. Although every reasonable effort has been made to assure the accuracy of the information, the ultimate responsibility for compliance with the regulations associated with the CJR model lies with the provider of services.*