



# Comprehensive Care for Joint Replacement (CJR) Model



*Introduction to  
Comprehensive Care for  
Joint Replacement (CJR) Model*

# Proposed Rule to Final Rule

- The proposed rule was published on July 9, 2015, with the comment period ending September 8, 2015.
- After reviewing nearly 400 comments from the public on the proposed rule, and considering commenters' thoughtful perspectives, several major changes were made from the proposed rule.
- On **November 16, 2015**, CMS finalized the CJR regulations.
- The full text of the rule is available now in PDF format here:  
[https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29438.](https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29438.pdf)  
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- The permanent online location of the final rule, starting on 11/24/2015, will be available here: [http://federalregister.gov/a/2015-29438.](http://federalregister.gov/a/2015-29438)

# CJR model: Rule Summary

- The **Centers for Medicare & Medicaid Services** have implemented 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** (formerly using the acronym CCJR), 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 (LEJR).

# Major Policy Changes from the Proposed Rule

- First performance period for the CJR model **will begin on April 1, 2016**, instead of the proposed January 1, 2016, performance period start date
- The CJR model will be **implemented in 67 MSAs**, instead of the proposed 75 MSAs
- Due to the public comments we received, we decided **not to finalize** our proposal to **allow beneficiaries the opportunity to decline having their data shared** at this time.
  - Beneficiaries retain freedom of choice to choose providers and services
  - All existing safeguards to protect beneficiaries and patients remain in place
  - Our proposals to protect beneficiaries have been finalized, including:
    - Additional monitoring of claims data from participant hospitals
    - Patient notification by providers and suppliers

# Major Policy Changes from the Proposed Rule

- 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.

# Major Policy Changes from the Proposed Rule

- **In response to comments, we have finalized:**
- Reconciliation payments will be phased-in and capped (**stop-gain**):
  - Years 1 and 2: **Capped at 5%**
  - Year 3: **Capped at 10%**
  - Years 4-5: **Capped at 20%**
- Hospital responsibility to repay Medicare will be phased-in and capped (**stop-loss**):
  - Year 1: **No responsibility** to repay Medicare
  - Year 2: **Capped at 5%** of target prices
  - Year 3: **Capped at 10%** of target prices
  - Years 4 and 5: **Capped at 20%** of target prices
- **Additional protection** for rural, sole community (SCH), Medicare dependent (MDH), and rural referral center (RRC) **hospitals with stop-loss of 3% for Year 2 and 5% for Years 3-5.**

# Major Policy Changes from the Proposed Rule

- 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 and successful reporting of THA/TKA patient-reported outcomes and limited risk variable data.
- **Composite quality score methodology** will determine:
  - Hospital eligibility for reconciliation payments if savings are achieved beyond the target price; and
  - Amount of quality incentive payment that may be made to the hospital

# Major Policy Changes from the Proposed Rule

- We finalized **two of the three proposed quality measures**:
  - 1) THA/TKA Complications measure (NQF #1550); and
  - 2) HCAHPS Survey measure (NQF #0166).
- We did not finalize the THA/TKA Readmissions measure (NQF #1551)
- Voluntary Submission of THA/TKA patient-reported outcomes and limited risk variable data:
  - We finalized **a more achievable “successful” criterion** for voluntary submission of THA/TKA patient-reported outcomes and limited risk variable data.

# CJR Model: Overview

- The CJR Model tests bundled payments for LEJR across a broad cross-section of hospitals.
- The model applies to most Medicare fee-for-service (FFS) LEJR procedures within select geographic areas, with few exceptions.
- We use the term LEJR to refer to all procedures within the Medicare Severity Diagnosis Related Groups (MS-DRGs) 469 and 470, including reattachment of a lower extremity.
- Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in the selected MSAs will be included in the model, with the exception of hospitals currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes.

# What is the CJR Model designed to do for patients and the health system?

## Better Care

- Better care for patients through more coordinated, higher quality care during and after a lower extremity joint replacement or reattachment of a lower extremity (collectively referred to as LEJR)

## Smarter Spending

- Smarter spending of health care dollars by holding hospitals accountable for total episode spending, not just inpatient costs

## Healthier People and Communities

- Healthier people and communities by improving coordination in health care and by connecting care across hospitals, physicians, and other health care providers

# CJR Participants

- The CJR model will be implemented in **67** metropolitan statistical areas (MSAs).
- Participant hospitals in these selected MSAs are all acute care hospitals paid under the IPPS that are not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes.
- As of November 16, 2015, **approximately 800 hospitals are required to participate in the CJR Model.** This list is available at the CJR model website. <https://innovation.cms.gov/initiatives/cjr>

# Episode of Care definition: General

- Episodes are triggered by hospitalizations of eligible Medicare Fee-for-Service beneficiaries **discharged with diagnoses:**
  - **MS-DRG 469:** Major joint replacement or reattachment of lower extremity with major complications or comorbidities
  - **MS-DRG 470:** Major joint replacement or reattachment of lower extremity without major complications or comorbidities
- Episodes include:
  - **Hospitalization and 90 days post-discharge**
  - The **day of discharge** is counted as the first day of the 90-day post-discharge period.
  - **All Part A and Part B services**, with the exception of certain excluded services that are clinically unrelated to the episode

# Episode definition: Beneficiaries

- Care of Medicare beneficiaries is included if Medicare is the primary payer and the beneficiary is:
  - **Enrolled in Medicare Part A and Part B** throughout the duration of the episode,
  - **Not** eligible for Medicare on the basis of **End Stage Renal Disease**,
  - **Not** enrolled in a **managed care plan** (eg, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations), and
  - **Not** covered under a **United Mine Workers of America** health plan
- If at any time during the episode the Medicare beneficiary no longer meets all of these criteria aforementioned, the episode is canceled

# Episode definition: Services

## Included services

- Physicians' services
- Inpatient hospitalization
- Inpatient hospital readmission
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs and biologicals
- Hospice
- PBPM payments under models tested under section 1115A of the Social Security Act

## Excluded services

- Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery
  - Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care
  - The list of excluded MS-DRGs and ICD-CM diagnosis codes, including both ICD-9-CM and ICD-10-CM, is posted on the CMS Web site

# Payment and pricing:

## Risk structure

- **Retrospective, two-sided risk model with hospitals bearing financial responsibility**
  - Providers and suppliers continue to be paid via Medicare FFS
  - After a performance year, actual episode spending will be compared to the episode target prices
    - If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment
    - If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare
- Responsibility for repaying Medicare begins in Year 2, with **no downside responsibility in Year 1**

# Payment and pricing:

## Target price setting

- **CMS has established target prices for each participant hospital** (target prices will be set for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and **for episodes with hip fractures vs. without hip fractures**)
- Based on **3 years of historical data**
- Includes **3% discount** to serve as Medicare's savings
- Based on **blend of hospital-specific and regional episode data** (US Census Division), transitioning to regional pricing
  - Years 1 and 2: 2/3 hospital-specific, 1/3 regional
  - Year 3: 1/3 hospital-specific, 2/3 regional
  - Years 4 and 5: **100% regional pricing**

# Payment and pricing: Link to quality through pay-for-performance

- Hospitals are assigned a composite quality score each year based on their performance and improvement on the following **2 quality measures**:
  1. Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550)
  2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166)
- Participant hospitals who successfully submit voluntary **THA/TKA patient-reported outcomes and limited risk variable data** receive **additional points for their composite quality score**.
- More information on quality is available at the CJR model website. <https://innovation.cms.gov/initiatives/cjr>

# Payment and pricing: Link to quality through pay-for-performance

- Hospitals must have a minimum composite quality score for reconciliation payment eligibility if savings are achieved beyond the target price.
- Based on their composite quality score, **hospitals may be eligible for quality incentive payments of 1% or 1.5% of their episode price, changing the effective discount percentage at reconciliation to 2% or 1.5%.**
- More information on quality is available at the CJR model website. <https://innovation.cms.gov/initiatives/cjr>

# Payments and pricing:

## Risk limits and adjustments

- Episode payment **is capped at 2 standard deviations above regional mean (high payment outlier ceiling)** for calculating target prices and for comparing actual episode payments to target prices. Payments to providers and suppliers under Medicare FFS for episode services will not be capped.
- Reconciliation payments will be phased-in and capped (**stop- gain**):
  - Years 1 and 2: **Capped at 5%**
  - Year 3: **Capped at 10%**
  - Years 4-5: **Capped at 20%**
- Hospital responsibility to repay Medicare will be phased-in and capped (**stop-loss**):
  - Year 1: **No responsibility** to repay Medicare
  - Year 2: **Capped at 5%** of target prices
  - Year 3: **Capped at 10%** of target prices
  - Years 4 and 5: **Capped at 20%** of target prices

# Payments and pricing:

## Risk limits and adjustments

- **Additional protection** for rural, sole community (SCH), Medicare dependent (MDH), and rural referral center (RRC) **hospitals with stop-loss of 3% for Year 2 and 5% for Years 3 through 5.**
- These protections strike an appropriate balance between protecting hospitals that often serve as the only access of care for Medicare beneficiaries and having these hospitals meaningfully participate in the model.

# Overlap with BPCI

- Hospital **participation in BPCI vs. CJR** in selected MSAs
  - Hospitals in BPCI Model 1 or BPCI Models 2 or 4 for the lower joint replacement clinical episode **will remain in BPCI and not be required to participate in the CJR model**
  - BPCI participants that terminate from a BPCI model for the LEJR episode and are located in an MSA that has been selected for the CJR model are required to participate in the CJR model
  - Hospitals not already in BPCI **may not elect** to participate in BPCI in lieu of participation in the CJR model
- BPCI Model 2 and Model 3 LEJR episodes **initiated by participating physician group practices or post-acute care facilities** take precedence over CJR episodes.
  - CMS intends to continue the ongoing BPCI model test

# Overlap with ACOs and other models

- Hospitals selected to participate in the CJR model **may also participate in an ACO or other models.**
- The financial reconciliations under the CJR model and other CMS models and programs will, to the extent feasible, account for all Medicare Trust Fund payments for beneficiaries in those models and programs and generally ensure that Medicare saves the expected 3 percent discount on CJR episodes.

# Financial Arrangements: Gainsharing

- Consistent with applicable law, participant hospitals may have certain financial arrangements with Collaborators **to support their efforts to improve quality and reduce costs.**
- **CJR Collaborators** may include the following provider and supplier types:
  - Skilled nursing facilities
  - Home health agencies
  - Long term care hospitals
  - Inpatient rehabilitation facilities
  - Physician Group Practices
  - Physicians, non physician practitioners, and providers and suppliers of outpatient therapy.

# Financial Arrangements: Incentive Payments

- Participant hospitals may **share** with Collaborators:
  - Reconciliation payments in the form of a performance-based payment
  - Internal Cost Savings realized through care redesign activities associated with services furnished to beneficiaries during a CJR episode.
- All Collaborators (except for PGPs) **are required** to engage with the hospital in its care redesign strategies and to furnish services during a CJR episode in order to be eligible for such payments.

# Financial Arrangements: Risk sharing

- Participant hospitals **may assign various percentages of two-sided risk** to collaborators.
  - Where that is the case, CMS will continue to make **reconciliation payments and recoupments solely with the hospital**
  - The **hospital is responsible for payment and recoupments with its collaborators** according to the agreements between those entities
- **CMS limits the hospital's sharing of risk to 50% of the total repayment amount to CMS**
  - The hospital is required to retain 50% of the downside risk
  - The hospital is not permitted to share more than 25% of its repayment responsibility with any one provider or supplier.

# Financial Arrangements:

## Beneficiary Incentives

- **Subject to parameters outlined in the rule**, participant hospitals may choose to provide in-kind patient engagement incentives to beneficiaries in CJR episodes.
- **Particular clinical goals** of the CJR model may be **advanced through beneficiary incentives to encourage**:
  - Beneficiary adherence to drug regimens.
  - Beneficiary adherence to care plan.
  - Reduction of readmissions and complications resulting from lower extremity joint replacement procedures.
  - Management of chronic diseases and conditions that may be affected by the lower extremity joint replacement procedure.

# Program waivers: Skilled Nursing Facility

- CJR model **waives the SNF 3-day rule** for coverage of a SNF stay following the anchor hospitalization beginning in performance year 2.
- Beneficiaries discharged pursuant to the waiver **must be transferred to SNFs rated 3-stars or higher for at least 7 of the previous 12 months** on the CMS Nursing Home Compare website. A list of qualifying SNFs is posted to the CMS website prior to each calendar quarter to which it applies.
- Beneficiaries **must NOT be discharged prematurely** to SNFs, and they must be able to exercise their freedom of choice without patient steering.

# Program waivers: Home visits

- For CJR post-discharge home visits, **CMS waives the “incident to” direct supervision rule** for physician services.
- Allows clinical staff of a physician or non physician practitioner to **furnish a visit in the beneficiary’s home under the general supervision of a physician.**
- Permitted only **for beneficiaries who do not qualify for Medicare coverage of home health services.**
- Waiver **allows a maximum of 9 visits** during the episode, billed under the Physician Fee Schedule using a HCPCS code created specifically for the model.

# Program waivers: Telehealth

- **CJR model waives the geographic site requirement for any service on the Medicare-approved telehealth list** and the originating site requirement only to permit telehealth visits to originate in **the beneficiary's home or place of residence**
- Telehealth visits under the waiver **cannot be a substitute for in-person home health services** paid under the home health prospective payment system
- Requires all **telehealth services to be furnished in accordance with all other Medicare coverage and payment criteria except that payment for the special home health visits under the model will be paid at a special rate**
- The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary's home

# Data sharing: Specifications

- CMS will **share data with participant hospitals for hospitals** to
  - Evaluate their practice patterns
  - Redesign care delivery pathways
  - Improve care coordination
- In response to a hospital's request and in accordance with our regulations and applicable privacy laws, **CMS will share beneficiary Part A and B claims for the duration of the episode** in
  - Summary format,
  - Raw claims line feeds, or
  - Both summary and raw claims
- **Data is available** for the hospital's **baseline period** and no less often than on a **quarterly basis with the goal of as often as on a monthly basis if practicable** during a hospital's performance period.
- CMS will share **aggregate regional claims data** for MS-DRG 469 and MS-DRG 470 in the region where the participant hospital is located.

# Data sharing: Privacy

- Data sharing **fully complies with laws and regulations** pertaining to privacy.
- We have decided **not to finalize** our proposal to allow beneficiaries the opportunity to decline having their data shared at this time. Making data available will enhance participating hospitals' ability to identify existing care patterns as well as the kinds of strategies needed to improve their care practices so that they can be most successful under the model.

# Beneficiary protections:

## Access to care

- Beneficiaries' **access to care should not be impacted** by the CJR model.
  - This is a payment model that changes the payment methodology for hospitals in select geographic areas.
  - Beneficiary **deductibles and copayments will not change**
  - Beneficiaries may still **select any provider of choice with no new restrictions.**
  - Beneficiaries may still **receive any Medicare covered services with no new restrictions.**
  
- 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>.

# Beneficiary protections: Beneficiary notification

- Beneficiary notification about the CJR model will **support transparency**.
  - **Providers and suppliers involved in risk sharing** with a hospital are required to **notify beneficiaries of the payment model**
  - If there are no risk sharing arrangements, **hospitals** must notify beneficiaries of payment implications
- Beneficiary notification requirements focus the attention of all parties on the requirement to provide all medically necessary services.

# Beneficiary protections: Monitoring

- CMS **monitoring assesses compliance** with the model requirements for beneficiary protections.
- Hospitals are familiar with both bundled payment and risk-sharing and are unlikely to compromise patient care.
- Nonetheless, **CMS will monitor for potential risks** such as
  - Attempts to increase profit by delaying care
  - Attempts to decrease costs by avoiding medically indicated care
  - Attempts to avoid high cost beneficiaries
  - Evidence of compromised quality or outcomes

# Compliance with requirements of participation

- Participant hospitals, and any entity or individual furnishing a service to a beneficiary during a CJR episode, must comply with all **requirements of participation for the CJR model**.
  
- **CMS may do one or more of the following** if a participating hospital fails to comply with any of the requirements of the CJR model:
  1. Issue a warning letter to the participant hospital
  2. Require the participant hospital to develop a corrective action plan
  3. Reduce or remove a participant hospital's positive NPRA calculation.
  4. Increase the repayment amount on the reconciliation report by 25 percent for the performance year in which the noncompliance occurred by the participant hospital.
  5. In extremely serious circumstances, expulsion from the model and/or other sanctions including suspension of payments or revocation from the CJR model if indicated.

# Evaluation: Focus Areas

- Evaluation of the model will assess the impact of the CJR model on the aims of **improved care quality and efficiency as well as reduced health care costs.**
- Focus areas include
  - Payment impact
  - Utilization impact
  - Outcomes/quality
  - Referral patterns and market impact
  - Unintended consequences
  - Potential for extrapolation of results

# Additional Sources of Information

- The CJR model final can be viewed at [https://  
www.federalregister.gov](https://www.federalregister.gov)
- The waiver notice jointly issued by CMS and OIG is available at <https://www.cms.gov/Medicare/Fraud-and-Abuse/Physician>

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# Additional Sources of Information

- For more information about the CJR model, go to <https://innovation.cms.gov/initiatives/cjr>
- The CJR model Webinar #2 will be taking place on Monday, November 30th from 2:00pm – 3:00pm EDT
  - Register at <https://hendall2.webex.com/hendall2/onstage/g.php?MTID=>
- Questions regarding the CJR model can be directed to [cjr@cms.hhs.gov](mailto:cjr@cms.hhs.gov).