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Medicare Comprehensive Care for Joint Replacement (CCJR) Model Proposed Rule

OVERVIEW

On July 9th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to establish the Comprehensive Care for Joint Replacement (CCJR) Model to test mandatory retrospective bundled Medicare payments for hip and knee replacements, referred to as lower extremity joint replacements (LEJRs). CMS proposes to begin this five-year mandatory model in 2016.

CMS will accept comments on the proposed rule until September 8th. A detailed summary and fact sheet are available here. The proposed rule is available here.

CCJR MODEL

The CCJR Model would be implemented at all acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) in 75 geographic areas, including New York City, Los Angeles, and San Francisco. All IPPS hospitals in the 75 selected regions would be held responsible for the quality and cost of care associated with each Medicare fee-for-service beneficiary's LEJR episode.

Each LEJR episode would include all Medicare Part A and B services provided from the time of an admission that results in a LEJR-related discharge and would continue for 90 days post-discharge. CMS proposes to include the following categories of services in the CCJR episode:

- Inpatient services;
- Physician services;
- Inpatient psychiatric facility services;
- Skilled nursing facility services;
- Home health agency services;
- Hospital outpatient services;
- Independent outpatient therapy services;
- Clinical laboratory services;
- Durable medical equipment;
- Part B drugs; and
- Hospice.

Unrelated services that would be excluded in the episode costs include but are not limited to:

- 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.

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PRICING AND PAYMENT

At the beginning of each performance year, CMS would provide each participating hospital with a set price for a LEJR episode, referred to as the target price. The target price would include a 2 percent discount on anticipated episode spending and would be based on the specific hospital's historic experience as well as regional spending, with the regional component increasing over time.

Hospitals and all other Medicare providers and suppliers would continue to be paid under current Medicare payment systems throughout the performance year.

At the end of each performance year, total episode spending would be compared to Medicare's target price. Hospitals that meet three quality performance measures and spend less than the target price would earn the difference between actual spending and their target, up to a specified cap. Hospitals with episode spending exceeding targets will be required to repay Medicare the difference up to a specified limit.

Hospitals participating in Models 1 or Phase II of Models 2 or 4 of Bundled Payments for Care Improvement for LEJRs would be exempt from the new mandatory program.

ADDITIONAL FLEXIBILITIES FOR PARTICIPATING HOSPITALS

CMS proposes to waive certain payment system requirements for participating hospitals and collaborating providers and suppliers. These include:

- A waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered Skilled Nursing Facility (SNF) stay under certain conditions;
- Payment for certain physician visits to a beneficiary via telehealth; and
- Payment for certain types of physician-directed home visits for non-homebound beneficiaries.

CMS proposes that a participating hospital may share payments received from Medicare as a result of reduced episode spending with collaborating providers and suppliers that provide services to the beneficiary during a CCJR episode. Participating hospitals might also share financial responsibility for increased episode spending with collaborating providers.