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Medicare Comprehensive Care for Joint Replacement (CJR) Model Final Rule

OVERVIEW

On November 16th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to establish the Comprehensive Care for Joint Replacement (CJR) Model to test mandatory retrospective bundled Medicare payments for hip and knee replacements, referred to as lower extremity joint replacements (LEJRs). The first performance year (PY) for the five-year model will begin on April 1, 2016, instead of January 1, 2016, as originally proposed.

This document summarizes major provisions of the final rule. The final rule is available here.

CJR MODEL

The CJR Model will be implemented at acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) in 67 geographic areas, including New York City, Los Angeles, and San Francisco. CMS initially proposed to test the CJR model in 75 geographic areas, but eight areas have been excluded in the final rule due to widespread participation in Bundled Payments for Care Improvement (BPCI) Model 1 or Phase II of Models 2 or 4 for LEJR initiatives. *CMS finalized its proposal to exclude hospitals participating in Model 1 or Phase II of Models 2 or 4 of BPCI for LEJRs*.

Under the final rule, all IPPS hospitals in the selected areas will be held responsible for the quality and cost of care associated with each Medicare fee-for-service beneficiary's LEJR episode. The episode will continue for 90 days post-discharge. CMS finalized its proposal to include the following categories of services in the CJR episode:

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

Unrelated services that will 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.

PRICING AND PAYMENT

CMS finalized its proposal to provide each participating hospital with a set price for a LEJR episode, referred to as the target price. The rule finalizes the proposal to set separate target prices for Medicare Severity-Diagnosis Related Groups: 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) and 470 (Major joint

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replacement or reattachment of lower extremity without MMC). The final rule also adds a provision to risk stratify target prices for patients with hip fractures.

Beginning in PY 1, hospitals that meet quality performance measures and spend less than the target price will earn the difference between actual spending and their target. CMS changed its proposal to allow all hospitals to participate in upside-only risk in PY 1. Beginning in PY 2, hospitals with episode spending exceeding targets would be required to repay Medicare the difference.

Under the proposed rule, hospitals would have had to meet specific quality thresholds to be eligible for reconciliation payments. Instead, the final rule establishes composite quality scoring to determine the level of a hospital's reconciliation or repayment. The composite quality score will be based on the following three measures:

- Complications within 90 days of hospitalization for elective total hip and total knee replacement;
- The Hospital Consumer Assessment of Healthcare Providers and Systems survey; and
- The voluntarily-submitted patient reported outcome (PRO) measure.

Under the proposed rule, the target price would include a 2 percent discount on anticipated episode spending based on the specific hospital's historic experience as well as regional spending, with the regional component increasing over time. The final rule adjusts the discount percentage according to quality performance:

Composite Quality Score		Reconciliation Discount	Repayment Discount		
		PYs 1-5	PY 1	PY 2	PYs 3-5
Poor	≤ 5	-	-	2%	3%
Acceptable	>5 and ≤ 9.25	3%	-	2%	3%
Good	>9.25 and $\leq$15.2	2%	-	1%	2%
Excellent	>15.2	1.5%	-	0.5%	1.5%

The final rule also reduces the total amounts hospitals stand to gain or lose in the CJR model. In PY 2, the repayment risk for most hospitals will be capped at 5 percent, rather than the proposed 10 percent, of the hospital's target price multiplied by the number of episodes. The loss limit will gradually increase to 10 percent in PY 3 and 20 percent in PY 4 and 5. The final rule also limits the amount hospitals stand to gain in the model to 5 percent in PY 1 and 2; 10 percent in PY 3; and 20 percent PY 4 and 5, instead of 20 percent for all five years, as originally proposed.

ADDITIONAL FLEXIBILITIES FOR PARTICIPATING HOSPITALS

The rule finalizes the waiver of certain payment system requirements for participating hospitals and collaborating providers and suppliers. These include:

- Payment for certain physician services to a beneficiary via telehealth;
- Payment for certain types of physician-directed home visits for non-homebound beneficiaries; and

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- A waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered Skilled Nursing Facility (SNF), beginning in PY 2. The final rule adds that a qualified SNF must receive an overall rating of at least three stars on the *Nursing Home Compare* website for at least seven of the 12 preceding months.

CMS finalized its proposal to allow participating hospital to gain share with collaborating providers that care for the beneficiary during a CJR episode. The rule finalizes the proposal to prevent beneficiaries from being able to opt-out of the CJR model, but does allow hospitals to recommend preferred providers.