Comprehensive Care for Joint Replacement (CJR) Model

Q1: Where can I find a copy of the final rule?

A1: The CJR model final rule can be viewed at https://www.federalregister.gov starting November 12, 2015.

Q2: What are the major policy changes from the proposed rule to the final rule?

A2: After reviewing and considering the nearly 400 comments from the public on the proposed rule, several changes were made from the proposed rule.

- *Start Date:* In order to allow participant hospitals more time to prepare, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016, performance period start date.
- *Site Selection:* The CJR Model will be implemented in 67 metropolitan statistical areas (MSAs), instead of the proposed 75 MSAs, to respond to comments asking for us to incorporate the increased participation in the Bundled Payments for Care Improvement (BPCI) initiative since publication of the proposed rule and to incorporate BPCI physician group practice participation levels into our MSA selection methodology.
- *Pricing:* CJR hospitals will receive separate episode target prices for MS-DRGs 469 and 470, reflecting the differences in spending for episodes initiated by each MS-DRG. In response to comments, 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.
- *Linking Quality to Payment:* 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 finalized for this model (THA/TKA Complications measure (NQF #1550) and the HCAHPS patient experience Survey measure (NQF #0166)), and successful reporting of THA/TKA patient-reported outcomes and limited risk variable data. We adopted a composite quality score methodology to determine: 1) the hospital eligibility for reconciliation payments if savings are achieved beyond the target price; and 2) the amount of quality incentive payment that may be made to the hospital.
- *Payment:* In the proposed rule, we had proposed to apply stop-loss limits of 10 percent in performance year 2 and 20 percent in performance years 3 through 5 for participating hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals. Several commenters requested a more gradual transition to downside risk and a lower stop-loss limit to allow for hospitals to have more time to gain experience under the model. In response, we are finalizing our policy for no repayment responsibility in performance year 1, as well as a reduced discount percentage for repayment responsibility in performance years 2 and 3. We have finalized 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 participating hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers,

and sole community hospitals. (We are finalizing the stop-loss limit for these hospitals at 3 percent in performance year 2 and 5 percent in performance years 3 through 5.) We have finalized a parallel approach for the stop-gain limits to provide proportionately similar protections to CMS and hospital participants, as well as to protect the health of beneficiaries. All hospital participants will be eligible to earn up to 5 percent of their target price in performance years 1 and 2, 10 percent in performance year 3, and 20 percent in performance years 4 and 5. We believe it is appropriate that as participant hospitals increase their downside risk, they can similarly increase their opportunity for additional payments under this model. We also believe that these changes will both facilitate participants' abilities to be successful this model and allow for a more gradual transition to financial responsibility under the model.

- *Beneficiary Data:* In response to the public comments we received, we did not finalize our proposal to allow beneficiaries to decline having their data shared at this time and have decided to provide participating hospitals with as complete data on their beneficiaries as is possible under the law. We believe that making these data available will enhance participating hospitals' ability to identify existing care patterns that can be changed or strengthened, 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:* We have finalized the following proposals to protect beneficiaries: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable privacy laws; and patient notification by providers and suppliers. Further, beneficiaries retain their freedom of choice to choose services and providers and all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's Quality Improvement Organization (QIO). If concerns are identified, CMS can initiate audits and corrective action under existing authority.
- *Waivers:* No waivers of any fraud and abuse authorities are being issued in the final rule. Rather, CMS and OIG will jointly issue a notice regarding the waiver of certain fraud and abuse laws for purposes of testing this model. The notice will be published on the CMS and OIG websites.

Q3: How will the Comprehensive Care for Joint Replacement (CJR) model support the HHS delivery system reform goals of better care, smarter spending, and healthier people?

A3: The CJR model is an alternative payment model that will contribute to the Medicare goals set by the Administration of having 30 percent of all Medicare fee-for-service payments made via alternative payment models by 2016 and 50 percent by 2018. Effective implementation of the CJR model will improve the quality and efficiency of care for Medicare beneficiaries, which is essential to creating a health care system that delivers better care, spends our dollars more wisely, and leads to healthier Americans.

Q4: Who will be affected by the CJR model?

A4: Nearly all hospitals in selected geographic areas will be required to participate in the model and will have the opportunity to partner with surgeons, other physicians, and post-acute care providers to coordinate patient care more effectively. Additionally, Medicare beneficiaries meeting certain criteria who have an inpatient hospitalization for lower extremity joint replacement (LEJR) and/or other major leg procedure as designated by MS-DRG 469 or 470 at participant hospitals will be included in the model. These MS-DRGs primarily include single-joint total hip and total knee replacement procedures.

Q5: Where will the CJR model be implemented?

A5: The CJR Model will be implemented in 67 geographic areas, defined by MSA. By definition, 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 non-BPCI LEJR cases between July 2013 and June 2014, of which:

- For MSA including both Maryland and non-Maryland counties, no more than 50 percent of otherwise qualifying LEJRs occurred in a Maryland hospital;
- No more than 50 percent of the LEJRs in an MSA occurred in a hospital participating in the BPCI initiative for LEJR episodes; and
- No more than 50 percent of the otherwise qualifying episodes who received care in that post-acute care type were treated in a BPCI Model 3 skilled nursing facility (SNF) or home health agency (HHA) participating in the LEJR episode.

The originally proposed 75 participant MSAs were selected using a two-step stratified, randomization process. First, MSAs were placed into eight groups based on average wage-adjusted historic LEJR episode payment quartiles and the MSA population size divided at the median. Second, MSAs were randomly selected within each group using a selection percentage within each payment quartile (30 percent for lowest payment quartile to 45 percent for highest payment quartile). After reviewing the comments, we assessed MSA eligibility criteria using more recent information about participation in BPCI since the publication of the proposed rule and subsequently removed 8 MSAs from selection. The 67 MSAs selected can be found on our website. https://innovation.cms.gov/initiatives/cjr

Q6: How were hospitals chosen to participate in the model?

A6: Hospitals paid under the Inpatient Prospective Payment System (IPPS) physically located in selected MSAs and not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement initiative for the lower extremity joint replacement clinical episode are required to participate in the model.

As of November 12, 2015, approximately 800 hospitals are required to participate in the CJR Model. This list can be found on our website. https://innovation.cms.gov/initiatives/cjr

Q7: Why are hospitals required to participate in the CJR model?

A7: The CJR model tests implementation of a model at the geographic regional level. We believe it is important to test this alternative payment model among a wide range of hospitals, including those that would not necessarily apply to participate. We believe that by requiring the participation of a large number of hospitals with diverse characteristics, the model will result in a robust dataset for evaluation of this bundled payment approach and will stimulate the rapid development of new evidence-based knowledge. Testing the model in this manner allows us to learn more about patterns of inefficient utilization of health care services and how to incentivize the improvement of quality for common LEJR procedure episodes. This learning could inform future Medicare payment policy.

Section 1115A of the Social Security Act (the Act) authorizes the Innovation Center to test innovative payment and service delivery models, such as the CJR model, to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.

Q8: Why are you testing the CJR model?

A8: We believe that there is an opportunity to improve care for Medicare beneficiaries who undergo LEJR. LEJR are common, expensive procedures with a significant recovery period. There is substantial regional variation in care patterns and episode spending in that the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas.

The CJR model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to better align incentives for hospitals, physicians, and post-acute care providers to improve quality and coordination of care from the initial hospitalization through discharge and recovery. The goal of this model is to improve care coordination and care transitions between medical settings and produce better outcomes for Medicare beneficiaries.

Q9: When will the CJR model start and for how long will it last?

A9: The first performance period for the CJR model will begin on April 1, 2016. This performance period start date will provide hospitals with more time to prepare for participation by identifying care redesign opportunities, beginning to form financial and clinical partnerships with other providers, and using data to assess financial opportunities under the model.

The CJR model consists of approximately 5 performance years, per the table below.

PERFORMANCE YEARS FOR CJR MODEL

Performance year	Calendar year	Episodes included in performance year
1	2016	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
2	2017	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
3	2018	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
4	2019	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
5	2020	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

Q10: How will the CJR model improve the quality of care for patients?

A10: 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 receive quality incentive payments 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

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF#0166).

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 also 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.

Q11: How will providers and suppliers be paid under the CJR model?

A11: Providers and suppliers will be paid under the existing payment systems in the Medicare program for episode services throughout the year. Every year, the model will set Medicare target episode prices for each participant hospital that includes payment for all related services received by eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital. Following the end of a model performance year, actual episode spending for a participant hospital will be compared to the applicable Medicare target episode prices for that hospital. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or, beginning in the second year of the model, may need to repay Medicare for a portion of the episode spending.

Q12: How will this model be evaluated?

A12: Like all models tested by CMS, there will be a formal, independent evaluation using quantitative and qualitative data. Outcomes evaluated will include both quality and costs of care.

Q13: Can hospitals/doctors/patients participate in BPCI models and the CJR model?

A13: Hospitals participating as episode initiators in Model 1 or Models 2 or 4 of the BPCI initiative for the LEJR clinical episode are excluded from participation in the CJR model. Participation in the CJR model is at the hospital level, so individual physicians or other practitioners have not been selected to participate in the model.

Q14: If hospitals/doctors/patients are already in BPCI, what happens?

A14: If an acute care hospital is already participating in BPCI Model 1, or BPCI Model 2 or Model 4 for the major joint replacement of the lower extremity clinical episode, that hospital will not be a participant in the CJR model. If a BPCI participant other than an acute care hospital participating in the LEJR episode initiates an LEJR episode during a CJR episode (e.g., physician group practice or post-acute care provider), then the BPCI episode will continue and the CJR episode will be canceled (i.e., not included in calculations at the time of reconciliation). If any BPCI participant initiates any episodes other than an LEJR episode during a CJR episode, then both episodes will continue.

Q15: Will hospitals be able to partner with other providers and share their savings?

A15: The model will allow participant hospitals to enter into financial arrangements with certain types of providers and suppliers (SNFs, long-term care hospitals, HHAs, inpatient rehabilitation facilities, physician and non-physician practitioners, and outpatient therapy providers) who are engaged in care redesign with the hospital and also furnish services to Medicare beneficiaries during a CJR episode. Those arrangements will allow participant hospitals to share, subject to the limitations outlined in the rule, with these third-party providers and entities the following: reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare.

Q16: Can an ACO or other third party entity enter into an agreement with a CJR hospital to coordinate the care of beneficiaries that are served by an ACO and have a CJR episode?

A16: Yes, nothing in this rule precludes ACOs and CJR hospitals from working together to coordinate the care before, during or after the episode; nor sharing the cost of or responsibility for care coordination services for beneficiaries that may be served by an ACO and have a CJR episode. Such arrangements must comply with all applicable laws and regulations.

Q17: Will this model restrict beneficiaries from receiving certain types of services?

A17: Medicare beneficiaries retain their freedom to choose their providers and services, and providers may continue to provide any medically necessary covered services. The model will not require beneficiaries to receive services from certain providers, nor will it limit them to certain types of services. 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.

Also, patient data will continue to be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable privacy laws. Under the CJR model, CMS shares data only with participant hospitals and only in response to a request by the hospital for data that meets the requirements of the HIPAA Privacy Rule. Participant hospitals are subject to all applicable HIPAA requirements.